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Eliza Morgan
Forming Therapeutic
Relationships with
People Living with
Schizophrenia-Spectrum
Diagnoses

ABSTRACT

This study aimed to explore how one attempts to build a therapeutic alliance with someone who is living with a schizophrenia-spectrum disorder. Finding out more about how one attempts to form therapeutic relationship with a client who has symptoms of schizophrenia-spectrum may help provide more insight about the challenges that may arise in trying to connect to these individuals, what mental health workers have found to be barriers and how they attempted to mend any breaks in the relationship, thus adding to literature for further research.

A narrative online survey link was emailed to all members on the United States list serve for the International Society for Psychological and Social Approaches to Psychosis (ISPS); snowball sampling was also used to recruit further participants. This study acquired 20 participants who answered open-ended questions aimed at professional experience with a specific client of their choosing.

Findings supported the notion that forming therapeutic connection with those living with schizophrenia-spectrum diagnoses can present as challenging. Data looked at the different ways participants mentioned working with their clients, differences in clients with schizoaffective versus schizophrenia diagnoses, and how professionals sustained their efforts despite facing challenges. Further research is needed.

**FORMING THERAPEUTIC RELATIONSHIPS WITH PEOPLE LIVING WITH
SCHIZOPHRENIA-SPECTRUM DIAGNOSES**

**A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work**

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I. Introduction

Schizophrenia is a debilitating psychological disorder which can include symptoms such as “delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, negative symptoms” and several other components as established by the DSM-IV-TR (APA, 2000). The signs and symptoms of schizophrenia are also associated with impaired social and/or occupational functioning (APA, 2000). The diagnosis also comes with societal stigma and judgmental fears because of these impairments. It is easy to imagine that it would be difficult under these circumstances for one to connect in deep relationships with others. Many of us in this world are able to form multifaceted relationships with people, make friends, talk with colleagues, and have intimate partners which add to our support networks and our feelings of connectedness in the world. If the relationships people form without major mental illness can be beneficial and life-enhancing, how could forming social connection not be helpful to those with schizophrenia-spectrum disorders? The specific question this research aims to explore is however, is *how* does one attempt to build a therapeutic alliance with someone who is living with a schizophrenia-spectrum disorder? This study may add more insight, through the experiences shared by professionals, to how these therapeutic relationships can be established and how they shift or evolve over time.

If clinicians are not looking at the emotional/affective part of psychosis, we may not be providing adequate interventions. This topic is relevant to treatment and work with clients across the entire spectrum of practice, policy, research and education. If clinicians working with

individuals with schizophrenia-spectrum are not aware of what may or may not be more or less helpful we may do more harm than good, albeit unintentional. According to Ciompi and Hoffmann, most of the studies available on the effects of antipsychotic medication on schizophrenia “neglect the crucial variable ‘emotional atmosphere of the therapeutic setting’” (2004, p.144). In examining the work of Frieda Fromm-Reichmann it is seen that a fundamental piece of her work “was the communication of understanding” (Cohen, 2010, p.213). As humans it is of course impossible that we will understand everything all the time. According to Karon, throughout the difficulty that can arise when trying to help someone who is struggling with psychosis, it is imperative that the therapist “tolerate not understanding; the moment you decide you will not abandon the patient just because you do not understand or the material is painful or the patient is hostile, you are already being helpful” (2003, p.11).

Patricia Deegan, PhD has done a lot of work toward patient empowerment, is an activist in the movement for disability rights and she has gone through her own recovery after her diagnosis of schizophrenia when she was a teenager (Deegan, 2011). Deegan also emphasizes to those studying in the helping professions that “relationship is the most powerful tool they have in working with people” (Deegan, 1996, p.92). And she continues to say that the client who may seem to have such “a hardened heart will reject...and reject again...[the] Staff must role model hope and continue to offer options and choices even if they are rejected over and over again” (Deegan, 1996, p.95). Therefore, this is part of the struggle as well, figuring out how we can take care of ourselves, we are not indestructible, so that we *can* continue to provide the best care we can for such pained individuals.

Finding out more about how one attempts to form therapeutic relationship with a client who has symptoms of schizophrenia-spectrum may help provide more insight about the

challenges that may arise in trying to connect to these individuals, what mental health workers have found to be barriers and how they attempted to mend any breaks in the relationship. This may lend more information to the mental health community on how to create the best suited interventions for these individuals.

Looking back over the last couple of centuries, there can really be no doubt that the treatment of those living with major mental illness has changed considerably. It was not until the late 1700s and early 1800s that asylums were created to house “lunatics.” Alms- and work- houses already existed in order to usher the poor out of sight and this same idea was then applied to the growing numbers of people with mental illness. These asylums became known as mental hospitals (Kelly, 2009). The conditions in these asylums were horrendous. Though there may have been a few exceptions, most of these institutions were built with locks, barred windows and security; it is no wonder people feared those that were placed there. Asylums were said to have been created with the idea of providing a therapeutic space for those living with mental illness where they could be safe and receive treatment (Fink & Tasman, 1992). But in many places there did not seem to be treatment at all. They became “warehouses for the chronically insane” (Shorter, 1997, p.33). Kelly reports that “patients were sometimes found virtually abandoned and chained to walls in small rooms filled with human excrement” (2009, p.8).

Places for those with mental illness ranged in size from a few people living with a psychiatrist to hundreds of people in private institutions (Shorter, 1997). As Shorter states, “these private institutions offered custody, not therapy, for individuals too unmanageable for their own families at home” (1997, p.5). Mental hospitals were dreary and distressing and throughout the wards staff would commonly see the misery of patients laid out for their eyes to behold. Shorter relates that “one would see the schizophrenics ‘who spent their entire day in assumed statuesque postures’ ...[and] In those days smearing with feces and open masturbation were still common”

(1997, p.191). People may have thought they were doing the right thing by creating these asylums, and it definitely set change in motion, but the reality was not so alluring.

These early mental institutions lasted for decades. As mental hospitals shifted throughout the decades there was more highlighting of the role of psychiatry. The “lock them away” mentality that existed through the 1950s began to shift even more throughout the following decades (Kelly, 2009, p.120). In the 1960s mental health policy shifted toward the idea of deinstitutionalization. The prevailing view was that more services needed to be provided within community settings to diminish the sole reliance on mental hospitals (Grob, 1991). Then, along with ally groups, the 1970s Survivor Movement provided a lot of support for those living with mental illness. Groups of ex-patients diagnosed with mental illness began coming together to advocate for themselves, asserting that they had a special and necessary perspective on treatment of mental illness since they had personal experience (Tomes, 2006). Survivor-run organizations are still being established today and there continues to be an increased effort from mental health workers to understand the views of those they are serving (Tomes, 2006).

Those living with mental illness were seen as less than human for hundreds of years. Throughout history, and still today, people living with mental illness have had to put up with the social stigma associated with their diagnosis but there have been many improvements even though it has taken hundreds of years to get where we are today. So, with all of this change, what are we doing effectively? How can we as professionals form therapeutic alliances with people who are struggling with the hardships of schizophrenia-spectrum disorders? It is vitally important that we know how to best serve the populations we work with so that we are providing the most useful treatment possible. Part of this process entails looking at our own work, our own experiences with clients, and reflecting on what has been shown to be helpful, challenging or

detrimental. It is my aim in carrying out this thesis to be able to share the experiences of those professionals around us in order to further develop the existing knowledge within the mental health community. It is certainly not to say that we have all the answers, that we have reached a contented plateau in our treatment of Schizophrenia-spectrum diagnoses. However, if others throughout these past centuries had not taken the time to reevaluate and expand their knowledge, our mental health system would surely be dramatically different from what it is today.

This thesis topic affects a wide population; the countless people who suffer with Schizophrenia as well as their family and friends who care about their loved ones' well-being. This topic speaks to an even larger application on a more systemic structure as well. Often in a medical model we treat the symptoms and not the causes. Ultimately "long-term therapy with antipsychotics is associated with a range of adverse effects, poor adherence, and high rates of medication discontinuation" (Guo et al. 2010). If there are other methods that could be used in combination with medications to help people more effectively connect with others, engage in relationships; reduce/eliminate stigma, dependence, side-effects, physical/mental damage, and increase autonomy and quality of life, this could help to change the structure of the mental health system. In drug-testing trials scientists work on reviewing and improving medication treatments, for example moving from first generation to second generation antipsychotics (Schwartz & Stahl, 2011). We should also use the same care in determining what other psychosocial interventions may best serve populations living with schizophrenia-spectrum disorders.

II. Theoretical Literature

For those diagnosed with schizophrenia, forming social relationships can often be very difficult. People who experience psychosis often lose people in their social circle, so the role of close family and mental health workers becomes that much more important (Berry, Wearden & Barrowclough, 2007). What does this mean for those living with schizophrenia-spectrum disorders who have difficulty connecting to others? How does one attempt to form therapeutic relationship with these individuals? Looking back on Freud's theory of transference we see that Freud did not believe that people with schizophrenia could even have a beneficial transference relationship with their therapist (Post, 1982).

Transference, Freud believed, was "the most powerful resistance" to psychoanalytic treatment (Freud, 1994). According to Freud, transference is what makes unconscious conflicts visible and able to be accessed by the psychoanalytic process (Freud, 1994). The psychoanalyst's role is to try to make the client "fit these emotional impulses into the nexus of the treatment and of his life-history, to submit them to intellectual consideration and to understand them in the light of their psychical value" (Freud, 1994, p.17). He differentiated between two types of transference, positive and negative (hostile). He further elaborated positive transference as friendly, affectionate and reality-based (Freud, 1994). He asserted that an affectionate or dependent relation could actually help a person to admit to things that otherwise may be difficult

to talk about (Freud, 1994). Resistance to treatment, he argued, was solely negative transference and the unconscious positive transference (Diener & Monroe, 2011). He claimed that negative and erotic transference actually “obstructed the analytic process [and] Negative transference was thought to distance the patient from the therapist (Freud, 1994, p.6).

Freud theorized that the ways that all of us form emotional connection to others by ways such as friendship, trust, and sympathy were developed solely out of sexual desires and that transference occurred when one’s libidinal needs were not met at some point in their lives (Freud, 1994). If someone’s libidinal needs are not met by reality, Freud claimed one would then be “bound to approach every new person he meets with libidinal ideas” (Freud, 1994, p.8). He also emphasizes the logic of this process by pointing out that the regression or introversion of one’s libido would not occur unless it had originally been justified by an external experience in the real world, that these libidinal deficits are based in reality (Freud, 1994).

Freud believed that psychoneurosis could only be cured when dealing with affectionate transference and that “where the capacity for transference has become essentially limited to a negative one, as in the case with paranoics, there ceases to be any possibility of influence or cure” (Freud, 1994, p.16). It is interesting that Freud believed that people struggling with schizophrenia could not be helped because they were incapable of externally relating (Post, 1982). Perhaps what seems irrational and disconnected in someone with schizophrenia-spectrum, did at one time have a link to the external world. In fact he discussed how transference is made up of both the conscious libidinal ideas as well as those that have been repressed or restricted to the unconscious (Freud, 1994). However, given that Freud’s theory of transference so greatly relies on connecting the internal world to the external world, it stands to reason when considering schizophrenia that he would have faced some challenges.

Contrary to Freud, a German psychiatrist named Frieda Fromm-Reichmann was one who believed that rather than lacking the ability to form transference relations with a therapist, that those affected by schizophrenia were “incapable of anything but distorted and extraordinarily intense transference relationships” (Cohen, 2010, p.212). Fromm-Reichmann asserted that people with schizophrenia were actually very sensitive to the therapist’s internal processes as well, both conscious and unconscious (Cohen, 2010). She adamantly believed that even those living with catatonia were able to see and hear everything outside of themselves even though they were unable to react externally (Karon, 2003). In fact Karon asserts that “schizophrenics are constantly trying to solve their problems, but they are too frightened to deal with the real problems directly; they deal with symbols” (2003, p.12). Karon continues by stressing that it is only when the symbols, or the manifesting symptoms, and the original triggering event from the past are reconnected in one’s conscious mind that one can mend it (2003).

It is understandable that individuals with schizophrenia spectrum diagnoses would be difficult to work with given their complicated and sometimes severe symptom presentations. Often when a therapist talks to someone struggling with schizophrenia-spectrum, the therapist may feel anger, depression, or discomfort because the client is not reacting as the therapist would wish them to (Karon, 2003). One of the reasons this may be happening, which suggests there is a definite transference relationship happening, is that these are also the client’s feelings (Karon, 2003). This implies that there may actually be a way to understand what these clients are going through. Often it can be extremely difficult to read a person who is struggling with schizophrenia-spectrum symptoms and therefore this makes the therapeutic relationship complicated. It makes sense that doing deep transference work with someone who is so guarded may not even be possible until some kind of trust is established. Fromm-Reichmann believed

that the central piece of therapeutic work with people diagnosed with schizophrenia “lies in the sympathetic understanding and skillful handling of the relationship rather than in the intellectual comprehension or technical exactness of the therapist” (Post, 1982, p.214). Jung also stated “that the schizophrenic ceases to be schizophrenic when s/he meets someone by whom s/he feels understood” (Post, 1982, p.208). As this thesis attempts to uncover, however, how does one attempt to form this therapeutic relationship with these individuals? Fromm-Reichmann felt that a therapist’s comments should be phrased more as inquiries rather than facts and that the authenticity of the worker’s attempts at understanding were almost as important as the questions themselves (Cohen, 2010).

Over time there have been new ideas and additions to theories on the therapeutic relationship, most not focusing on the schizophrenia-spectrum diagnoses. Most of the more modern theories of psychotherapy put strong emphasis on having a positive therapeutic relationship in order to see benefits from the therapy itself (Hoglend et al, 2011). The term *working alliance* was established by Greeson who described this relationship as one where “positive collaboration between therapist and patient is crucial for effective treatment” (Diener & Monroe, 2011, p.238). Within this partnership therapists may use relationally-based skills in order to reflect on issues in the therapeutic alliance, discuss any ruptures, the meaning behind them, and be able to examine and uncover any connection to the continuing work (Diener & Monroe, 2011, p.244). However, this is provided that the client can attend to the present moment, as they are oriented to person, place and time. Also if someone is fearful of the therapist, finds them threatening or dangerous, it will make this process of relationally-based therapy difficult. Additionally if one is experiencing delusions, hallucinations or not able to adequately verbalize their experiences, reflecting transference issues may be perceived as

threatening, irrelevant, or nonsensical. Individuals living with schizophrenia-spectrum diagnoses may struggle with staying on topic, they may answer questions with responses that seem loosely related or entirely unrelated, and although rare some people have severely disorganized speech which is nearly unintelligible (APA, 2000). The achievement of working alliance therefore poses a challenge when working with clients who have schizophrenia-spectrum diagnoses.

Bordin proposed his own theory of the content of a working alliance. Bordin claimed that the working alliance has three major components which he deemed necessary for meaningful therapeutic work to occur: agreement on the goals, tasks, and bond (Taber, Leibert & Agaskar, 2011). He believed that “the initial alliance is formed through the mutual agreement of goals for therapy focusing on the changes that are to take place in the life of the client” (Taber, Leibert & Agaskar, 2011, p.376). This also may presents a dilemma when working with schizophrenia-spectrum individuals if the individual remains uncommunicative, fearful, distant, or distrusting of anyone in general. How then does the mental health professional attempt to form a therapeutic alliance with this person?

The bond that Bordin refers to is the “degree of trust, respect, and liking for each other deemed necessary for the tasks to be effective” (Taber, Leibert & Agaskar, 2011, p.376). People with schizophrenia-spectrum disorders may face a variety of different symptoms including delusions, persecutory delusions being the most common form (APA, 2000). In these persecutory delusions one believes that they are being “tormented, followed, tricked, spied on, or ridiculed” (APA, 2000, p.299). This poses a problem for attempting to reach any kind of mutual agreement of tasks or goals. If someone is fearful and untrusting how can one attempt to form goals of treatment? Additionally people with schizophrenia-spectrum may experience problems in “any form of goal-directed behavior” which can lead to struggling with activities of daily

living (ADL) such as even taking care of person hygiene (APA, 2000, p.300). If one has difficulty taking care of small tasks such as this, forming goals on a larger scale is going to be extremely trying.

Holland had another theory, that “people with ‘identical or related types [of personality] will be attracted to one another and will be more understanding of one another and will enjoy one another, because similar types will act as reinforcing environments for one another” (Taber, Leibert & Agaskar, 2011, p.377). However, the task of pairing people with schizophrenia-spectrum with therapists with similar personality types would prove difficult given that symptoms of these disorders can mask one’s personality. Negative symptoms of schizophrenia “include restrictions in the range and intensity of emotional expression” which can present as affective flattening (APA, 2000, p.299). Additionally the diagnosis of schizoaffective disorder includes a major depressive, manic or mixed episode along with Criterion A symptoms of schizophrenia (two or more of: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, or negative symptoms) (APA, 2000). During times of a major depressive episode, for example, one may find that a client’s ability to adequately represent their individual personality is significantly affected and complicated. In addition to any Criterion A symptoms for Schizophrenia-Spectrum, symptoms of a major depressive episode may make it even more difficult to connect to or even see one’s personality. Some people struggling with these schizophrenia-spectrum disorders may not even know who they are and believe themselves to be someone else. It has been suggested that interpretive work in therapy only be conducted with those individuals who have good ego strength, have an ability for self-reflection and are able to tolerate the anxiety that this work may bring up (Hoglund et al, 2011). More supportive techniques are suggested for use with people who do not have these abilities; again however,

these suggestions are made based on individuals who are not living with schizophrenia-spectrum symptoms (Hoglund et al, 2011). Lazarus also proposed that “therapists should tailor their relational approach to the client’s expectations, and...not treat every client in the same manner for the sake of adherence to theory” (Taber, Leibert & Agaskar, 2011, p.379).

Since the therapeutic relationship requires being able to connect to the client on some level, it would be helpful to get an idea of what the individual struggling with one of these diagnoses is actually going through. To do this we will look at Object Relations and Attachment theories. Hallucinations are one of the main Criterion A symptoms for schizophrenia-spectrum diagnoses, auditory hallucinations being the most common (APA, 2000). Karon proposes that the reason for predominantly auditory hallucinations is that schizophrenia is an “interpersonal disorder” (Karon, 2003, p.13). The idea being that even though people who experience psychosis may be withdrawing into themselves, this internal world to which they retreat is still one of object relations (Post, 1982). When someone with schizophrenia retreats into themselves they “create within themselves a relationship that usually exists between oneself and another person. They split themselves in two and relate to part of themselves as to an object or other” (Post, 1982, p.213). A reason for this withdrawal that has been suggested, from object-relations perspective, is that someone with schizophrenia both longs for connection and understanding of the fundamental parts of themselves but fears it simultaneously (Post, 1982). The fear that exists is that if one becomes too connected with another, their love will engulf and destroy the object of their affections so instead they detach as a protective measure (Post, 1982). At times it may seem that someone struggling with schizophrenia-spectrum is unfeeling or callous because of their detachment, there is often a fierce internal battle; “under the hardened heart lies the breaking heart” (Deegan, 1996, p.95). As Karon states so well, “balancing between fear and loneliness is

the best description of what it feels like to be schizophrenic” (Karon, 2003, p.2).

In addition to the fear of engulfing and destroying others, this fear is further complicated by the fact that people with schizophrenia also see others as being devouring which leads them to avoid relationships altogether, viewing them as too risky and dangerous (Post, 1982). In order to seek safety, the individual tries to do without any objects at all (Post, 1982). The dilemma however is that the same people they cut themselves off from are also needed in order to maintain their own identity; in their fear of being destroyed, they end up either destroying others or destroying themselves (Post, 1982). To someone living with schizophrenia-spectrum, relationships may feel like a lose-lose situation not worth the risk. Either they engulf their love objects and thus lose the objects that are necessary to maintain their own identity or they themselves become engulfed by the love objects and lose their identity that way (Post, 1982). This perspective allows us to understand that although someone may appear very removed and cold, it is because they have locked their inner selves deep inside in order to avoid more pain. The body can then interact with the world around them while the real self is put into storage (Post, 1982). For this reason, forming a therapeutic relationship with someone who is so fortified against hurt, can be a struggle.

Attachment theory may also lend more insight into the experiences of someone with schizophrenia-spectrum and also why these complicated symptoms may arise. The primary functions that attachment serves is to help the infant gain a sense of security and also to help regulate their emotional states (Davies, 2011). The information which we all take in from the external world is formed into “unconscious assumptions about self and others, which are used to make sense of the inherently ambiguous interpersonal world” (Diener & Monroe, 2011, p.242). The attachment assumptions that are formed within our unconscious help us to relate to others in

different ways depending on the situation (Wachtel, 2011). One can imagine that when one does not have secure attachment as a child, that this may lead to deficits in emotion regulation, uncertainty and anxiety. When children are not “helped to regulate arousal with the attachment relationship...they...[tend] to feel at the mercy of strong impulses and emotions (Davies, 2011, p.9). Furthermore, within each of us is a set of intricate “feedback loops” which play into one another based on past experiences; “actions and perceptions often generate consequences that end up ‘confirming’ the view of the world from which those consequences originated” (Wachtel, 2011, p.66). Thus the patterns of fear, anxiety, insecurity and distrust that were established as a child may be perpetuated again and again.

Attachment is developed over time, the internal feedback loops are formed based on recurring interactions with people in our lives (Allen, 2001). For those who have developed insecure attachment styles “the assumptions connected to their internal working models reflect a distrust of the motives and intentions of others, a more negative self-representation, [and] a wariness to engage intimately with others...” (Diener & Monroe, 2011, p.242). Also, since attachment is formed by repeated interaction with love objects, “without coherent models, interactions become unpredictable, chaotic, and frightening” (Allen, 2001, p.54). This is known as attachment trauma, and interestingly it describes some of the same distrusting and fearful characteristics as those who struggle with schizophrenia-spectrum.

Although the symptoms of schizophrenia-spectrum disorders can seem erratic and without reason, there may be a logical reason for their occurrence. Karon asserts that “if one listens carefully to the patient, the disorder always makes psychological sense and seems inevitable in terms of the life as experienced by the person” (Karon, 2003, p.9). The fear, anger, loneliness, shame, etc... that someone dealing with schizophrenia spectrum may face may seem

to be inappropriate but “inappropriate affect is usually *socially* inappropriate, not inappropriate to the patient’s inner experiences” (Karon, 2003, p.4). Many people struggling with schizophrenia have discussed memories of “incest, sexual abuse, and physical abuse” which have often been casted aside as delusional rants (Karon, 2003, p.3). But what if these were events were true?

It would seem quite reasonable that someone who had gone through such trauma might have trouble trusting others. As Allen describes, “attachment trauma damages the safety-regulating system and undermines the traumatized person’s capacity to use relationships to establish a feeling of security” (Allen, 2001, p.22). Furthermore, in someone who is living with schizophrenia-spectrum, the past and present can merge. For someone with schizophrenia, “the past is the present...[and] the present goes back into the past and *is* the past” (Post, 1982, p.213). Because of this it would stand to reason that an individual struggling with extreme distrust and fear would have a hard time making new connections with people. Consequently, in therapy, “these individuals have a more difficult time cultivating an emotional bond, agreeing with their therapist on goals for treatment and on tasks to achieve these goals” (Diener & Monroe, 2011, p.242).

Searles believed that the reasons for the turbulent transference seen in people with schizophrenia was due “to the time in the schizophrenic’s ego development when the mother-infant symbiosis was so intensely ambivalent that it prevented the natural sequence of identification and subsequent individuation to take place” (Post, 1982, p.213). This again ties into the idea of ruptured attachment perhaps giving us an explanation for the experiences of those with schizophrenia-spectrum diagnoses. Post believed that in order for one with schizophrenia to move through this trauma and gain some kind of hold, trust, security of the

outside world was “through the therapist’s survival of the schizophrenic’s destructive transference reactions” and it is then that an object outside of the self can develop (Post, 1982, p214). How does one begin to attempt to form a therapeutic relationship with someone who is continually withdrawn or fearful of the worker? The attacking, distant, or fearful nature of a client’s actions could be very difficult for a mental health worker to withstand. Allen provides some hope in saying that “an opportunity to form a close relationship with a responsive caregiver offers the possibility of change from insecure to secure attachment” (Allen, 2001, p.56). Because the therapist can have a more central role in peoples’ lives who have lost a wider social network, it makes the connection which therapeutic relationship can provide more significant.

Attempts at discovering the mechanism behind social connection have also looked at the concept of mentalization regarding the ability to connect to other’s emotions and states of mind. This is also known as Theory of Mind (ToM) and it classifies the ability of people to form social relationships as being able to “infer mental states and to understand how they can be used to predict others’ behavior” (Pijnenborg et al. 2009, p.240). Additionally mentalization concerns the ability of one to understand the emotional states of *themselves* as well and to also infer “the impact of mental states on one’s cognitions, affective states and behavior” (MacBeth et al., 2011, p.44). People with schizophrenia often have an impaired ability to do this (Pijnenborg et al. 2009). This may explain why those with schizophrenia have a harder time with community functioning (Pijnenborg et al. 2009).

The ability to mentalize forms through secure attachment experiences (MacBeth, 2011). Moreover, the distressing, painful or traumatic relational events that one experiences in childhood and in adolescence can actually “reduce an individuals opportunities to develop mentalization skills, subsequently compromising their understanding of mental states”

(MacBeth, 2011, p.44). It has been suggested that perhaps these types of trauma histories could be used as red flags so that the therapist could “predict the potential for ruptures in the alliance and intervene proactively to minimize their deleterious effects while also capitalizing on the therapeutic opportunities inherent in working through them” (Diener & Monroe, 2011, p.242). While this sounds helpful in theory, someone struggling with severe schizophrenia-spectrum symptoms may be difficult to predict.

The mainstream method for reducing psychotic symptoms so that people can better integrate into society, and hopefully have better quality of life, is through the use of antipsychotic medications which unfortunately often have undesirable side-effects (Schwartz & Stahl, 2011). Others comment that using antipsychotic medication for the treatment of schizophrenia overlooks emotion as a key component of the therapeutic environment and treatment (Ciompi & Hoffmann, 2004). The theoretical concept of Affect-Logic stresses that the increasing of emotional tensions “are capable of provoking sudden global shifts...in the...patterns of feeling, thinking, and behaving...from normal mental functioning to psychosis” (Ciompi & Hoffmann, 2004, p.141). Given the importance of how these emotional aspects may influence one’s psychosis, “the creation of a therapeutic setting that consistently reduces emotional tension” may be critical to the treatment of these individuals forming social connection (Ciompi & Hoffmann, 2004, p.141). In a Soteria setting, for example, there is an environment which provides peer support from staff to client which provides direct social support and cushions against stress buildup (Bola & Mosher, 2003). It is one aspect of their program that has been shown to be helpful in treatment with those living with schizophrenia-spectrum disorders (Bola & Mosher, 2003). The therapeutic relationship can promote understanding of a client, acknowledge emotions and precipitating factors, and place them in

context within a client's life and social relationships (Bola & Mosher, 2003).

Five of the articles reviewed emphasized physical environment as an important factor in the community functioning of individuals with schizophrenia or psychotic disorders (Beal et al. 2005; Bola & Mosher, 2003; Ciompi & Hoffmann, 2004; Humberstone, 2002; Roe et al. 2006; Roy, Rousseau, Fortier, & Mottard, 2009). It is not just the person in an environment but the environment and the situation itself which leads to how one copes with stressors or symptoms (Roe et al. 2006). Additionally, the way that people form relationships is by attaching some level of meaning to them (Beal et al. 2005). The Model of Competence theorizes that the interplay of person, environment, activity and an individual's role results in situations which become either enhancing and successful or hindering and handicapping (Roy et al. 2009). The kinds of interactions one has is dependent on "where or when the relationship takes place and the 'rules' and 'resources' attached to those conditions" (Beal et al. 2005, p.208).

The experiences that the environment provides is enormously important. Broaden-and-Build theory posits that as one experiences positive emotions, ones' internal resources are increased (Johnson et al. 2009). Perhaps this has implications for the treatment with schizophrenia, as some of the internal resources that are built upon may be aspects such as motivation and social functioning (Johnson et al. 2009). What kinds of positive experiences can build these resources? One study looked at how alternative health care practices may affect recovery for those with major mental illness, looking at multiple alternative practices such as yoga and religion (Ruscinova et al. 2002). Loving Kindness Meditation has also been studied to see how it may specifically influence the reduction of negative symptoms associated with schizophrenia-spectrum disorders (Johnson et al. 2009). Symptoms are a significant restraint in the lives of people with schizophrenia-spectrum. Often negative symptoms prevent people from

even getting out into the world to try to make connections with others and this reduced interest in forming relationships is notably important because it relates to one's quality of life (Johnson et al. 2009). In order to even attempt relationships of any kind, someone with this impaired ability to connect must be motivated enough to do so.

Current literature does support that those with schizophrenia-spectrum diagnoses have deficits in social functioning and that the client-provider relationship is an important one since "individuals with severe and persistent mental illnesses often have strained social and family ties" (Buck & Alexander, 2006, p.478). There have been more studies over the past few years on the types of elements in a caseworker-client relationship that clients with severe mental health issues appreciate (Buck & Alexander, 2006; Tunner & Salzer, 2006; Ware, Tugenberg & Dickey, 2004). In past studies the elements that clients comment as being important are things such as "feeling known" or "feeling like 'somebody'" (Ware, Tugenberg & Dickey, 2004, p.557). Buck and Alexander also found that clients reported "being there" as being an important factor in therapeutic alliance; one client saying in response to what was most helpful, "the way she's there to talk with me, to help me, to be with me. She's there for me and I like that" (2006, p.477). However, these current studies do not look at how the relationship is attempted to be formed. This limitation will be discussed further in a later section.

III. Empirical Literature

There have been many different theories and treatments for different disorders over the years which did not actually prove to be useful to the clients. Lobotomy used to be used which really just allowed people to treat those with schizophrenia without having to relate to them at all (Karon, 2003, p.7). At the end of the 18th century moral treatment began gaining recognition and produced significant results in France, England, Scotland and the United States with 60-80% of patients being discharged (Karon, 2003, p.2). Moral treatment included not using cruelty or humiliation and no use of physical force as a form of punishment but only when deemed necessary to protect the client from hurting oneself or others (Karon, 2003). However, in the early 20th century these methods began to be replaced by physical treatments and discharge rates then dropped to 20-30% (Karon, 2003).

Several studies suggests that attending to emotional and social factors appears to be relevant to social/community functioning in those diagnosed with schizophrenia (Bola & Mosher, 2003; Ciompi & Hoffman, 2004; Guo et al. 2010; Pijnenborg et al. 2008). In fact, research has shown that attending to a client's interpersonal needs can not only help in reducing symptoms of schizophrenia but also at times without the use of anti-psychotic medications (Bola & Mosher, 2003; Ciompi & Hoffmann, 2004). Theory of Mind, the ability to understand and infer the mental states of others, has also been shown to be a significant predictor of community

functioning of individuals with schizophrenia (Pijnenborg et al, 2008). This research suggested that patients who were impaired by schizophrenia symptoms may not always be able to process social contexts successfully (Pijnenborg et al, 2008).

The importance and effectiveness of cognitive behavioral therapy with schizophrenia has also become recognized with “preliminary evidence that such interventions may be effective in helping individuals with schizophrenia manage their own emotional states” (Henry et al, 2008, p.478). This is especially important in learning how to form therapeutic relationships with those living with schizophrenia-spectrum. One study looked at how suppression and reappraisal were used by those with schizophrenia since it has been suggested that “blunted affect may reflect overuse of suppression...as an emotion-regulatory strategy” (Henry et al, 2008, p.473). The significant limitations found in amplification of emotion-expressive behaviors may imply that those with schizophrenia might not have the ability to express emotion that matches their subjective experience (Henry et al, 2008). This would make it very difficult for someone to connect in any social relationship, including therapeutic situations. Henry et al found that this use of suppression of emotions “may contribute to interpersonal behavior that is strained, distracted, and avoidant” because it may require more cognitive ability to actively maintain the suppression (Henry et al, 2008, p.477). Furthermore findings showed that “for both individuals with schizophrenia and control participants, greater reported use of reappraisal was significantly associated with better social functioning” (Henry et al, 2008, p.475). This may indicate that more use of cognitive-behavioral techniques may prove effective in working with those with schizophrenia to change these cognitive patterns which may be hindering emotion regulation and subsequently interpersonal functioning.

As discussed earlier, Attachment may also affect interpersonal functioning and emotion

regulation. Diener & Monroe looked at therapeutic alliance by looking at a meta-analysis of existing literature and found that the greater the attachment security, the stronger the reported alliance (Diener & Monroe, 2011). Research findings suggest that individuals who have more insecure attachment may find the therapeutic exchange frightening or overwhelming which can then lead them to detach from therapeutic interventions in order to attempt to regulate their emotions (MacBeth et al, 2011, p.52-53). Laurie Post discusses object relations and how her client David feared that getting close to her would only lead to more pain and this created a vicious circle of wanting and needing love but hating “himself for allowing himself to be touched” (Post, 1982, p.211). Existing literature reports that those “with a more dismissing/avoidant stance to attachment were less likely to disclose symptomatology, more likely to minimize the interventions of case managers, and less likely to engage with treatment” (MacBeth et al, 2011, p.45). These are some significant barriers to be faced with when trying to work with someone with severe schizophrenia-spectrum symptoms. Additionally, the “levels of anxiety and avoidance can vary depending on the nature of attachment relationships that are being assessed” (Berry, Wearden & Barrowclough, 2007, p.975). How one interacts with a therapist may differ from their parents or someone in community. This proposes “that individuals with psychosis have the capacity to modify ways of relating to others” (Berry, Wearden & Barrowclough, 2007, p.975).

Findings do suggest that people struggling with psychotic symptoms tend to have small social circles which are made up primarily of family and mental health professionals (Berry, Wearden & Barrowclough, 2007). This, in turn, makes the therapeutic relationship that much more potentially beneficial or harmful. Tunner & Salzer discussed that “persons with schizophrenia also have been found to have a slightly greater desire to be involved in treatment

decision than persons in primary care... and a good working alliance can facilitate this involvement” (Tunner & Salzer, 2006, p.679). Transference plays a major role in attempting to form therapeutic alliance. Taber, Leibert & Agaskar found that “congruence between client and therapist is associated with the client perceiving a bond with the therapist in the early stages of therapy” (Taber, Leibert & Agaskar, 2011, p.378). However, this early stage of therapy may prove to be tumultuous if the client is experiencing difficult schizophrenia-spectrum symptoms.

Additionally, individual characteristics of the individual getting treatment are important factors that can affect the relationship between the therapist’s offered transference observations and the outcome of the therapeutic work (Hoglund et al, 2011). Hoglund et al also found that these transference observations are “crucial when treating patients with more severe and chronic difficulties...Transference work may [in fact] be more helpful to more disturbed patient’s understanding of the distortions they bring to the transference” (Hoglund et al, 2011, p.702). However, in this study, patients with psychosis were excluded from the study (Hoglund et al, 2011). It may prove to be more difficult to use this transference work with those living with schizophrenia-spectrum disorders, but perhaps it would also be possible with more work. Benedetti and Furlan “reported a series of 50 severe schizophrenic case treated with intensive psychoanalytic therapy (2-5 sessions per week) for 3-10 years by supervisees, with very good results in 80% of the cases” (Karon, 2003, p.6). The question remains however, how to go about forming a therapeutic relationship with someone who may be very guarded, suspicious, dealing with interfering delusions or hallucinations, etc... Using transference work with someone in this chaotic and painful subjective world may not be the most helpful idea, at least in the beginning of therapy, but more research would need to be done. This again emphasizes the importance of forming a therapeutic relationship which consists of some rapport and trust.

Several studies also found that the environment and context itself played an important part in the way one deals with and perceives different situations (Beal et al. 2005; Ciompi & Hoffman, 2004; Roe et al. 2006; Roy et al. 2009). For instance, looking at subjective accounts of clients with first episode psychosis, one study found that they often experience more handicap-producing situations than proficiency-producing situations in relation to interactions in education and work environments (Roy et al. 2009). The environment itself can present opportunities for different types of interactions (Beal et al. 2005). Certain research suggests that perhaps people who have impaired social cognition may not be able to perceive context as effectively as others and not be able to pick up on helpful social cues in these different situations (Pijnenborg et al. 2009). Surprisingly, there was not a significant difference between impaired clients versus unimpaired clients in how many friends one had, if one had a partner, or in being involved in work or social activities (Pijnenborg et al. 2009). If people with schizophrenia-spectrum disorders have social cognition deficits (Pijnenborg et al. 2009), then what is the difference between unimpaired and impaired individuals? Is it the depth that a relationship reaches? Or how similar or different a partner is?

Other studies found that religious/spiritual activities/beliefs were ways that people with schizophrenia coped with mental illness (Mohr et al. 2006; Revheim et al. 2010; Russinova et al. 2002). Religious coping was found to be the most frequently sought alternative practice for coping with symptoms (Russinova et al. 2002). Studies found that religious/spiritual activities/beliefs also affected social functioning and symptoms (Mohr et al. 2006; Revheim et al. 2010). In one study, 54% of participants reported a lessening of psychotic and general symptoms due to their religious practices and 28% reported an increase in social functioning (Mohr et al. 2006). These findings could imply that the religious practices people were involved with were

healing and coping experiences that helped lessen symptoms in and of themselves. Perhaps this could also suggest that religious activities provide opportunities to interact with others which may aid in their communication skills and hence increase one's social functioning.

Although studies do show that medications can be very helpful in reducing symptoms of schizophrenia, the more symptomatic someone is, the higher the dose which then leads to more side effects (Schwartz & Stahl, 2011). Additionally, some antipsychotic medication can actually produce side effects that can mimic actual symptoms of schizophrenia such as bradykinesia which may mimic affective flattening (APA, 2000). The differentiation between actual negative symptoms and those that are medication-induced is often a judgment call (APA, 2000). Studies have shown that certain medication combinations can reduce the intensity of negative symptoms associated with schizophrenia but as one such study stated, there was no significant change in positive symptoms or general pathology (Akhondzadeh et al. 2008). Also, the side effects brought on by medications make it difficult for clients to adhere to strict medication regimens and long-term psychotropic intervention has been associated with high rates of medication discontinuation (Guo et al. 2010). However, when alternative treatment is *paired* with pharmacological interventions, these groups show more improvement in insight, social functioning, ADLs, and quality of life than controls who receive no kind of psychosocial intervention (Guo et al. 2010). This shows the significance of therapeutic work and how important a role the therapeutic relationship can play.

In addition to the different DSM-IV-TR subtypes of schizophrenia diagnoses across sex and gender (APA, 2000), one study suggests developmental differences in the progression and manifestation of the disorder related specifically to sex (Kleinhaus et al. 2010). Research suggests that there is actually little difference between males and females until the mid-teens but

that from the mid-twenties on there is an large increase and higher incidence in males (Kleinhaus et al. 2010). Perhaps this would suggest that the role of forming relationships might be different for individuals not only based on personality, culture, gender, but also the specific type of schizophrenia one has.

IV. Study Design & Sample

Study designs were varied in the literature, using both qualitative and quantitative data to support their hypotheses. Many of the reviewed studies looked at participants' subjective experiences by using descriptive designs via semi-structured interviews, surveys and/or case studies (Beal et al. 2005; Buck & Alexander, 2006; Henry et al. 2008; Humberstone, 2001; Johnson et al. 2009; MacBeth et al. 2011; Mohr et al. 2006; Post, 1982; Roy et al. 2009; Taber, Leibert & Agaskar, 2011; Tunner & Salzer, 2006; Ware, Tugenberg & Dickey, 2004). Only three of the studies reviewed used longitudinal study designs of 1-2 years (Barnes et al. 2008; Ciompi & Hoffmann, 2004; Matthews et al. 1979). Additionally, Guo and colleagues looked at effects of medication-only treatment versus medication treatment combined with psychosocial intervention and participants in this study were treated over 12 month periods (Guo et al. 2010). Only two of the studies I found used cross-sectional designs for correlational studies (Pijnenborg et al. 2008; Revheim et al. 2010). Out of the literature I read, five of the studies were experimentally based, looking at antipsychotic medication treatment (Akhondzadeh et al. 2008; Bola & Mosher, 2003; Guo et al. 2010; Harrow & Jobe, 2007; Schwartz & Stahl, 2011).

There was also a wide range of sample sizes in these studies. Four of the studies had relatively small sample sizes ranging from 1-22 subjects (Beal et al. 2005; Ciompi & Hoffmann, 2004; Humberstone, 2001; Post, 1982; Roy et al. 2009; Revheim et al. 2010). Other studies used

larger sample sizes ranging from 40 (Tunner & Salzer, 2006) to 1268 (Guo et al. 2010). Many of the studies reviewed looked specifically at people diagnosed with schizophrenia-spectrum illnesses (Barnes et al. 2008; Beal et al. 2005; Berry, Wearden & Barrowclough, 2007; Bola & Mosher, 2003; Ciompi & Hoffmann, 2004; Guo et al. 2010; Harrow & Jobe, 2007; Henry et al. 2008; Humberstone, 2001; Johnson et al. 2009; Kleinhaus et al. 2010; MacBeth et al. 2011; Matthews et al. 1979; Mohr et al. 2006; Pijnenborg et al. 2008; Post, 1982; Roy et al. 2009; Revheim et al. 2010; Russinova et al. 2002; Schwartz & Stahl, 2011; Tunner & Salzer, 2006; Ware, Tugenberg & Dickey, 2004; Winship, 2011).

Many of the examined studies had participant groups which were predominantly male (Akhondzadeh et al. 2008; Berry, Wearden & Barrowclough, 2007; Bola & Mosher, 2003; Guo et al. 2010; Harrow & Jobe, 2007; Humberstone, 2001; Kleinhaus et al. 2010; Mohr et al. 2006; Pijnenborg et al. 2008; Revheim et al. 2010; Roy et al. 2009; Ware, Tugenberg & Dickey, 2004). A couple of studies did not specify sample demographics in their write-up but only two studies had samples made up of predominantly females (Taber et al. 2011; Russinova et al. 2002). A couple of studies did have fairly equal ratios of male to female subjects (Henry et al. 2008; Hoglend et al. 2011; Matthews et al. 1979; Tunner & Salzer, 2006). Buck & Alexander reported that their participants were equally divided between males and females but they had an odd number of participants so that this was not clear (Buck & Alexander, 2006). Perhaps one reason for this is that men typically have a higher incidence of schizophrenia throughout most of the lifetime (Kleinhaus et al. 2010).

Only ten of the studies specified Race/Ethnicity in their demographics and of those, seven of those samples were predominantly white or European American (Berry, Wearden & Barrowclough, 2007; Bola & Mosher, 2003; Buck & Alexander, 2006; Mohr et al. 2006;

Russinova et al. 2002; Taber et al. 2011; Ware, Tugenberg & Dickey, 2004). However, Ware et al did have a close percentage ratio of 51% White versus 49% people of Color (Ware, Tugenberg & Dickey, 2004). Another study was slightly more diverse with 4/20 white people in one group and 10/20 out of the 2nd group but did not specify the racial identity of other participants (Revheim et al. 2010).

Of all the studies I read, there were three studies that looked specifically at populations with reduced or no antipsychotic medication (Bola & Mosher, 2003; Ciompi & Hoffmann, 2004; Harrow & Jobe, 2007). However there were a couple studies that happened to have participants that were not on antipsychotic medication due to first episode psychosis not yet being prescribed medication (Pijnenborg, 2009; Russinova et al. 2002). Other studies simply did not report on this in participant information.

V. Biases, Strengths & Limitations

Several biases, strengths and limitations could be found throughout the reviewed literature. Because of previous experience that subjects had in regards to meditation or religious/spiritual practice, this contaminates some results found around the benefits of these practices on symptoms and social cognition (Johnson et al. 2009; Revheim et al. 2010). Medication is the most widely used method of treatment for schizophrenia, the mechanism by which second-generation medications work however is only *presumed* (Schwartz & Stahl, 2011). In the same study that agreed to this fact they also claimed these “presumed” mechanisms to be “tried and true” (Schwartz & Stahl, 2011, p.111). I found this to be underlying bias in the mainstream treatment. There were some conflicts of interest in certain studies due to past research or consultation involvement with pharmaceutical industries which may bias their methods or findings (Revheim et al. 2010; Schwartz & Stahl, 2011). Additionally, a couple of studies may be biased or limited in their findings since they were conducted on their own method of treatment which they helped to develop (Bola & Mosher, 2003; Ciompi & Hoffmann, 2004). Another study paid each participant \$20 which may have skewed responses (Ware, Tugenberg & Dickey, 2004).

One of the strengths of this body of literature is that studies were done all over the world in Australia (Henry et al. 2008), Canada (Beal et al. 2005; Roy et al. 2009), Switzerland (Ciompi

& Hoffmann, 2004; Mohr et al. 2006), China (Guo et al. 2010), New Zealand (Humberstone, 2001), Norway (Hoglund et al. 2011), Jerusalem (Kleinhaus et al. 2010), The Netherlands (Pijnenborg et al. 2008), The UK (Barnes et al. 2008; Berry, Wearden & Barrowclough, 2007; Winship et al. 2011). This shows a wide range of study sites. Eight of the reviewed studies were conducted in the USA (Bola & Mosher, 2003; Harrow & Jobe, 2007; Johnson et al. 2009; Post, 1982; Revheim et al. 2010; Russinova et al. 2002; Schwartz & Stahl, 2011; Taber et al. 2011). One limitation of the research findings is that it does not figure in the aspect of culture in regards to schizophrenia treatment, coping, and relationship building within the findings. For example, if a study in the Netherlands does not take into account aspects of forming relationships and social boundaries for that specific culture, how do we know how culture may affect the treatment? Two studies referenced culture as an informative factor of the research (Bola & Mosher, 2003; Guo et al. 2010).

Another strength is that several studies looked at alternative treatment modalities in treatment of schizophrenia which shows a variety of treatment methods and their effects on community building and social functioning for those with schizophrenia. However, I found one of the limitations to be that these studies have mostly discussed patients who were on a medication regimen, understandably since this is the mainstream method of treatment. Only four of the studies reviewed looked specifically at reduced or no antipsychotic medication (Bola & Mosher, 2003; Ciompi & Hoffmann, 2004; Harrow & Jobe, 2007; Matthews et al. 1979). Although there were certain participants in other studies who happened not to be on medication, this was not a focus (Pijnenborg, 2009). There needs to be more research on the effects of psychosocial, therapeutic, alternative interventions in and of themselves.

More studies over the past few years have looked at the types of elements in a

caseworker-client relationship that clients with severe mental health issues appreciate (Buck & Alexander, 2006; Tunner & Salzer, 2006; Ware, Tugenberg & Dickey, 2004). However, in the reviewed studies, the relationship has already been established and people are asked to reflect on what they believe is currently the most helpful in that relationship (Buck & Alexander, 2006; Tunner & Salzer, 2006; Ware, Tugenberg & Dickey, 2004). It may be more helpful in the future, if examining Client specific responses, to see how the relationship is perceived over time from the beginning, before the therapeutic alliance was achieved. Additionally, none of these studies examined *how* the professional/caseworker/clinician attempts to achieve these relationships.

Also, it is one thing to point out the elements that someone reports appreciation for in a relationship but with every relationship there is a growth process to get to these places of connection. Tunner and Salzer noted at the end of their study that “notably, no identified set of practiced guidelines addresses the interactions between consumers and providers. Although words like ‘friendly’ and ‘non-threatening’ are used to describe how treatments are to be administered, no recommendations focus on the interaction itself” (2006, p.678). In one study clients reported appreciating socialization, affective support and getting services (Buck & Alexander, 2006). However, how does one attempt to provide these elements when someone is guarded, paranoid, angry, etc? What if a promise or intention falls through and does not work out? How does a provider address these setbacks when this happens? This current thesis study aimed to provide further literature on the evolution of the therapeutic relationship, the problems that may arise and how one tries to address these.

Since most study populations had a majority of men as their sample populations, findings are not able to be as generalizable to *women* with schizophrenia . One reason for more males in studies may be due to a higher incidence of schizophrenia in males (Kleinhaus et al. 2010). Also,

even though studies were done in different countries around the world, race and ethnicity was not well represented which shows that we need research which works with more diverse populations. Karon also relates that “the prognosis for schizophrenics is better in nonliterate cultures” (2003, p.3). The effects of more developed societies are not considered in these studies.

Sample size also contributes to the limitations of findings. Studies have reported findings that are based on such small samples that it limits the power of their findings. One study claimed that family and friends may not be able to affect the illness of schizophrenia itself in respect to re-hospitalization (Beal et al. 2005, p.208). If one cannot have an effect on the illness itself, how can clinical teams do so? This study was implemented with only four subjects which is not able to be generalized to a large population so this conjecture seems limited (Beal et al. 2005). Other studies had wider sample sizes of 19-22 but were all taken from the same site (Ciompi & Hoffman, 2004; Roy et al. 2009). Another study which used cases from 12 different residential sites only had 13 participants (Humberstone, 2001). It seems that the findings would be more convincing if there were more subjects used from each site.

Additionally several of these studies looked at patients who were not chronic or who did not suffer with schizophrenia spectrum disorders at all (Hoglend et al. 2011; MacBeth et al. 2011; Roy et al. 2009; Taber et al. 2011). This limit's the application of findings on those who have had long-standing and severe struggles with schizophrenia-spectrum disorders. Participants struggling with less restricting life circumstances and/or less limiting levels of symptoms may be more oriented and able to attend to the present environment. It may be much more difficult to address complicated topics with those struggling with schizophrenia-spectrum symptoms.

Additionally to assess subjective experiences it is of course necessary to use self-report measures but these may be limited if someone is not cognizant and oriented to person, place and

time. Taber, Leibert & Agaskar used self-report measures to assess the degree of established working alliance (2011). This may prove limited however depending on the severity of symptoms experienced by the individual, if they are able to comprehend or attend to the questions posed to them in order to answer regarding their subjective experience. It also suggests that an individual will also need to have some level of self-awareness.

VI. Methodology

Although more research is needed, studies have begun to show how people with schizophrenia form relationships and community (Beal et al, 2005; Ciompi & Hoffmann, 2004; Humberstone, 2001; Roy et al. 2009). Research is being geared toward what struggles people with schizophrenia have in forming bonds within community (Beal et al. 2005; Humberstone, 2001; Pijnenborg et al. 2009; Roy et al. 2009). However, there does not seem to be a lot of research on *how* one attempts to form therapeutic relationships with those struggling with schizophrenia spectrum disorders. Studies are beginning to show that environment and the clinician's role in creating this environment is more significant than perhaps was once thought (Bola & Mosher, 2003; Ciompi & Hoffmann, 2004; Roe et al. 2006). Several studies have looked at how to form therapeutic alliance but not with consideration of the difficulties that arise with schizophrenia-spectrum disorders. Perhaps this connection in the client-clinician relationship could begin to develop information on the specific elements of relationship building that are helpful to those with schizophrenia-spectrum diagnoses.

The study aimed to look at *how* one attempts to form therapeutic relationships with clients who are struggling with schizophrenia-spectrum disorders. This study sought to find out the helpful aspects, difficulties, limitations, and the evolution of forming these relationships that mental health professionals have found in their own experiences with clients. Knowing the

evolution of relationship building with this population may help clinicians to be better attuned to clients, to help in forming therapeutic bonds which contributes to treatment benefits and successes.

This study used a qualitative methods design by surveying people about their specific experience in working professionally with people who have schizophrenia-spectrum disorders. Email surveys, using narrative and demographic questions were distributed to all of those on the email list serve for the International Society for Psychological Treatments of the Schizophrenias and Other Psychoses (ISPS) (Note: When beginning this study this is what the organization was called. Throughout the course of this study, however, the name has now changed to The International Society for Psychological and Social Approaches to Psychosis, same abbreviation of ISPS). This design was chosen to identify personal experience in therapeutic relationship building as identified by professionals at a particular point in time. The intention of collecting such data was to get more information to contribute to a deeper and more detailed understanding of the ways that people with schizophrenia-spectrum disorders form relationships, by looking at the treatment process. The collected data was narrative and is through the professionals' eyes therefore this study is limited in that there may be bias and assumptions made by the professionals since their own ego may be involved in their work with clients (For Narrative Survey Questions see Appendix H). Additionally, level of experience may vary between participants, as well as level of training and one's therapeutic orientation.

In the first week that I had my survey open online, I seemed to be getting several responses. However, after having my online survey open for 13 days it seemed that I was no longer getting a flow of responses. Therefore, after conferring with the Human Subjects Review Board, I decided to open up my study beyond ISPS. I then contacted people I know who work, or

have worked, in the mental health profession and asked them to pass on the survey to anyone else they may know who would be interested and qualify. I also sent out a reminder email to ISPS list serve members. Additionally, I deleted the question regarding USA membership of ISPS from my survey's exclusion questions since it seemed to be perhaps unnecessarily excluding people from my study. Originally the question was only meant to try to keep participants in the study that were working in the USA. However, it came to my attention when I saw people were being excluded from the study, that perhaps there were people on the list who were not a USA member of ISPS but were on the list serve somehow. Also, when I opened up my sampling to people outside of ISPS this question no longer applied. These interventions seemed to start up the flow of responses again.

This study looked at professionals who have worked with clients with schizophrenia-spectrum over any period of time. It would of course be advantageous to see the experiences of these professionals long term, especially from the beginning of working with a client through discharge, but this would have proved to be complicated due to time constraints and finding an available population of professionals starting work with patients who had schizophrenia-spectrum. Further study looking at the subjective experiences of those living with schizophrenia-spectrum would be also be significant but gaining access to a population for this purpose would have been more ethically difficult since it would be categorized as a more vulnerable population.

I made sure to remain aware of my personal biases while creating my questions for my study and also later when analyzing my collected data. It is my inclination to assume that connecting with ones' emotions is of critical importance within the treatment of schizophrenia. I personally connect with the concept of affect-logic in the treatment of schizophrenia (Ciompi & Hoffman, 2004). I also am intrigued and lean toward the idea of Soteria Houses, alternative

treatment methods and that medication in treatment of schizophrenia is not always necessary for improvement of symptoms and recovery; although it certainly appears justified in certain cases of schizophrenia (Bola & Mosher, 2003; Ciompi & Hoffmann, 2004; Harrow & Jobe, 2007). I do believe that psychotropic medication used in treatment for major mental illness in our country can at times be excessive and unwarranted. Studies have shown that not all schizophrenia patients need to use medication continuously for the rest of their lives (Harrow & Jobe, 2007). It was important that I kept my own biases on this subject in mind while pursuing this research and developing my survey questions and moving forward with my data analysis. I did so by checking in with my thesis advisor and making sure that I was not developing biased questions or questions that were too broad or unrealistic to be answered.

VII. Sample

For this research I sampled professionals who have had experience working with people with schizophrenia-spectrum disorders, specifically with one client and continuously or intermittently for any length of time. The study population consisted of those professionals who are on the ISPS email list serve, others in my life whom I know have had mental health professional experience and anyone that they passed on the recruitment email to. In order to not limit my sample too extensively I decided to look at professionals whom have worked with people with a variety of schizophrenia-spectrum disorders, not solely schizophrenia.

This study used a non-probability and snowball sampling selection by using ISPS members, those that I contacted individually and anyone that those people passed the survey onto. Using these data collection methods, my sample was fairly select from the wider population of clinicians and professionals around the world. The ISPS lists members with various professional degrees and from 34 different states in the USA, as well as a few professionals in France, Brazil, and India. I sent a link to an online survey to those professionals who are on the USA ISPS list serve. My intention in choosing ISPS was to help me to get a wider geographic sample of professionals around the USA and also to narrow in on professionals who have hopefully worked with patients who have schizophrenia-spectrum disorders. After survey responses stopped coming in and due to time constraint, I needed to expand this pool.

However, the exclusion criteria remained the same; after deleting the one question about USA ISPS membership of course when I opened up my sampling to others outside ISPS.

Choosing ISPS and using a snowball approach for my sampling frame did make my sample limited in that those that belong to ISPS may have different viewpoints from the wider mental health population as a whole. The ISPS mission states that members “promote the appropriate use of psychotherapy and psychological treatments for those suffering from psychotic disorders” which may mean that there is already an openness on learning how to best help this population (ISPS-US.org, 2005). Also, this organization is research oriented and promotes “research into individual, family, group psychological therapies, preventive measures and other psychosocial programs for those with psychotic disorders” which may mean that these members were more inclined to respond to my survey as well (ISPS-US.org, 2005). The ISPS mission also states that it supports “treatments that include individual, family, group and network approaches and treatment methods that are derived from psychoanalysis, cognitive-behavioral, systemic psycho-educational and related approaches” which shows that members may be more inclined to look at alternative treatment approaches for this client population (ISPS-US.org, 2005). Additionally, people that I know may or may not have similar opinions as me or could have been more inclined to answer because they knew me.

I recruited ISPS participants through their email addresses which are available on the ISPS website and used email to contact those professionals that I knew as well. This population is limiting in certain ways too since I unfortunately had no way of knowing in what capacity any of the ISPS individuals have worked with patients with schizophrenia-spectrum disorders until I received their returned surveys. However, I feel this also could have been a benefit in getting participants from many different settings. Also, this survey could only reach those with internet

access and, in the case of ISPS members, only those who had chosen to pay for ISPS membership. However, in order to obtain a more representative sample of clinicians across the United States, I thought it would be more feasible for me to use an internet survey. I did not want to use clinicians solely from a more accessible population, like my surrounding area of Northampton, MA, because it would not be representative of the wider population of clinicians that work with this client population. By using the ISPS member listing as a starting off place I had a greater likelihood of obtaining participants who are working and have worked with this client demographic. Sex and Race are two characteristics of my sample population that were difficult to control for in this study. There is no demographic information given on the website member listing and thus I was not able to anticipate the racial/ethnic/gender/professional diversity of my sample population.

VIII. Data Collection Methods

The distributed survey collected demographic and qualitative data. Demographic data included race/ethnicity, gender, age, education level, geographic location (i.e. which USA state), type of practice setting (i.e. urban, rural, suburban), number of years one has been working with schizophrenia-spectrum clients, and number of years in their field. The majority of the survey consisted of open-ended questions regarding specific aspects of working with these clients; questions about the forming of their therapeutic relationship, what was helpful, what interfered in forming this relationship, the connection to their client, etc... will collect qualitative data. I used unstructured responses in my internet survey in order to allow participants to freely elaborate from their own experience.

IX. Data Analysis & Findings

The collected data was both quantitative and qualitative. Since my survey was made up of predominantly open-ended questions, I used content analysis for these narrative responses. After I received responses from participant surveys I reviewed them and looked for common themes; similarities and differences throughout responses based on breaking all participants into different subgroups (ie. Male versus Female, Masters degrees versus Doctorates, those who worked with clients with schizophrenia versus schizoaffective diagnoses, years of experience with schizophrenia-spectrum population). I also made sure to keep participants' responses in their own words as much as possible when extracting quotes.

The sample that I acquired was made up of a total of 20 participants from a combination of both ISPS (International Society for Psychological and Social Approaches to Psychosis) list serve members and snowball sampling. My sample was fairly even between Males and Females, with 9 Males and 11 Females. Using these two data collection methods I collected responses from 12 different states (CA, CT, DE, HI, IL, MA, MD, MI, NJ, NY, OH, WY). Participants identified working in multiple geographic settings with the majority being in Urban settings; 35% Urban, 25% Rural, 20% Suburban, 20% Other (which included 15% "Urban/Suburban" classification and 5% "Combination rural/urban/suburban").

Participants ranged in experience and professional levels; including MSW students,

Masters, PhD, and MD levels of education and a range of 6 months to 40 years experience with the schizophrenia-spectrum population. Participants ranged in age with the youngest being 28 years old and the oldest being 75 years old. The mean age was approximately 48.9 years old, with a median of 53 years old. Although I did get an almost equal sample of Males to Females and a wide range of geographic location, my data was still not racially diverse, as I had hoped. I did not use a scale when asking about ethnicity and people typed in their own classifications; 80% of participants self-identified as White/Caucasian, 15% as Multiracial and 5% as Jewish.

I began analyzing the narrative responses of participants by reviewing each participant's completed survey as an independent case study. Then I split participants into two subgroups, Males versus Females, and compared and contrasted responses to see what similarities or differences they may hold. The main differences I noticed between these two groups was that males reported both higher levels of education and many more years of experience with the schizophrenia-spectrum population than did females. All males reported at least 10 years of experience. Furthermore, six out of the eight participants (combined males and females) who reported over 20 years experience were males. All participants who reported less than 10 years experience with this population were female. Also, a couple of the female participants reported still being in school for Masters programs and 55% of males had a PhD/MD versus 27% of females who reported a PhD/Doctorate. I also noticed that more males reported resolved-psychosis with their clients versus only one female who reported a reduction in psychosis. Perhaps this is due to more years of experience with this specific population, more time in their field or length of time working with an individual client. Unfortunately this cannot be learned from this data set since most participants did not mention length of time working with their client and a couple participants did not answer survey questions based on a specific client. Still, even

for those that recovered, attempting to form connection with these clients was challenging. As one participant who worked with their client for over a decade reported, their client barely spoke a word, they were “not moving, not even swallowing...[and] after a year [my client] began to talk...But she did not improve, rather she seemed to get worse.” This work can be immensely challenging and it was several years before this client was able to reach recovery.

While reviewing participants’ open-ended responses I tallied how many people from each subgroup mentioned different ways of interacting and working with their clients (Patience, Being Non-Judgmental, Listening/Trying to Understand, Flexibility of their Agenda, Use of Encouragement/Reassurance/Validation, Connection through Common Interests, Compassion/Empathy, Authenticity/Respect, Self-Confidence, Speaking Clearly/Succinctly, Talking about Ruptures within the Relationship, Hope, and Humility/Being Unobtrusive). There did not seem to be much difference in content between the Male and Female subgroups; they both seemed to speak of the same types of ways to work with these clients. Males did not mention use of Self Confidence or Discussion of Ruptures within the Therapeutic Relationship at all; one female mentioned Self-Confidence as being useful and two females mentioned Discussion of Ruptures as useful. On the other hand, females did not report use of Humility/Being Unobtrusive whereas 33% of males mentioned this as an element in their work. Another noteworthy difference in responses between males and females was that 54% of females mentioned Authenticity/Respect in their responses whereas only 33% of males mentioned this. Also, more males than females mentioned use of being Nonjudgmental in their work (55% males versus 27% females). Overall males and females appeared fairly equal and consistent in their presentation of their actual work with individuals with schizophrenia-spectrum diagnoses in attempting to form therapeutic alliance.

I then recombined males and females into one data set and separated the data into different subgroups, this time based on level of experience with the schizophrenia-spectrum population (less than 5 years, 5-7 years, 10-15 years, and over 20 years). By separating the data into these categories I found that the majority of people who reported having their expectations exceeded with the schizophrenia-spectrum population were all female (85%) and all of these had less than 10 years experience with the population, except for one male who had over 20 years experience. As one participant stated, “I had only ever experienced mental health through the lens of pop culture and came into the work with a slightly media-stigmatized approach.” Perhaps one reason for this exceeded expectation level is that those with lower levels of experience with the schizophrenia-spectrum population have lower expectations for their work with this population. Another participant stated, “I found the establishment of connection to be easier than I might have imagined” but they also discussed difficulties saying that, “a pattern of distance alternating with clinging was notable in the early stages...[and]...there were times when questions I asked would provoke more suspicion about my intentions.”

Looking at expectations from the opposite side, 75% of participants who reported 20 years or more experience with this population also reported that they either had no expectations entering work with their client or that their expectations had been met. Perhaps this set of participants, with higher levels of experience with the schizophrenia-spectrum population, have learned that for some reason having no expectations entering the therapeutic work is helpful in some way. Or maybe these participants have learned to be able to adjust their expectations more readily to each client or diagnosis, thereby having their expectations fluctuate, adapt and/or be met. However, as with all of the narrative responses reviewed from participants, I do not know what each individual’s definition of therapeutic alliance is. Therefore, differences in each

participant's conceptions of the alliance may explain differences in the expectations of their clients.

While still using these subgroups I looked again at the different ways of working with their clients that each subgroup mentioned (i.e. Patience, Being Non-Judgmental, Listening/Trying to Understand, Flexibility of their Agenda, Use of Encouragement/Reassurance/ Validation, Connection through Common Interests, Compassion/Empathy, Authenticity/Respect, Self-Confidence, Speaking Clearly/Succinctly, Talking about Ruptures within the Relationship, Hope, and Humility/Being Unobtrusive). Again, participants in each subgroup reported on many of the same elements in their work with clients. However, Humility/Being Unobtrusive was mentioned only by the 10-15 year group and the over 20 years group. The largest subgroup was people who mentioned Humility/Being Unobtrusive had over 20 years experience and they also had the most mentions of Listening/Trying to Understand and Being Non-Judgmental. It seems understandable that with increased experience with this population that one would have attempted more ways to form therapeutic connection with their client.

Next I broke down participants into new subgroups divided by whether their specific client had been diagnosed with a Schizoaffective versus Schizophrenia diagnosis. When dividing data into these subgroups, there were seven participants who did not give a diagnosis for their client and/or did not use a specific client when answering survey questions and they were not able to be included in this segment of the data analysis. The majority of participants used for this section of data analysis reported working with clients who had been diagnosed with Schizophrenia (including specified Paranoid Type and Catatonic diagnoses). The respondents reporting patients with Schizoaffective disorder was about half the size of those reporting clients

with Schizophrenia.

The main difference that I found between these two subgroups was that almost all of those in the Schizoaffective-Diagnosis subgroup (three out of four) reported having their expectations exceeded by their specific client. This is a significant contrast to only one out of nine in the Schizophrenia-Diagnosis subgroup. Additionally, a majority in both subgroups spoke about difficulties in trying to form this connection. The only ones who reported an actual easiness were part of the Schizophrenia subgroup; no one in the Schizoaffective subgroup actually reported forming therapeutic alliance to be “easy” (and two did not provide enough information). One participant said that their client “came to therapy and was...really quite open to engaging in the relationship. He had a clear sense of working on handling delusions and hallucinations and was looking for help in doing so.” It is not known how much help this client had received in the past or if that is even relevant to his apparent openness of connection. Reported ease of connection did not seem to vary with how much experience participants reported having with either group; most of those within the Schizophrenia subgroup had over 20 years experience. Two of the three who reported ease of connection had over 20 years of experience but one of them had less than five. A participant with less than 5 years experience commented on their work with their client saying, “it was always an easy relationship. I didn’t find a lot of testing of the relationship. When he needed something he would ask for help.”

Interestingly, only *one* of those who reported an ease of connection said that they also had their expectations exceeded. However, the participant who reported this also stated that they still “don’t think he has schizophrenia- either because his diagnosis truly is wrong or I still have some fixed misconceptions about people with a [Schizophrenia-Spectrum Disorder].” Those who reported an easy connection all reported different levels of expectations; one had none, one met

expectations and one exceeded expectations. A larger sample size for both subgroups may help in looking at the differences in forming connections with these two diagnosis subgroups since there were not many participant's data to work from especially in regard to Schizoaffective Disorder.

Overall, this sample did support the notion that forming therapeutic connection with those living with schizophrenia-spectrum diagnoses presents as challenging. One participant stated that even after working with their client for over a decade, "working with delusions is always so touchy. This patient still cannot forgive me for having a different perspective than he does, and confuses this different point of view, quite often, with a belief that I am attacking him [or] disdaining him." Another participant noted that in the beginning their client "was extremely anxious talking non stop in his own language... It was exhausting being with [my client] each time knowing little what was going on." In fact, half of the participants who reported having their expectations exceeded also talked about ways in which attempting to form connection was difficult. It may take quite a while to increase connection, if possible, and even then it is not without struggle. A participant shared that "in the early months, my client alternately clung to me desperately and attacked me...[my client then] began a long period of phoning me many times a day...[and] I found myself feeling totally invaded by [their] mind... [my client's] trust in me has steadily grown (though with many relapses)." Even attempts at trying to be kind could be seen as threatening as one participant reported, for their client "danger could be perceived paradoxically from gestures of kindness or over-caring" which led the participant to attempt to remain "somewhat neutral." Eight of the thirteen participants from these combined subgroups (Schizophrenia and Schizoaffective) spoke of difficulties in attempting to form therapeutic connection.

Alternatively, although this work can be quite difficult or challenging at times, there were also participants who noted the satisfaction they get out of working with these clients as well. One participant stated, “they are my favorite patients to work with...although improvement and treatment gains are slow I find working with them incredibly rewarding.” Another commented that “I was always excited to work with these types of folks.”

The last element I looked at was in regards to how people were able to sustain their personal efforts and maintain a thoughtful, caring and empathic stance with their client despite any struggles that the work may have brought up. I did this by using the ‘years of experience’ subgroups (less than 5 years, 5-7, 10-15, and more than 20 years). Interestingly a majority of *both* the less than five years subgroup and the over 20 years subgroup reported that having Understanding, Compassion and Empathy for their client was helpful in sustaining their personal efforts. Both the 5-7 and 10-15 year subgroups had a majority that reported Supervision and/or Talking with other Staff was helpful in carrying on their personal efforts during this sometimes challenging work with clients. It seems to make sense that those in this higher experience bracket may feel less need to check in with other staff or supervisors. It is interesting however, that those with less than 5 years experience did not report at all on supervisory support. This does not mean that it is not a useful or helpful element, since this was an internet survey I am limited by only what participants thought of and decided to write down.

X. Discussion

I chose this thesis topic because of my passion for the issue, both personally and professionally, and for the potential to add more information to the literature to better serve people living with schizophrenia-spectrum diagnoses. After completing this study I am still convinced that this topic is worthwhile not only for my recent research but also for future studies. Learning how one attempts to form connection with someone who may be very guarded, paranoid or fearful of connection; who may be experiencing psychotic symptoms in the moment, or who may be catatonic and/or nonverbal can help lend more information on how to attempt building alliance in this sometimes very challenging work.

By looking at a more generalized overview of therapeutic relationships with people who live with schizophrenia-spectrum diagnoses, it helps to open up this complex topic. I did not ask to get into the specifics of what each participant's interpretation of "therapeutic alliance" was, how they formed their theories on the topic, or their stance on mental health structure, which may have complicated answers. Additionally, I did not ask participants what "*one thing*" helped their client the most. The reason I did not ask this is because I do not believe in fact that there is one single thing that a professional can do to answer such a complex issue. There are so many aspects of ourselves as individuals that we cannot possibly control and which influence our interactions with others, both personally and professionally. It seems impossible to choose and

apply only a single aspect of our interactions with another, without any other characteristic influencing the relationship. Additionally, when surveying mental health professionals it seemed unlikely that I would get many responses to such a narrow, uninformed, undeveloped question. Also, if participants had answered such a specific question, again it would seem highly unlikely that it would be possible to select one specific aspect of their interaction. On the other hand, if one did have to choose one area of focus to look at work with individuals who may at times be terrified of connection; who may fear being engulfed by another, who has difficulty trusting, who is paranoid or who fears that closeness will cause them to cease to exist, it is clear that looking at how one attempts to form therapeutic relationships with these individuals is a vital piece of the work to research and develop. When asking more general questions in regards to *attempting* to form a therapeutic alliance, this does not require a single definitive answer. Rather, these more general questions allow us to simply observe the process of *trying* to form connection, whether or not the attempts worked.

My study structure was to use an online survey which worked in getting people from across 12 different states and various disciplines. I chose to use an internet survey since I did not want to limit my findings to the small Northampton, MA area. However, since I obtained several of my participants from ISPS (The International Society for Psychological and Social Approaches to Psychosis), several of my participants are also from a narrow sample field which also may have a unique view of the issues being studied. Choosing to get a broader sample from across the USA also seemed to coincidentally help to obtain a fairly equal male-female ratio of participants.

Of course, there were other limitations of using an internet survey. One limitation was that I was not able to ask any of my participants any follow-up questions. Whatever information

they chose to send to me is the only information I received. There were a couple of participants who did not use a specific client when answering survey questions, as the survey was intended. However, because my survey was a one-time anonymous online survey, there was no way to correct this or get more clarification from anyone. For example one participant, when asked about how they sustained their personal efforts during their work, responded that they did “nothing out of the ordinary.” Because I am not sure what ‘ordinary’ means to this individual I would have liked to ask more questions. Because this is an internet survey however, all my data is limited to what people have chosen to write. If one was able to go further in this research and have one-on-one interviews with participants then more detail could be taken from the interviews. The questions I asked were more open and generalized and with the ability to ask more follow-up questions perhaps studies could get some more in-depth information.

Since I did not get into the specifics of each participant’s views or theories on therapeutic relationships and what that means to each of them, participants’ answers may be different depending on how they are classifying therapeutic relationship. For instance, one person may interpret therapeutic connection for someone with a schizophrenia-spectrum diagnosis as an understanding of the therapeutic work between the two of them where the client can talk openly and honestly and the professional is able to lend feedback in a way that appears non-threatening to the client; whereas to another, perhaps they interpret connection as simply having their client attend appointments regularly. Without knowing this piece, it is hard to fully analyze participant responses in regards to how much of a therapeutic alliance was or was not established, if at all.

Not knowing one’s perspective on therapeutic alliance also makes it difficult to understand why an individual may interpret their relationship with a client as connected when it may not have sounded as such. For example, one participant spoke about how their client did not

seem to want to talk about much in depth with their case worker but would talk to another clinician in more detail. However, this participant also stated, “I feel that this patient was engaged. I believe if I had not worked with him in regards to [scheduling]...he probably would have stopped coming....*This is where I believe the therapeutic alliance was achieved*” (italics added). My perspective on therapeutic alliance may be completely different from that participant’s perspective which makes it more difficult to entirely understand how they view the formation of therapeutic alliance.

Another piece of the study that could not be controlled for is an individual’s sense of professional pride. Participants may or may not have felt the need to give answers in such a way as to not be seen in a negative light and represent their professional competence. This may influence what pieces of information people may be willing to share with me, a complete stranger. Though perhaps one benefit of having an online survey is that there is more anonymity to the study; no face-to-face contact which may serve as more inhibiting to a participant. On the other hand, when conducting one-on-one interviews there may be more of a chance to create open dialogue and for the participant to feel safer sharing information with someone that they feel is competent and understanding themselves. However, there is no way to control for this feeling of safety and rapport in an interview either.

Some of the people I emailed, and therefore perhaps some of my participants, were friends, acquaintances, peers, colleagues. This also adds another element to participants perhaps wanting to say the “right” thing; showing their professional competence to someone they actually know. Although the study is anonymous there may or may not have been anxieties around having me recognize their responses and then how I might interpret or view their responses.

I believe that the area of study around forming therapeutic relationships with those living with schizophrenia-spectrum diagnoses should most certainly be researched further. Perhaps there are more differences in connection and ways of attempting to form these connections depending on diagnosis along the schizophrenia spectrum. Also, obtaining a larger sample size would be helpful since I did not have a lot of participant data to work from. This study did show however that this work with people living along the schizophrenia-spectrum can be challenging to work with, even when they are also wonderful people to work with.

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Appendix A

Informed Consent Form

Dear ISPS Member,

I am a graduate student at the Smith College School for Social Work in Northampton, Massachusetts and I am conducting research exploring how mental health professionals work with people who have been diagnosed with schizophrenia-spectrum disorders. In particular, the purpose of this study is to look at how one attempts to build therapeutic-alliance with someone who is living with a schizophrenia-spectrum disorder. Current literature supports that those with schizophrenia-spectrum diagnoses have *deficits* in social functioning but there does not seem to be adequate literature on how one attempts to develop a therapeutic relationship in relation to those with people with these diagnoses. It is my aim that this study will provide further insight into how to better serve this population. The data collected from this study will be used to further research in the schizophrenia-spectrum realm; it will be used for my Masters of Social Work thesis as well as professional presentations and publications.

The survey itself will request your demographic information and responses to open-ended questions. The open-ended questions are intended to get a more narrative and personal account of your own experience with an individual client. Specifically you will be asked to reflect upon your professional experiences with one particular client (past or present) with a schizophrenia-spectrum diagnosis with whom you have worked continuously or intermittently. You will be asked a series of questions about the formation of the therapeutic relationship; how it evolved over time, and how you addressed any difficulties that arose during your therapeutic efforts and how you personally sustained those efforts. In order to participate in this study you must be a United States member of ISPS, understand English, be 18 years of age or older and also have professional experience working with people who have been diagnosed with schizophrenia-spectrum disorders. This survey could be completed in as little as 15 minutes.

There is minimal risk anticipated from participation in this study. All information will be kept anonymous and kept in a locked location; none of your identifying information will be linked to your narrative responses. I also ask that in discussing information about your client that specific names, dates, places and physical identifiers not be used. As a member of ISPS which is geared toward the in-depth treatment of this population, your participation will be contributing to ongoing research on the clinical process with people living with schizophrenia-spectrum diagnoses. By participating in this study you will lend information intended to expand conceptions on how to work with people who live with these diagnoses. It is my hope that it will provide insight into how to better serve this population by understanding how one develops therapeutic relationships with this population. No other compensation will be provided for participation in this study.

It is a challenge in the mental health profession to build a therapeutic alliance with clients who suffer from severe thought disorders along this spectrum. I hope that the mental health system can learn from your experiences and knowledge and that your observations can lend clues as to

how to address difficulties that arise in this work. It is my hope to be able to learn from your experiences about interventions you have found to be helpful or inadequate in order to add to the existing literature and to better serve our clients. All data collected in the survey will be compiled together for data analysis so that there remains no link to any participant from a particular US State and will be kept anonymous. All data used in professional publications or presentations will be disguised and presented without linking identifying features. The digital data collected from the online surveys will be transferred to a zip drive which will be kept in a locked file cabinet. My research advisor will have access to my data as well but no identifying information will be linked to any participant responses. If another analyst is used for data analysis they will be required to sign an agreement of confidentiality. This data will be kept secure for a period of three years as per federal guidelines. After this period data will be destroyed or, if I continue to have a need for this data I will continue to keep it in a secure location until it is no longer needed and it will then be destroyed.

If you wish to lend your understanding and experience, the following web link will remain active until April 20, 2012 at which time the web page will be deactivated and participation will no longer be possible. Your participation in this study is, of course, absolutely voluntary. You are free to skip any questions you find problematic or irrelevant. You are free to withdraw from the study at any time up until selecting the final "Submit" button to complete the survey. Once this "Submit" button is selected data will be used in this study. You may contact me at any point with questions/concerns before or after the survey is completed.

Researcher's Contact:

Eliza Morgan
Lilly Hall
Smith College School for Social Work
Northampton, MA 01063

Should you have any concerns about your rights or about any aspect of this study, please contact me (using the above information) or the Chair of the Smith College School for Social Work Human Subjects Review Committee at 413-585-7974.

Please print a copy of this informed consent for your records

BY CHECKING "I AGREE" BELOW YOU ARE INDICATING THAT YOU HAVE READ AND UNDERSTAND THE INFORMATION ABOVE AND THAT YOU HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Appendix B

Recruitment Email to ISPS

Hello ISPS Member,

I am a graduate student at the Smith College School for Social Work in Northampton, Massachusetts and I am conducting research exploring how mental health professionals work with people who have been diagnosed with schizophrenia-spectrum disorders. Have you had experience working with people living with schizophrenia-spectrum diagnoses? If so, I request that you please help me with my study in how one attempts to build therapeutic relationship with someone who is living with a schizophrenia-spectrum diagnosis.

The survey will request some of your demographic information and responses to open-ended questions. The open-ended questions are intended to get a more narrative and personal account of your own experience with an individual client with a schizophrenia-spectrum diagnosis with whom you have worked. Narrative questions will be about the formation of the therapeutic relationship, how it evolved over time, and how you addressed any difficulties that arose during your therapeutic efforts and how you personally sustained those efforts. This survey could be completed in as little as 15 minutes.

It is a challenge in the mental health profession to build a therapeutic alliance with clients who live with severe thought disorders along this spectrum. I hope that the mental health system and I can learn from your experiences and knowledge and that your observations can lend clues as to how to address difficulties that arise in this work. If you wish to lend your understanding and experience, it would be greatly appreciated. The following web link will remain active until April 20, 2012 at which time the web page will be deactivated and participation will no longer be possible.

<https://www.surveymonkey.com/s/2GVM35F>

Thank you for your time and consideration!

Eliza Morgan

Lilly Hall

Smith College School for Social Work

Northampton, MA 01063

Appendix C

Volunteer or Professional Data Analyst's Research Confidentiality Agreement

This thesis project, *Forming Therapeutic Relationships with People Living with Schizophrenia-Spectrum Diagnoses*, is firmly committed to the principle that research confidentiality must be protected and to all of the ethics, values, and practical requirements for participation protection laid down by federal guidelines and by the Smith College School for Social Work Human Subjects Review Committee. In the service of this commitment:

- ⇒ All volunteer and professional data analysts for this project shall sign this assurance of confidentiality.
- ⇒ A volunteer, or professional data analyst, should be aware that the identity of participants in research studies is confidential information, as are identifying information about participants and individual responses to questions. The organizations participating in the study, the geographical location of the study, the method of participant recruitment, the subject matter of the study, and the hypotheses being tested are also to be confidential information. Specific research findings and conclusions are also usually confidential until they have been published or presented in public.
- ⇒ The researcher for this project, *Eliza Morgan*, shall be responsible for ensuring that all volunteer or professional data analysts handling data are instructed on procedures for keeping data secure and maintaining all of the information in and about the study in confidence, and that they have signed this pledge. At the end of the project, all materials shall be returned to the investigator for secure storage in accordance with federal guidelines.

PLEDGE

I hereby certify that I will maintain the confidentiality of all of the information from all studies with which I have involvement. I will not discuss, disclose, disseminate, or provide access to such information, except directly to the researcher, *Eliza Morgan*, for this project. I understand that violation of this pledge is sufficient grounds for disciplinary action, including termination of professional or volunteer services with the project, and may make me subject to criminal or civil penalties. I give my personal pledge that I shall abide by this assurance of confidentiality.

_____ Signature

_____ Date

_____ *Eliza Morgan (Researcher)*

_____ Date

Appendix D

Email from ISPS

Karen Stern <stern.k.s@gmail.com>

Tue, Feb 28, 2012 at 6:26 PM

To: Eliza Morgan <elizajmorgan@gmail.com>

Hi Eliza. I am the contact for everything administrative at ISPS-US. Your thesis sounds great, and it's fine to send to our members. I would much rather that you send it to our listserv though (Yahoogroup), so that only those who have opted in to receive emails would get it. You would also reach more people that way, since we allow nonmembers to try it for 3 months. Either I can forward it for you, or I can put you on the list and you can do it yourself. I would prefer that, since it's set to send replies to the sender, and our members are not always good about paying attention to who the reply is going to. You also might learn a lot on the list. (If you want to become a member at some point, by the way, it's only \$55 for students, which includes a journal subscription.)

Karen Stern, MAT

Executive Director

ISPS-US

P.O. Box 491

Narberth, PA 19072

contact@isps-us.org

<http://www.isps-us.org>

Appendix E

Recruitment Email to Friends, Colleagues & Classmates

Hello Friends, Colleagues, or Classmates,

Many of you may know that I am currently working on my Master's Thesis as part of my Masters of Social Work program at Smith College School for Social Work. I am conducting research exploring how mental health professionals work with people who have been diagnosed with schizophrenia-spectrum disorders. I am sending you this email to ask for your help with recruiting participants for my research study which consists of an online survey. Have you had experience working with people living with schizophrenia-spectrum diagnoses? If so, I request that you please help me with my study in how one attempts to build therapeutic relationship with someone who is living with a schizophrenia-spectrum diagnosis. Please send this email along if you know of any others who may qualify and be interested in helping me with my study.

The survey will request some of your demographic information and responses to open-ended questions. The open-ended questions are intended to get a more narrative and personal account of your own experience with an individual client with a schizophrenia-spectrum diagnosis with whom you have worked. Narrative questions will be about the formation of the therapeutic relationship, how it evolved over time, and how you addressed any difficulties that arose during your therapeutic efforts and how you personally sustained those efforts. This survey could be completed in as little as 15 minutes.

It is a challenge in the mental health profession to build a therapeutic alliance with clients who live with severe thought disorders along this spectrum. I hope that the mental health system and I can learn from your experiences and knowledge and that your observations can lend clues as to how to address difficulties that arise in this work. If you wish to lend your understanding and experience, it would be greatly appreciated. The following web link will remain active until April 20, 2012 at which time the web page will be deactivated and participation will no longer be possible. I would greatly appreciate it if you could send this along to any others you know who may be interested in being a part of my study. It would be very helpful!

<https://www.surveymonkey.com/s/2GVM35F>

Thank you for your time and consideration!

Eliza Morgan

Lilly Hall

Smith College School for Social Work

Northampton, MA 01063

Appendix F

Reminder Email to ISPS

Hello,

I am a graduate student at the Smith College School for Social Work in Northampton, Massachusetts and I am conducting research exploring how mental health professionals work with people who have been diagnosed with schizophrenia-spectrum disorders. I have already heard back from a few of you, thank you for your time! However, I still need more respondents for my study.

Have you had experience working with people living with schizophrenia-spectrum diagnoses? If so, I request that you please help me with my study in how one attempts to build therapeutic relationship with someone who is living with a schizophrenia-spectrum diagnosis. If you would like to help me with my research study on this important topic please click the link below which will be active until April 20th, 2012.

<https://www.surveymonkey.com/s/2GVM35F>

Please feel free to pass this survey along to any others you know who may qualify or be interested in being a part of my study. I would greatly appreciate it!

Thank you for your time and consideration!

Eliza Morgan

Lilly Hall, Smith College School for Social Work

Northampton, MA 01063

Appendix G

Approval Letter from Human Subjects Review

March 19, 2012

Dear Eliza,

Your changes are all very clearly made. I think it is very interesting. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

I wish you the best of success!

Sincerely,

A handwritten signature in black ink, appearing to read "David L. Burton", with a long horizontal flourish extending to the right.

David L. Burton, M.S.W., Ph.D.
Chair, Human Subjects Review Committee

CC: Roger Miller, Research Advisor

Appendix H

Narrative Survey Questions

1. Please give a brief overview of the therapeutic context: type of work with your client; diagnosis, age, frequency of sessions/interactions, length of meetings. Please do NOT use actual names, dates, places or physical descriptors in any of your responses.
2. How did the therapeutic relationship experience BEGIN with you and your client? What were your early experiences of attempting to establish a therapeutic relationship and your early experiences of your client? How did the client appear to experience this relationship in the beginning? How did they test it, cling to it or ward it off?
3. How did your client APPEAR to experience YOU? Did you find a way to be available rather than 'dangerous' to this client? If so, how?
4. What were your initial expectations about working with someone with a schizophrenia-spectrum diagnosis? How did the reality of this client interaction meet, exceed and/or fall below your expectations?
5. What did you find helpful in forming a working therapeutic relationship with this client? What was problematic? Did you get stuck? How did you alter your approach? How did your efforts to connect with this client shift over time?
6. How resistant and/or engaged in treatment was this client? What client interference in this relationship-building, if any, did you encounter? To what extent do you feel a therapeutic alliance was achieved?
7. If the services terminated, please describe why and how this occurred.
8. What did you do in order to carry on your personal efforts during this work? How did you sustain a thoughtful, caring, empathic stance with your client despite any struggle this work may have brought up?