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Combined Minimal Medication and Psychosocial Interventions in Acute-Phase Schizophrenic Psychosis: Knowledge, Attitudes, and Practices of Psychiatrists in South Africa

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A research report submitted to the Faculty of Humanities, University of the Witwatersrand, Johannesburg, in partial fulfillment of the requirements for the degree of Master of Arts in Clinical Psychology.

October, 2010

DECLARATION

I declare that this research report is my own, unaided work. It is submitted for the degree of Master of Arts in Clinical Psychology at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any other degree or examination at this or any other university.

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Nardus Saayman

October, 2010

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ABSTRACT

Combined minimal medication and psychosocial interventions in acute-phase schizophrenic psychosis are seen by many as the way to address the problems inherent in the use of antipsychotic medication as the mainstay treatment for schizophrenic psychosis. This research report explores the Knowledge, Attitudes, and Practices of South African psychiatrists working in public hospitals with regard to these alternative interventions. Eight psychiatrists were interviewed using a self-designed semi-structured questionnaire consisting mostly out of open-ended questions. A qualitative approach was adopted, while thematic content analysis was used to identify themes that address the aims of the research. Analysis revealed that: None of the participants had any in-depth knowledge of combined minimal medication and psychosocial interventions in acute-phase schizophrenic psychosis, while one participant was aware of their existence; The participants were unanimously opposed to the use of psychological interventions in acute-phase schizophrenic psychosis, as medication is viewed as the mainstay in treatment, with psychosocial and psychological interventions seen only as an adjunct, and contraindicated in the acute phase; Schizophrenia is viewed as a biological disorder; The majority of participants were not willing to minimize or withhold medication, as psychosis is seen as toxic to the brain, while one participant did report delaying medication in cases where there was uncertainty around diagnosis; The lack of resources in South African mental health care greatly influences treatment approaches.

1.) INTRODUCTION

Schizophrenia is one of the most serious and debilitating mental health disorders treated by psychiatrists today. It places massive physical, cognitive, and emotional burdens on the sufferer, family members, and caregivers, and has immense financial implications for those involved as well as for the country (McEvoy, 2007). The disorder has a very poor outcome, and is characterized by a spectrum of symptoms that include hallucinations, delusions, disorganized speech, grossly disorganized or

catatonic behavior, flattened affect, and an impairment of goal-directed behavior (American Psychiatric Association, DSM-IV-TR, 2000). Schizophrenia is also one of the most stigmatized mental disorders, creating a vicious cycle of social discrimination and breakdown of social networks for sufferers (Rössler, Salize, Os, & Riecher-Rössler, 2005). From a professional point of view the matter is further complicated as the accuracy and applicability of the definition of the disorder is in dispute (Boyle, 1990; Kennard, 2009). These difficulties and debates are accompanied by a more practical contention, however, which is how schizophrenia should be treated and whether non-medical interventions, such as psychosocial interventions, have a significant role to play, or not, within the practical reality of clinical care today.

The treatment of schizophrenia is a highly complex affair, with the call for an integrated approach to its treatment having grown markedly over the last decade (Alanen, Chávez, Silver & Martidale, 2009). The discussion surrounding the optimal treatment of patients suffering from schizophrenia is in great part focused on the debate between those who support purely biological science and those who support the implementation of psychological and/or psychosocial interventions to aid biological treatment (Alanen et al., 2009; Aaltonen, Alanen, Cullberg, Haugsgjerd, Levander & Rosenbaum, 2009). Particularly in the United States of America (USA) those advocating the use of psychological and/or psychosocial interventions report feeling like they are caught up in a never-ending battle with what they refer to as 'biological reductionism' (Koehler & Silver, 2009). The implementation of psychological and/or psychosocial interventions in schizophrenia is being opposed by a number of factors that include: the natural science tradition's reluctance to develop an adequate respect for alternative theoretical outlooks due to its commitment to medical research and education; the belief that schizophrenia is exclusively a brain disorder that is unrelated to psychological elements, apparently supported by the development of brain research; the pharmaceutical industry's strong position of influence; and the assumption that psychological interventions in schizophrenia are not applicable in the wider public health area due to a lack of resources (Olanen, 2009). The main reason given for the lack of clear and in-depth recommendations for psychological interventions is a general lack of quality evidence that supports its efficacy (Lehman & Steinwachs, 1998a; Olanen, 2009). Exactly how realistic the

possibility of implementing psychological interventions are in the treatment of schizophrenia in South Africa, remains unclear, in part due to factors such as the absence of locally relevant treatment guidelines, the relative lack of comprehensive studies that look at the practices of psychiatrists regarding the treatment of this disorder in the South African context, and in part the under-resourced nature of health care in South Africa (Koen, Magni, Niehaus, & le Roux, 2008; Trump & Hugo, 2006). These debates form the context for this study, and encompass some of the crucial elements that could influence the way a psychiatrist views and treats schizophrenia. It is also precisely these factors that the researcher aims to investigate to determine what South African psychiatrists' knowledge, opinions, and practices are regarding minimal medication interventions in schizophrenia. For the rest of the paper, the terms 'schizophrenia' and 'acute-phase schizophrenic psychosis' will be used interchangeably to provide clarity in terms of the focus of treatment.

2.) AIMS

The pivotal aims of the research study are:

1. To explore the knowledge of South African psychiatrists of combined minimal medication and psychosocial interventions in acute-phase schizophrenic psychosis.

2. To explore the attitudes of South African psychiatrists toward combined minimal medication and psychosocial interventions in acute-phase schizophrenic psychosis.

3. To explore the practices of South African psychiatrists with regard to the treatment of acute-phase schizophrenic psychosis.

3.) RATIONALE

Mental health care professionals' frustration with the different approaches to treatment of acute-phase schizophrenic psychosis used by other individuals, institutions, and countries, continues to be a theme that sparks heated debate between those involved. There are several different schools of thought regarding the treatment of acute-phase schizophrenic psychosis, and the way that any specific school influences a clinician's thinking, will invariably have an effect on his or her treatment approach. A great deal of psychiatrists regard schizophrenia as a mental disorder with an internal biological cause that can often be traced to a specific genetic abnormality, which should be treated primarily with antipsychotics as it responds unfavorably to psychotherapy (Laungani, 2002; Ross, 2006). Others view environmental factors such as communication difficulty and hostility within dysfunctional family context, abuse, racism, social marginalization, and early loss of parents or caregivers, as significant contributors to the development of schizophrenia (Koehler, 2004; Read, Seymour, & Mosher, 2004). This view adds to the ever-expanding body of research that views schizophrenia as a disorder of social cognition (Lewis, 2008). Lewis (2008) further clarifies social cognition as "the capacity to mentally represent self and other as a guide to social interaction", and states that there are numerous studies that support this view, finding that these deficits present themselves throughout the course of schizophrenia, and that they may persevere in spite of the use of antipsychotics (p.54). Many of the proponents of psychological interventions reflect negatively on the exclusive use of antipsychotics by stating that the patients, as well as their families, are settling for treatment methods that propose to make the patient a life-long invalid who does not upset others too much (Karon, 2003).

The researcher agrees with the viewpoint that effective clinical reasoning is based on several different types of knowledge, and that, because there are many complications and problems inherent in the various approaches to the treatment of acute-phase schizophrenic psychosis, this attitude seems crucial (Hietala, 2009; Higgs & Titchen, 1995). In the search for approaches that address these problems, and in particular problems related to antipsychotic use that include fatigue and lack of energy, poor concentration, a decrease in libido, problems related to sexual performance,

disturbances in sleep patterns, having a dry mouth, and anxiety, there has been a development of innovative minimal medication programs combined with psychological interventions that provide an unmistakable polarity to the medical practices of developed countries (Bola, Lehtinen, Cullberg, & Ciompi, 2009; Trump & Hugo, 2006). Instead of institutionalizing and immediately treating acute first-episode schizophrenia patients with antipsychotics, these pilot programs clearly show the practicality of the combination of specifically developed psychological treatments with time-limited antipsychotic medication postponement (Bola et al., 2009). It can be argued that psychological intervention is a vital part of the treatment of psychosis (Jackson, 2009). Approaches such as those based on psychodynamic theory can assist clinicians working with patients suffering from schizophrenia, and aid them in finding meaning in eccentric and bizarre communications (Jackson, 2009). Mental health professionals working with psychotic individuals also find themselves in a highly stressful environment, and could benefit from a theoretical framework that increases their ability to understand the patient, and to relate to his/her experience (Jackson, 2009). A psychodynamic understanding of psychosis greatly supplements the understanding of empirical findings of interpersonal processes communicated in psychosis (Martindale, 2008). Jackson (2009) references Freud as proposing the following:

> *...So many things that in neurosis have to be laboriously fetched up from the depths are found in psychosis on the surface, visible to every eye. For that reason the best subjects for the demonstration of many of the assertions of psychoanalysis are provided by the psychiatric clinic…in the long run even the psychiatrists cannot resist the convincing force of their own clinical material (p.78).*

Others hold a more cautious and skeptical view. Hoffman (2009) cites Carl Jung stating that:

> *...The psychogenesis of schizophrenia also explains why certain lighter cases…can be psychotherapeutically cured. But one should not be too optimistic with respect to this possibility of cure. These are rare cases, for the nature of the illness and the decay of the personality hinder precisely*

the active agency of the therapy, namely the exertion of psychic influence (p.41).

The findings and arguments of these groundbreaking studies do, however, stand outside the currently permitted body of treatment recommendations as set out by the American Psychiatric Association (APA), the Patient Outcomes Research Team (PORT), and Britain's National Health Service's (NHS) National Institute for Health and Clinical Excellence (NICE) (American Psychiatric Association, 2009; Lehman & Steinwachs, 1998a; National Institute for Health and Clinical Excellence, 2009). The fact that South Africa does not have locally relevant treatment guidelines for schizophrenia, provincial or national, further adds to the difficulty of combining the relevant pharmacological and therapeutic elements to treat South African patients suffering from schizophrenia (Koen et al., 2008). This also makes it very difficult to determine the legitimacy of different clinicians' approaches to the treatment of schizophrenia (in all phases), as there is not a locally relevant baseline to measure differences against. The lack of resources in South Africa in terms of health care, and the fact that many people are not receiving a high level of service, further compound the situation, particularly because these alternative methods of intervention could potentially demand even more resources (Bola et al., 2009; Trump & Hugo, 2006). These factors all heavily contribute to the need to determine what psychiatrists in South Africa consider important and effective in the treatment of acute-phase schizophrenic psychosis, and why.

4.) LITERATURE REVIEW

4.1.) Global Prevalence and Statistics of Schizophrenia

The global prevalence of lifetime schizophrenia is estimated to be between 14 and 55 people for every 10 000 and between 33 and 34 people for every 10 000 in terms of the one-year prevalence of the disorder (Goldner, Hsu, Waraich, & Somers, 2002; Jablensky, 2000; Saha, Chant, Welham, & McGrath, 2005). The grave implications of this disorder are clear, as it remains one of the major contributors to the worldwide encumbrance of disease (Saha et al., 2005). Life expectancy of those suffering from

schizophrenia is reduced by roughly 10 percent, with between 4.9 and 13 percent committing suicide (Rössler et al., 2005; Tatarelli, Pompili, & Girardi, 2007). To better quantify the burden of schizophrenia, the Global Burden of Disease (GBD) methodology uses a metric that calculates the disability-adjusted life year (DALY) of an individual suffering from this disorder, basically constituting the loss of a healthy year of life (Rössler et al., 2005). In terms of the global burden of disease, schizophrenia accounts for approximately 1.1 percent of the DALY loss, a significant amount that contributes to schizophrenia being listed as the 8th leading cause of disability-adjusted life years worldwide (Rössler et al., 2005).

4.2.) Prevalence and Statistics of Schizophrenia in South Africa

Mental illness is a devastating force in South Africa (Trump & Hugo, 2006). The South African Association of Psychiatrists reports that 58 percent of visits to general practitioners are the result of circumstances that are generated from, or made worse by mental illness (Trump & Hugo, 2006). Literature on the current prevalence rate of schizophrenia in South Africa is lacking, but it is estimated that 1 percent of the South African population suffers from schizophrenia, amounting to a figure of roughly 500 000 people (following census estimates of population size) suffering from this disorder at any given time (Trump & Hugo, 2006). Loss of productivity as a result of early onset and early retirement, as well as the financial burdens on families and caregivers are among the factors that make schizophrenia a very expensive disease for the country to deal with (McEvoy, 2007; Rössler et al., 2005).

4.3.) Tertiary Health-Care as it Exists Today

Despite the substantial financial implications of schizophrenia on the health care system, South Africa does not have national or provincial treatment guidelines developed specifically in South Africa to regulate the practices of professionals in mental health care working with schizophrenia (Koen et al., 2008). The effect of this is visible in a recent study that looked at the clinical practices of three psychiatric hospitals in the Western Cape (Koen et al., 2008). It was found that the participating hospitals had differing treatment approaches, and evidence of antipsychotic

polypharmacy was found with a rate of 28.6 percent, a significantly higher rate than in other countries such as the USA and New Zealand (Koen et al., 2008).

Treatment guidelines such as those put forward by the APA (2009), the PORT (1998a; 1998b; 2009) and the NICE (2002) provide clear guidelines based on a substantial amount of scientific research. The implementation of these guidelines in South Africa is, however, not a straightforward endeavor (Koen et al., 2008). These guidelines were established in developed countries, and the picture regarding the availability of mental health care in a developing country such as South Africa, simply does not look the same (Emsley & Booysen, 2004). Developing countries tend to have an absence of decentralized mental health services; mostly find new generation antipsychotic drugs to be too costly; and in many instances have an absence of essentially patient-centered mental health legislation, all of which are factors that need to be taken into account in the formation and implementation of treatment guidelines in South Africa (Burns, 2008). The cost effectiveness or cost neutrality of new generation atypical antipsychotics as indicated in developed countries is another factor that has become questionable in terms of its relevance in developing countries (Emsley & Booysen, 2004). Atypical antipsychotics are very expensive, and many of the developing countries including, South Africa, simply cannot afford them, thus relying on classical antipsychotics in state health services, leaving patients at greater risk to experience extrapyramidal side effects (Emsley, Oosthuizen, Joubert, Hawkridge & Stein, 1999). The direct financial demand of schizophrenia on a country's health-care system includes the cost of the treatment provided in inpatient care, outpatient care, as well as long-term care (McEvoy, 2007). To give the reader an idea of the severity of the cost, the United States of America spent the equivalent of R438.8 billion in 2002 on schizophrenia and related factors with a calculated prevalence rate of 51 people for every 100,000 (McEvoy, 2007). Unfortunately a search of the literature has failed to present similar data in terms of the expenditure in South Africa. The fact is, however, that South Africa does not possess a health-care system that can be compared to those found in the USA, Europe, or the UK's NHS. A lot of people in South Africa simply do not receive the level of mental health care that they require due to restrictions imposed by many of the medical aid service providers for mental health conditions (Trump & Hugo, 2006). Those medical aid service providers that do cater for mental illness, place a limit on

the available benefits, making it incredibly difficult for patients to recover completely (Trump & Hugo, 2006). This is reflected by the high percentage of mental health consumers who terminate psychotherapy and medication because of financial implications – 46 percent discontinuing therapy, of which more than half state that medical aid funds were depleted, and 23 percent discontinuing medication based on financial constraints (Trump & Hugo, 2006). One has to wonder whether the South African health care system, notwithstanding all of the negative factors involved, can accommodate minimal medication interventions in schizophrenia that incorporate psychological interventions, especially since these types of interventions are typically executed in closely monitored, multidisciplinary, 24 hour facilities (Bola et al., 2009). It should also be noted that, compared to pharmacological interventions, psychological interventions are considerably more expensive to establish, the recruitment of participants is a difficult task, and a great deal of resources are needed to ensure the quality and consistency of the therapy, all of which are factors that could heavily strain the South African health care system (Gleeson, Krstev, & Killacky, 2008).

The exploration of the limitations of health care settings in South Africa with regard to the implementation of psychological interventions is a much-needed endeavor, and, although beyond the scope of this study, will hopefully be done in part when looking at the attitudes of psychiatrists towards these innovations in South African context.

4.4.) Treatment Guidelines

The fidelity and quality of mental health care is largely built on evidence-based psychiatry and treatment guidelines (Kozumplik & Uzun, 2009). The development of these treatment guidelines for schizophrenia are influenced by a number of factors that include: the impact on budget and outcomes; patient tolerability, safety, and efficacy; new treatments; updated information regarding new treatments; and the experiences of users (Buckley, Miller, Chiles, & Sajatovic, 1999). In 1992 in the USA, the Agency for Health Care Policy and Research (AHCPR) in association with the National Institute of Mental Health, founded the Patient Outcomes Research Team (PORT) (Lehman & Steinwachs, 1998a). The PORT combines the expertise of three of the leading research centers, has as its main purpose the development of treatment

recommendations for individuals suffering from schizophrenia, and remains among the most referenced treatment guidelines for schizophrenia (Larsen, 2008; Lehman & Steinwachs, 1998a). The treatment recommendations that are put forward by the PORT report is claimed to be based on a substantial body of scientific evidence, but seems lacking in terms of alternative treatment recommendations that incorporate psychotherapy (Lehman & Steinwachs, 1998a). The authors do, however, acknowledge this, and state that psychological interventions are not seen as less effective than the use of antipsychotics, but that they are left out because of the lack of scientific evidence supporting their efficacy (Lehman & Steinwachs, 1998a). Each treatment recommendation is substantiated with a rationale that links it to a supporting body of scientific evidence (Lehman & Steinwachs, 1998a). Only the first five recommendations, as well as recommendation number twenty-two will be looked at in this paper, as they are central to the themes covered and constitute some of the factors that could influence the treatment of schizophrenia. Lehman and Steinwachs (1998a) state the first treatment recommendation as follows: "Antipsychotic medication, other than clozapine, should be used as the first-line treatment to reduce psychotic symptoms for persons experiencing an acute symptom episode of schizophrenia" (p.2). Lehman and Steinwachs (1998a) rationalize this recommendation by stating that:

> *…Over 100 randomized double-blind studies consistently support the efficacy of antipsychotic medications relative to placebo in reduction of the acute positive symptoms (hallucinations, delusions, thought disorganization, bizarre behavior) of schizophrenia. Approximately 50 to 80 percent of persons will improve significantly with this treatment compared with about 5 to 45 percent on placebo (p.2).*

The second recommendation states that the minimum dosage should be used (300-1000 chlorpromazine equivalents per day), with the third recommendation following that the level of dosage should always remain in the lower end of the spectrum (Lehman & Steinwachs, 1998a). Recommendation four advises against massive loading doses of antipsychotics, or 'rapid neurolpeptization' (Lehman & Steinwachs, 1998a). The fifth recommendation deals with factors that influence the choice of antipsychotic, and states that it should be based on the patient's acceptability, prior individual drug response, long-term treatment plan, and side-effect profile (Lehman &

Steinwachs, 1998a). With regard to the use of psychotherapy, recommendation twenty-two states that individual as well as group psychotherapy (based on a psychodynamic paradigm), even in combination with the use of antipsychotics, should *not* be implemented in the treatment of schizophrenia (Lehman & Steinwachs, 1998a). The supporting rationale states that, as mentioned previously, there is not a sufficient body of scientific evidence supporting its use (Lehman & Steinwachs, 1998a). Silver (2000) attacks the validity of the previous recommendation made against the use of psychodynamic psychotherapy, and states that it is based on the work done by Scott and Dixon (1995) in which they looked at psychological interventions for schizophrenia, and, instead of doing a meta-analysis, doing a literature review that lacked in depth and scope. One could also argue that, even though alternative forms of psychotherapy were not advised against, their complete absence in the recommendation makes them seem less than important.

In terms of the implementation of the recommendations made by the PORT, Lehman and Steinwachs (1998b) discuss the results of a survey done by the PORT that looked at the correspondence of current treatment plans with the recommendations made. The PORT surveyed a random stratified sample of 716 patients that were diagnosed with schizophrenia, and found that the correspondence rates between recommendations and actual treatment provided was less than 50 percent (Lehman & Steinwachs, 1998b). In light of this, the PORT made the following recommendation (number twenty-three) with regard to the use of psychological treatments:

> *...Individual and group therapies employing well-specified combinations of support, education, and behavioral and cognitive skills training approaches designed to address the specific deficits of persons with schizophrenia should be offered over time to improve functioning and enhance other target problems, such as medication noncompliance (Lehman & Steinwachs, 1998b, p.17).*

It is important to note that, although no psychodynamic-based treatment is mentioned, it is not advised against as in previous reports (Lehman & Steinwachs, 1998a).

As research evolves, the PORT has revised their recommendations, with the first update done in 2003 (Dixon, Dickerson, Bellack, Bennett, Dickinson, & Goldberg et

al., 2009). The recommendations that were published in December 2009, as relevant to this paper, state that the following therapeutic interventions are advisable for persons suffering from schizophrenia; Assertive Community Training (ACT), Supported Employment, Skills Training, Cognitive Behavioral Therapy (CBT) – in addition to an established pharmacotherapy regimen to aid the alleviation of persistent psychotic symptoms, and Token Economy Interventions (Dixon et al., 2009). Psychosocial interventions are indicated for factors that are occasionally associated with schizophrenia, such as substance abuse – for which ACT, Motivational Enhancement (ME), and CBT are prescribed, and weight management problems – for which, among others, behavioral self-management and ME are recommended (Dixon et al., 2009). Once again, no psychodynamic-based approaches are mentioned.

The most recent set of treatment guidelines for schizophrenia as provided by the APA state that "treatment with antipsychotic medication is indicated for nearly all episodes of acute psychosis in patients with schizophrenia" (American Psychiatric Association, 2009). The guideline further states that treatment with antipsychotics should be commenced as soon as is clinically practicable (APA, 2009). The delay of treatment is advised to be justifiable only in cases where patients need further diagnostic evaluation, patients refuse to take medications, or patients experience a rapid recovery as a result of severe stress or substance abuse accounting for their psychotic symptoms (APA, 2009). Needless to say, these recommendations leave very little room for alternative interventions supplemented by lower dose antipsychotics in the acute phase. The use of psychosocial interventions are recommended only in the stable phase, with approaches such as family interventions, supported employment, social skills training, ACT, and cognitive behaviorally orientated psychotherapy being associated with improved outcomes (APA, 2009). A supplement to these guidelines can be found in the latest version of Guideline Watch (Dixon, Perkins, & Calmes, 2009).

Treatment guidelines as stated by the NICE functioning under Britain's NHS provide a significantly clearer picture regarding the implementation of psychological interventions in the treatment of schizophrenia (NICE, 2002). Since 2002 family intervention therapy as well as CBT have been approved as treatments that should be made available to all NHS patients (Kennard, 2009; NICE, 2002). This guideline cites psychological treatments as a crucial component in the treatment of schizophrenia,

stating that these forms of intervention should be used to ameliorate symptoms, decrease the risk of relapse, improve insight, and support compliance with medication (NICE, 2002). As stated, neither this recommendation, nor the ones made by the PORT and the APA respectively advocate the use of a psychodynamic-based approach. This is very likely due to the fact that, although both CBT and psychodynamic theory claim to be evidence-based, psychodynamic theory's evidence is based on clinical observation in therapeutic settings, whereas the evidence supporting CBT is based on systematic research that implements quantified observations of clinical samples (Kennard, 2009). Karl Popper (In Bentall, 2006) goes as far as stating that, because psychodynamic theory is unfalsifiable, it is unscientific and therefore carries no weight. The lack of scientific evidence supporting the efficacy of psychodynamic interventions is, however, defended by some who argue that, due to the delicate and personal nature of psychotherapy and the fact that it is more reliant on relationships than technique, randomized trials are probably not the most effective method to scrutinize it (Hinshelwood, 2002).

South Africa currently does not have comprehensive treatment guidelines for schizophrenia that are based on South African-specific needs and research done in South Africa (Koen et al., 2008). The Standard Treatment Guidelines and Essential Drug List for South Africa, as stipulated by the Department of Health, covers the majority of health care in the country (Department of Health, 2008). The three page section devoted to schizophrenia affirms that it is the most common psychotic disorder and states that family counseling, psycho-education, CBT in stabilized patients, and group therapy could be used as supportive interventions (Department of Health, 2008). This is the only reference with regard to psychological interventions. The guideline further recommends the use of antipsychotic medication as treatment for schizophrenia listing haloperidol, chlorpromazine, lorazepam, zuclophentixol acetate, and benzodiazepines respectively based on the level of sedation needed, acuteness of psychosis, and aggression of the patient (Department of Health, 2008).

The implementation of psychological interventions in South Africa will clearly have to be preceded by the development and implementation of comprehensive South African-specific treatment guidelines that will regulate and support these interventions.

4.5.) Problems Related to Current Treatment Approaches in Acute-Phase Schizophrenic Psychosis

The most severely experienced side effects of antipsychotic medication as reported by South African mental health consumers are; fatigue and lack of energy, poor concentration, a decrease in libido, problems related to sexual performance, disturbances in sleep patterns, having a dry mouth, and anxiety, with between 33 and 50 percent of patients suffering from schizophrenia reporting at least one of these symptoms (Trump & Hugo, 2006). The use of antipsychotic medication implies that a neurobiological problem needs to be rectified or countered, with one of the major areas in neurobiological research focusing on the genetic component of mental illness. The role that genetics play in the likelihood that an individual could develop schizophrenia has been reported as massive, with a monozygotic twin having, on average, an almost 50 percent chance of developing schizophrenia, should the other twin be affected by the disorder (Barlow & Durand, 2005; Gottesman & Shields, 1976; Kendler, 1993;). Ross (2006) attacks Kendler, a lifetime achievement award winner for his work in the field of schizophrenia, for his statement that the genetic influence in the development of schizophrenia completely overshadows all other possible factors. Kendler supports his claim with findings from his own research that indicates a 31 percent rate of concordance for schizophrenia in monozygotic twins, a figure that actually points to the environment, rather than genetics, playing a bigger role (Kendler, 1993 In Ross, 2006). Ross goes as far as stating that, based on evidence, it is a scientific fact that schizophrenia is principally caused by environmental factors (Ross, 2006). It is also important to be aware of the fact that, before any of the literature that provide empirical evidence for the role of genetics in the development of schizophrenia existed, in 1899, Kraepelin, the discoverer of the constellation of symptoms then referred to as dementia praecox, believed and claimed that an inherited predisposition played the most significant role in the development of schizophrenia (Boyle, 1990). Others argue that the relationship between genetics and environment is better understood when described in terms of the genetic control over and individual's sensitivity to the environment, and the environment's control over the expression of the gene (Tienari, Wynne, Sorri, Lathi, Laksy, & Moring et al., 2004). These are but a few examples of the large debate surrounding the respective effects of environment and genetics on the aetiology of schizophrenia. There are those

who might even insist that it has become so incontestable that the behavior of humans is regulated by interactions between the social environment and genetic makeup that the 'nature-nurture' debate is of historical significance only (Read & Hammersley, 2006). While it is not within the scope of this paper to get involved in this debate, Geekie and Read (2008) contend that the dispute over the nature of schizophrenia amounts to the very meaning of the term schizophrenia. An example of the effect of viewing a disorder in an exclusively specific way, is the recent uncovering that close to 60 percent of psychiatric inpatients in Israel are Holocaust survivors, and that, for half a century, the majority of them have been diagnosed as suffering from the 'genetically-based disorder schizophrenia', and, with the effects of trauma being completely ignored, have been treated correspondingly (Read & Masson, 2004). Inquiring about abuse histories and traumatic events in patients suffering from schizophrenia is essential, as contextualizing the patient's symptoms and experiences could dramatically change the way that they are viewed and treated (Janssen, Krabbendam, Bak, Hanssen, Vollebergh, & de Graaf et al. 2004). It has also been argued that the environment and traumatic events can alter the neurology and structure of the brain, which could play a vital role in the development, presentation, and outcome of schizophrenia (Read, Perry, Moskowitz, & Connolly, 2001).

For a very long time, from an international perspective, the use of antipsychotic medication in the treatment of schizophrenia has been viewed as the most decisive element of treatment (Alanen et al., 2009). The efficacy of these antipsychotic interventions is regarded by many as supporting evidence that schizophrenia is in fact the result of neural-chemical imbalances (Nemade & Dombeck, 2009). Strong evidence exists both for, and against this efficacy, and one can be selective in choosing a study, as well as the way that the results are presented, to support or refute either side. To refute it, the reader is referred to a study done by Arvantis and Miller (1997) involving 361 individuals suffering from schizophrenia, from 26 centers in North America participating in a randomized, double-blind, prospective, placebo-controlled trial of the atypical antipsychotic quetiapine, otherwise referred to as Serequel. The average reduction in score on the Brief Psychotic Rating Scale (BPRS) per participant receiving a dose of 150gm of Serequel was 19.1 percent, with average scores falling from 47.2 to 38.2 (Arvantis & Miller, 1997). Attaining a score of 38.2 on the BPRS is still within the range of severe psychosis, and higher than the score of

27 that was used as a cut-off mark for inclusion in the study (Arvantis & Miller, 1997). Conversely, in support of the claim of efficacy the reader is referred to the same study by Arvantis and Miller (1997) as it is described by Kasper and Muller-Spahn (2000). Kasper and Muller-Spahn (2000) state that Serequel is at least as effective as other antipsychotics such as chlorpromazine and haloperidol, and that it demonstrates long-term efficacy in the relief of both positive and negative symptoms in acute-phase schizophrenic psychosis (Kasper & Muller-Spahn, 2000). They substantiate these claims by showing a 40 percent or greater reduction in BPRS scores compared to subjects who received the placebo (Kasper & Muller-Spahn, 2000). The mere existence of bodies of information that, depending on how the data is presented, substantiates or negates claims that heavily influence treatment policy, supports the view that the treatment of psychosis is a highly complex affair. The complexity is in part a result of the diverse range of stakeholders where treatment is concerned, including: the government, pharmaceutical companies, clinicians, patients, and patients' families/caregivers, as well as personal and social factors relating to the patient, such as ethnic and cultural background, level of intelligence, substance use, trauma history, developmental stage, socioeconomic class, academic level, and duration of untreated psychosis (Miller, McCormack, & Sevy, 2008). This complexity further lends weight to the importance of the questions that this study aims to answer in order to shed light on the elements that are currently influencing the treatment of schizophrenia in South Africa. The results of studies are, however, clearly not the only factors that are part of the debate. Many studies that aim to prove the positive effects of antipsychotics are attacked for a multitude of reasons including; the lack of methodological rigor, researchers generating hypotheses that are implausible, the publishing of data obtained from the subgroup exclusively, or the viewing of effects as artifacts (Irwin, 2004). In 2004, Irwin did a review of all the available studies of the antipsychotic chlorpromazine that met the criteria of being randomized, placebo controlled, and including individuals with a history of no contact with antipsychotic medication that had a minimum of one year of follow-up. Only three studies met the criteria (Irwin, 2004). Bola (2006), in a meta-analytic review of the effects of medication-free research in early-episode schizophrenia, states that the most noticeable finding in his review is the paucity of high-quality evidence that compares the long-term effects of initial treatment with antipsychotics compared with short-term medication postponement in early episode schizophrenia research. One could

certainly argue that these findings draw into question the myriad claims that these widely used antipsychotics are well-researched forms of treatment for schizophrenia (Bola, 2006; Irwin, 2004).

The arguments against the use of antipsychotics also include the following themes; high cost, adverse side effects (including metabolic side effects), clinicians ignoring psychosocial factors when administering medication, patient autonomy and decision-making rights, clinicians being too heavily focused on treatment rather than prevention, treatments that are not conceptually linked to the problem, non-medical justifications for the promotion of antipsychotics, the over-prescription of drugs, extrapyramidal side effects, lowered life expectancy, restlessness, obesity, sexual dysfunction, drowsiness, weight gain, and a higher incidence of cardiac arrhythmias. Treatment resistance and noncompliance are also important issues that need to be taken into account, with an estimated 20 to 40 percent of patients showing marked resistance to these drugs, and noncompliance with conventional antipsychotics approximated to be between 41 and 55 percent (Fenton, Blyler, & Heinssen, 1997; Hellewel, 1999).

The body of evidence that supports the efficacy of antipsychotics is massive, as is the body of evidence that addresses the negative effects associated with this approach. Clearly there are serious issues that need to be addressed, some of which could possibly be solved with the supplementation of antipsychotic treatment with psychological interventions. Although promising, the literature suggests that a substantial amount of research needs to be done before enough is known about the effects of psychological intervention to allow this approach to be recommended. Ultimately it is about finding a balance, and meeting the specific needs of the patients (Alanen, 1997). The fact remains that current treatment guidelines only advocate the use of psychological interventions for schizophrenia patients in the stable phase (APA, 2009). The psychological interventions that are mentioned are done so in a very brief and narrow manner, with an absence of supporting evidence for their efficacy given as the reason for this (Lehman & Steinwachs, 1998a). The researcher does, however, want to make it very clear that the problems associated with antipsychotic-use sited in this paper do not form part of an argument that goes against the use of said medication. There are problems inherent in all forms of intervention in schizophrenia, and the combination of the right treatment elements that cater for a

specific individual's needs remains an incredibly complex task. It is therefore crucial to attempt to remain objective in the search for the most beneficial relationship between different treatment elements that supplement each other in a way that compensates for respective flaws, and optimally treats the patient suffering from schizophrenia. The way that South African psychiatrists view this relationship remains unclear, and, since these factors play a large and important role in the treatment of psychosis, is in urgent need of clarification.

4.6.) Alternative Models of Intervention in Acute-Phase Schizophrenic Psychosis

The treatment of acute-phase schizophrenic psychosis can never be an either/or endeavor. The literature clearly indicates that there are a myriad of psychological and biological factors that need to be taken into account to ensure comprehensive treatment for a specific individual under specific circumstances. Alanen (1997), as well as Bola et al. (2009) advocate treatment that is patient-specific, which implies that the treatment approach is, or should be, constantly evolving. When considering reasons for the withholding of antipsychotics from patients suffering from acute-phase schizophrenic psychosis, Belleza et al. (1978) cite the rationale presented by Boisen (1942) which states that an individual suffering from an acute schizophrenic episode is faced with a specific problem that must be solved, and that there is an attempt to reconstruct their situation which may or may not succeed. A team led by Carl Rogers made a similar argument stating that the use of antipsychotics has a negative effect on the patients' emotions, hindering an awareness of their situation, thus making psychological intervention less effective (Rogers, Gendlin, Kiesler, & Traux, 1967). This concept relates to the 'developmental crises' notion that it is possible to experience growth from psychosis (Perry 1974 In Bola & Mosher, 2003). Belleza et al. (1978) adds:

> *In order to solve the basic problem of living, the acute schizophrenic needs to attain his sensitivity and awareness and must have full access to all his psychological resources. Phenothiazines, by reducing neurological sensitivity, may interfere with these problem solving, reintegrative responses* (p.107).

This is directly related to the issues of purpose of treatment. If the purpose of treatment is to provide the context for psychological intervention, antipsychotics that impede on higher cognitive processes used for problem solving could prove unproductive (Bola & Mosher, 2003). If, however, the purpose of pharmacological intervention is to keep a psychotic patient from behaving violently, harming him or herself, or from committing suicide, the use of antipsychotics seems warranted irrespective of possible neurological effects that could hinder thinking processes (Hughes, 1999). Ultimately the purpose of treatment should be to meet the needs of the patient, however complex this might be (Alanen, 1997).

The Soteria model of intervention is put forward as an alternative to over-reliance on antipsychotics, and is based on the work of Loren Mosher who viewed psychosis as "a coping mechanism and a response to years of various events that were subjectively experienced as traumatic and led the person to retreat from reality" (Aderhol, 2009, p.329). The model's original objective is to determine whether a specifically designed intensive psychological treatment, based on a relationship-focused approach that incorporates the minimal use of antipsychotics over a period of 6 weeks, will produce equivalent or better outcomes in the treatment of newly diagnosed schizophrenic patients when compared to 'traditional' hospital psychiatric ward treatments that rely exclusively on antipsychotics (Bola & Mosher, 2003). During the development of the Soteria approach to treatment, in addition to the aim of minimizing the use of antipsychotics, the approach was supplemented with the following three concepts:

> *...the recognition of significant rates of recovery without drug treatment in early episode psychosis; the observation that many patients do not benefit from medications (through drug treatment resistance and noncompliance); and a valuing of interpersonal care and treatment of mentally ill patients* (Bola & Mosher, 2003, p. 220).

According to Bola and Mosher (2003) the Soteria model of treatment incorporates "a small, homelike, intensive, interpersonally focused therapeutic milieu with a nonprofessional staff that expected recovery and related to clients in a manner that did not invalidate their experiences of psychosis" (p. 221). The treatment components utilized in this approach include: milieu, which was characterized by support, spontaneity, and involvement; attitudes, especially those of Soteria staff, who expected

positive change in patients, and were seen as more introverted, tolerant, and flexible than the average hospital staff members; therapeutic relationships, which was seen as one of the key therapeutic factors of the Soteria model and acted as the context for staff to understand patients' subjective experiences of psychosis, and which functioned as a guide toward social reintegration; social networks providing support and helping patients buffer stress, were implemented by providing the patient with a surrogate family that helped him/her with social reintegration; cultural factors also played a role leading to comparisons made between the positive effect on outcome that the social climate of the Soteria model has, with the cultural influence of social interaction on the outcome of schizophrenia in developing countries as documented by the World Health Organization (Bola & Mosher, 2003) and other studies (Irwin, 2004). The rates of recovery without the use of antipsychotics are reported as significant, in particular for those individuals suffering from early episode psychosis (Bola & Mosher, 2003). There clearly are significant differences in treatment approach when comparing conventional use of antipsychotics to combined minimal medication and psychosocial interventions in schizophrenia. It is, however, difficult to determine the specifics of these differences with regard to exact dosage used in each situation, and formalized models of implementation. The literature is vague on these points, and, in some cases, makes these alternative treatment approaches seem more like on-the-spot improvisation than evidence-based intervention, which is, as has been shown, one of the main arguments against the implementation of psychological interventions in schizophrenia (Lehman & Steinwachs, 1998a). The comparison made between conventional and alternative interventions in schizophrenia focuses primarily on the different treatment milieus in the respective approaches, and argue that it is precisely the differences in setting, staff attitude, and approach that warrants the discarding of psychopharmacological interventions (Mosher & Vallone, 1992). Five categories were identified that made the experimental setting significantly different from the control setting (representing standard hospital settings): approaches to social control that avoided codified rules, regulations, and policies; keeping basic administrative work to a minimum so as to allow a great deal of undifferentiated time; limiting intrusion into setting; working out social order on a face-to-face emergent basis; and commitment to a non-medical model that did not require symptom suppression. Unfortunately the literature does not provide the exact details of how these differences are established, regulated, and maintained. In a final review of the effects of the

Soteria approach, Mosher and Vallone (1992) state that they expected the long-term effects of psychosocial interventions to mirror those of conventional antipsychotic use, which, seemingly, was the case. What surprised them was the fact that they found the control group exposed to antipsychotics changed markedly less during the initial six week period compared to patients in the group not exposed to antipsychotics (Mosher & Vallone, 1992). Mosher & Vallone (1992) reported that these findings are contradictory to evidence put forward by pharmaceutical companies, but also stated that it is entirely possible that the control group that was treated with antipsychotics could have deteriorated even more if left untreated, which could be a reflection on the differences in treatment milieu, and the effects of those differences. One factor that is very revealing of Mosher and colleagues' attitudes toward mental illness and its causes, is the fact that they explicitly state that individuals who are relatively competent (studying, working, successfully living independently) and suffer an acute onset of psychosis as a result of life events, should not be treated with antipsychotics (Mosher & Vallone, 1992). They do not elaborate on this point, but could not blame the reader for inferring that they are leaning toward a primarily psychosocial cause for schizophrenia, which could explain their lack of confidence in the use of antipsychotics that aim to address imbalances in neurological functioning. The definition given of a relatively competent individual also typically precludes the case where an individual suffers impairment marked enough to justify a diagnosis of schizophrenia. The findings of their study reflect favorably on the absence of antipsychotics in the treatment of schizophrenia, but need to be seen in the context of the larger debate that includes: different theories regarding the causes and progression of schizophrenia; conflicting results of different studies that look at the side effects of the same antipsychotics; available resources; and the complex and idiosyncratic experience of the individual suffering from schizophrenia. Some of the measures used in this Soteria study are, however, oversimplified, and weaken the methodological rigor of the study (Mosher & Vallone, 1992). These include measures that look at precipitating events that lead to psychosis, as well as measures that determine the degree of psychosis experienced by the patient (Mosher & Vallone, 1992). Many of the ideals strived for in the Soteria model are psychologically sound, but are, unfortunately, contextualized by a lack of specific information in terms of what exactly is meant by concepts such as 'minimal-medication', 'psychosis', 'non-professional staff', and 'need-based interventions'.

The fact is that there exists a large amount of studies that report positive outcomes for the use of psychological treatments for schizophrenia in general, as well as for acute-phase schizophrenic psychosis (Aderhold, 2009; Aderhold & Gottwalz, 2004; Bola, 2006; Bola et al., 2009; Bola & Mosher, 2003; Calton et al. 2007; Chen & Moreno, 2006; Dudley & Turkington, 2009; Irwin, 2004; Kanas, 2000; Kennard, 2009; Koehler & Silver, 2009; Morrison, 2004; Mosher, 2004; Mosher & Bola, 2004; Rogers, Gendlin, Kiesler, & Traux, 1967; Scott & Dixon, 1995; Silver, 2000; Silver et al., 2004; Thorgaard & Rosenbaum, 2006). One such study (Rogers et al., 1967) states that therapy, compared to the use of antipsychotics, has a superior effect with regard to the patient's ability to: manage interpersonal relationships; decrease emotional distance from the events that they related; exhibit appropriate emotional expression; and deal with themselves, as well as the world that they inhabit.

There are, however, those that state that the Soteria model, in spite of its success as reported by the abovementioned studies, still needs to be the subject of scientific study until there is ample quality evidence indicating that this is a legitimate alternative method of treatment for acute-phase schizophrenic psychosis, and that it can not, as of yet, be put forward as such an alternative (Calton, Ferriter, Huband, & Spandler, 2007). This is also emphasized in the PORT report in which the authors state that psychological interventions are no less important than pharmacological interventions, but that there simply is not enough quality evidence to support its use (Lehman et al., 1998a). Others would argue that the criteria for a legitimate intervention method have not exactly been met by approaches that imply the exclusive use of antipsychotics either (Bentall, 2009; Bola, 2006; Irwin, 2004). Following the establishment of Soteria in 1971, roughly twelve homogenous projects have been launched around the globe, the majority of them in Europe (Aderhold, 2009). It is theorized that the lack of similar programs in the USA could be due to Mosher's supposed anti-psychiatric inclination, but many hope that the advancement of neurobiological research will reveal the 'antipsychotic' results of therapeutic relationships and stimulating surroundings, and that these will contribute to the rationale for the establishment of Soteria programs in the USA and other countries (Aderhold, 2009).

The Soteria approach is, however, but one alternative to the exclusive use of antipsychotics. There exists a range of effective evidence-based psychosocial

treatments for psychosis that must be made available to all that need it (Read & Hamersley, 2006). CBT is among the most researched of the psychological approaches, and has been proven effective in many studies. (Dudley, Brabban, & Turkington, 2009; Morrison, 2004). Other psychosocial interventions that are also put forward as treatments for schizophrenia and acute-phase schizophrenic psychosis are: family therapy (Aderhold & Gottwalz, 2004); psychodynamic psychotherapy (Silver, Koehler, & Karon, 2004); and group therapy as an integrated approach (Kanas, 2002). A more in-depth look at these alternatives is, however, beyond the scope of this paper.

The matter of the ethical implications related to the withholding of antipsychotic treatment is another issue that forms part of the battle for psychological interventions to be recognized as legitimate. This issue is addressed in a meta-analytic review that did not find any indications of long-term harm from short-term medication postponement in acute-phase schizophrenic psychosis (Bola, 2006). To ensure the ethical adequacy of medication-free research, Bola (In Chen & Moreno, 2006) suggests applying the 'middle ground' approach of Emanuel and Miller (2001). The middle ground approach utilizes three criteria for the assessment of individual research protocols to guarantee that the brief medication-free periods are ethically acceptable (Chen & Moreno, 2006). The three criteria are: 1.) A conclusive scientific argument provides grounds for the study and its design; 2.) Respondents that experience intentional trial-related medication-free periods should not be markedly more likely than those in the active-treatment group to die, to suffer any other harm including disability or permanent morbidity, to suffer non-permanent yet serious harm, or to endure grave discomfort; and lastly, 3.) Studies that meet the respective ethical and methodological criteria, are still required to implement precautions to minimize the risk of harm (Chen & Moreno, 2006). Bola et al. (2009) state that the ethical conduction of medication-free research allows for the exploration of numerous scientific questions, including:

> *...the comparison of new medications to placebo; minimum dosage requirements and dose-response predictors; whether the minimum dose of medication includes zero; developing the role of psychosocial acute treatment in the therapeutic armamentarium; identifying patients with spontaneous remission or less serious forms of psychotic disorder (e.g. schizophreniform disorder) and which distinct treatments they should*

> *receive; how to estimate effect size for the components of treatment (apart from the combined effect of many treatments); and what the predictors of patient responsiveness to different treatment components are* (p.5).

The contribution to knowledge that medication-free research stands to make, lends strong support to its implementation. This includes: a more homogeneous sub-grouping of early-episode patients; enhanced patient outcomes; a more sophisticated utilization of the medical model; and a decrease in measurement-error in the analysis of the causal factors underlying the subtypes of psychotic disorders (Bola et al., 2009).

One can argue that the specific types of psychotherapy that could be used to treat acute-phase schizophrenic psychosis in South Africa are far from being established in terms of official guidelines. In a paper termed 'Integrating Approaches to Psychotherapy in Psychosis' Margison and Davenport (2008) argue for the consolidation of different psychological perspectives in the treatment of psychosis. Interestingly, they also state that integration is significantly easier on a practical level than on theoretical level (Margison & Davenport, 2008). Unfortunately the literature suggests that the current treatment climate in South Africa does not leave a great deal of room for the practical development and integration of psychological interventions in the treatment of acute-phase schizophrenic psychosis. What is happening in reality, however, and what is possible, could be a different matter altogether. The authoritative role that psychiatrists have in leading treatment decisions in psychiatric settings in South Africa, makes them the group with the richest body of information regarding which interventions in schizophrenia work, which do not, and why, which is precisely what this research paper aims to explore.

5.) RESEARCH QUESTIONS

- What is the knowledge that South African psychiatrists have of combined minimal medication and psychosocial interventions in acute-phase schizophrenic psychosis?
- What are the attitudes that South African psychiatrists have toward combined minimal medication and psychosocial interventions in actue-phase schizophrenic psychosis?
- What are the preferred practices of South African psychiatrists for the treatment of acute-phase schizophrenic psychosis?

6.) RESEARCH METHOD

6.1.) Research Design

The proposed study has a qualitative design, allowing the researcher to gain information of the participant's experience in the specific subjective context in which it is experienced (Willig, 2001). A qualitative design also allows for the study of complex areas of health care, such as the treatment of psychosis (Fosey, Harvey, McDermott, & Davidson, 2002). Inasmuch as the responses of the research participants have a subjective nature, and are not based on simple, objective constructs, an interpretive research paradigm was applied (Scwandt, 1994). An interpretive paradigm accommodates the subjective nature of the responses as it gives importance to the attempt to discover and understand the meanings of an individual's actions and experiences (Fosey et al., 2002). It also emphasizes the importance of providing accounts of these meanings from the perspectives of those involved (Fosey et al., 2002). Semi-structured interviews with psychiatrists in Johannesburg were used in an attempt to determine their knowledge, attitudes, and preferred methods of treatment regarding minimal medication interventions in acute phase schizophrenic psychosis. Multiple data gathering techniques, such as triangulation, were not used

(Fosey et al., 2002). The use of interviews exclusively allowed the researcher to obtain sufficient information to answer the research questions, as the information was obtained directly from the group on which the research questions focus. A cross-sectional method was used instead of a longitudinal method. The participants were interviewed only once, since the researcher is interested in the participants' knowledge, attitudes, and practices, with regard to minimal medication interventions in acute-phase schizophrenic psychosis as it stands at the time of interview, and not if, or how, these constructs develop over time (Howell, 1997).

6.2.) Procedure

The researcher telephonically contacted psychiatrists working in hospital in-patient settings in Johannesburg, South Africa. The nature of the research, as well as its purpose, was explained to the psychiatrists, with a subsequent request for their participation made by the researcher. In addition to the telephone call, an information sheet containing the contact details of the researcher, the details of the research, and the research procedure as it involves the participant, was e-mailed to the psychiatrists. E-mails were sent to psychiatrists who could not be reached telephonically. The content of the e-mail resembled that of the telephone conversation. A purposive sample of 8 participants was selected from different hospital in-patient settings in Johannesburg. The researcher administered a self-designed semi-structured questionnaire in face-to-face interviews with all 8 participants. The questionnaire, which can be viewed in Appendix D, contained a maximum number of 8 questions, all of which were probed further, which allowed the researcher to obtain in-depth information. The participants were all interviewed at the hospital where they currently work. The researcher obtained informed consent from all the participants in order to allow their participation. The researcher was of aware his professional background, and acted to control for it as it could have resulted in preconceptions when conducting the interview, which could have influenced the formulation of the questions, as well as the researcher's responses to the participant's answers (Coar & Sim, 2009). Further consent was obtained to allow for the digital recording of the interviews, and the subsequent transcription thereof. Confidentiality is maintained through the use of pseudonyms, and no personal information that could lead to the identification of

participants is included in the research report. Some direct quotations are included in the report to substantiate an argument, or highlight a point. Although this implies the verbatim account of the interviewee's responses, all personal information that could lead to identification is either omitted or altered. A debriefing was not done, as the interview did not touch on any personal sensitive issues. Thematic content analysis was used to analyze the transcribed material, and is explained in detail in the analysis section. As per the Health Professions Counsel of South Africa's guidelines the recorded material will be destroyed a minimum of 2 years after publication, or after a minimum of 6 years if not published.

6.3.) Participants

The researcher has chosen to conveniently sample Johannesburg, as easy access to psychiatrists was available (Howell, 1997). Psychiatrists working in hospital in-patient settings in Johannesburg were purposively sampled, with the exclusion of psychiatrists in private practice, to promote a relatively homogenous practice environment amongst participants. Another requirement for admission to the study was that participants needed to be currently employed in a hospital in-patient setting, or need to have been a full-time employee in such a setting in the last three years. This was a non-random sample that ensured that the researcher could survey the behavior and experiences of the specific group, yielding information that will be more valuable than information obtained from a random group of individuals (McBurney, 2000). As is the nature of qualitative research based on interview, the researcher aimed to permeate social reality beyond the explicit meanings as presented by participants (Crouch, 2006). Thus, seeing that the researcher aimed to do an in-depth inquiry into the naturalistic environment of practicing psychiatrists in South Africa, a small sample was warranted (Crouch, 2006). Consequently, a purposive sample of eight psychiatrists working in hospital in-patient settings in Johannesburg were interviewed to obtain saturated data that is in-depth and rich enough to support the study.

6.4.) Data Collection Tool

A self-designed semi-structured questionnaire consisting of a maximum of 8 questions was administered by the researcher in face-to-face interviews. The use of semi-structured interviews is warranted as it allowed for a flexible interview with a conversational style (Whitley, 2002). This is advantageous when dealing with the participants' subjective experiences and attitudes, as it does not force them to answer in a specific format, and enables participants to relate their experiences of dealing with acute-phase schizophrenic psychosis in a way that reflects their own reality (Whitley, 2002). Semi-structured interviews also enabled the researcher to employ open-ended questions to allow for probing, which placed the researcher in a position to procure an increased understanding and richer information (Reja, Manfreda, Hlebec, & Vehobar, 2003). Although these questions could have been answered by doing a survey, and many more psychiatrists could be reached in this way, time constraints lead the researcher to choose a qualitative approach. Previous studies conducted within university research projects using questionnaires, have been met with very poor response rates when trying to recruit psychiatrists as participants. This drastically hindered the successful completion of the research. Interviews with a relatively small sample also allowed the researcher to gain a more informed view of the participants' reality, and yielded information that is more in-depth and richer in nature (Crouch, 2006). The questions were set in three main categories that focus on the participants' knowledge, attitudes, and practices as they relate to the combined minimal medication and psychosocial interventions in acute-phase schizophrenic psychosis. The researcher was aware of the fact that the interview constitutes a social situation, and that reflexivity possibly played a role (Coar & Sim, 2009). This means that the responses that the participants produced may be conditioned by the wider professional and social context of the interviews (Coar & Sim, 2009). This includes the participant's own agenda, his/her desire to maintain his/her professional identity, and his/her interpretation of the role that the interviewer fulfills (Coar & Sim, 2009). The researcher took these elements into account by keeping a journal of relevant factors and being mindful of the effect that he had on the interview process.

6.5.) Data Analysis

After the interviews were digitally recorded, they were transcribed verbatim. Thematic content analysis was used in the identification of patterns and central themes (Coffey & Atkinson, 1996). More specifically, the analysis approach of Potter and Wetherell (1987) was used, and the researcher was mindful that the participants' responses could have been influenced by their view of the objective of the interview. The researcher gathered sections of text under broad categories, and added provisional categories, after which these categories were refined in the search for emerging themes (Boyatzis, 1998). These themes made the large quantity of in-depth information that interview studies typically yield more manageable. The next step was coding the data in order to link relevant responses to the determined themes, and to compare the responses (Boyatzis, 1998). After the data was coded and sorted into relevant themes, and was reduced to a manageable size, the researcher familiarized himself with the data. This entailed the meticulous reading of the data to identify the main themes, which lead to the focusing of the data (Sarantakos, 1998). The final step in the analysis process was the interpretation of the data. The researcher was fully aware of the fact that both the quality and the authenticity of the research are greatly affected by the extent to which interpretations are made from the information gathered (Fosey et al., 2002). In accordance with this the researcher aimed to maintain awareness of the possible effects that external and personal factors could have had on the interpretation of the responses. These effects were also included in the data analysis section to improve the transparency of the research process (Oliver, 2004). To avoid 'conceptual blindness', the researcher took care not to allow his familiarity with the area of study to dominate the process of data analysis (Coar & Sim, 2009). This also helped to ensure that the acquisition of novel insights remained possible (Coar & Sim, 2009). The research supervisor acted as a point of verification in this regard.

6.6.) Ethics

Since there are clearly many different and opposing schools of thought with respect to the treatment of schizophrenia, the researcher was careful not to put participants into a difficult position by making them feel that they should advocate a specific approach

to treatment. The researcher's responses to the participants' answers were given carefully, ensuring that the participants did not feel evaluated or judged. The researcher also took care not to place the participants in an exam-like situation in which they could feel that their knowledge was being tested (Coar & Sim, 2009). This could, however, have happened despite the fact that the interviewer was looking for conceptual understanding of alternative methods of treatment in acute-phase schizophrenic psychosis, rather than a factual understanding (Coar & Sim, 2009). Thus, from the outset, the researcher informed the participants of this fact, and explained that there are no wrong or right answers. It was also stated clearly that no preparation would be necessary prior to the interview. This also allowed the participants to maintain their professional identity (Coar & Sim, 2009).

With regard to issues of confidentiality, participants might not want their opinions made public. Thus, an agreed upon alias was used during transcription. Issues of confidentiality have been more thoroughly addressed in the 'procedure' section. Participants obtained a signed copy of the consent form ensuring the confidentiality of the material. The recorded and transcribed data is kept in a secure location, with only the researcher and his supervisor having access. Since the researcher is aware of the participants' personal information, anonymity cannot be preserved. The informed consent form also contains the contact details of the researcher, should participants have any questions or concerns.

It is extremely difficult to conduct research separately from its political, administrative, legal, and economic considerations. Thus it is important for researchers to adhere to a code of conduct where research is concerned, especially where human participants are involved. Included in this code of conduct is the researcher's duty to ensure that all participants are completely informed.

To ensure this, the researcher followed these guidelines provided by Fink and Kosecoff (1998):

- Give a fair explanation of the procedures to be followed and their purposes.
- Provide a description of any risks and benefits.
- Offer to answer any inquiries.
- Provide the instruction that the participant is free to withdraw consent and to discontinue participation without prejudice.

7.) RESULTS

Thematic content analysis was used to identify themes as they emerged in the interviews. Themes have been selected based on their relevance to the literature, the frequency of responses, and the focus of the study. These themes have been grouped under the headings Knowledge, Attitudes, and Practices, which was also the structure used to inform the content and layout of the interview schedule. The themes will be presented thus, supplemented by relevant quotes from the participants' answers. The interpretation of these themes will follow in the Discussion section.

7.1.) KNOWLEDGE

This section looks at the themes that correspond to the Knowledge component of the participants' responses. These themes were selected based on the frequency with which they occurred in the responses, and their relevance to the participants' knowledge regarding combined minimal medication and psychosocial interventions in acute-phase schizophrenic psychosis.

7.1.1.) Problems Related to the Definition of Schizophrenia and its Phases

The definition of schizophrenia was a contentious issue for some of the participants, as the disease manifests in a variety of ways, and has a broad range of symptoms that play out in a particular way depending on the profile of the patient.

> ***Participant 1:*** *Well I would be very interested in knowing what kind of schizophrenia patients they treat, um, was it people who were only deluded, or did they have predominantly negative features or behavioral features? Were they sort of acting out on command hallucinations? Because if you go and look at acute-phase schizophrenia there is a huge variety of how people can present.*

The matters of the progression of schizophrenia, and the subsequent phases that follow were also mentioned as problematic, as the different phases warrant different approaches. Even though the researcher defined acute-phase schizophrenic psychosis

as an active psychotic state experienced by an individual suffering from schizophrenia, some participants still felt that the definition is somewhat unclear.

> **Participant 2:** I just, getting back to your definition, I would put in psychosocial interventions in the acute phase after two weeks, depending on the patient. Acute as in the first six months, then definitely. It just depends on the definition.

7.1.2.) Participants' Awareness and Knowledge of Combined Minimal Medication and Psychosocial Interventions in Schizophrenia

More than half (5 out of 8) of the participants were not aware of the existence of combined minimal and psychosocial interventions in acute-phase schizophrenic psychosis.

> ***Participant 4:*** *No, not in our circuit that I know of, or wider spread either.*

> ***Participant 5:*** *I'm not aware of these projects in terms of these patients being psychotic yet, basically I am aware of withholding medication in patients in the pre-phase of schizophrenic, the prodromal phase, so my answer would be no I am not really aware.*

Less than half (3 out of 8) of the participants were aware of the existence of combined minimal and psychosocial interventions in acute-phase schizophrenic psychosis, although they did not possess any detailed knowledge regarding the interventions.

> ***Participant 2:*** *Uh, I think there is the ones in Melbourne, they were using lots of psychosocial interventions in Melbourne, and I think there's some in America, so I am aware of some of the projects. The one that, in particular early intervention in psychosis is the one in Melbourne, but um, I must be honest, I am aware of it, but not in much detail.*

> **Participant 5:** I sort of briefly read about them, but not extensively, I know that it happens, but my knowledge of it is not very good.

7.2.) ATTITUDES

This section focuses on the Attitudes component of the participants' responses. The sub-themes reflect the different aspects that make up the participants' attitudes toward combined minimal medication and psychosocial interventions in acute-phase schizophrenic psychosis.

7.2.1.) Negative Attitudes toward Soteria-Based Models of Intervention

Participants were given a standardized explanation of what combined minimal medication and psychosocial interventions in schizophrenia would look like, in particular based on the Soteria approach. This explanation can be viewed in Appendix E. More than half (5 out of 8) of the sample stated negative opinions of this model.

> ***Participant 1:*** *But, in my opinion I would be against it, because we know from the literature that untreated psychosis could be detrimental to a patient, so we want to try and reduce the psychotic episode to lessen the cognitive fallout and things like that, so for me I'm more to advocate structure, boundaries, containment, I think the patients do well, so from my perspective, those projects I would not be in favor of.*

> ***Participant 4:*** *Very negative, because it is very difficult to predict outcome. I think my sort of thought process and focus in terms of schizophrenia and psychosis in the acute phase is basically maybe three fold, immediate, medium term and long term. Now the most concerning for me are the long-term effects of psychosis if left untreated.*

> ***Participant 3:*** *I still wouldn't think much of that kind of approach. We are very clear on schizophrenia being a severe biological illness, and the psychosocial factors are certainly there in terms of promoting relapses and making people remain unwell, but certainly as a causative factor on it's own, and definitely when people are acutely ill, to withhold treatment from such people may even be unethical in many cases.*

Participant 5: I think it would have very low value, I cant see such an approach being implemented first of all, because I think South African research is very much in keeping with international trends in terms of etiology and management of schizophrenia being largely biologically based with antipsychotics, and then psychosocial interventions being adjunct.

7.2.2.) Psychosocial Interventions in Acute-Phase Schizophrenic Psychosis Seen as Negligent and Unethical

More than half (5 out of 8) of the participants stated that they see the withholding of medication, and the substitution of medication with psychosocial interventions as negligent and unethical.

Participant 2: *Once again I think in the acute-phase schizophrenia psychosis psychosocial intervention is much less, or even negligent, versus the effect of medication.*

Participant 3: *The first thing is that ethically I don't know how one can get clearance for that, it's almost as though one is doing a placebo trial, you know that leaving the person psychotic is dangerous to them for a number of reasons, and you have treatment available that is helpful and you are not using that, so ethically I have a problem with those kind of studies.*

Participant 6: We are very clear on schizophrenia being a very severe biological illness, and the psychosocial factors are certainly there in terms of promoting relapses and making people remain unwell, but certainly as a causative factor on it's own, and definitely when people are acutely ill, to withhold treatment from such people may even be unethical in many cases.

7.2.3.) Psychosocial Interventions only Indicated for 'Soft' Psychosis

Half of the participants made it clear that psychosocial interventions are indicated only in cases of softer psychosis, in particular where the patient does not exhibit severe behavioral problems, or poses as significant danger to themselves or others.

> ***Participant 1:*** *Ja, you have to remember, that X is a psychiatric hospital. We receive the people that are really bad, I mean they have to be made involuntary after they arrive. So they are at the extremes of the spectrum, and um, like I say I don't believe that the ones that we receive acutely are in any way, I think that they would be considered dangerous for people to work with, they are quite irritable, the schizophrenia, they may lash out, and I must say that I don't have the experience that in the acute psychotic phase that any kind of psychological intervention helps them.*

> ***Participant 3:*** *You know it's difficult to say, probably there is a broader aspect of what is the acute phase, I mean patients we see here at Y often are not just psychotic but are aggressive, and have behavior problems. But often there are just the deluded, that don't have any aggressive behavior problems, and they might be sort of, more suitable for psychological intervention.*

> ***Participant 4:*** *However, schizophrenic is too heterogeneous, it is a very broad disorder, either spectrum you may get very different patients with very different symptoms, in terms of behavior control and aggression, secondary to the psychosis, it is very risky I would say, but that is sort of a very bird's-eye view, from my point of view.*

7.2.4.) Psychosocial Interventions in Schizophrenia Viewed as Supportive Only

All of the participants stated that they see psychosocial interventions, and approaches that involve the delay of medication as supportive only, and that these models of interventions need to be viewed as adjunct if indicated, and not as primary interventions.

Participant 1: *I don't think their brains are quite organized enough to work with therapy, um, socially, um, yes I think that, maybe in a supportive role, but those would be essentially for mood related issues… Other than supportive I don't see, I don't generally offer psychologists in the ward in the acute phase.*

Participant 2: *So the psychological would be family therapy, um, sorry I don't know if I'm answering the question right, family intervention as in supportive psychotherapy... For the patient could be supportive, um, you know looking at the impact of the social as part of the illness, so very different from what you are describing. It is more supplementary, and thereafter to bring in alternative interventions, thereafter I am all for insight orientated therapy, CBT or whatever, but, my first and foremost is medication.*

Participant 5: *Mostly acute phase schizophrenia the psychologists don't get involved, it's a bit later, unless it's the family, we get the family involved to try and understand what is going on, so only in terms of social circumstances.*

Participant 7: *That does not say that we are not doing individual therapy, it is definitely there too, primarily on a constant interview basis, getting collateral, making them part of family therapy, is most definitely part of it.*

Participant 8: *In terms of their being a role, it certainly would not be the pivotal role or the dominant role, it would be more supplementary, in terms of interaction with the patient, getting them to trust you, and longer term with compliance with... and that is not to treat psychosis, but to treat the impact that the psychosis is having on the individual, which is actually part and parcel of the management of that individual.*

Most of the participants (7 out of 8) supplemented this view with their understanding that the effect on a patient suffering from schizophrenia renders them incapable of making use of psychotherapeutic interventions.

Participant 1: *I don't think their brains are quite organized enough to work with therapy.*

Participant 5: *At this moment I must say I don't think there is a role for a psychological intervention in someone who is acutely psychotic, um, because of the patient's psychosis, be it their thought content or their thought disorder, there is actually no role for it in the acute phase.*

Participant 6: *Now psychosocial interventions in the acutely psychotic person it is very difficult because we don't view them as having enough sort of insight into understanding psychological processes. In our mind the basis for psychosis is, there is disturbed understanding of reality and self.*

Participant 8: *Well I don't think it is going to be very helpful when the patient is psychotic. You can't talk to them cause they don't have any sense. The psychologists say that it is no use to talk to them… These are psychotic people, they are out of touch with reality, I would leave them on the medication.*

7.2.5.) Negative Attitudes Toward Psychodynamic Interventions in Schizophrenia

When participants were probed in terms of specific psychosocial or psychological interventions that they would not be willing to implement, 7 out of 8 stated that they would not be willing to implement any form of psychodynamic psychotherapy when treating acutely psychotic patients suffering from schizophrenia.

Participant 1: *Whilst I do believe that the delusions can serve some kind of psychological purpose, um, I don't believe that there's a role in the initial phase, um, in fact, I dealt with a patient that was psychotherapised in the initial phases, and it actually worsened his psychosis significantly, and kind of created a whole new set of sexually inappropriate delusions. I have to say that that was done with*

psychodynamic therapy, which I think we all know is not appropriate to it... But my general experience is that it becomes too abstract for the schizophrenic to deal with.

Participant 2: *I don't think it has a place to be honest, I would go more supportive, maybe CBT, but I would definitely not go with psychodynamic psychotherapy. Patients not in touch with reality, they are agitated and irritable, they can't reflect, but that's why I say possibly a CBT approaches for the here-and-now, and the delusion, uh, but not psychodynamic, definitely not psychodynamic.*

Participant 5: *Well it may reflect more my experience and my knowledge base of what the relevant treatment for a condition like schizophrenia is, and it doesn't include psychodynamic therapy, you know I have seen patients who can completely regress with psychodynamic psychotherapy, but when you are dealing with a psychotic patient you already have someone where ego boundaries are tenuous, where reality testing is impaired, and to use a psychodynamic approach can be even dangerous.*

It should also be noted that the respondent who did not state negative opinions toward a psychodynamic approach, did not state any favorable opinions toward it either, and failed to mention it in its entirety.

7.2.6.) Cognitive Behavioral Therapy Indicated for the Treatment of Schizophrenia

The majority of participants (5 out of 8) indicated that they are in favor of Cognitive Behavioral Therapeutic (CBT) interventions in the treatment of schizophrenia, although this method of intervention was also indicated as a secondary adjunct to medication.

Participant 3: *Well, like we all know Cognitive Behavioral Therapy has been proven beneficial. One would obviously have to establish if the person has the cognitive abilities before you start.*

Participant 4: *If they are acutely psychotic what I generally find is that, if the delusions are not shifting, then you could use maybe a CBT approach in the acute phase, then yes there's a place, maybe challenge the delusions, but, I think in the acute phase it's more support.*

Participant 6: *Um again I think I am kind of showing my concrete nature, that it is about what is possible, that CBT generally is time-limited, where psychodynamic is rather more intensive and long-term.*

7.2.7.) Psychosocial Interventions in Schizophrenia Not Viable in South Africa

Most participants (7 out of 8) indicated that they do not think that combined minimal medication and psychosocial interventions in schizophrenia are viable in South Africa, as the current health-care system simply does not have the necessary resources available.

Participant 1: *I don't think it would be viable. I mean first of all to get minimal, in terms of the South African health-care system, at present we don't even have enough in terms of the structured facilities, homes, rehab centers. So for something that is so, in terms of very little literature, and very little evidence based, I would not waste my resources.*

Participant 3: *We are struggling to get patients that have been fully medicated and with some level of psychotherapy in our wards out into the community and keep them stable with the current resources. It sounds like these projects needs lots of fairly intense and trained people, and you need high numbers of these environments. It could be fairly difficult if it is state-run, based on what I know of the state's mental institutions, and what I know of the district psychiatric services. It seems to be fairly under-funded and under-staffed, and um, very difficult to track psychiatric patients because of the nature of their illness in general.*

Participant 7: *And that is again based on elements that we have to take into consideration, um, like resources, that once again does not say that you are not going to do psychosocial, but just to think how we are going to do it with one, personally I don't think, not viable.*

7.2.8.) The Importance of a Biopsychosocial Approach to Treatment

Half of the participants stated the importance of a biopsychosocial approach to the treatment of schizophrenia. These participants made it clear that linear approaches to the treatment of the disorder will fail, as they do not address the vast range of needs that these patients have.

Participant 1: *I think psychological is very important, because I think you know, giving someone a diagnosis of schizophrenia has major implications, and I think the patient needs a lot of support, understanding, insight into the condition and, also um, you got to give, remember that the high emotional state increases their risk of relapse, so you need to contain the patient in psychotherapy in long-term, it's vital for a patient with schizophrenia, because you want to reduce their stress. So they need therapy.*

Participant 7: *I'll try and approach the answer to say that it could not be seen as an either/or scenario. To just think that you need to use medication is ignoring a total critical part of the reality of care. To try and focus just on psychosocial issues without the immediate, if I can call it the medical side of it, you would also be I think, not dealing with the whole picture. So in my view, I think that you should always include at least 3 issues together, and that it is not an either/or choice, I don't think it should be.*

7.2.9.) Schizophrenia Understood as a Biological Illness

The majority of participants (5 out of 8) made it clear that they understand schizophrenia to be a biologically based disease, and that interventions need to reflect this fact.

> ***Participant 1:*** *Ok, uh, psychologically, I don't think there is a place initially. We know that it's a biological illness, and it's got clearly shown biological undertones.*

> ***Participant 4:*** *Now we, I think we've been made aware as psychiatrists in terms of the positive effects of medication, structurally on the brain and all that.*

> ***Participant 5:*** *I mean schizophrenia is a biological illness, so biological treatment is the mainstay, so effectiveness would not compare, in terms of not being as good as medication biologically... we are very very clear on schizophrenia being a very very severe biological illness.*

> ***Participant 8:*** *I think South African research is very much in keeping with international trends in terms of etiology and management of schizophrenia being largely biologically based with antipsychotics... there's well-documented evidence for biological treatments for an illness like schizophrenia.*

7.3.) PRACTICES

7.3.1.) Psychosocial Interventions Not used in the Treatment of Acute-Phase Schizophrenic Psychosis

The majority of participants (7 out of 8) stated that they do not employ psychological interventions in acute-phase schizophrenic psychosis.

> ***Participant 1:*** *In the acute phase I haven't found it useful. I don't use the psychologists for that no.*

> ***Participant 8:*** *Well I don't think it is going to be very helpful when the patient is psychotic. You can't talk to them cause they don't have any sense… But once somebody is psychotic, and they are out of touch with reality, once they say they are not from this planet, and they are directly from God, like, um, there's really no alternative to medication… I don't think that psychosocial interventions are an alternative to somebody who is psychotic.*

There was one participant who stated that they do in fact employ psychological interventions in the acute phase on his ward. These interventions do not, however, include insight-based individual psychotherapy.

> **Respondent 7:** Our psychology colleagues have 3 sessions or groups, during the week, a more introductory group on a Monday, a sort of progress group on Wednesday, and a discharge, or being prepared for discharge group on a Friday so, that doesn't mean that any psychological support process has been concluded by then, but in attempt to see how one can manage the further containment or experience of being on the ward, being like in a situation of having to do with different people, strange fellow patients, staff, medication, experience is part of it, so we try to touch base in 3 different phases of it, and see that as the process, rather than having an individual process with each individual person. That does not say that we are not doing individual therapy, it is definitely there too, primarily on a constant interview basis, getting collateral, making them part of family therapy, is most definitely part of it.

7.3.2.) Medication Primarily Indicated in the Treatment of Schizophrenia

The majority of participants (7 out of 8) stated that medication is the mainstay in the treatment of schizophrenia.

> ***Participant 2:*** *I am very pro medication in the acute phase. I do not think that patients should be made to believe that they can be healed by psychotherapy. The mainstay is medication and that should be clear*

from the start. I don't think that people should be made to believe that you can heal it with talk therapy.

Participant 5: Well, acute-phase schizophrenia psychosis implies that the patient is at that time acutely ill, and our definition of acute psychosis is that it is people who warrant urgent biological intervention first and foremost.

7.3.3.) Psychiatrists Not Willing to Withhold Medication

Six out of eight participants stated that they are not willing to withhold medication in the treatment of schizophrenia.

Participant 3: *No, because of all the answers that I have given before. There's well documented evidence for biological treatments for an illness like schizophrenia.*

Participant 4: *If somebody presents to me and they are psychotic for whatever reason, and I believe that it is the result of schizophrenia and not a medical condition, or a substance or something of that nature, I would not withhold medication under any circumstances.*

7.3.4.) Psychiatrists Willing to Minimize Medication

The majority of participants (5 out of 8) indicated that, under the right circumstances, they would be willing to decrease the dose of medication. The dosage would not, however, be decreased below the effective threshold, and it would not be done in view of the implementation of insight-based psychological interventions.

Participant 1: *So ja, um, the medication definitely has an impact on patients, but for me it is, if a patient has to live in the community, they cannot sit with the impairment that they sit with here, so we have to decrease the dose and make it possible for them to live, if they are that sedated and impaired they will stop the medication, so hopefully then they can start with therapy. But when I use such high dosages of*

medication they are acutely ill, and are a danger to themselves and others, and therapy might not be indicated. Once they are not that problematic, I decrease dosage so that they are more likely to stay on the medication and more likely to function.

Participant 4: One would try to get away with the lowest allowable dose, so if I think that the patient was doing well with regard to the psychosocial treatment that was available to them, obviously I would decrease to as little as possible.

7.3.5.) Practices in Terms of Delay of medication

The majority of participants (5 out of 8) stated that, if a diagnosis of schizophrenia has been made, they administer medication as early as possible, and that there are severe risks to delaying medication, as the psychotic process is toxic.

Participant 1: *I think the risks are too obvious and too great to not help. I mean the whole drive in psychiatry at the moment is to diagnose early, and start treatment early, and therefore prevent, um, further progression of the illness, and that's the whole debate at the moment, at what point is it enough to start medication, which is a drastic step. If psychology has a role in the pre-morbid intervention, I'm not sure, I don't know enough. Actually once they have been diagnosed I think they should be treated.*

Participant 5: *We also know that the toxicity of ongoing psychosis is well documented as well, and that the earlier you intervene and treat, the better the long-term outcome may be.*

Participant 6: *I think in the acute phase you need to get rid of the psychotic symptoms firstly because of the distress it causes the patient and secondly because of the toxicity of the psychotic state to the individual.*

Contrastingly, one participant stated that they have delayed medication in the treatment of acute-phase schizophrenic psychosis, although it was stated that this is not standard practice.

> ***Participant 3:*** *Yes I have, um, like I said this would be in cases where the patient presents with psychosis, possible schizophrenia psychosis, but I am not sure if he needs medication, or if this is just a reaction to an underlying psychological problem, but this would be cases where patients are obviously not a danger to themselves or others, and are more contained. But yes I have done that, and sort of, also bearing that in mind, you also need a psychologist that is prepared to work with a patient like that, so I have been fortunate in that I have a few intern psychologists that are keen to try it. Not many, I think less than ten patients.*

7.3.6.) Treatment Approach Based on Available Resources

Half of the participants stated that a lack of resources greatly influences their treatment approaches with regard to schizophrenia, and that this has an impact on their use of alternative interventions, or lack thereof.

> ***Participant 3:*** *I often wonder if what we are doing is the right way, its the only way that we have, the only choice, but if we had the facilities or the time for this I would be very interested to see what the effect would be. Because like I say there is often doubt in prescribing medication, increasing it all the time until the patient gets better, it would be good to know that there's an alternative. But we often deal here, you have to get the patient better to get the bed open for the next aggressive demanding patient, so the luxury of waiting and seeing is sometimes necessary but not possible, and um, so that's why I say if we could work on the circumstances and look at this I would be fascinated, if there is an alternative to just medicating.*

> ***Participant 6:*** *I know that right here at X I could not do that with my patients, there's not the skills, there's not the people available, so on a*

purely practical level I know I could not do anything like that to allow me to not give medication.

7.3.7.) Query of Diagnosis in Cases of Schizophrenia indicated for Psychosocial Intervention

Half of the participants stated that, if a psychological intervention were indicated for acute-phase schizophrenic psychosis, they would question the diagnosis of schizophrenia.

> ***Participant 4:*** *And we've had some good results with psychological, but then I query the diagnosis of schizophrenia, they come with a diagnosis of schizophrenia, but I then doubt. Because we mostly get referrals and the diagnosis says schizophrenia, but then we take time or the psychologist takes time, and we sort of revisit the diagnosis, and then I don't think it's schizophrenia.*

> ***Participant 8:*** *Cause that may often be still a question, it may be co-morbidity, it may be substance related, but acute psychotic presentations, what one is saying in terms of the medication treatment is pertaining specifically to schizophrenia.*

7.4.) DISCUSSION

The aims of this research project were, firstly, to determine the knowledge that psychiatrists, currently practicing in acute psychiatric wards in government hospitals in Johannesburg South Africa, have of combined minimal medication and psychosocial interventions in acute-phase schizophrenic psychosis. A second aim was to explore the attitudes that these psychiatrists have toward combined minimal medication and psychosocial interventions in acute-phase schizophrenic psychosis. Lastly, a third aim was to determine the practices of these psychiatrists when treating acute-phase schizophrenic psychosis.

The results clearly indicate that none of the participants had in-depth knowledge of combined minimal medication and psychosocial interventions in acute-phase

schizophrenic psychosis. The majority of participants (5 out of 8) were completely unaware of these interventions, while of the three participants who were aware of them, only one had some knowledge on the subject. With regard to attitudes, the majority of participants (5 out of 8) clearly stated that they would be against the use of combined minimal medication and psychosocial interventions in acute-phase schizophrenic psychosis, as it would be unethical and negligent to withhold or minimize medication due to both the distress caused by psychosis, and the toxic effect that it has on the brain. All of the participants specified that they view psychosocial interventions (at any phase of psychosis) as supportive only (and not having any direct role in managing or reducing symptoms), with some participants stating that psychological interventions need to focus on the needs of the family of the patient. Most participants (7 out of 8) indicated that the implementation of combined minimal medication interventions in acute-phase schizophrenic psychosis would not be viable in South Africa, as the required resources are not available. With regard to practices, the majority of participants (7 out of 8) stated that they do not use any form of psychological intervention aimed at the patient during acute-phase schizophrenic psychosis, as the patient cannot make use of a psychological intervention. This view was supplemented by the fact that the majority of participants (7 out of 8) stated that medication is the mainstay in the treatment of acute-phase schizophrenic psychosis as it is a biological disorder. Most of the participants (5 out of 8) would not be willing to minimize or withhold medication during an episode of acute-phase schizophrenic psychosis, while two participants did not comment on this, and one stated that he has withheld medication in cases where there was uncertainty regarding the diagnosis. Again the issue of available resources was raised, as half of the participants stated that the lack of resources in public mental health care in South Africa has a marked influence on the interventions that they choose to implement in the treatment of acute-phase schizophrenic psychosis. These findings will now be discussed in more detail.

The knowledge section of the results consists of two sub-themes, the first being ‘Problems Related to the Definition of Schizophrenia and its Phases’. Although the researcher did not originally set out to investigate psychiatrists’ understanding of the definition of schizophrenia and its phases, it is crucial to indicate that this theme did in fact emerge, as each participant’s understanding of the definition of schizophrenia will influence their subsequent use of the term and their understanding of

schizophrenia's progression from one phase to another. It was, however, communicated to participants that acute-phase schizophrenic psychosis was defined within the study as referring to a patient who has been diagnosed with schizophrenia and is acutely psychotic. This theme is also linked to the literature that discusses the use and misuse of the term schizophrenia, and how the differing opinions regarding a definition alter the way that the disorder is understood, researched, and treated (Boyle, 1990; Kennard, 2009; Potvin, Stip, & Roy, 2005).

The second theme focused on the participants' awareness and knowledge of combined minimal medication and psychosocial interventions in acute-phase schizophrenic psychosis. The majority of participants (5 out of 8) were unaware of any minimal or delayed medication interventions, or psychological interventions, in acute-phase schizophrenic psychosis. It is not possible to measure the novelty of this finding against a locally relevant understanding or baseline of what psychiatrists in South Africa do know, or should know, about alternative interventions in acute-phase schizophrenic psychosis, as an exhaustive literature review has produced no such studies. This finding was, however, in line with relevant international treatment guidelines, as well as local treatment guidelines, as South African psychiatric training and treatment approaches in schizophrenia are very much in keeping with American and British treatment guidelines, and alternative interventions are not indicated for acute-phase schizophrenic psychosis in these guidelines (APA, 2009; Department of Health, 2008; NICE, 2002).

The attitudes section of the results consists of multiple sub-themes, some of which have been grouped as they inform one another. Participants were clearly against the use of minimal medication or psychosocial interventions that incorporate the elements of the Soteria model when treating acute-phase schizophrenic psychosis. These elements include the minimal or delayed use of antipsychotic medication, an unstructured non-hierarchical approach, the understanding that therapeutic relationships are pivotal in treatment, and the use of non-professional staff (Bola & Mosher, 2003). These responses are reflective of the rationale provided in the literature advocating against the minimizing or withholding of medication when treating a patient suffering from acute-phase schizophrenic psychosis. This rationale in part revolves around two important issues, the first being that psychosis is toxic to the brain, and the second that psychosis is greatly distressing to both the sufferer and

to those around them (Potvin, Stip, & Roy, 2005). Both of these issues were cited by participants and given as reasons for viewing certain aspects of the proposed minimal medication interventions as unethical and negligent. Half of the participants indicated that they view psychological interventions to be more indicated in cases of 'soft' psychosis. Although there are no formal definitions of 'soft' and 'hard' psychosis, participants did distinguish between the two as they indicated that, at times, there are certain behavioral problems and aggression coinciding with acute-phase schizophrenic psychosis, that necessitates the use of antipsychotic medication in order to ensure the safety of the patient and those around them, perhaps partially influencing these cases being referred to as 'hard' psychosis. Although there are no formal distinctions between 'soft' and 'hard' psychosis, participants did seem to view 'hard' psychosis as denoting a more acutely psychotic and behaviorally problematic state than 'soft psychosis'. Interestingly, the literature does make a distinction between 'organic psychosis', which clinically presents with hallucinations, delusions, and marked disordered thought, and a newly proposed term 'behavioral psychosis' which is typically characterized by disturbances in reality testing or "minor, nonlocalizable, objective abnormalities… that represent a developmental lag rather than a fixed abnormality" (Barkus, Stirling, Hopkins, & Lewis, 2006, p.1; Venugopal & Murali, 2010). The latter definition does not seem to imply acute-phase schizophrenic psychosis as informed by the DSM-IV-TR (American Psychiatric Association, DSM-IV-TR, 2000).

The view that it is unethical and negligent to withhold or delay medical treatment, that psychotic schizophrenic patients cannot make use of psychological interventions, and the fact that there are severe behavioral problems that need to be taken into account in many of the institutions where the participants practice, all contextualize and motivate the fact that the participants unanimously stated that psychosocial interventions in acute-phase schizophrenic psychosis are seen as an adjunct to medication in the non-acute phase only. These responses are in concordance with the treatment guidelines as stated by the APA (2009) and the Department of Health of South Africa (2008). Participants' view of psychosocial interventions as supportive only, is further informed by their view that schizophrenia is understood as a biological illness. The majority of participants (5 out of 8) stated that schizophrenia is caused by biological processes, and that treatment should reflect this. This attitude toward the cause and

nature of schizophrenia is widely cited in the literature, and typically presented as the main rationale for the use of medication in the treatment of acute-phase schizophrenic psychosis (Laungani, 2002; Ross, 2006). Biases toward a biological explanation for the aetiology of schizophrenia is viewed by some as reductionist, as Bentall (2009) points out that "biological investigators have almost universally failed to consider the possibility that their findings might reflect the tribulations of life, rather than some legion or genetic scar carried by the victim from birth" (p.152).

Despite the fact that psychosocial interventions are seen as supportive only (as opposed to having any use in managing or reducing core symptoms), half of the participants stressed the notion that the treatment of schizophrenia necessitates a biopsychosocial approach, as there are a multitude of psychosocial environmental factors that influence the development of the disorder, relapse rates, and successful treatment (Koehler, 2004; Read, Seymour & Mosher, 2004). This advocating of an integrated approach does not, however, resonate with Alanen's (1997) idea of patient-orientated treatment, as the psychosocial intervention as seen by participants acts as an adjunct to support the use of medication as primary intervention, and not as a possible primary intervention in its own right. This was further emphasized as participants stressed that the psychosocial interventions in acute-phase schizophrenic psychosis that are indicated as supportive, do not include insight-based psychological interventions such as psychodynamic psychotherapy. Psychodynamic psychotherapy is at the forefront of contentious aspects inherent in psychological interventions in acute-phase schizophrenic psychosis as it necessitates a patient that can make use of interpretations, and insight-orientated therapy. The literature reflects this inasmuch as none of the treatment guidelines advocate its use in the acute phase, and most of them advise against it, including as an adjunct to medication (APA, 2009; Dixon et al., 2009; Lehman & Steinwachs, 1998a; Lehman & Steinwachs, 1998b; NICE, 2002). Most of the participants (7 out of 8) made it clear that they are against the use of psychodynamic interventions in acute-phase schizophrenic psychosis. Participants substantiated this view by stating that the acutely psychotic schizophrenic patient is too agitated to tolerate increased anxiety, and that psychosis renders them incapable of making use of insight-orientated therapy as they are thought disordered and incapable of reality testing due to tenuous ego-boundaries. This view, although somewhat anticipated based on the literature, and in accord with relevant treatment

guidelines, is also partially in opposition to arguments put forward by proponents of psychodynamic approaches to the treatment of acute-phase schizophrenic psychosis who state that it allows clinicians to make sense of patients' bizarre and eccentric communications via the use of an in-depth theoretical framework (Jackson, 2009; Martindale, 2008). These proponents do not, however, explicitly advocate for the use of psychodynamic interventions in acute-phase schizophrenic psychosis, but rather highlight the fact that a psychodynamic approach enables the clinician to think about the dynamics of the patient, and make some sense of the bizarre content of their thought and speech (Jackson, 2009; Martindale, 2008).

Cognitive Behavioral Therapy (CBT) was viewed in a contrasting light, with the majority of participants (5 out of 8) stating that they would be for its use, although as supportive, and a supplement to medication only in the non-acute phase. The main reason provided by participants for this was that CBT is a time-limited, symptom-focused, and scientifically proven and verifiable psychological intervention, which reflects the rationale provided by the most influential treatment guidelines which indicate that, unlike Psychodynamic interventions, CBT as supportive intervention warrants inclusion in the recommendations precisely because of its scientifically proven efficacy (APA, 2009; Fenton, 2000; Kennard, 2009; Lehman & Steinwachs, 1998a; Lehman & Steinwachs, 1998b; NICE, 2002). Lastly, participants' attitudes toward combined minimal medication and psychosocial interventions in acute-phase schizophrenic psychosis were heavily influenced by the under-resourced nature of the South African health care system, and the contrasting resource intensive nature of the proposed alternative interventions (Koen, Magni, Niehaus, & le Roux, 2008; Trump & Hugo, 2006). The majority of participants indicated that, due to a lack of resources, they do not think that the proposed alternative interventions would be viable in South Africa.

Psychiatrists' practices in terms of the treatment of schizophrenia as reported by participants clearly reflect the treatment guidelines as stipulated by the American Psychiatric Association (2009), the NICE (2002), and the Department of Health (2008). In accordance with these guidelines all of the participants stated that they do not employ psychotherapeutic interventions when treating acute-phase schizophrenic psychosis, with some indicating that it instills false hope to lead a patient to believe that schizophrenia can be treated with psychotherapy. One participant indicated that

they do employ psychotherapeutic interventions, but that these focus only on gaining collateral information, aiding the patient in medication compliant behavior, and supporting the patient in terms of their adjustment to the ward and readiness to be reintroduced into society.

In terms of psychosocial interventions, only two forms were mentioned by half of the participants, and it was stated that these were used as an adjunct, aimed at supporting the medication-orientated intervention. These were, firstly, interventions aimed at educating and supporting the patient's family, and secondly, interventions aimed at supporting the patient in the process of being reintroduced into the community, which included skills training and Assertive Community Training. Half of the participants stated that they would seriously query a diagnosis of schizophrenia if a psychological intervention were in fact indicated as treatment in any given case. Psychological interventions are viewed as supportive only as indicated in the 'attitudes' section, which is further confirmed by the fact that most of the participants (7 out of 8) made it clear that they always use medication to treat acute-phase schizophrenic psychosis, as this is the mainstay. This practice is also indicative of a strict adherence to the aforementioned treatment guidelines (APA, 2009; Department of Health, 2008; NICE, 2002). The majority of participants (5 out of 8) stated that they do not minimize, delay, or withhold medication when treating acute-phase schizophrenic psychosis, as their practice is informed by their understanding that schizophrenia is a biological disorder, that psychotherapeutic interventions are not indicated for its treatment, and that it is negligent and unethical to minimize, delay, or withhold medication in a patient who is diagnosed as schizophrenic. It was indicated that the current thinking in psychiatry is moving towards treating as early as possible to prevent the progression of the disorder, and that, rather than delaying medication, participants would treat as soon as a diagnosis of schizophrenia has been made. This perspective is also in keeping with the current thinking influencing the development of the DSM-V, as Attenuated Psychotic Symptoms Syndrome is currently being proposed for inclusion in the manual in order to aid the early detection and treatment of schizophrenia (APA, 2010). Participants did, however, state that they treat with the minimal effective dosage, as they want to avoid the severe side effects of medication as far as possible. Significantly, one participant stated that they have delayed medication in cases where they were considering a diagnosis of schizophrenic psychosis, but were not certain as

the possibility that the psychosis may be the result of an underlying psychological problem was being considered. This participant stated that this was not standard practice, and that it has been the case with roughly ten patients. This is, however, in marked contrast to the practices as stated by the other participants, and, in some respects in opposition to the indicated treatment guidelines for schizophrenia, although this approach could be defended in light of the diagnosis being questioned, which further indicates the complex nature of psychiatric care (APA, 2009; Department of Health).

The literature abounds with similar alternative treatment approaches that focus on a delay of medication and a more emphasized role for psychotherapeutic interventions in the treatment of schizophrenia in the acute phase (Aderhold, 2009; Aderhold & Gottwalz, 2004; Bola, 2006; Bola et al., 2009; Bola & Mosher, 2003; Calton et al. 2007; Chen & Moreno, 2006; Dudley & Turkington, 2009; Irwin, 2004; Kanas, 2000; Kennard, 2009; Koehler & Silver, 2009; Morrison, 2004; Mosher, 2004; Mosher & Bola, 2004; Rogers, Gendlin, Kiesler, & Traux, 1967; Scott & Dixon, 1995; Silver, 2000; Silver et al., 2004; Thorgaard & Rosenbaum, 2006), and there are a myriad of factors that could influence a psychiatrist's decision to withhold or delay treatment in favor of more suitable alternatives. These factors include available resources in terms of beds, staff and training; possible behavioral problems and aggression in patients; patients' response to antipsychotic medication; and indications of psychological causes for psychosis such as severe stress or trauma (Jansen et al., 2004; Koehler, 2004; Lewis, 2008; Ross, 2006). The problems inherent in such an alternative approach to the treatment of acute-phase schizophrenic psychosis include: firstly, the fact that these alternatives are not proven effective (Lehman & Steinwachs, 1998a); secondly, the aggressive nature of many of the institutionalized patients who suffer from acute-phase schizophrenic psychosis, this being in direct opposition to the contained patient that is described by the aforementioned participant; and thirdly, the serious lack of resources necessary to implement these alternative treatment approaches. One participant stated that the delay of medication in favor of a psychological intervention is practical only if, among other factors, there are psychologists available, able, and willing to do therapy with psychotic patients, which is rarely the case. The effect that South Africa's resource strained health care system has on psychiatrists' treatment approaches is evident. Half of the participants stated

that a lack of resources greatly influences their treatment approaches with regard to schizophrenia, and that this does have an impact on their use of alternative interventions, or lack thereof.

7.5.) CONCLUSION

While it is clear that the majority of participants had no in-depth knowledge of combined minimal medication and psychosocial interventions in acute-phase schizophrenic psychosis, it is also clear that the participants were not in favor of these alternative approaches when presented with the rationales and guidelines. It was also shown that participants did not view their lack of knowledge as a factor that hinders their treatment approaches, as they are following scientifically verified treatment guidelines. The proposed alternative interventions were viewed as contraindicated for the treatment of schizophrenia and/or psychosis, while psychological interventions were seen as supportive only, and not to be used in the acute psychotic phase of schizophrenia. These factors, and the predominantly shared perspective that alternative interventions in acute-phase schizophrenic psychosis are unethical and negligent, combined with the severely under-resourced nature of the South African health care system, all highlight the marked difficulties involved in the proposed alternative interventions being implemented in psychiatric health care in South Africa. The resource intensive nature of the treatment of schizophrenia, and patients' difficulties regarding medication compliance and side effects, do, however, remain problems that need to be addressed in innovative, sustainable, and viable ways. Although medication remains the mainstay in the treatment of acute-phase schizophrenic psychosis in South Africa, there do seem to be certain psychosocial and psychological elements inherent in alternative treatment that need to be investigated in order to address the current problems involved in treatment with antipsychotics. Psychiatric care in South Africa could benefit from actively and continually engaging with other mental health care professionals around these complicated issues, in order to start finding feasible and locally relevant alternatives that supplement current treatment approaches. Further research projects in terms of what the majority of psychiatrists in South Africa view as essential in the treatment of schizophrenia, and how these treatment approaches are informed, are also recommended. A summarized

list of recommendations follow, all of which are aimed at improving current practices in mental health care, and utilizing available resources in a manner that makes this possible.

7.6.) RECOMMENDATIONS

- Research on a larger scale, aimed at exploring the treatment approaches of psychiatrists in South Africa with regard to schizophrenic psychosis.
- Workshops or focus groups, aimed at allowing different mental health professionals including psychiatrists, psychologists, occupational therapists, and nurses to discuss and address current problems involved in the treatment of schizophrenic psychosis, and review the possibilities and opportunities to implement further psychosocial and psychological interventions in treatment.
- A review of the application of current available resources, as well as alternatives that include approaches that regulate the therapeutic and containing elements involved in the contact between psychotic patients and those involved in their care and treatment.
- The establishment of locally relevant treatment guidelines for schizophrenia.

7.7.) LIMITATIONS OF THE STUDY

Due to the specific scope of the study, and the large volume and depth of the data, the researcher was forced to omit certain themes and aspects of the participants' knowledge, attitudes, and practices with regard to alternative interventions and the treatment of schizophrenia, although no themes that address the research questions were left out. The data that has been included represents the responses that address the specific aims of the research. The researcher's relative lack of exposure to schizophrenic patients in an acutely psychotic state could possibly have lead to the study being predominantly theory-driven, leading to inadequate consideration of the practical implications of working with this specific group of patients.

In interpretive research there is an acknowledgement that the researcher, the participants, and the research field are all implicated in an evolving and dynamic process in which all of these elements mutually affect one another (Oliver, 2004). Implicitly, the researcher represents a body of professionals which may typically be seen as being opposed to the primary use of medication in the treatment of schizophrenia. This could have led to participants experiencing the interview as anti-psychiatric, or a witch-hunt of sorts, despite the fact that the researcher was aware of the possibility, and tried to control for it by remaining relatively neutral in approach.

The final question on the interview schedule (How does the response of a patient in acute-phase schizophrenic psychosis to psychosocial interventions in the hospital setting influence the dosage of medication that you prescribe?) was possibly leading, as it implies that the patient's response to a psychosocial intervention should in fact influence dosage.

As it has been mentioned, the researcher lacks experience in working with the identified patient group, and thus relies predominantly on theoretical knowledge on the subject. This knowledge is largely informed by the training received, which is rooted in a psychodynamic school of thought. This could have influenced the way in which participants answered the questions, and the extent to which they were willing to engage around psychological interventions, in particular psychodynamically driven interventions, although their engagement was critical (Eliot, Fischer, & Rennie, 1999).

The way in which the sample group was obtained could have lead to possible sampling bias, as participants were obtained through a network known to the researcher and the supervisor. The group of participants was, however, chosen to represent the larger public hospitals in Johannesburg, South Africa, although more information cannot be given in this regard as the researcher has an ethical responsibility to protect the identity of the research participants. Due to the nature of a qualitative study, and the consequent small sample size, the findings cannot be generalized to a larger population. A questionnaire method may be a way of accessing a broader population, although the researcher's decision against this is discussed in the 'Methods' section. In an effort to critically engage the participants in a discussion

of alternative intervention models, the researcher's presentation of the Soteria model could have invited critique, which may have distorted participants' attitudes toward it.

Lastly, as is the nature of qualitative research, this study defines the reality that it claims to measure. Thus assumed shared understandings of certain definitions may skew what is understood when a question is asked, and when an answer is provided. This was also addressed in the 'Results' section, as one of the themes dealt with the different understandings of definitions relating to schizophrenia and its respective phases. The research supervisor, as well as a research psychology doctorate student from the University of Pretoria did, however, act as checks in this regard to help ensure the consequent use of definitions as far as possible.

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9.) APPENDICES

9.1.) Appendix A: Cover Letter to Psychiatrists



The University of the Witwatersrand

School of Human and Community Development

Private Bag 3, Wits 2050, Johannesburg, South Africa

Tel: 011 717 4500 Fax: 011 717 4559

Date:

Honored Psychiatrist,

My name is Nardus Saayman, and I am conducting a research study for the purposes of obtaining a Masters degree in Clinical Psychology at the University of the Witwatersrand. One of the requirements to fulfill the degree is to conduct a supervised research project. The research that I wish to conduct aims to look at the knowledge, attitudes, and practices of South African psychiatrists with regard to minimal medication interventions that incorporate psychological and/or psychosocial interventions in acute-phase schizophrenic psychosis.

I would like to invite you to participate in the research. If you are interested in taking part, I will be conducting an interview either at your office, or in an office in the Emthonjeni Centre on the Wits campus, depending on your preference. The interview will last approximately 45 minutes and with your permission, I would like to record the interviews on a digital audio recorder. The recorded material will then be transcribed and interpreted. The digital audio recorder will be kept safe in a locked

drawer, and only I, the researcher, and my supervisor will have access to the recorded and transcribed material.

Because the interviews will be face to face, I cannot assure your anonymity. However, pseudonyms will be used in the research report and no personal identifying information will also be used in the research report. Therefore confidentiality will be maintained as far as is possible.

The results will be reported in my research report, which is to be handed in to the Department of Psychology at Wits. Where necessary in the research report, in order to illustrate some of the points or arguments, I will need to use some direct quotations. This means that interviewee's words may be reported directly, but given that any identifying information will be excluded or disguised, it will not be possible to link quotes to individuals. As per the Health Professions Counsel of South Africa's guidelines the recorded material will be destroyed a minimum of 2 years after publication, and after a minimum of 6 years if not published.

Your participation is entirely voluntary and you will not be advantaged or disadvantaged in any way should you choose to participate or not participate in the study. Should you choose to participate, you are also entitled not to answer any questions you find uncomfortable, and you can also terminate the interview at any time.

If you choose to participate in the study, please will you sign the consent forms. You will be able to access the final research report in the William Cullen Library. It is also possible that the findings of the research report may be published in a journal.

If you have any questions regarding this study, please don't hesitate to contact me.

Sincerely,

Nardus Saayman (Student) Patrick Connolly (Supervisor)

Cell: 082 940 8105 Office: 011 717 4547

Email: nardus4@gmail.com

9.2.) Appendix B: Interview Consent Form for Psychiatrists

I, _____, a psychiatrist working in Johannesburg, South Africa, hereby agree to participate in the study and to be interviewed by Nardus Saayman. I understand that the research is for the purpose of his obtaining of a Masters degree in Psychology and that the study will look at the knowledge, attitudes, and practices of South African psychiatrists with regard to minimal medication interventions that incorporate psychological and/or psychosocial interventions in acute-phase schizophrenic psychosis. I understand that participation in this study is entirely voluntary and that no personal identifying information pertaining to me will be reported in the research, except for the use of direct quotes where required. Furthermore, I may choose not to answer any questions I find uncomfortable, and may terminate the interview at any point. I will be able to access the final research report in the William Cullen. It is possible that the findings of the research report may be published in a journal.

Date: _____

Signature: _____

9.3.) Appendix C: Recording Consent Form for Psychiatrists

I, _____, a psychiatrist working in South Africa, Johannesburg, hereby agree to participate in the study and for the interview to be recorded on a digital audio recorder by Nardus Saayman. I understand that all information given in the interview will be held privately by the researcher, Nardus Saayman. I also understand that direct quotes may be used in the final research report, but that all identifying information will be omitted if this should be the case. The digital audio recorder will be kept in a safe place and only the researcher, Nardus Saayman, and his supervisor will have access to the recorded and transcribed material. As per the Health Professions Counsel of South Africa's guidelines the recorded material will be destroyed a minimum of 2 years after publication, or after a minimum of 6 years if not published.

Date: _____

Signature: _____

9.4.) Appendix D: Possible Interview Questions

1. A.) According to you, what is the role of psychosocial interventions in acute-phase schizophrenic psychosis? B.) Specifically, what do you think is the role of psychological interventions in acute-phase schizophrenic psychosis?

2. According to you, what is the effectiveness of psychosocial interventions relative to the effectiveness of medication in the treatment of acute-phase schizophrenic psychosis?

3. A number of projects in the world has experimented with minimal medication interventions that involve delaying medication, withholding medication, or giving very low dosages for an individual in acute-phase schizophrenic psychosis, all during an intensive psychosocial intervention: A.) Are you aware of any such projects or activities? B.) What is your opinion of such practices?

4. What do you think is the practical viability of such approaches in the South African psychiatric health-care system at present?

5. Have you ever delayed or withheld antipsychotic medication while assessing the effectiveness of an alternative intervention in acute-phase schizophrenic psychosis, and if so, under which circumstances did you do so? If not, why not?

6. How does the response of a patient in acute-phase schizophrenic psychosis to psychosocial interventions in the hospital setting influence the dosage of medication that you prescribe?

9.5.) Appendix E: Standardized Explanation of Combined Minimal Medication and Psychosocial Interventions in Acute-Phase Schizophrenic Psychosis Based on the Soteria Model

The proposed combined minimal medication interventions for the treatment of acute-phase schizophrenic psychosis as proposed by Alan Mosher (2004), is largely based on the following three concepts:

> *…the recognition of significant rates of recovery without drug treatment in early episode psychosis; the observation that many patients do not benefit from medications (through drug treatment resistance and noncompliance); and a valuing of interpersonal care and treatment of mentally ill patients* (Bola & Mosher, 2003, p.220).

This approach follows an unstructured guideline based on need-based intervention, and makes use of non-professional staff (Mosher, 2004. The use of antipsychotics are not automatically indicated in acute schizophrenic psychosis, with the focus being on interpersonal and therapeutic relationships. Social interventions are also incorporated, aimed at helping the patient reintegrate into the community by placing them with a surrogate family to support them. Five categories were identified that made the experimental setting significantly different from the control setting (representing standard hospital settings): approaches to social control that avoided codified rules, regulations, and policies; keeping basic administrative work to a minimum to allow a great deal of undifferentiated time; limiting intrusion into setting; working out social order on a face-to-face emergent basis; and commitment to a non-medical model that did not require symptom suppression.