



Graduate Program in psychology

Table of Contents

Acknowledgment	4
Summary	5
Acronyms	7
Introduction	9
Background	11
Statement of the problem	13
Rationale of the study.....	13
Research question.....	14
Operational definitions	14
Standard definitions.....	14
Literature review.....	16
Objective	20
Methods.....	21
Study setting	21
Study design.....	21
Study period.....	21
Source population.....	21
Sampling method.....	21
Data collection	22
Analysis	23
Data management	23
Ethical consideration.....	23
Results.....	24
Discussion.....	35
Conclusion.....	39
Appendix	40

Data Collection Form/ Appendix I..... 40

Topic guide/ Appendix II 42

Participants’ information sheet/ Appendix III..... 43

Participant consent form/ Appendix IV 43

Amharic translated appendixes 45

References/ Appendix V 50

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Summary

Introduction

Arts therapies have positive effects on psychotic symptoms, psychosocial functioning and the ability to mentalize in patients with schizophrenia (3). These therapies are not formally practiced by trained art therapists in Ethiopia however the term 'arts involving activities' is used in this paper to describe interventions that promote the experience of creative artistic activities such as painting and drawing, dancing, music and drama.

In our country, Amanuel Mental Specialized Hospital is the only psychiatric specialized hospital that provides art involving activities, and the subjective experiences of patients with schizophrenia participating in such activities are not yet explored.

Statement of the problem

Patients' subjective experiences of participating in arts involving activities are unexplored.

Research question

What is participants' understanding of the reasons for participating in arts involving activities?

What do participants enjoy/ like about, not like/ avoid from the activities and what are their respective reasons?

What are participants' perceived benefits from the activities and their opinions regarding the service they were involved in?

Method

An exploratory qualitative research design was used. In-depth interviews with the use of prepared topic guides were conducted after obtaining consent form each participant. We involved 18 patients with the diagnosis of schizophrenia who fulfilled inclusion criteria. Data was recorded, transcribed verbatim, translated into English, coded and thematically analyzed.

Results

Majority of patients reported having mental illness and need for treatment as their reason of admission; getting entertainment and happiness was reported as their reason of participation in rehabilitation center. Significant number of patients reported positive experiences by participating in arts involving activities. Few of patients reported their negative experiences in their participation of specific arts involving activities. Majority of patients reported positive outcomes but no negative outcome from their participation. Our findings indicate positive impact of arts involving activities on their mood, communication skills, social engagement, overcoming stigma, physical health and on their motivation to take role for their recovery. Nearly all of them were content with the service provision with some indicating room for improvement.

Conclusion

In treatment of schizophrenia, focus on the patient as a whole rather than symptom reduction is required to facilitate the process of recovery.

Acronyms

ADTA- American Dance Therapy Association

AMSH- Amanuel Mental Specialized Hospital

AT 1-18- Identification number for participants in the study

CBT- Cognitive behavioral therapy

EXA- Expressive Art Therapy

HIC'S- High income countries

HMIC'S- High and middle income countries

IEATA- International Expressive Art Therapy Association

LIC'S- Low income countries

MIC'S- Middle Income counties

NICE- National Institute for health and Clinical Excellence

SMI- Severe Mental Illness

Introduction

Schizophrenia is a chronic, severe, disabling illness which affects approximately 1% of the population globally and has a life time prevalence of 4.7/1000 in Ethiopia (1,25). The characteristic symptoms of schizophrenia involve a range of cognitive, behavioral and emotional dysfunction (4). In addition to the wide range of clinical symptoms, the severe and long standing nature of the illness causes significant and multidimensional challenges for the personal functioning of the patients (1). A person with schizophrenia may experience difficulties in distinguishing self and non self; this is called a loss of ego boundaries (6). One of the other distortions of thinking is called 'concrete thinking 'and refers to literalness of expression and understanding (6). Primary mental function is moderately to severely impair in patients with schizophrenia (7). Primary mental function refers to the individual's ability in orientation, attention, calculation, memory, recall and language (7). This impairment causes dysfunction in occupational, social and economic functioning in schizophrenia and an important treatment target (7). The most common treatments for people with this condition are the use of antipsychotic medications and psychosocial therapies, particularly CBT and family therapy (1). These treatments work well for patients with positive symptoms (1). However patients with negative symptoms do not respond as well (1). The negative symptoms of schizophrenia include a lack of interest in pleasurable activities and social interaction, diminished speech output, flattening of affect and decreased in motivated self-initiated purposeful activities(4).

Arts therapies are complex interventions that combine psychotherapeutic techniques with activities aimed at promoting creative expression (2). The creative process is used to facilitate self-expression within a specific therapeutic framework (2). According to the International Expressive Art Therapy Association, the Expressive Art Therapy combines different modalities of art forms including the visual arts, movement, drama, music, writing and other creative processes to foster deep personal growth (8).

Art therapy is a modality that uses visual arts as the therapeutic intervention; it emerged in the 1940s in Europe as a form of psychotherapy (9). It is based on the idea that the creative process of art making is healing, life enhancing and is a form of non-verbal communication of thought and feeling (10).

Drama therapy was developed in the 1970s from the theoretical foundations of theatre, psychology, psychotherapy, anthropology and play (11). Defined as "the intentional use of drama and or theatre processes to achieve therapeutic goals" by National Association for Drama Therapy (11). The rationale for the use of drama therapy in schizophrenia is that as creativity oriented therapy, it has some helpful features not present in purely talking therapies (12).

Dance movement therapy began as a formal psychotherapeutic practice in the U.S in the 1940's (13). ADTA defines "the psychotherapeutic use of movement to further the emotional, cognitive, physical and social integration of the individual based on empirically supported premise that the body, mind and spirit are interconnected "(14).

Music therapy defined by World Federation of Music Therapy as "the use of music and musical elements by a certified music therapist with a client or group, in a process designed to facilitate and promote communication, relationship, learning, mobilization, expression, organization and other relevant therapeutic objective, in order to meet physical, mental, social and cognitive needs"(15). The therapy is through either "passive listening" or "active participation" in the way one relates musically, it sheds light on how one relates in other areas of his or her life(5).

Patients with psychosis experience music therapy as mental health recovery and positive mental health than primary focus on symptom remission and functional improvement (18). Mental health recovery is a pillar structure for music therapy for patients with psychosis than it has a primary focus on symptom remission and elevation of functions (18). Recovery refers to the ways in which a person with a mental illness experiences and manages his or her disorder in the process of reclaiming his or her life in the community.

Background

Amanuel Mental Specialized Hospital is the only public hospital delivering in-patient psychiatric services in the capital, Addis Ababa. It was established in the late 1930's and gives emergency, out-patient and in-patient adult psychiatric services delivered by several case-teams. With a total of 270 beds, in-patient services are given for patients with severe mental illness from all over the country.

In addition to the psychiatric services delivered for in-patients, admitted patients are given access to participate in activities that take place in the "rehabilitation center" also known as the "rehab". This is a unit within the hospital compound and functions as a space within which a team of professionals hold group therapy, arts involving activities, occupational activities(includes hand craft) and psycho-education groups.

This rehabilitation center under the umbrella of clinical directorate of AMSH, is led by a case team leader. In 2014 arts involving activities were formally endorsed by the hospital as one of the therapies practiced at ASMH after a professional painter trained patients to draw for two days per week for a total of three months. Prior to 2014, there was inconsistent effort to do different kinds of art activities in the rehabilitation center. Occasionally patients were given painting materials to do painting. In the last year there have been art exhibitions of work painted by patients and artists at different times. Two art exhibitions were held at the Hilton Hotel and in the compound of AMSH. Three years ago, drama involving around 5 participants was presented for patients participating in rehabilitation center. Service by the rehabilitation center has now become consistent, with hiring of specific staff. Currently, 3 psychologists (first degree graduates), 1 diploma theatre graduate and 1 diploma graduate of instrumental playing (drum) provide and supervise arts involving activities. Almost all activities are in a group format except for those patients who are interested in visual art and instrument playing, which are non-scheduled activities and done individually. The goals of arts involving activities are to improve socialization, problem solving skill and the ability of expressing self. Since January 2017, the rehabilitation center personnel select voluntary patients from each ward after filling the intake form and bring them to the rehabilitation center. The criterion for patient selection is informal and is guided by identified hobbies from the patients and the rehabilitation center professional's appraisal of their interest and ability to take part in the activities. There is no detail assessment of function for patient selection from wards. The rehabilitation center also lacks a feedback mechanism through which it communicates back to each patient's treating case team.

Currently there are activities involving music, visual art, dance, exercise and different types of games which are summarized below. Games (card games) and puzzles which most of the time involved activities focusing on problem solving skill, are done as individual or as group activities on two days per week, lasting from 30 to 90 minutes. These games are usually played before or after other arts involving activities, they involve 7 - 12 patients at a time and are run by one psychologist and diploma graduates to support involved patients. In addition, on two afternoons per week, Amharic movies will be available for interested patients to watch together as a group. There is also coffee ceremony which involves all participating patients once per week or two week. There is currently no drama involving activities. However, the “rehabilitation center” is planning to provide such activities in future.

Table 1: Review of arts involving activities provided by rehabilitation center

Types of arts involving activities	Schedule per week	Number of participants per session	Type of activity	Duration of time	Service providers
Music involving activities	Two times per week	20-25 (both male and female)	Singing together with or without music, listening music or playing piano and/or reflection on what has emerged after the music	20-90 minutes	2 diploma graduates
Dance involving activities	Two times per week	10-15 (both male and female)	With a background music, patients let to dance by the music or watching others dancing	50 minutes - 1 hr	2 diploma graduate
Visual art involving activities	Two to three times per week	7-15 (both male and female)	Paper distributed for all involved with pencil, patients select ideas for drawing individually then at the end patients discuss the drawing of themselves or watching othersdrawing	1hr-90 minutes	All the three psychologist and two diploma graduates

Statement of the problem

National Institute for health and Clinical Excellence suggest that arts therapies improve the negative symptoms of psychosis (2). NICE guideline also suggests that arts therapies should be considered as adjunctive treatment because there is limited evidence to prove their effectiveness (2). Currently, the data for the effectiveness of arts therapies to improve social functioning and quality of life is still very limited (2).

In Ethiopia, there has been no study focused on arts involving activities in rehabilitation center of Amanuel Mental Specialized Hospital, although this hospital is the only public hospital which provides these activities. Even though the arts involving activities have been provided since 2014 under the rehabilitation center, the subjective experience of patients with schizophrenia participating in arts involving activities which includes their reasons for participation, experience and outcome of their participation are still unexplored.

Rationale of the study

Mental health improvement is not all about symptom reduction but it is also related with feeling better which central idea of recovery is. Positive mental health arises from mental health recovery which is indicated in the studies as the main benefit of arts involving activities. So, to identify those factors related with mental health recovery that arises from participation in arts involving activities, it is wise to explore the subjective experience of the participants themselves. This might have an additive effect for mental health recovery by improving the quality of service provision for better satisfaction of patients' needs. Therefore, this study can serve as a baseline for future studies on this topic.

Research question

In patients with diagnosis of schizophrenia:

What is participants' understanding of the reasons for participating in arts involving activities?

What do participants enjoy/ like about, not like/ avoid from the activities and what are their respective reasons?

What are participants' perceived benefits from the activities and their opinions regarding the service they were involved in?

Operational definitions

- Arts involving activities: describe activities that are composed of all art, music and dance involving activities not including the games, puzzles and exercise involving activities
- Visual Art involving activity: describe interventions that promote the experience of specific visual artistic activities such as drawing or watching other's drawing
- Music involving activity: describe activities including singing together with or without a music, listening to music, playing an instrument (piano, drums) and/or reflecting on what emerged for the patient during and following the musical experience.
- Dance involving activity: describe activities involving letting patients to dance by the music or watching others dancing

Standard definitions

- Arts therapies: therapies which integrates therapeutic tools and techniques from many different art forms (music, drama, drawing, painting, writing, dancing) which are more organized and structured provided by a specialist trained at a Master's level.

- Positive symptoms of schizophrenia: which characterized as hallucination, delusion, disorganized speech and behavior
- Negative symptoms of schizophrenia: which characterized as flattening of affect, diminished speech output, decreased in motivated self initiated purposeful activities, lack of interest in pleasurable activities and social interaction
- Cognitive symptoms of schizophrenia: which is characterized as different neurocognitive deficits including work memory, attention and executive functions (planning)

Literature review

According to Cochrane systematic review, the use of art therapy, dance therapy and drama therapy for patients with schizophrenia and schizophrenia like illnesses should continue to be under evaluation as benefits or harms are unclear(1,6,12). However, NICE recommends arts therapies for the alleviation of negative symptoms for patients with schizophrenia, suggesting therapy can be started either during the acute phase or later in in-patient settings (2). Systematic literature review from NICE describes interventions consisting of 12 sessions on average in groups of 6-8 people in the UK with an average duration of 1 hour (2). Arts therapies are provided by therapist with specialty training at Master's level (2). Currently the data on outcomes such as social functioning and quality of life related to the effectiveness of arts therapies is still very limited(2).

Symptomatic improvement is not good enough for the well being of patients with schizophrenia. Some might feel better without symptom remission. In one qualitative study, patients with psychosis experienced music therapy as a tool of mental health recovery and positive mental health than a primary focus on symptom remission and functional improvement. Mental health recovery is more about the challenges and possibilities of living with various degrees of illness than cure and treatment of illness. Positive mental health described as wellness and feeling better(18). This may require a shift in focus away from illness reduction toward promotion of positive mental health and wellness, away from methods, techniques, and interventions toward music, and away from standardized procedures and manuals towards personal and social agency (the perceived ability to affect one's own destiny and to engage meaningfully with others and reflects the dimensions of mastery and positive relationship with others)(18).

In a center for psychiatric rehabilitation found in Boston, a qualitative, longitudinal analysis was done with individuals participating in rehabilitation to explore themes associated with improvement in functioning and subjective experience. 12 patients with a diagnosis of schizophrenia or schizoaffective disorder were randomly selected from a just concluded 2 year study of psychiatric rehabilitation. Each patient was followed for additional 4 years and data collected. Analysis of the data characterized the process of recovery as having phases, tasks and barriers. The experience of involved patients fell into 3 broad phases: overwhelmed by the disability, struggling with the disability and living with the disability. Four out of 12 patients were able to reach the phase of living with the disability. Two patients stayed in the phase of feeling overwhelmed by their disability. Six patients remained in the struggling with their disability phase. Tasks of recovery mentioned by those who participated included: developing

an explanatory frame work for understanding the experience of schizophrenia, to get some control over the illness itself and to move into roles that are meaningful and productive in the society. Barriers identified are presence of co morbid substance abuse, social disadvantage (poverty) and age of onset of schizophrenia. In this literature the course, dimension of recovery, how recovery occurs and possible benefits were not described(26).

"The meaning of recovery will vary, depending upon who is asking and interpreting, in what context, to what audience and for what purposes"(28,29). Recovery refers to the ways in which a person with a mental illness experiences and manages his or her disorder in the process of reclaiming his or her life in the community (30). According to guidelines for recovery-oriented behavioral health care, the practice of recovery should be based on the participation of people in recovery and their close relatives; making contact with the person rather than with the diagnosis, building trust over time, attending to the person's stated goals and needs; ensuring continuity of care; offering individualized recovery planning by involving the patient and identifying and addressing barriers to recovery (30). If a person is in the process of recovery, he/she passes through an acceptance of his or her illness; overcomes stigma; has hope and commitment; becomes responsible for one's own recovery, actively participates in treatment and symptom management; develops empowerment which is a sense of mastery over one's environment and is enabled to participate as a full, contributing member of society. (27,28,29).

Key components of recovery process includes hope, spirituality (important source of hope), responsibility and control (over one self), empowerment, connection (social aspect of recovery), purpose, self –identity (re- defining oneself in the face of Severe Mental Illness) and symptom management (31).

In working with patient with schizophrenia related to the art therapy, three fields of communication are identified (20). "Intrapersonal field" is the potential for image making and is maintained for the patient by the therapist, the patient develops a unique interaction with the art material that can result in healing (20). "Intermediary field" creates an environment for play where the patient can experiment with objects and learn that they don't have concrete effects on themselves or the therapist (20). "Interpersonal field" is the relationship between the patient and therapist (20).

On one narrative review of literature which identified 18 papers from HMIC'S, high quality quantitative articles give inconclusive result for the effectiveness of art therapy in adults with psychosis (21). From the same review, high quality qualitative articles indicated that therapists and clients considered art therapy to be a beneficial, meaningful and acceptable

intervention although this conclusion was based on small number of studies (21). Art therapy enables people to express their emotional, cognitive and psychotic experiences in their art and process them at a pace that feels comfortable (11). In one journal that aimed to determine the effectiveness of art therapy on primary mental function among patients with schizophrenia after involving 40 subjects, the result show that art therapy is effective in improving primary mental function among patients with schizophrenia(7).In one exploratory RCT of art therapy as an adjunctive treatment in schizophrenia; the outcome of patients randomized to 12 sessions of art therapy were compared with those who received standard psychiatric care; patients were assessed on a range of measures of symptoms, social functioning and quality of life at pre, post treatment and six month follow up(22). From the result, art therapy produced a significant positive effect on negative symptoms though had little and non-significant impact on other measures (22).

Music therapy in addition to standard care helps people with schizophrenia to improve their mental state (including negative symptoms) and social functioning if sufficient numbers of sessions are provided by qualified music therapist (16). The results of Cochrane systematic review suggest that at least 20 sessions may be needed to reach clinically significant effects. Adjunct music therapy to standard treatment was associated with a significantly better treatment effect in patients with schizophrenia than control patients, not only in negative or mood symptoms but also in positive symptoms(5). Music therapy has a positive influence on self-perception and it can strengthen the ego of patients with schizophrenia (17). In one study which used mixed approach, the perception of different music therapy interventions identified from in patient with severe mental illness, participants rated an individual music therapy as most helpful and a group music therapy as the most enjoyable on separate Likert-Type Scales (23). No overt differences between music therapy intervention types based on results from analysis of qualitative and quantitative data (23).

On one qualitative study of how patients diagnosed with psychosis experience music therapy, findings showed that mental health recovery and positive mental health were related to music therapy in mental healthcare than a primary focus on symptom remission and functional improvement (18). In one exploratory quasi-experimental study of the effect of music therapy on negative and positive symptoms in patients with schizophrenia, participants were randomly assigned to either a control group or 2 experimental groups. One experimental group being participants who received active music therapy (individual) and group playing, improvisation, singing and movement, while the other experimental group received passive music therapy (listening to recorded music) in weekly sessions over a period of one month, the findings indicated that music therapy may have beneficial effects on negative and positive symptoms of residual type of schizophrenia in which there is an absence of prominent positive symptoms but continuing evidence of schizophrenia (negative or positive symptoms in an

attenuated form) (19). A study done on psychosocial rehabilitation effects of music therapy in chronic schizophrenia examined the use of music therapy as an adjunct therapy to medication (17). In chronic patients with schizophrenia who had social disability, the result suggested a more positive and significant effect of music therapy combined with medication on negative symptoms and social disability than medication alone (as reflected by the score on sluggishness, blunted affect and poverty of thought (17)).

Drama therapy in schizophrenia as an action oriented therapy is found to have some helpful features not present in the purely talking therapies. It acts as a tool to differentiate what is real from not, for patients with schizophrenia who can have distorted thoughts and emotions that are hard to organize (12). So, conventional therapy can be problematic because it requires the ability of reality checking. The story in drama can be seen as a tool for checking the reality to add to the safety of the experience as well as giving a degree of mirroring and normalization for the participant .When it is compared with standard care with medication plus other additional psychosocial interventions, the result of adjunct drama therapy is unclear whether it has any effect on mental state, interpersonal relationship, quality of life and self-esteem (12).

Factors which might indicate dance therapy as a therapeutic tool include movement during dancing stimulate feelings or emotions; a person able to communicate non verbally; creates joy emotionally and physically from the free movement with rhythm combination and if it occurred in non-critical setting, leads to reduction of anxiety (1). The foundation of dance therapy is “the physical phenomena that provokes the occurrence of emotion”(1).

Studies from LIC’s regarding arts therapies or involving activities for treatment of severe mental illness are not available. In South Africa, focus group discussion tried to explore participants’ perception of psychologist and psychotherapy, barriers to seeking treatment among group of black Africans of 18 years and older which conducted at Itsoseng Clinics on the Mamelodi campus of the university of Pretoria. Reasons for seeking treatment include; HIV and AIDS, problems related to socioeconomic situation, relationship issues and educational (learning) problems. Reasons for barriers to service utilization include; the stigma of mental illness, lack of knowledge, affordability of treatment, lack of trust and lack of cultural sensitivity(24).

Data related to expectations and outcomes of patients with diagnosis of schizophrenia that have participated in arts therapies is not available. In addition, data related to lack of perceived needs, challenges and recommendations of patients with diagnosis of schizophrenia who participated in arts therapies is not available.

Objective

General

- To explore subjective experiences of patients with schizophrenia participating in arts involving activities at AMSH;

Specific

-What is participants' understanding of the reasons for participating in arts involving activities?

-What do participants enjoy/ like about, not like/ avoid from the activities and what are their respective reasons?

-What are participants' perceived benefits from the activities and their opinions regarding the service they were involved in?

Methods

Study setting

The study was conducted at Amanuel Mental Specialized Hospital, Addis Ababa, Ethiopia.

Study design

An exploratory qualitative research design was used to explore the general and specific objectives.

Study period

April 2017 - Dec 2017

Source population

All patients admitted with diagnosis of schizophrenia as documented in charts at Amanuel Mental Specialized Hospital during the study period.

Sampling method

A purposive sample of participants was interviewed using the following inclusion and exclusion criteria.

Inclusion criteria

Patients with a diagnosis of schizophrenia, with any duration of illness and clinical data recorded from their chart, that:

- Are receiving treatment as an in-patient at Amanuel Mental Specialized Hospital
- Have participated in one or more art involving activities provided at the “rehabilitation case team”.
- Are stable enough and capable of verbally expressing him/herself in an interview
- Are able to give informed consent
- Are able to participate in an interview conducted using Amharic language

Exclusion criteria

Patients with diagnosis of schizophrenia who:

- Are not involved in arts involving activities
- Are not psychologically stable enough to participate in an interview
- Are incapable of verbally expressing him/herself in an interview
- Do not have capacity to give consent.

Admitted patients participating in any arts involving activities were first identified by professionals working in the re-habilitation case team. From those identified, psychiatric or clinical nurses screened patients using the above inclusion and exclusion criteria. Those who fulfilled all the criteria were approached after a brief explanation of the study and were invited to participate in the study. For those who agreed, detailed information about the study were provided in the form of an information sheet (Appendix III). Those who were willing to participate, were required to give written, informed consent prior to participation for their participation in a taped interview (Appendix IV). Rehabilitation case team professionals and psychiatric or clinical nurses were compensated for their participation in the study.

Sampling continued until theoretical saturation was achieved; as much as possible we were seeking to recruit a representative sample from both sexes and different socio-demographic and clinical background. We involved two female and sixteen male, a total of 18 patients in the study. We couldn't find more female patients who fulfilled the study inclusion criteria.

Data collection

Clinical characteristics and socio demographic data of participants were extracted from patients' charts using a structured form (Appendix I). Before any data collection, English tools composed of data collection form, topic guide, participants' information sheet and participant consent form were converted into Amharic. The data collection form included information such as age, gender, religion, address, educational status, employment status, marital status, number of children, source of support, total number of persons living in the house, mode of hospitalization, number of admissions, medications prescribed, duration of illness, type of art involved activity and number of participation (Appendix II). After this data had been filled, semi structured interview was carried out using a topic guide to help direct the process (Appendix II). While the study is in progress, the topic guide was modified as necessary. In addition, the interviewer was also making note of non- verbal communications of the participants.

The interview was carried out in Amharic. Directive or leading questions were avoided. The interview lasted 30-40 minutes on average and they were recorded on tape. Participants were informed that we might use quotations from the interviews in reports from the study. The interviewer was also taking notes in Amharic throughout the interview process.

Analysis

Co- investigators/supervisors independently coded transcribed data and discussed and resolved discrepancies. Audio- taped data and notes from the interview were transcribed verbatim (in Amharic) and then translated into English for analysis. Analysis was carried out in conjunction with data collection to allow iterative development of the interview topic guide.

Findings were checked back against the original data. Qualitative analysis software (Open Code) was used to facilitate the process of analysis.

The main concepts covered by the interview guide were the starting point and were included as themes at the beginning of the process of analysis

Data management

Anonymity was maintained all the time. The tape-recordings of data and the written notes were deleted after transferred to a personal computer. Both transcript files and audio records were kept in different area, anonymised and finally stored in password secured folder.

Ethical consideration

This study was carried out after ethical approval has been obtained from Department of psychiatry, College of Health Science, A.A.U and Amanuel Mental Specialized Hospital research ethics committee. The purpose and aim of the study was explained to all participants. All informants' right of free choice was respected. Before carrying out any interview, informed consent was obtained using informed consent sheet.

Physical harm from participating in the study was unlikely. Every caution was taken to ensure that all participants felt safe, comfortable and felt the freedom to take a rest from the interview, reschedule the interview or withdraw from the study if they felt the need to without

any negative effects on any component of their stay at Amanuel. Confidentiality was respected all the time. No personal or identifiable information was recorded or printed in the study.

Results

A total of 18 participants were interviewed. Table 2 shows characteristics of participating participants. From participants two were female and 16 were males. Half of the participants were from Addis Ababa and the remaining half was from out of Addis Ababa among who half were from rural areas. All of the participants from the city and out of Addis Ababa were admitted consensually.

Seven of the participants were jobless prior to their admission and among them only one was married. From all the participants, only three men were married and four participants had children. Only one participant lived alone prior to admission. Except for one participant, all were formally educated.

Eleven of the participants were admitted to the hospital with their willingness. Except for three participants, all were previously admitted. All of the participants were being treated for Schizophrenia with medication. At the rehabilitation center all of them participated in music involving activities; in addition, eight of them participated in dance involving activities and ten of them participated in visual art involving activities.

Table 2: Characteristics of participating participants with schizophrenia.

Characteristics	Number of participants with schizophrenia (N=18)
Age	
21-25	3
26-30	3
31-35	8
36-40	4

Sex	
Male	16
Female	2
Religion	
Orthodox	6
Muslim	7
Protestant	4
None	1
Address	
Addis Ababa	8
Out of Addis Ababa	
Urban	5
Rural	5
Educational status	
No formal education	1
Primary	6
Secondary	7
Higher education	4

Employment status	
Unemployed	7
Employed	11
Marital status	
Single	15
• With child/children	1
Married	3
• With child/children	5
Source of support	
Self	2
Family	12
Organization	2
Self and family	2
Number of people within a household	
0	1
1-5	12
6-10	2
11-15	2
>15	1

Way of admission	
Voluntary	11
Compulsory	7
Number of previous admissions	
0	3
1-5	13
6-10	2
Medication	
Antipsychotic only	7
Antipsychotic and anti-cholinergic	6
Antipsychotic and benzodiazepine	1
Antipsychotic and antidepressant	4
Duration of mental illness	
1-5	7
6-10	4
11-15	3
>15	4
Number of times involved in arts involving activities	
0-6	8

7-10	5
11-15	1
>15	4
Type of art involving activity	
Music involving	5
Music and dance involving	3
Music, dance and visual art involving	5
Music and visual art involving	5

Themes identified

Major themes arising from thematic analysis are summarized presented as follows.

1. Reason for admission and visiting the rehabilitation center

Reason for admission

When participants were asked the reason for their admission, most stated that it was for a mental illness or because of some form of abnormal behavior including those that were admitted involuntarily. Half of the participants acknowledged the need for treatment.

“.....I was admitted here seeking treatment of my mental illness which people call “madness”. But I understood it is a mental illness and I came here....” [AT 001]

One of the male participants who was admitted voluntarily reported “addiction” as a reason for his admission. Only one male participant being treated for schizophrenia who reported that he was admitted willingly didn’t know the reason of his admission.

Reason for visiting rehabilitation center

All the participants had a reason for their involvement in the art involving activities at the rehabilitation center despite the fact that some of them were admitted unwillingly. Although some considered their involvement as one way of “spending their time”, most had reasons which implicitly expressed their positive expectations of the outcome of engaging in such activities. Significant number of them reported that they visited the rehabilitation center for reasons related to their state of feeling and this was described as a means of getting “entertainment”, “happiness” and so that they would “feel better”. In addition, some were able to state reasons expecting positive outcomes in other dimensions such as their physical, cognitive, social or occupational functioning. Among these reasons are getting lessons about music and how to draw, updating oneself, and sharing experiences with other patients.

“.....for example I learn about music and how to draw. It is an entertaining and learning experience.....”[AT 009]

One male participant being treated for schizophrenia who had participated more than fifteen times reported that he continues to participate because of the hand craft skill he is acquiring.

One female participant who was diagnosed to have schizophrenia and seemed relatively stable related the activities to its positive effect on her physical and mental health.

“.....to be physically fit, not to be re-admitted, to be more active and show improvement....”[AT 010]

On the other hand, two male participants didn't know the reason for their participation. One of them stated that even if he didn't know the reason initially, he subsequently continued to participate anticipating to be entertained and learn.

2. Experiences about arts involving activities

Positive experiences

Even though many participants' admission was compulsory, once engaged in the art involving activities, nearly all of them described their experience at the rehabilitation center in a positive way. A recurrent theme throughout participants' accounts of their engagement in art involving activities was having an enjoyable and a learning experience across the different kinds of activities.

Regarding music and dance involving activities

Most of the participants expressed a sense of relaxation, pleasure and liberating them of negative emotional states. Some particularly preferred music that provoked some movement or dancing as it made them feel more “alive”. Others also mentioned that being in an environment where others were dancing and singing as a pleasurable experience by itself.

“.....oh, it gives me chills, I sing along with the music. It touches me deeply beyond my flesh. I used to just hear it, but now I listen to it seriously.....I think because I have been through a lot, it makes me feel happy when I listen to the music.....”[AT 005]

“.....I like it because I feel at ease of the burden I am feeling. I am here against my will and I can't leave whenever I want to. Listening to music helps me forget all those things. It is like for everybody else I think it helps you relax and makes you feel good....”[AT 012]

Apart from mere enjoyment, being exposed to familiar songs was seen as a means of re-connecting with “good old times” or childhood experiences. Others described it as a learning experience and a way of finding an expression of their emotions. One participant described it as having a therapeutic effect on his mental health problem.

“..... I liked it because it makes me calm, there are certain kinds of music that help your mind relax, it is not allowed in Muslim religion to listen to music but I believe it is like medicine for mental illness....” [AT 0133]

Regarding visual art involving activities

Very strong positive experiences and benefits were expressed by those participating in the visual arts involving activities. These activities were described as a means of expressing oneself, reducing anxiety or worry and an opportunity to engage and relate with others. Particularly one female participant with schizophrenia who was single and jobless described it as a means of actively contributing to her recovery and this has instilled a sense of hope that she can help herself.

“.....the first thing I liked is, I think about the past and my previous condition. I believe my health will return and I know so. Other than the times I get sick, I feel fine the rest of the times. I don't lose my mind; I want to prevent it from happening again, I want to be a merchant again and I believe with God's help it will work out. Whenever I draw, I feel

like I will not just sit around and wait for help I might be able to do something for myself....."[AT 010]

Negative experiences

Regarding music involving activities:

Few participants didn't enjoy listening to music which they couldn't dance to. A female participant who has completed primary school and was admitted voluntarily stated that she felt uncomfortable and inadequate when she saw music instruments in the center during her participation.

A female protestant Christian participant who was admitted without her willingness hated her experience of participating in music involving activity as she was exposed to music that conflicted with her belief system and because of incidents that made her feel unsafe in the presence of other participants.

".....I don't like the rehabilitation, I hate it.....i don't know it is not exciting.....I don't like secular music I like Christian songs.....I like protestant spiritual songs.....the other patients who were participating in dancing were fighting, I got scared when I saw them.....I was scared because I am a petit.....I thought they would hit me....."[AT 011]

3. Perceived outcomes

Apart from one female participant who had concerns about her safety during her participation in music involving activities, all described having benefited from their involvement in one or more ways. Apart from her report of not having benefited in any meaningful way, there were no findings of negative outcomes as a result of their engagement.

Positive outcomes

Majority of the participants reported perceiving benefits in many ways. Among these, the central theme was the positive effect on their mood and in general a sense of wellbeing. Most of them expressed feelings of happiness, relaxation, being rid of worries and bringing excitement and hope regarding their future. Particularly one male participant who was admitted voluntarily mentioned that it has helped him come to a "normal state".

".....to me entertainment means getting mental satisfaction. When I first came here I was depressed that is why I was pushing for discharge. But after I started to come to the rehab center, I started to get happiness and relaxation that is what I meant by

entertainment....on the other hand, from what I am experiencing in here; I guess I am trying to bring myself to normal state."[AT 001]

One very strong positive view expressed by the same male participant after his experience in music and visual art involving activities was that it changed his previous attitude regarding the mentally ill and this has given him hope. He mentioned that the mentally ill are labeled as "useless" and how art involving activities can be used as a tool to fight this stigma.

".....I didn't participate more than two days, but the first visit changed my old attitude....this hospital usually is called by the society as a place for treatment of "mad people". Once you are admitted here, people start to call you mentally ill and you lose your value. But after I came here, I saw patients working on different things and I started to think we can work..... You see being treated in here doesn't mean that you are useless or your brain can't function any more. When people come here, they will find help that will enable them to use their potential and show it to others. So, I began to understand that after being treated any one can do anything...."[AT 001]

Others mentioned that it has helped them improve their social skills as a result of a calmer state of mind, improved ability to communicate and to express themselves these activities have given them.

Regarding its effect on their mental health, in addition to the psychological benefits, participants reported that it contributed to their willingness to remain in the hospital and receive treatment. It is also noteworthy that once involved, participants were becoming more and more motivated to continue actively engaging in such activities.

One woman who was admitted willingly appreciated having lost weight after her involvement in dancing.

".....I liked dancing it makes me happy even though I am not good I try. I have lost some weight after that, it is a way of exercising....."[AT 010]

Some mentioned that it was one way of spending time; particularly one male participant who had multiple prior admissions reported that it helped him avoid uncomfortable ward environments and fight boredom.

".....it is way better than sitting around the ward which is noisy and full of psychiatric patients..."[AT 002]

4. Gaps / Recommendations

Though majority of participants described only benefits and positive experiences regarding the arts involving activities, some have, implicitly or explicitly, identified different gaps and problems in the service provision. Almost all of them were satisfied with the service they received and expressed their appreciation.

Generally, regarding all the art involving service provision, few commented on the absence of follow up for patients' progress who participated in these activities. Others also mentioned the gap created in service provision on weekends. Other problems that were noted include the limited space that is given for this service and not involving patients' family or caregivers in the service provision.

“.....my suggestion will be, we have healthy friends and family members and if they could see us while we participate and if we could help each other depending on our talents.....”[AT 010]

Regarding visual art involving activities

Few of the participants mentioned being given inadequate time for the activity, the lack of more challenging drawing and variety of coloring instruments as alternatives as current gaps in the service.

Regarding music involving activities

Few participants described that some of the songs played are not in languages they could understand making it difficult for them to enjoy while others preferred music that are more suitable for dancing to be played. Other problems identified by few participants include the need for variety of music, limited playlist and limited kinds of music instruments.

One female participant who was admitted without her willingness who felt unsafe during her participation did not reflect on this issue.

Recommendations

Most participants refrained from recommending ways of improving the service as they were content with the current service. However, some had general comments about the service and few others had specific recommendations.

A male participant from Addis Ababa talked about the need to have follow up for patients during and after service provision to measure patients' progress as a result of their participation.

“.....what I mean is it can help to measure how much the patient is becoming normal or progressed.....this is because pharmacological treatment only might not bring the change....what I mean is even if medication can change our physiological condition, it cannot help us to express ourselves. But coming here and participating on different activities will help to express ourselves. From both coming here taking medication we can appreciate the changes.....”[AT 001]

One male patient from out of Addis Ababa recommended availing such services on weekends while another one mentioned the need to have a larger space to accommodate larger number of patients. Recruiting and involving other patients in the hospital so that they too can benefit from the activities was also mentioned by a participant. A female participant stated that she would have liked her caregivers to observe her activities while in the rehabilitation center.

In addition, including activities that are intellectually more engaging, like sorting alphabets, were also mentioned as possible areas of improvement.

Recommendations on visual art involving activities

Recommendations given regarding the visual art involving activities include provision of more challenging drawing tools and variety of coloring instruments so that patients would have several options to enhance their skills and enjoy the activities better.

Another comment was regarding increasing the time they are allowed to spend on the activities.

“.....well we use only pencil and paper if possible using colors would be better.....well we are not professional artists, if we were pencil might be good enough we are not so if we use colors our paintings would be nicer and more expressive; that is why I mentioned colors....”[AT 012]

Recommendations on music involving activities

Participants expressed their preference of music in languages that they are familiar with, having more variety and more engaging (“not boring”) music.

Others suggested adding variety to the music instruments that are available for participants and using music videos would increase patients’ enjoyment and satisfaction.

“.....I wish there were more music instruments.....i think people would enjoy the instrument and the unique sound of the instrument they like.....”[AT 007]

Discussion

Cochrane systematic review from HMIC’S showed that the benefit or harm of arts therapies is unclear; this study has demonstrated that patients who participated in arts involving activities have perceived positive outcomes including being happy and entertained, change of negative attitude, getting better in communication and socialization, having hope, better physical and psychological state of self and benefited by the service provision. Our study we didn’t identify any negative outcomes or harm from participating in the services provided (1, 6, 12).

Recovery refers to ways in which a person with a mental illness experiences and manages his or her disorder in the process of reclaiming his or her life in community (30). From our study, patients found hope, better socialization and communication, change of negative attitude (part of overcoming stigma) and expression of emotion as positive outcomes of their participation in arts involving activities which are also key components of recovery and the process. (27, 28, 29, 31).

In our findings patients experienced enjoyment, happiness, entertainment, relaxation, expression of emotion, learning, being reminded of pleasant memories during their participation in music involving activities similar to findings from one qualitative study from HMIC’S on experience of music therapy on patients with psychosis.

Music therapy has a positive influence on ability of becoming aware of self (self-perception)(17). From our finding, patients experienced expression of emotion, which is part of self-perception, from their participation in music involving activities.

All patients in the study participated in music involving activities and the outcome of our research showed better communication and socialization of patients which goes along with the results from HMIC'S studies. These studies have indicated more positive and significant effect of music therapy on negative symptoms and social disability when combined with medication than medication alone (17).

We found that patients experienced expression of self and being out of worries through their participation in visual art involving activities which is similar with the concept of art therapy enabling people to express their emotional, cognitive and psychotic experiences in their art and process them at a pace that feels comfortable (11). Our findings of the positive effect on their communication is supported by a study from one exploratory RCT from HMIC'S (22) which showed a significant positive effect on negative symptoms (decreased social interaction is part of those symptoms) as result of art therapy. Regarding dance involving activities, patients experienced relaxation, happiness, entertainment, alertness and state of free of stress during their participation; and these findings were also reflected on Cochrane systematic review from HMIC'S(1).

In general, regardless of patient's level of insight or willingness for admission, nearly all have described benefiting from their participation. This study has demonstrated that arts therapies have direct impact on the state of mood patients, improves motivation, instills hope, enhances skills and strengths of patients and reduces social isolation. Apart from this, it has been clearly described as giving patients a role to play in their own recovery and a responsibility to take. Some have noted that they are more compliant to treatment and participate more actively in managing their health. This process of recovery has enabled a patient overcome stigma and has given others hope and commitment to improve themselves as they fight to be "normal again". This powerful effect of arts therapy in helping patients accept their illness, overcome stigma and empowering them to participate as a full, contributing member of society has been well studied (27,28,29).

Even though the activities were few in number and the participants expressed limitations in space and other resources, all were content and mostly satisfied with the service being provided. Apart from those that had few recommendations, most had low expectations from these services and were grateful for having participated.

Limitations of the study

The main limitation of the study is that the sample may not be representative of patients with the diagnosis of schizophrenia. Those who are being treated as out-patients, who are not psychologically stable enough to participate, incapable of verbal expression of self, who don't have capacity to give consent and those who are not able to participate in an interview conducted using Amharic language were not included and likely to be underrepresented.

We were able to recruit two female participants in this study who fulfilled the inclusion criteria indicating their underrepresentation in our study.

Participant's awareness of the psychiatric background of the interviewer (researcher) may have limited reports of their challenges particularly around the service provision and its outcome.

Implication of the study

The positive outcomes of patients' involvement in arts involving activities includes having hope, feeling better, better communication and socialization, change of negative attitude (overcoming stigma) are key components of recovery. This effect was seen across all participants regardless of their duration of illness or mode of admission. Another striking finding was that their involvement had an effect on their compliance for admission and had an empowering effect for change.

All the stated outcomes are not specifically targeting symptom reduction by focusing on the diagnosis rather all target different components of recovery which leads to focusing on the person as a whole.

The findings might enhance and modify our treatment provision by giving more emphasis on recovery than symptom remission. The recommendations by participants have demonstrated that there are means of improving these services in such resource limited settings. This study sheds a light into what can be achieved if recovery was given better emphasis in our services.

Recommendations

- Regular functional assessment for patients who are admitted to recruit those who are able to participate in arts involving activity to get more participating patients.
- Integrate family members, care givers and close social supports in the service provision to make them partake in the process of recovery and to ensure continuity after discharge from hospital.
- Regular pre (before participation), intra (during participation) and post (prior to discharge) service provision follow up of patients participants to monitor their progress and collaborate with their treating case team.
- Address issue of space and resources by mobilizing support to improve current services. This will help accommodate more participants with a wider range of interests and skills;
- Ensure safety of patients during their participation.
- Engage patients according to their interests, skills, strengths, limitations and needs paying attention to their socio-demographic differences.
- Extend service provision to include patients after their discharge during their outpatient visit in order to build on what is already achieved during their admission and to monitor their progress.
- Regular, scheduled and structured service provision by mobilizing all available resources including time, material/ equipment, staff, knowledge/ skill for the best interest of the patients.
- Build the capacity of human resources that are particularly trained for providing such services for patients with severe mental illness.
- Create a mental health service provision centered on recovery and mobilize resources and support to expand the current services to include art involving activities.

Conclusion

In treatment of schizophrenia, focus on the patient as a whole rather than symptom reduction is required to facilitate different components and process of recovery. It is worth taking into consideration the above findings and recommendations to enhance the service provision towards recovery.

Appendix

Data Collection Form/ Appendix I

1. ID number/ coded
2. Age (in years)
3. Gender Female Male
4. Religion
5. Address From Addis Ababa Out of Addis Ababa Rural Urban
6. Educational status No formal education Primary Secondary Higher
7. Employment status prior to hospitalization Employed Unemployed
8. Marital status Currently married/ live with a partner Divorced/separated Widow Never married
9. Number of biological? Dependent? Children
10. Source of support None Self Family Organization Other
11. Total number of persons living in the house
12. Hospitalization

Compulsory	Voluntary
13. Number of previous admissions	
14. Name and amount of medication the patient is currently taking	
15. Duration of illness (in years)formally or informally recognized	
16. Number of times in the rehabilitation center for arts involved activities this admission 0-1 7-10 11-15>15	
17. Type of art involved activity currently at AMSH Visual art Music Dance / movement Other	

Topic guide/ Appendix II

Thank you for your willingness to participate in this study. I would like to hear about your experience of participating in rehabilitation center provided by AMSH.

1. What are your reasons for being in Amanuel?
2. Have you been to the rehabilitation room? How many times?
3. What do you feel after you are in Amanuel prior to your participation in rehabilitation room?
4. Why do you go to the “rehabilitation room”?
5. What do you do when you are there?
6. What do you enjoy/like about the activity? Why?
7. What do you not like/avoid from the activities? Why?
8. How do you feel afterwards? In comparison with your feeling prior to participation?
9. Have you benefited by your participation? If so, how?
10. How satisfied are you with the activities?
11. Is there anything else in rehab that you would like for you or others to be improved? Any suggestion? Why??

Participants' information sheet/ Appendix III

I am conducting a research project which focuses on the experiences of participants in arts involving activities.

This form will explain why the study will be conducted, what your role will be in the study and confidentiality of the information you give for the study. There is no expected harm to you by participating in this study. This will be done by conducting an interview using questions for each participant. The interview will take up to 50 - 60 minutes but the duration and structure will primarily be determined by your (participant's) responses. You will be compensated in cash (amount) for the time you spend with us.

The questions you will be asked are about "rehabilitation center" activities that you have participated in and will be concerned about your experiences in these. I will need to hear your true perception and real experiences about the issues (not just about good aspects of service) and you will not be judged or in any way penalized for what you will say.

With your permission, the interview will be audio-recorded. Your confidentiality will be strictly protected; your name or any identifying information about you will be deleted from the transcription of your interview.

After data is converted into English language, it will be stored in password protected folders in my computer. Any personal information that could lead to your identification will never be disclosed in either written or oral form. You have the right of free choice to participate in the study without any obligation. If there is any question that you don't want to answer you can miss out that question. You can ask further clarifications of questions that are not clear to you. Anytime during the interview, you can ask for a break or to reschedule. You have the full right to withdraw from the study or choose not to participate at any time without consequences. This will have no effect on any aspects of your treatment or stay at Amanuel Hospital. I would also like to inform you that this study is approved by the ethical committees of the Department of Psychiatry, Addis Ababa University and Amanuel Mental Specialized Hospital.

The principal investigator is Dr. Biruh Alemayehu, Department of Psychiatry, AAU.

Email: biruhalmayehu.ba@gmail.com

Participant consent form/ Appendix IV

My name is_____. I have received and understood the information I have been given verbally and in the letter of invitation to take part in the study which is composed of an interview to explore my experiences of participating in the rehabilitation room activities provided by AMSH.

I have understood that participating in the study isentirely my decision and that I have the right to withhold information, refuse or dropout of the study any time I want to do so without any negative consequences to any part of my treatment or stay at Amanuel Hospital.

Yes No

I have received adequate information regarding the nature of the study and understood what will be expected from me. I have understood that my confidentiality will be kept for all the information I give during the study.

Yes No

I agree to the interview being audio-recorded.

Yes No

I hereby consent to participate in this research study.

Participant's signature:.....

Date:.....

Researcher's signature:.....

Date:.....

Amharic translated appendixes

መረጃ፣ መሰብሰቢያ፣ ቅጽ

1. መለያ፣ ቁጥር
2. እድሜ/ በአመት
3. ጾታ
 - ሴት
 - ወንድ
4. ሀይማኖት
5. አድራሻ
 - ከአ.አ
 - ከአ.አ፣ ውጪ
 - ገጠር
 - ከተማ
6. የትምህርት፣ ደረጃ
 - መደበኛ፣ ትምህርት፣ ያልተማረ
 - መጀመሪያ፣ ደረጃ፣ ያጠናቀቀ/ች
 - የሁለተኛ፣ ደረጃ፣ ያጠናቀቀ/ች
 - ከፍተኛ፣ የትምህርት፣ ደረጃ፣ ያጠናቀቀ/ች
7. በሆስፒታል፣ ከመግባት፣ በፊት፣ የነበረ፣ የሰራ፣ ደረጃ
 - ሰራ፣ ላይ፣ የነበረ
 - ሰራ፣ ላይ፣ ያልነበረ
8. የጋብቻ፣ ሁኔታ
 - ያገባ/ች፣ እና፣ ከትዳር፣ አጋር፣ ጋር፣ የሚኖር
 - የተፋታ/ች፣ ወይም፣ የተለያየ/ች
 - ሚስቱ፣ የሞተች/ ባላ፣ የሞተ
 - ያላገባ/ች
9. የልጆች፣ ቁጥር
 - ከራሱ፣ የተወለዱ
 - ከራሱ፣ ጋር፣ የሚኖሩ
10. የድጋፍ፣ ምንጭ
 - ምንም
 - ራሱ፣ በራሱ

- ቤተሰብ
- ድርጅት
- ሌሎች

11. በአጠቃላይ፡ በሚኖርበት/ የምትኖርበት፡ ቤት፡ ውሰጥ፡ ያለ፡ ሰዎች፡ ቁጥር

12. ሆስፒታል፡ የገባበት/ችበት፡ ሁኔታ

- በግዴታ
- በፍላጎት

13. ከዚህ፡ በፊት፡ ሆስፒታል፡ የገባበት/ ችበት፡ ጊዜ፡ በቁጥር

14. በአሁኑ፡ ሰዎች፡ ታካሚው፡ እየወሰደ፡ ያለው፡ መድሃኒት፡ ስምና፡ መጠን

15. በአጠቃላይ፡ ታካሚው፡ በህመም፡ የቆየበት፡ ጊዜ

16. በአሁኑ፡ ሆስፒታል፡ ከገባ/ች፡ በኋላ፡ በአጠቃላይ፡ በሰነ-ጥበብ፡ ያካተቱ፡ ክንዎኔዎች፡ ላይ፡ የተሳተፈበት/ችበት፡ ጊዜ

- 0-1
- 7-10
- 11-15
- ከ15፡ በላይ

17. የሰነ-ጥበብ፡ አካታቹ፡ ክንዎኔ፡ አይነት

- የመሳል፡ እና፡ ሰእል፡ ነክ
- ሙዚቃ፡ እና፡ ሙዚቃ፡ ነክ
- ዳንስ፡ እና፡ ዳንስ፡ ነክ
- ሌሎችም

በዚህ፡ ጥናት፡ ውስጥ፡ ለመሳተፍ፡ ፈቃደኛ፡ በመሆን/ ሽ፡ አመሰግናለሁ ፤ በአማኑኦል፡ የአእምሮ፡ ስፕሻላይዝድ፡ ሆስፒታል፡ ሪሃቢሊቴሽን፡ ክፍል፡ በሚሰጠው፡ አገልግሎቶች፡ ላይ፡ ያለህን/ሽን ፡ ልምድ፡ እና፡ ተሞክሮ፡ ከአንተ/ቺ ፡ መሰማት፡ እፈልጋለሁ።

1. አማኑኦል፡ እንድትገባ/ቢ፡ ያደረገህ/ ሽ፡ ምክንያት፡ ምንድነው?
2. ከዚህ፡ በፊት፡ በሪሃቢሊቴሽን፡ ክፍል፡ ውስጥ፡ ተገኝተህ/ሽ ፡ ታቃለህ/ታቂያለሽ? ሰንት፡ ጊዜ?
3. አማኑኦል፡ ከገባህ/ሽ ብኋላ፡ በሪሃቢሊቴሽን፡ ክፍል፡ በሚከናወኑ፡ ድርጊቶች፡ ከመሳተፍህ/ሽ ፡ በፊት፡ ምን፡ ይሰማህ/ሽ ፡ ነበር?
4. ወደ፡ ሪሃቢሊቴሽን፡ ክፍል፡ የምትሄደው/ጅው ፡ ለምንድነው?
5. መጨረሻ፡ በሪሃቢሊቴሽን፡ ክፍል፡ ውስጥ፡ በነበርክ/ሽ ፡ ጊዜ፡ ምን፡ አደረክ/ሽ?
6. በሪሃቢሊቴሽን፡ ክፍል፡ ውስጥ፡ በተሳተፍክባቸው/ሽባቸው ፡ ክንውኖች፡ ላይ፡ የወደድከው/ሽው ፡ ወይም፡ የተደሰትክባቸው/ሽባቸው ፡ ሃሳቦች፡ ምንድን፡ ናቸው? ለምን?
7. በሪሃቢሊቴሽን፡ ክፍል፡ ውስጥ፡ በተሳተፍክባቸው/ሽባቸው፡ ክንውኖች፡ ላይ፡ ያልወደድከው/ ሽው፡ ወይም፡ ያልተደሰትክባቸው/ሽባቸው፡ ሃሳቦች፡ ምንድን፡ ናቸው? ለምን?
8. በሪሃቢሊቴሽን፡ ክፍል፡ በሚሰጠው፡ ክንዋኔዎች፡ መሳተፍ፡ ከጀመርክ/ሽ፡ በኋላ፡ ያለህ/ሽ ፡ ውስጣዊ፡ ስሜት፡ እንዴት፡ ነው? በተለይ፡ በክንዋኔዎቹ፡ ከመሳተፍህ/ሽ ፡ በፊት፡ ይሰማህ/ሽ ፡ ከነበረው፡ አንጻር?
9. በክንዋኔዎቹ፡ በመሳተፍህ/ሽ ብምን፡ መልኩ፡ ተጠቅሜአለው፡ ትላለህ/ሽ?
10. በክንዋኔዎቹስ፡ ምን፡ ያህል፡ ረክተህ/ሻል?
11. በሪሃቢሊቴሽን፡ ክፍል፡ ውስጥ፡ አሁን፡ ካለው፡ የተለየ፡ ቢኖር፡ ኖሮ፡ ደስ፡ ይለኝ፡ ነበር፡ የምትለው/ ይው፡ ወይም፡ ሌሎች፡ ሰዎችም፡ ቢሆኑ፡ ደስ፡ ይላቸው፡ ነበር፡ ብለህ/ሽ ፡ የምትለው/ ይው፡ ነገር፡ አለ? ለምን?

የተሳታፊዎች፣ የይሁንታ/ ፈቃድ፣ ቅጽ

እኔ፣ ስሜ፡.....፣ ይባላል። በአማኑኤል፣ የአእምሮ፣ ስፔሻላይዘድ፣ ሆስፒታል፣ የሪሃቢሊቴሽን፣ ክፍል፣ በሚሰጠው፣ አገልግሎት፣ ውስጥ፣ መሳተፍ፣ የሚፈጥረውን፣ ልምድ/ ተሞክሮ፣ ለማጥናት፣ በሚደረገው፣ ጥናት፣ ውስጥ፣ ለመሳተፍ፣ በቃልም፣ እንዲሁ፣ በጽሁፍም፣ የቀረበልኝን፣ ጥያቄ፣ ተረድኼ፣ ተቀብያለሁ።

በጥናቱ፣ ውስጥ፣ የምሳተፈው፣ እኔ፣ ፈቃደኛ፣ ስሆን፣ እንደሆነ፣ ተረድቻለሁ፤ ከዚህ፣ በተጨማሪም፣ በአማኑኤል፣ ቆይታዬ፣ ላይ፣ ወይም፣ በህክምናዬ፣ ላይ፣ ያላንዳች፣ አሉታዊ፣ ተጽእኖ፣ በጥናቱ፣ ስሳተፍ፣ የፈለኩትን፣ መረጃ፣ መደበኛ፣ በፈለኩትም፣ ጊዜ፣ እንቢ፣ ማለትና፣ ከጥናቱ፣ ተሳታፊነት፣ እራሴን፣ ማግለል፣ እንደምችል፣ ተረድቻለሁ።

ስለሚደረገው፣ ጥናት፣ ተገቢ፣ የሆነ፣ መረጃ፣ አግኝቻለሁ። እናም፣ ምን፣ እንደሚጠበቅብኝ፣ እውቄታለሁ፤ በጥናቱ፣ በምሳተፍበት፣ ወቅት፣ እኔ፣ የምሰጠው፣ መረጃ፣ ሁሉ፣ ለማንም፣ ተላልፎ፣ እንደማይሰጥብኝ፣ ተረድቻለሁ።

በጥናቱ፣ በምሳተፍበት፣ ጊዜ፣ በሚኖረው፣ ቃለመጠይቅ፣ ላይ፣ በመቅረጽ፣ ድምጽ፣ መቀዳትን፣ ፈቅጃለሁ።

እዚህ፣ ላይ፣ በጥናቱ፣ ለመሳተፍ፣ መስማማቴን፣ እገልጻለሁ።

የተሳታፊው፣ ፊርማ

ቀን.....

የአጥኝው፣ ፊርማ

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