

Psychosocial Treatment and the Revolving-Door Patient

In this module, participants will learn:

- 1) The nature of poor insight in schizophrenia.**
- 2) Evidence-based practices aimed at engaging patients in treatment who do not believe they are ill.**
- 3) That there is a critical role family members can play in helping patients to accept treatment and services**
- 4) How mental health providers can work more closely and effectively together.**

Discussion Questions

After completion of the film’s credits, ask the questions which appear below. After each question you will see points to amplify and develop during the discussion.

- 1. Why do you suppose Millie believed that she was not ill?**
 - Was this a defensive coping strategy (e.g., denial)?
 - If so, after more than two years of improvement following her acceptance of both medicine and services (e.g. the supervised group home), why is it that she continues to think she is not ill? Why didn’t she gain insight?
 - Were Susan and Tina able to convince Millie that she has an illness and needs treatment? If so, how did they do this?

2. Millie ultimately agreed to take medication. Why do you suppose she agreed?

- Emphasize the fact that she was NOT being involuntarily treated as an outpatient and ask what other factors convinced her to take medicine on a daily basis.
- What would you predict Millie would do if not living in a supervised setting today? Would she take medication on her own?
- By the end of the film, how did Millie feel about taking medication?

3. In the years preceding her most recent housing situation and treatment setting, who was more important to her treatment: mental health providers or her family?

- During this time period Millie was taking medicine and receiving other forms of treatment on-and-off at her own discretion. What benefit, if any, did she receive from her brief interactions with the mental health system?
- What role did mental health providers play in insuring her safety and that of her children?
- Who ultimately helped to protect Susan and Tina from being “secondary victims” of schizophrenia?
- What role have Susan and Tina played in insuring Millie’s well being and safety?

4. What barriers kept mental health providers and Millie’s daughters from working together to insure that Millie was receiving treatment, housing and needed services (e.g., occupational rehabilitation, other medical care, etc.)?

- Why would a mental health provider not want to speak with Millie’s daughters?

- Over and above HIPPA regulations and ethical considerations, why do you suppose Millie’s mental health providers were generally very resistant to speaking with Susan and Tina?
- What did Susan and Tina do to open up communication between themselves and Millie’s mental health providers?
- What could they have done short of obtaining guardianship?

Teaching Points for the Facilitator

- 1) A large body of empirical literature published over the last fifteen years indicating that severe and persistent lack of insight in schizophrenia, as Millie exhibited, is usually the consequence of the cognitive deficits associated with the disorder. Most studies implicate deficits in executive, or frontal lobe, function. This research has resulted in expert consensus reflected in the following excerpt of the DSM-IV-TR™, Schizophrenia and Other Psychotic Disorders section: *“A majority of individuals with schizophrenia have poor insight regarding the fact that they have a psychotic illness. Evidence suggests that poor insight is a manifestation of the illness itself rather than a coping strategy. It may be comparable to the lack of awareness of neurologic deficits seen in stroke, termed anosognosia. This symptom predisposes the individual to non-adherence with treatment and has been found to be predictive of higher relapse rates, increased number of involuntary hospital admissions, poorer psychosocial functioning, and a poorer course of illness.”*¹
- 2) Poor insight, or deficits in illness awareness, is common, affecting approximately one-half of all patients with the disorder (estimates hover around 60%). In addition, as noted in the DSM IV-TR, unawareness of the illness predicts nonadherence with treatment. This should come as no surprise. After all, who would want to take medicine or attend a rehabilitation program for an illness they don’t believe they have?
- 3) Such problems with insight are very difficult to improve. In fact, despite clinical myth, insight rarely improves with pharmacological treatment.^{2 3} Meanwhile, psychosocial interventions that utilize techniques of

Motivational Enhancement Therapy (MET) --- sometimes referred to as Motivational Interviewing because the technique involves asking the patient questions rather than giving advice or reality testing --- are significantly more effective in engaging patients in treatment who do not believe they are ill. Ironically, MET does **not** focus on helping the patient gain insight into being ill. Instead, such approaches focus on helping the patient articulate his or her goals and then linking the achievement of those goals to specific treatment and services.

For example, a patient who complains that “No one believes me; no one wants to help me with the conspiracy... I know my neighbors are trying to kill me and I know they’re communicating with each other about me using the pattern of lights they put on in their windows at night...” is not used to someone listening to this concern without also giving him a dose of reality testing. Sometimes the reality testing is subtle and takes the form of: “So if I understood you correctly, you *believe* that...” Using terms like “you believe” or “you feel that this is happening” usually alienate the patient making him feel, once again, that no one believes him and must seem to think he’s crazy whenever he tries to talk about the most important thing that is happening in his life (i.e. the conspiracy).

Moreover, this person is not used to someone conveying their respect for their point of view and showing genuine interest in hearing more. Typically, we don’t listen without trying to point out how the belief is delusional. Or, we won’t convey our appreciation and respect for what this person is going through because we are fearful of “colluding” with, or somehow worsening the delusion if we don’t make it immediately clear that we don’t think it’s true. In most cases this worry is unfounded. There is no evidence that one can worsen a delusion by allowing the patient to make the mistake that you might believe it’s true also.

One should never be deceptive and say they believe a delusion is true. Rather, the focus is on not going out of your way to make the point you think the belief is delusional. MET requires that we *listen* without such corrections and that we *convey our respect* for the speaker’s experience with empathy while normalizing it: e.g. “anyone would feel that way if their neighbors were trying to kill them.” By actively listening without reality testing, while conveying empathy and normalizing the person’s experience, we form the cornerstone on which we can build an alliance that is based on trust and mutual respect for differing points of view.

One form of MET titled LEAP (“Listen-Empathize-Agree-Partner” in “I am Not Sick, I Don’t Need Help!” by Xavier Amador (Vida Press, 2000) offers strategies for when the time is right to convey your point of view (e.g. this is actually a delusion and you probably would benefit from medicine) and how to do it without damaging the alliance you have built. The overarching goal is to build a relationship characterized by the following:

The person feels that you

- 1) listen carefully to their point of view and accurately convey your understanding of it
 - 2) respect their point of view and never reality test or offer a contrary opinion unless asked for your opinion several times
 - 3) empathize with them that you would feel the same way were you in their situation
 - 4) think they would benefit from treatment
- 4) Finally, this relationship is focused on helping the individual discover what is most important to him or her and partnering on those specific goals. In Millie’s case, she wanted a home and a job. MET would focus on linking these goals to accepting medicine and services. But if she were more acutely ill, it could as easily focus on helping her to deal with the conspiracy against her by offering her social support and medicines that would help her handle the sleep disturbance and fear she is feeling because of the conspiracy.
- 5) Motivational Enhancement Therapy (MET) was first developed to help persons with substance-abuse disorders accept treatment. Interventions based on MET have been found to be affective in patients with schizophrenia who have problems with adherence. In one review of empirical studies aimed at improving medication adherence in schizophrenia, published over a 20-year period, the authors concluded that *“...although interventions and family therapy programs relying on psychoeducation were common in clinical practice, they were typically ineffective [with respect to improving adherence]... Motivational*

*techniques, [on the other hand] were common features of successful programs.”*⁴

- 6) Obviously, MET is relevant for all mental health providers working with persons with schizophrenia and related psychotic illnesses. Psychiatrists, psychologists, social workers, psychiatric nurses, law-enforcement officers, case workers, consumer-peer counselors, and residential counselors all have been trained in this approach.⁵ In addition, many family caregivers have also been trained. Recently, studies testing the efficacy of motivational interviewing techniques used by psychiatric nurses and family members suggest that persons with varying professional backgrounds can be equally effective in improving adherence. Indeed, one of the advantages of MET training for both family caregivers and “front-line” mental healthcare providers is that there are many more opportunities for interaction than is possible during monthly appointments.
- 7) Because MET is effective with opportunistic encounters and does not require that one have special “sessions,” it is particularly relevant for family members, assertive community treatment teams, nurses, and residential counselors. Finally, if they exist, maladaptive communication patterns in the family usually are improved when MET is learned, resulting in reduced “expressed emotion,” discord and estrangement.⁶
- 8) Among the top evidence-based strategies for improving continuity of care, reducing relapse and increasing adherence to treatment is Assertive Community Treatment (ACT), which is sometimes also referred to as PACT. Typically, ACT programs include: interdisciplinary treatment teams with shared caseloads, 24-hour access and mobile crisis teams, assertive outreach to treat clients in their own environments, individualized treatment plans, medication access and support and rehabilitation services. Another hallmark of this approach is the consumer-centered perspective that focuses on helping the patient achieve goals that are meaningful and important to him or her. This is in contrast to programs that are based on the structure of the institutions, such as homeless shelters. Consumer goals often relate to work, housing, and establishing fulfilling interpersonal relationships. In this way, ACT is very similar to MET which focuses only on the consumer’s stated goals and attempts to link his or her desires to treatment and services.

- 9) There have been approximately 25 randomized controlled trials demonstrating the clinical and cost effectiveness of the ACT program, the most cited study being the Schizophrenia Patient Outcomes Research study (PORT), funded by the National Institute of Mental Health and Agency for Health Care Policy and Research. The PORT study recommended that *ACT is essential for individuals who suffer repeated relapse and hospitalization and have trouble complying with treatment.*⁷ In another paper that reviewed research studies, the authors concluded that ACT reduces hospital time, improves housing stability, improves symptomatology and improves quality of life.⁸
- 10) Although Millie was not involved in an ACT program when she left the nursing home and entered the group home she lives in today, her daughters Susan and Tina actually performed many of the functions of an ACT program, such as, outreach to where Millie was living and focusing on her goals (e.g. helping her to move out of the nursing home, get a job, live in a house) and insuring she had access to medication and other relevant services.
- 11) Finally, the benefit to improving communication and collaboration between family caregivers and mental health providers cannot be stated more eloquently here than it was in the film. The benefit to the patient is typically obvious. And yet, many family members complain bitterly about their inability to work together with their loved one’s providers. Meanwhile, many providers find that family members are a distraction or feel that contact with the family is necessarily a breach of confidentiality: illegal and unethical.
- 12) There are several strategies one can use to improve the collaboration that does not require that one act unethically or break the law. For example, patient confidentiality laws and guidelines do not prohibit providers from listening to family members. This strategy is an effective first step to improving continuity of care as the provider has the benefit of information about treatment and other relevant history that they would otherwise never have (e.g. previous serious dystonic reactions to a particular medication, history of elopement from the hospital, of “cheeking”, drug use, etc.).

The provider need not confirm that the person the family member is calling about is a patient of his or hers. One need only say: “I am willing to listen to what you have to tell me about your family member.” Other strategies include insisting that the patient identify at least one family member or

close friend that the provider can be in contact with and obtaining written consent.

- 13) Finally, family meetings are as vital at admission to the hospital as they are at discharge. An early meeting with family may not only help to plan the course of treatment, but also identify whether any children or other vulnerable persons (such as the elderly) have been affected by the illness (e.g., neglect, abuse, etc.).

References

DSM-IV-TR, American Psychiatric Association, pp 304, 2000.

² Amador XF & David A, Eds. *Insight and Psychosis*, 2nd Edition. Edited volume, Oxford University Press, 2004.

³ Amador XF, Andreasen NC, Flaum M, Strauss DH, Yale SA, Clark S, & Gorman JM. “Awareness of illness in schizophrenia, schizoaffective and mood disorders.” *Archives of General Psychiatry*, 51(10):826-836, 1994.

⁴ Zygmunt, Annette; Olfson, Mark; Boyer, Carol A; Mechanic, David. Interventions to improve medication adherence in schizophrenia. *American Journal of Psychiatry*. Vol 159(10) Oct 2002, 1653-1664.

⁵ Amador, Xavier F. *Learning to L.E.A.P. Training Manual*, Vida Press, 2007.

⁶ Amador Xavier F. “I am Not Sick, I Don’t Need Help!” Vida Press, 2007.

⁷ Lehman AF, Steinwachs DM. Patterns of usual care for schizophrenia: initial results from the Schizophrenia Patient Outcomes Research Team (PORT) client survey. *Schizophrenia Bulletin*. 1998;24:11-20; discussion 20-32.

⁸ Mueser, K. T., Bond, G. R., Drake, R. E., & Resnick, S. G. (1998). Models of community care for severe mental illness: A review of research on case management. *Schizophrenia Bulletin*, 24, 37-74.

Recommended Reading

Amador, Xavier F. “I am Not Sick, I Don’t Need Help!” Helping the seriously mentally ill accept treatment. Vida Press, 2007.

Amador, Xavier F. *Learning to L.E.A.P. Training Manual*, Vida Press, 2007.

Torrey, E. Fuller. *Surviving Schizophrenia: A Manual for Families, Patients and Providers* (5th Edition). Harper Collins, 2006.