4

The Right and Wrong Approach

"Tell me one last thing," said Harry. "Is this real? Or has this been happening in my head?" Dumbledore beamed at him…" Of course it is happening in your head, Harry, but why on earth should that mean it is not real?"
J.K. Rowling, *Harry Potter and the Deathly Hallows*, 2007, page 723

Dr. Karen Holloway sighed and said, "Michael's back," as she walked toward where I was sitting in the nurse's station. "I need you to go to the E.R. and do his admission," she added.

"Michael Kass?" I asked, incredulous.

"Afraid so," Karen replied, a bit amused by my surprise. "Get used to it, Xavier. Some patients are stuck in the revolving door, and Michael's one of them."

This was 1988 and Karen was the Chief Resident at the hospital in New York City where I was an intern. To this day she remains one of the more compassionate, bright, and level-headed clinicians with whom I have ever had the pleasure of working. The diagnosis of "Revolving Door Patient" was not one she made lightly or without compassion. Michael Kass had been discharged from the hospital only six weeks earlier after a one-month hospitalization. When he left, he was no longer hearing voices. His delusions still lingered, but he felt little pressure to talk about them, and he was scheduled to receive follow-up treatment in one of our outpatient clinics. Judging by Karen's comment, I

guess I didn't hide my disappointment and surprise that he was back so soon.

I took the stairs two at a time, eight floors down, to the Emergency Room—no use waiting for the overburdened elevators—and walked to the door labeled "Psych. E.R." Behind this door, sequestered from the rest of the E.R. service, was a suite of five rooms with four patient bays to the left and the nurses' station to the right. As I entered I took a quick right and ducked into the nurses' station. I didn't want Michael to know I was there until I'd had a chance to talk to the triage nurse. The report I got was frustrating to hear.

After leaving the hospital, Michael went home to live with his parents but never showed up for his first outpatient appointment. His parents, in their late sixties, didn't know that Michael hadn't gone to see his doctor. They'd asked about his appointment, but he didn't want to talk about it. They'd called the clinic, but no one would speak to them about whether or not their thirty-five-year-old son had kept his doctor's appointment. They also didn't know that after the one-week supply of medications he'd been given when he left the hospital ran out, he'd never had the prescription refilled.

I spent about twenty minutes looking at his old chart, which the triage nurse had ordered up from medical records. Then I stepped out of the nurses' station and greeted my new-old patient.

"Hi, Michael, how are you?"

"Dr. Amadorafloor! What are you doing here?" he answered, *clanging*[6], laughing, and talking a mile a minute. "You've got to get me out of here! I was minding my own business—I wasn't hurting anyone—the police got it all wrong. Get me out of here, okay? You've got to get me out because..."

"Michael, Michael, hold on, wait up a minute!" I tried to interrupt.

6. [6] A feature of thought disorder, a frequent symptom of psychosis, that involves word associations based on rhyme.

".I'm not supposed to be *beer*. They'll find me here if I stay. Gotta go, gotta get out, okay?"

"Michael, try to slow down and tell me what happened. Okay?"

"I'm telling you what happened. I'm not supposed to be here," he shot back, clearly annoyed with me.

It took almost an hour to get through the checklist I was trained to use. I completed a *mental status exam*[7], evaluated his current symptoms, and listened to his version of what had happened and why he was in the Psych. E.R.. Excusing myself while he was again pleading with me to get him out, I escaped to the nurses' station to write down what I had learned.

Michael was once again hearing the voices of government agents who were commenting on his every move. While we were talking, I asked him what the voices were saying, and he repeated, "He is sitting on the bed, talking with that doctor, he can't escape us now." Given the voices he was hearing, it isn't surprising he'd developed the delusion that some secret federal agency was monitoring his movements and planning to assassinate him.

I noted in his chart the re-emergence of the hallucinations and exacerbation of the longstanding delusion about government agents persecuting him. I also noted that he was not currently suicidal or homicidal, that his "insight into illness" was poor, and a number of other observations I had made while interviewing him. My written recommendation was to restart the antipsychotic medication he'd been on when he was discharged six weeks ago and to admit him to our inpatient psychiatric unit "for stabilization." Then I went back to see Michael, told him my recommendation, and asked him to sign himself into the hospital for a couple of weeks. He refused.

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7. [7] A cornerstone of psychiatric assessment, the mental status exam involves an assessment of the clarity of consciousness, memory, attention, emotion, thought process, insight into illness, and various symptoms of mental illness.

"The only thing wrong with me is that I'm going to get killed if I stay here any longer!"

Since he had been found hiding in a subway train tunnel and had struggled with the police when they extracted him, I thought we had a fairly good case for an involuntary admission. When he was found, he hadn't eaten or bathed in several days and he had made camp dangerously close to an active track, explaining to police that "they [the federal agents] would never think to look for me here." I called Dr. Holloway; she agreed, and the appropriate papers were signed to admit him against his will for 72 hours. If he didn't want to stay after the 72 hours, and if at that time we felt he was still a danger to himself because of his mental illness, we would take him before a mental health court and try to get a judge to order thirty days of involuntary treatment.

When I explained the plan to Michael, he understandably went ballistic. He was terribly frightened and felt certain that he would be killed if he stayed in the hospital. However, after accepting medication by injection, he calmed down considerably and was moved upstairs to the psychiatric ward.

Unless something was done to engage Michael in treatment, this hospitalization would be nothing more than a band-aid.

Though we had resolved the current crisis, unless something was done to engage Michael in treatment, this hospitalization would be nothing more than a band-aid. He would be "stabilized" and discharged with prescriptions he would never fill and an appointment he would never keep because, as he put it, "I am not sick! I don't need medicine—I need protection from the feds!"

The Wrong Approach

I was using the medical model with Michael, which, in most cases, is the wrong approach to take for dealing with the long-term

issue of poor insight and refusal to take medicine. The medical model is supposed to work, more or less, in the following way. Once the diagnosis and treatment are decided upon, the patient is informed of both. If the patient refuses, and if he fits the legal criteria for an involuntary admission to a hospital, the doctors take charge. In some cases, medical doctors operating under a benevolent paternal ethic are able to order treatment against a person's wishes. Like a parent who knows what's best for her child, the physician can take control by admitting the person and treating him against his will. We abide by similar, although less dramatic laws every day (e.g., laws that require seatbelts, mandatory rabies inoculation of pets, and motorcycle helmets; those that prohibit drunk driving, etc.).

My next task under this model was to educate Michael about his illness and the need for treatment. If you are reading this book, you know that when it comes to individuals like Michael, education about their illness does not translate into their gaining insight. And, indeed, that is what happened over the two-week period Michael was in the hospital.

I told him all about delusions and hallucinations and confronted him about his "denial" of the illness. I explained to him the nature of the problems he had and why he should accept the treatment being offered. As he had during his previous hospitalization, once he became more stable, he readily agreed that he would take the medication when he left the hospital. When I confronted him and said, "I think you're just saying that so you can get out of here," he sometimes sheepishly admitted to the lie and told me there was nothing wrong with him except the fact that people wouldn't leave him alone. But most often he would stick to the party line and say, "I know the medication helps me and that I need to take it." Ironically, as some of his symptoms responded to the medication, he got better at consistently feigning allegiance to the doctor's orders.

For people with serious mental illness who are unaware of the illness, this traditional approach rarely works. It rests on the mistaken assumption that the patient has come to see the doctor because he feels he has a problem and wants help. It assumes a collaborative approach from the start: The doctor as an ally, not an adversary.

Although the details might differ, Michael's story of hospitalization followed by outpatient noncompliance, worsening illness, and readmission to the hospital, is all too typical. So was my inadequate response to the bigger problem of what would happen to him when we were done with him (again). I was operating under a medical model that focused on the tasks of diagnosis and treatment. This is the wrong approach when dealing with someone who has, for many years, consistently argued that there is nothing wrong with him and doesn't need help. It's not a bad approach for the short term, but it's mostly worthless over the long term because the "patient" doesn't see himself as a patient.

If you can imagine something like this happening to you, then you have some idea of what it is like for someone with a mental illness to have a delusion and anosognosia.

An analogy might be useful to help you understand why this is so. Imagine I told you that that you did not live where you live. You might laugh and tell me to stop joking around. But what if I produced a restraining order from a court that ordered you to stay away from what you told me was your home address. Now let's say you live with other people, perhaps members of your family, and you saw that they had signed off on this court order. What would you think? And imagine that you then called them to ask why they'd signed off and they said something like, "You seem like a nice person, but if you keep coming around here we

are going to call the police. You don't live here, and we don't want to press charges, but we will if you put us in that position. Please stop calling us; you need help!" If you can imagine something like this happening to you, then you have some idea of what it is like for someone with a mental illness to have a delusion and anosognosia.

Stay with the analogy and imagine you went home only to be arrested by the police. The nice people at your address did not want to press charges, so the police took you to the E.R.. Would you be receptive to my advice that you should take psychiatric drugs for your "delusion" that you live where *you know* you live? I doubt it. I have done this role play countless times and the answer is always "No!" When I ask why, my role play partner usually laughs and says, "Because it's the truth. I know who I am and where I live!" Well, that's what its like for a person with a serious mental illness to have a delusion and anosognosia. The medical model is not going to win this person's trust and cooperation over the long haul. Like you or me, if we were in this situation, once the person is out of the hospital and on his own he will not take medicine. If you can see the situation from that person's perspective, its common sense really.

The Right Approach

In my experience, it is often easy to change such an adversarial relationship into an alliance and long term engagement in treatment. It takes some focused effort, but it's not hard to do once you learn the main lessons. The hardest part is putting aside your preconceptions and remembering that no amount of arguing has previously changed your loved one's opinion about being mentally ill. My best advice to you is to stop trying to convince him he is ill. When you accept your powerlessness to convince him you know the answer to the penultimate question (Is he, or is he not, mentally ill?) you will begin to open doors you didn't

even know existed. Remember, if you had truly succeeded in convincing your loved one he has a mental illness you would not be reading this book. The first step, therefore, is to stop arguing and start listening to your loved one in a way that leaves him feeling that his point of view—including his delusional ideas and the belief that he is not sick—is being respected.

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Professor Dumbledore's answer to Harry Potter's question quoted at the start of this chapter is exactly right. For all intents and purposes your loved one's experience is very real indeed. He truly is not sick. If you can relate to your loved one in this way, you will be much closer to becoming allies and working together to find the reasons *he* may have to accept treatment—even though he is not sick. You don't have to agree with his reality—the realness of his experience—but you do need to listen to it and genuinely respect it.

My colleagues and I have helped many patients accept treatment for a wide range of problems that they feel have nothing to do with mental illness: e.g., to relieve the stress caused by the conspiracy against them; to help them sleep; to get their families "off their back"; to lower the volume on the voices being transmitted by the CIA, etc..

I don't expect you to immediately embrace this idea. Most people find it counter-intuitive and even a little scary. Others like the concept of stepping back from the debate about whether or not the person is ill but are not sure about how it is going to help. Let me start addressing these concerns by describing my approach and the science behind it.

Motivational Enhancement Therapy and LEAP

Anyone who has dealt with severe denial in a loved knows that it can't be fixed simply by educating the person about the problem he doesn't believe he has. Such attempts are futile because the "patient" doesn't see himself as a patient. And, research shows that confrontation and group "interventions" also rarely work. In fact, contrary to what most people believe, "interventions" often do more harm than good! So what does work?

Motivational Enhancement Therapy (MET) is a science-proved method that helps people in denial accept treatment. It was first developed more than twenty years ago for professionals like me who were working with substance- and alcohol-abusing patients. Unfortunately, despite its proven effectiveness for engaging people with substance abuse problems in treatment, few therapists are trained to use it with patients who have a serious mental illness. This needs to change because there is plenty of research to support using MET with such individuals.

In 2002, the *American Journal of Psychiatry* published a review by Dr. Annette Zygmunt and her colleagues of studies published over a 20-year period that were aimed at improving medication adherence in schizophrenia. The researchers found that "…although interventions and family therapy programs relying on psychoeducation were common in clinical practice, *they were typically ineffective* [with respect to improving adherence to treatment]… *Motivational techniques,* [on the other hand] were common features of *successful programs*." By "motivational techniques" the authors meant the main elements of MET.

I realized almost immediately that the specific communication skills and strategies we were teaching therapists could be learned by anyone.

Relying on the same evidence base reviewed by Dr. Zygmunt and her colleagues, Dr. Aaron T. Beck (considered by many to be the father of cognitive psychology) and I developed a form of MET we called Medication and Insight Therapy (MAIT) for an inpatient research study to be used with people who have serious mental illness. At the time (mid-1990s), we taught this method only to therapists. But I realized almost immediately that anyone could learn the specific communication skills and strategies we were teaching. I felt it was more a communication style than a complicated therapeutic intervention. I came to believe that you don't need an M.D., M.S.W., or Ph.D. to use the main elements of this therapy effectively. Consequently, I developed a lay-friendly version that can be taught to lay persons and mental health professionals alike.

Listen-Empathize-Agree-Partner (LEAP) method

The result was the Listen-Empathize-Agree-Partner (LEAP) method. Over the past six years, since the publication of the first edition of this book, I have taught LEAP to thousands of people across the country and overseas. Although the focus of my LEAP workshops was to show family members and health providers how to convince someone with serious mental illness to accept treatment, people at every seminar have commented on the usefulness of this method across a range of problems. That has been my experience as well. So whether or not you believe your loved one has anosognosia for mental illness, or simple denial of illness, LEAP can help.

5
Learning to LEAP

When I was five years old I wanted to be Batman. It's true that Superman, Spiderman, and the Hulk were also appealing, but for me they were all a distant second to Batman. It wasn't his mask and ears--which I remember thinking looked goofy--it was that amazing "Bat Utility Belt." I had to have a Batman costume for Halloween—nothing else would do. I still remember how I felt when I strapped on that belt for the first time. I could conquer all evil, set things right and live to tell the tale. I had power to do good.

The best thing about Batman was that he was a regular person. He did not have super powers.It was his tool belt--and that's really all it was--that set him apart from mere mortals. There were many high tech tools in that belt, but my favorite was the grappling hook attached to a dental-floss-thin rope that he used to walk up the sides of buildings. With those tools, there was no wall he could not climb, no obstacle he could not overcome. There was no enemy he could not beat.

I want you to imagine that you, too, have a tool belt. It can be made of any material you like, stylish (Dolce and Gabbana) or purely functional looking (Craftsman). Imagine it is full on the left side with all the tools we use when relying on the medical and psychoeducational approaches (e.g., Making a diagnosis, educating the person about his diagnosis, giving him his prognosis and prescriptions for treatment, reality testing about delusions, etc.). These tools are highly effective when we are dealing with persons who have insight and want our help. They are ideal for persons who identify themselves as patients or consumers.

Now I want you to imagine that your tool belt is empty on the right side. Loops, hooks, and pockets all lay open and

ready to receive the tools you will need to help someone accept treatment even thought he does not believe he is ill. I'm going to be providing you with the tools to fill that side of your belt. They will serve you well, but you'll have to practice using them.

The first and most important tool you will put in your belt is the focus of next chapter—the *Reflective Listening Tool*. But you will also learn how to not "buy into delusions" while listening without judgment, how to *delay giving your opinion* when asked potentially deal-breaker questions like "So do you think I'm sick and should take this medicine?" (I will also explain all the reasons you should delay answering such questions and choosing the right time to finally give your opinion); and a tool for *giving your opinion* in a manner that allows your loved one to save face, retain dignity, not feel betrayed and most importantly, stay in the conversation and not walk away.

To make all this happen you have to put your goal of convincing your loved one he is sick high up on a shelf, at least for the time being.

I think you will find that LEAP's effectiveness for dealing with someone in denial or with anosognosia is immediately intuitive. Once you learn the basic principles, it simply makes sense that it will work far better than what you've been doing all along. The core tools are *Listening* (using "reflective" listening), *Empathizing* (strategically--especially about those feelings you've ignored during your previous arguments about your loved one's being sick and needing treatment), *Agreeing* (on those things you can agree on and agreeing to disagree about the others), and ultimately *Partnering* (forming a partnership to achieve the goals you share).

More often than not the first aim of LEAP is to repair the damage done to the relationship by your (or other's) previously

adhering to the medical model and taking the "Dr. knows best approach." The second task is to help your loved one find *his own reasons* to accept treatment. To make all this happen you have to put your goal of convincing your loved one he is sick high up on a shelf, at least for the time being.

Listen with only one goal: to understand the other person's point of view and reflect your understanding back to him

The cornerstone of LEAP is reflective listening. It is also the one feature of the method that immediately turns down the volume on everyone's anger, builds trust, and mends fences. The reason is that you listen with only one goal: to understand the other person's point of view and reflect your understanding back to him. You don't comment on what he just said, point out ways in which you think he's wrong, judge, or react in any way. Sounds easy until the person starts talking about the fact that there's absolutely nothing wrong and he doesn't need treatment!

Listen

Reflective listening is a skill that needs to be cultivated. It doesn't come naturally to most people. To succeed, you will need to learn to really listen and not react to what your loved one feels, wants, and believes. Then, after you think you understand what you were told, you need to reflect back, in your own words, your understanding of what you just heard. The trick is to do this without commenting, disagreeing, or arguing. If you succeed, your loved one's resistance to talking with you about treatment will lessen and you will begin to gain a clear idea of *his* experience of the illness and the treatment he doesn't want. When you know how your loved one experiences the idea of having a mental illness and taking psychiatric drugs, you will have a foothold you can use to start moving forward. But you will also need to know