The nurse's role in using concordance skills: a case study

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Reflective Case Study

the name, personal and background details of the service-user have been significantly changed to ensure anonymity and confidentiality

Introduction

In this paper, I will discuss the psychological interventions that were employed in the care of a service-user who found it difficult to adhere to his antipsychotic medication. After providing a short background of this service-user's situation, I will describe the collaborative care processes of assessment, formulation, planning, implementation and evaluation of care that were undertaken with this service-user. In particular, I will highlight the impact on the patient of his illness and how he was actively involved in his own care.

Background

James, a 35 year old gentleman, has had numerous in-patient admissions for mental health problems. He used to attend a day centre prior to his most recent in-patient admission to a low secure unit, before he disengaged, making allegations that staff had tried to poison him via injections. He also complained that the food served at the day centre was poisoned, such that he stopped attending. These beliefs led James to stop eating, even at his group home, and he began to stop visiting his relatives nor allow them to visit him.

James was admitted under Section 136 of the Mental Health Act (HMSO 1983). Whilst in the unit, his paranoid thoughts did not abate and he continued to refuse food, drink and medication, purporting they were poisoned. My initial attempts to engage James proved futile. Realising that I would not achieve his cooperation instantly, I gathered information about his problems, from his case notes, previously involved practitioners and from his relatives. This collaborative approach is vital in patient care as it promotes respect, encourages participation and fosters team work (Henneman et al 1995). The involvement of James' relatives was critical – relatives often possess vital information about the illness (Birchwood and Shepherd 1992). This information gathering activity revealed that James first experienced a psychotic episode at the age of 16, from which time he had been treated with antipsychotic medication – he has always subsequently disengaged and discontinued his medication. He had been formally admitted on six occasions and

informally on a further three occasions. As an in-patient, he had developed animosity and contempt towards health professionals as a result of having been forced to take medication, sometimes via restraint and injection. His mental state would typically improve whilst taking medication and deteriorate upon discontinuation.

Engagement

Actively engaging James continued to be difficult. Kuipers et al (1997, cited: Yorke and Gayland 2003) claim that to achieve the cooperation of 'difficult to engage' patients, their experiences and ideas should be valued. My experience suggests that extending friendliness and warmth to such clients is likely to reduce their resistance, and so this approach was used in inviting James to talk about his experiences. The option of talking about his difficulties together was introduced and the cognitive-behavioural model was used in capturing his interest and promoting a mutual understanding of his problems.

Assessment

The cognitive-behavioural model was presented to James, emphasising five inter-related areas (Padesky & Mooney 1990), both as a framework for understanding his problems and as an approach for promoting his engagement. The interview-based Brief Psychiatric Rating Scale (BPRS) was used in assessing the severity of his symptoms (Miller & Faustman 1995). This revealed some of his perceptions, which included hallucinations. He spoke of being able to smell an unknown gas that he believed to be poisonous, and that this was also in the food and drink. Barker (1997) refers to this experience as both olfactory and gustatory hallucinations, and reports that individuals with such experiences may feel persecuted.

Another assessment was conducted to ascertain James' insight into his illness. In the literature, Lewis (1935, cited: MacPherson et al 1996) holds the notion that 'Schizophrenia is a severe psychiatric illness leading to disordered mental function, which requires antipsychotic treatment, but often differs from a patients perception, and this discrepancy is referred to as the patient's lack of insight'. Appleby and Forshaw (1990, cited: David et al 1992) regard the assessment of insight as part of the mental state examination. David et al (1992) argue that the concept is composed of three different but overlapping constructs: the ability to re-label unusual mental events (e.g. hallucinations) as pathological; recognition by the patient that s/he is suffering from an illness and that the illness is mental; and treatment compliance. The assessment confirmed that James had insight in the first two components, although he expressed ambivalence about adherence to antipsychotic treatment.

The five areas assessment model was introduced to James, with an explanation of each domain (environment, thoughts, mood, behaviours, physical reactions), as presented by Williams and Garland (2002). Information was collected from several sources: from case notes, professionals and relatives.

Developing an Illness Timeline

Kemp et al (1996) in their study on compliance therapy recommend interventions to be provided in phases, but commencing with a review of the patient's illness history. They report that this helps in exploring and clarifying the patient's own conceptualisation of their problems and insight, reminds the patient of more troublesome symptoms, and if, during the completion of the

illness timeline, a relationship between medication cessation and relapse becomes apparent, this can be gently amplified. Finally, they suggest that reviewing previous experiences of treatment will unveil likely barriers to medication adherence. Developing an illness timeline with James confirmed a clear link between symptom management and taking medication, as he would start to re-experience hallucinations whenever he stopped taking the medication – a claim that was confirmed by his relatives and by day centre staff. At the end of the interview, James agreed to collect retrospective information on his experience of smell and how he coped.

Initial Formulation

Following this review of his illness history and assessment, an initial case formulation was developed.

Exploring Ambivalence

Having established from his illness timeline that deterioration in his mental state was attributable, at least in part, to medication refusal, it was decided to explore this further. Kemp et al (1996) refer to this exercise as an 'exploration of ambivalence'. Before highlighting the use of this strategy, it is useful to briefly consider the literature relating to non-compliance with antipsychotic medication.

Kennedy et al (2000) report that there is overwhelming evidence from clinical trails to demonstrate the benefits of the use of antipsychotic medication in the treatment of schizophrenia. Marder et al (1999, cited: Gray et al 2002) also claim that the prophylactic use of antipsychotic medication can prevent relapse. However, compliance with antipsychotic medication is generally poor and often results in re-hospitalisation and poorer outcome in patients with psychotic disorders (Kemp et al 1997, cited: Gray et al 2002). Breen and Thornhill (1998, cited: Awad 2004) estimate the rate of non-adherence to be between 70-80% of patients and this is associated with hospital admission which costs the UK around £100 million per year (David and Drummond 1990, cited by: Perkins and Repper 1999). A recent comprehensive review of 39 studies conducted since 1980 revealed a series of factors that are most consistently associated with non-adherence: poor insight, negative attitudes or subjective responses towards medication, previous non-adherence, substance abuse, shorter illness duration, inadequate discharge planning or aftercare environment, and poor therapeutic alliance (Lacro et al 2002, cited: Awad 2004). In addition, Blackwell (1972, cited: MacPherson et al 1997) attributes non-compliance to the complexity of the drug regime, a lack of social supervision, severe psychopathology and to doctors attitudes. van Putten (1974) found that 46% of patients with chronic schizophrena (N=85) took less of their antipsychotic than the prescribed amount, indicating partial compliance for many. However, the consequence of intermittent adherence, rather than taking medication regularly, may lead to problems such as tardive (or super-sensitivity) psychosis, in which psychotic illness develops rapidly as a result of antipsychotic withdrawal or dose reduction (Chouinard and Steinberg 1984, cited: MacPherson et al 1997).

Of course, as highlighted above, there is a problem with the language, as the term 'non-compliance' suggests that patients have not done what they were told by a mental health professional. The use of such language infers that patients are passive recipients of health care who

should only obey instructions from professionals (Perkins & Repper 1998). It is suggested that it may be preferable to use a term such as 'concordance', emphasising collaborative engagement and partnership.

I adopted a concordance skills approach In working with James, using collaborative strategies to educate and involve him in decisions about his own care. The collaborative exploration of the pros and cons of medication taking was one such strategy through which James could make an informed decision about his medication taking (Gray et al 2002). We agreed an agenda, which included: an exploration of his resistance, beliefs and concerns about psychiatric medication; the involvement of relatives and significant others; and, plans for the future. I listened with empathy as James recalled how he had in the past been restrained and forcibly injected, interjecting occasionally to reinforce the importance and value of now being actively involved in and making decisions about his own care. He was concerned about the side effects of his medication, and especially weight gain, sedation and hypersalivation—he was currently prescribed clozapine. As suggested by Gray et al (2002), James ranked the side-effects he experienced in order, from most distressing to least distressing, forming the basis for problem-solving. He was also encouraged to consider the benefits of his medication.

In the sessions that followed, a number of issues were further explored: his perception of his problems and his past coping strategies, even though this was mostly avoidance behaviour. As a consequence of exploring his problems, James was invited to consider the pros and cons of taking and not taking his medication—as shown in Table 1. His attention was also drawn to the indirect benefits of medication (Adams and Howe 1993, cited: Kemp et al 1996). He recalled how he used to get on and kept in close contact with his family when he was taking his medication. This led to an exploration of personal goals, which he completed as a homework task. He identified three goals: to stay out of hospital; to re-establish and maintain contact with his family; and, to reduce his weight. A problem-solving approach was then adopted in helping James to work towards these goals.
I provided information and education about the effects and side-effects of medication. The emphasis of the metaphor, 'medication as a protective layer', was explained and reinforced. Furthermore, as suggested by Falloon (1984), frequent summaries of key points about the efficacy of medication were made, which James was able to keep.

On Reflection
I have been able to successfully engage James, comprehensively assess his mental state, level of insight and degree of ambivalence, using a series of assessment measures. With his active collaboration, I was able to agree an initial formulation from which goals were set. During individual sessions, agendas were negotiated and set, and expectations identified and explained. He gradually engaged with the approach and agreed to and completed homework tasks, even if this was difficult to begin with.

Critical success factors included: adopting a collaborative approach; acting as equal partners in making decisions about his care; being prepared to share decision-making and promote his self-control; having a positive attitude to practising psychosocial interventions.

Table1: Exploring Ambivalence Exercise (excerpts from James)	
Taking Medication	
Not So Good	**Good**
I'll put on weight My mouth will constantly dribble Medication will make me ill	I will stay out of hospital My mental state will improve I will be in control of my life I will get on well with my family
Stopping Medication	
Good	**Not So Good**
I will regain my normal body weight Other side effects will vanish The medication will no longer poison me	My mental state will get worse I will be admitted to hospital I will feel persecuted I will be forced to take medication

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