

The outcome of behavioral intervention with a person living with schizophrenia who exhibited medication noncompliance: A Case Study

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Abstract

The behavioral counseling of a withdrawn and noncompliant schizophrenic South American person, who is an immigrant, by an Asian counselor taking place in the United States is introduced. Although some difficulties, such as a language barrier, exist in the clinical setting, a behavioral assessment to analyze the client's issues through focusing on overt matters is accomplished, and a behavior contract that is generated from the assessment promotes the intervention by educating the client about prospective procedures. The client starts taking medications, going for walks, and having more communications with his family as the result of the counseling.

Keywords: Medication noncompliance, schizophrenia, behavior therapy, multicultural counseling.

Introduction

A variety of multicultural issues in clinical settings have been studied and discussed and multicultural competence has become an important research area in the field of counseling psychology (Pope-Davis et al., 2002). One of the beliefs from the research is that if a client and a counselor do not match culturally, the sessions conducted between them can possibly have limitations (Sue, 1977). Besides, as concerned Flaskerud (1991), if a client suffers from a persistent mental illness, the limitations of multicultural counseling can be much greater.

Tim (assumed name) was a middle-aged single male immigrant from a South American country. He first became the client of a mental health agency in the United States during the 1990's for about half a year; his diagnosis was adjustment disorder with depressed mood. He was referred to the same agency again in the beginning of the 21st Century due to social withdrawal; his diagnosis was avoidant personality disorder. Within a year, he dropped out of treatment. Several years later, he became a psychiatric hospital patient with diagnoses of atypical depression and mixed (schizotypal and avoidant) personality disorders. Because of his tendencies to avoid going out in public and not to comply with taking his medications, the treatment did not last long. Tim's symptoms degenerated until his parents appealed to the above hospital for help. The parents claimed that Tim was withdrawn and had become uncontrollable. They could not get enough sleep since Tim was making loud noises every night. When they asked Tim to be quiet, he showed anger and pushed the parents occasionally. Tim refused to come to the hospital with them. The case was

accepted and the author, a Japanese counselor, was assigned the case. The author soon made a home-visit and met with Tim. Although he declined the author's proposal that the author would visit him once a week, he agreed to an alternative proposal that the author would visit him once a month. His diagnoses were: (a) Axis I: schizophrenia, paranoid type, and (b) Axis II: deferred.

Client

Tim resided with his parents who were both in their seventies. Tim had sisters who were married and living outside of his home. He was born and raised in a South American country. As a child he was quiet; he tended to prefer reading books or doing homework rather than playing outside. His grades were very good. When he was a teenager, he became a little more outgoing; he played sports and made friends. He and his family left their country and immigrated into the United States. After immigration, he enrolled in college. Due to the onset of the mental illnesses, he dropped out a couple of years later. He periodically did temporary work before and during his college days. He had been unemployed for a long time and was receiving social welfare. He had no friends; the only social interaction he had was with his immediate family. However, as the deterioration of his mental stability progressed, he avoided communication even with them. Since he was depressed, unable to concentrate, and developing some memory problems, he read psychology books and did certain psychotherapeutic exercises without supervision. Then, he had a panic attack and was sent to a psychiatric hospital. The precise year that his mental illness had entered the active phase was unknown. He was able to speak English to some degree, but the English abilities of his parents were limited.

Tim was 6 feet tall and weighed approximately 200 pounds. He had not have a history of major physical diseases. He had not received a medical checkup in the last 20 years, so his health conditions at the time was unknown. He looked healthy. He had an appetite. In his college days, he used alcohol and cigarettes. However, he has never been a substance abuser.

Tim was disheveled. His affect was flat. He did not leave his home at all and usually stayed in his room. He slept in the daytime and was awake at night. Late at night, he talked to himself, shouted from the window, and made loud noises by walking or pounding on things in his room. He did not have homicidal/suicidal ideations. He exhibited incoherence (e.g., "I won't go out because there are pregnant women outside." or "Medications don't work on me because I like dogs."). Although Tim had some

delusions, the author did not have opportunities to examine them; Tim once commented that his parents and the author had been talking in Japanese in spite of the fact that English was always used. Tim had an auditory hallucination (i.e., hearing voices), but did not explain what kind of voice he was hearing. He also had visual hallucinations in which he kept watching TV even after the broadcasts were over. He believed that he was not sick and that the people around him were sick. He declined psychiatric care including injections and medications.

Several psychological testings had been administered to Tim in the past. The results included: (a) the Wechsler Adult Intelligence Scale -Revised: full scale IQ = 73, verbal scale IQ = 75, and performance scale IQ = 73, (b) the Minnesota Multiphasic Personality Inventory: invalid, (c) the House-tree-person Test had suggested that he had been suspicious and frightened, and (d) the Rorschach Test and the Thematic Apperception Test had suggested that he had had a great deal of difficulty in constructing stories and identifying recognizable images.

Behavioral Assessment

According to the format by Kanfer and Saslow (1969), the author attempted the following behavioral assessment through: (a) interviews with Tim, (b) interviews with his parents, and (c) observations.

Assets and Limitations

Tim did not tend to run away from home. This enabled him to receive his daily needs consistently and to receive mental health services for his illness (e.g., the author was able to see him whenever visiting his home). His major limitation was in making no attempt to communicate clearly and accurately; the author was unsuccessful in obtaining substantial information from him. In addition, his being a non-native English speaker made the assessment difficult and incomplete.

Target Behaviors

The following behaviors were selected as the target behaviors of the treatment: (a) rejecting receiving a psychiatric evaluation at the hospital, (b) rejecting going to a pharmacy to buy medications, and (c) rejecting taking medications. The rationale of the selection of these behaviors as the target was: (a) they could be modified rather easily and (b) if they were modified, his overall symptoms might be reduced.

Antecedents to the Target Behaviors

The target behaviors could have occurred under any circumstances. No particular antecedent was associated with the target behaviors.

Consequences of the Target Behaviors

Whenever Tim was advised to go to a hospital, he refused. When it was insisted, he became angry. He sometimes resorted to force toward his mother who was 72 years old. Concerned individuals (e.g., his parents or therapists) were perplexed and/or frightened by that and they stopped advising. This contingency system may be modified by letting Tim realize that his refusal and anger would not have the same effect on the author.

Due to Tim's rejection of going to hospital, it was impossible to assess the consequences of his refusing to buy or take medications.

Motivational Analysis

It seemed that Tim did not have any motivation to change the target behaviors. This was possibly because he did not think that he had a serious mental illness. Or, this was possibly because he was thinking that he could function adequately with a mental illness. Therefore, helping him gain insight that he was not functioning well because of his illness and that he could function better in the future through medications might motivate him to modify the target behaviors (Kingdon & Turkington, 1994).

In addition, the author asked Tim if he wanted to have a counselor with the same ethnic background as his, because many clients tend to prefer counselors who are ethnically similar to them (Pope-Davis et al., 2002). The answer from him was, "You don't need to think about it."

Developmental Analysis

There probably are some cultural issues around Tim's symptoms. This can be assumed because culture is considered to play a strong role in the course of mental illnesses (Smith, Nolen-Hoeksema, Fredrickson, & Loftus, 2003). In spite of this, it was necessary for the author to attempt treatment without knowledge about Tim's ethnic and national backgrounds.

Tim went to a hospital before the active phase of his mental illness and was prescribed some medications. A side effect (i.e., cramping) occurred soon. That was the original reason why he became noncompliant, according to his self-report. Therefore, the target behaviors could be modified by letting him know that newer medications would not produce severe side effects.

Whether or not Tim was completely aware of having mental illness, he might have believed the stereotype that psychiatric patients could be compulsorily hospitalized. If so, it may be important to give him information about the actual American system regarding patient's rights in order to modify the target behaviors (Vera & Speight, 2003).

Furthermore, there may not have been any logical reasons why he had developed the target behaviors; inability of self-care is one of the symptoms of schizophrenia (American Psychiatric Association, 1994).

Analysis of Self-control

It seemed that Tim could not control the target behaviors by himself under any circumstances. What he needed may have been concrete guidance from others.

Analysis of Social Relationships

It appeared that Tim's parents were the most significant people in his environment. The parents could play an important part in the modification of the target behaviors by: (a) judging whether or not the author's treatment plans were acceptable, (b) providing Tim with reinforcers, such as encouragement, admiration, or material rewards, (c) modifying the parent-child interaction when necessary, and (d) monitoring the effects of the treatment.

Analysis of Former Interventions

According to the parents, therapists from a mental health agency and the hospital had "just tried to talk to our son." Thus, it could be assumed that mere verbal interventions had not modified the target behaviors. Tim might respond to a combination of verbal and visual interventions, however.

Course of Treatment

Treatment Plan

The author established a behavior contract (see Appendix). The contract partially involved the behavioral technique of "negative reinforcement." The rationale for using the technique was: (a) Tim needed to form new behaviors which counteracted the target behaviors, and (b) the technique was experimentally-clinically proven to form new behaviors (e.g., Rimm & Masters, 1979). The author also planned to let Tim know that: (a) he needed psychiatric and pharmacological help to function better, (b) today's medications were more advanced than years ago, and might not produce such intense side effects, (c) the author was encouraging him to see a doctor and to take medications in order to avoid his experiencing a unwilling situation, such as hospitalization, (d) the author would bring and show two taxi vouchers to prove to him that he would return home from the hospital, and (e) even if he got angry, the author would keep encouraging him to see a doctor. These plans were developed to provide him with what he might need, as generated by the behavioral assessment.

Treatment Goals and the Measurement of Outcomes

The treatment goals were stated as follows:(a) Going to the hospital: assessed by the author's direct observation, (b) going to the pharmacy: assessed by the author's direct observation, and (c) taking medications regularly: event recording by the parents of the number of times Tim took medications in front of the parents.

Contract

The author visited Tim at home, along with a South American/English interpreter from the hospital the author belonged to, bringing the contract. The contract was divided into two parts so that Tim did not need to read and comprehend long sentences. To explain the two parts, the author and the interpreter visited Tim twice. The author read the English part of the contract aloud to Tim and talked about what he needed to consider in English. Then, the interpreter translated it into a South American language. Tim was not enthusiastic, but gave his consent. His parents gave their consent, too.

Outcomes and Prognosis

On the day of the appointment, Tim was hesitant to go out. After some urging, he finally got into a taxi and went to the hospital with the author. At the hospital, Tim had a few conversations with a doctor. His utterances were: "Yeah," "Well, I think so," "No," or "Kind of." Then he obtained a prescription. He went to the pharmacy in the author's company the next day and bought Haldol (0.5 mg). He started taking it in front of his mother. The number of pills he took increased from zero per day to twice every day. He began to show side effects (i.e., dry mouth, sweating, and cramping) about one week later. Therefore, the author set up another appointment with an available doctor. At that time, Tim was prescribed Cogentin (1 mg). The medications soon showed their effect on him. He became calm and started going for walks, taking showers, and having some communication with his parents. These changes occurred immediately and were unusual according to his doctor. One day, when the author visited Tim at home, he asked, "How many years do you think I lost because of not taking any medication?" This question suggested that Tim's insight was becoming more organized. Then he started complaining that he had some difficulties regarding being awake and sleeping; he was sleepy during the daytime but could not sleep well at night. He was especially distressed by being awake in bed for hours every night before falling to sleep. It was presumed that his long-lasting life pattern of the reversal of night and day had confused his circadian rhythm. Also, the effects of medications could have been another cause of this complaint. The author gave Tim the advice that he had better try to get up at a fixed time every morning and remain awake during the daytime, but not try to fall asleep at the desired time in the evening. This was because it is impossible for anyone to control the time of dropping off to sleep. Even when he could not fall asleep smoothly, he should get up at a certain time the next morning. If he could not sleep at night, he should do something important, such as studying English, instead of trying to sleep. Tim understood and soon became able to deal with the problem.

Further intervention was done afterward. The author: (a) brought Tim to an internal clinic for a medical checkup, (b) taught his family about mental illnesses, and (c) conducted "social skills training" (Bellack & Hersen, 1993) aimed at behavioral improvement, such as conversational skills, that would enable him to have more extended social relationships.

Clinical and Multicultural Issues and Summary

The case described in the present article can have several clinical and multicultural implications. First of all, Tim started functioning better soon after he went out in public. This was beyond the expected

effect of medications. This phenomenon could be explained from the standpoint of "sensory deprivation" (Heron, 1961). The study found that, in the experimental circumstance where stimuli were removed as much as possible, subjects became irritable and dysfunctional. This finding is applicable particularly for those whose physical activities are remarkably limited. Tim was socially isolated and had had extremely reduced external stimuli for many years. That could have been one of the major reasons why he was not functioning well, not just because of the mental illness itself.

Second, in using assessment tools to identify psychopathology, mental health professionals must take into account the client's cultural context (Iwamasa, 1997). However, many researchers have commented that there is a scarcity of effective assessment methods for counseling culturally different individuals (e.g., McNeil, Porter, Zvolensky, Chaney, & Kee, 2000). When assessments that had not been culturally standardized are conducted with diverse populations, results drawn from the assessments can be possibly invalid or misleading (Barker-Collo, 2003). So then, the present case suggests the utility of behavioral assessment to deal with an immigrant client by focusing more on the current circumstances surrounding the problematic behaviors. This type of assessment seeks information about maintaining the conditions of specific targeted behaviors rather than the total personality and lifestyle that can be deeply influenced by the culture of the client (Spiegler & Guevremont, 1993).

Third, the use of the written form of the behavior contract improved the situation. It prevented the intervention from going off-point by informing Tim of the concrete process, and made his family committed to fulfilling their roles. These benefits can be expected even when there is not a language barrier as Spiegler and Guevremont (1993) discussed.

Fourth, both Tim and the author were not fluent English speakers, so there was a communication difficulty throughout the intervention. Quintana and Atkinson (2002) argued that mental health professionals who lack the necessary linguistic skills to work with foreign clients could render ineffectual an otherwise effective intervention strategy. A similar undesirable effect can occur during assessment (Heppner, 2006). The reliance on an interpreter avoided some of such problems and prompted a greater understanding and agreement between Tim and the author.

Finally, the author was not familiar with Tim's culture. Many have claimed that mental health professionals need to have appropriate cultural knowledge in order to be effective when they work with

clients from different cultures (e.g., Smith, 2004; Heppner, 2006). Irrespective of the importance of the claim, there can be occasions in which professionals see clients from other cultures without this certain knowledge. "Tolerance for ambiguity" (Samovar & Porter, 1988) is required in such specific cross-cultural clinical settings. Professionals must continue to be supportive just as they would with a more familiar population. As for the present case, the author's not knowing Tim's culture did not necessarily become a prominent obstacle for the intervention. Rather, the awareness of not knowing made the author more involved and prepared.

In summary, one multicultural counseling case that was conducted through a behavioral perspective was described. In this case, the author did not match the client's ethnicity and did not have enough knowledge about the client's culture. There was also a language issue. To improve the situation, a behavioral assessment that scrutinized the contingency systems of the client's behaviors was done, an interpreter was asked to participate, and an intelligible behavior contract was established. Together with the effect of medications, improvements took place (e.g., taking a walk, having communications with others) as a consequence of counseling. This result suggests that even when a helping professional faces some cultural obstacles, there is still a possibility that the professional can assist clients.

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Appendix

Contract Between Tim and Counselor (1)

The purpose of this contract is to explain the counselor's intervention with Tim and to reach a mutual agreement regarding the intervention. The contract does not have any legal powers over Tim. The contract will be changed according to Tim's wishes when the procedures of the intervention are discussed. Tim's parents will read the contract because they are part of the intervention. A South American/English interpreter will read the contract and explain the intervention in a South American language.

1. The counselor will explain to Tim the significance of seeing a doctor and of taking medications.
2. Tim has the right to refuse to see a doctor and to take medications.
3. If Tim does not wish to see a doctor for a medication evaluation, he will explain to the counselor all the reasons why.
4. An appointment to see a doctor at the hospital has been scheduled at 8:30 PM on day/month/year.
5. If Tim wishes to keep this appointment, the counselor will accompany him from home.
6. At the hospital, Tim will ask the doctor all the questions he has regarding the medications, such as possible side effects.
7. If Tim refuses to go to the hospital, the counselor will increase the frequency of home-visits to Tim from once a month to once a week.

I read the above sentences and I will voluntarily participate in the procedures.

Tim

Date

Counselor

Date

Contract Between Tim and the Counselor (2)

1. Tim will decide to take the medications if he understands the doctor's explanation.
2. The doctor will set up another appointment with Tim for follow-up.
3. The counselor will accompany Tim to the pharmacy when Tim goes to buy the medications.
4. At home, Tim's mother will manage the medications and give them to Tim as medically required every day.
5. Tim will take the medications in front of his mother.
6. If Tim does not take the medications in front of his mother, the mother will call the counselor. Tim will take the medications in front of the counselor.

7. Tim may have side effects from the medications. These were explained by the doctor and will be treated in the next session. Tim will however continue to take the medications.
8. If the side effects become intolerable, Tim can call the counselor. The counselor will set up an emergency appointment with an available doctor to lessen the symptoms.

I read the above sentences and I will voluntarily participate in the procedure.

Tim Date

Counselor Date

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