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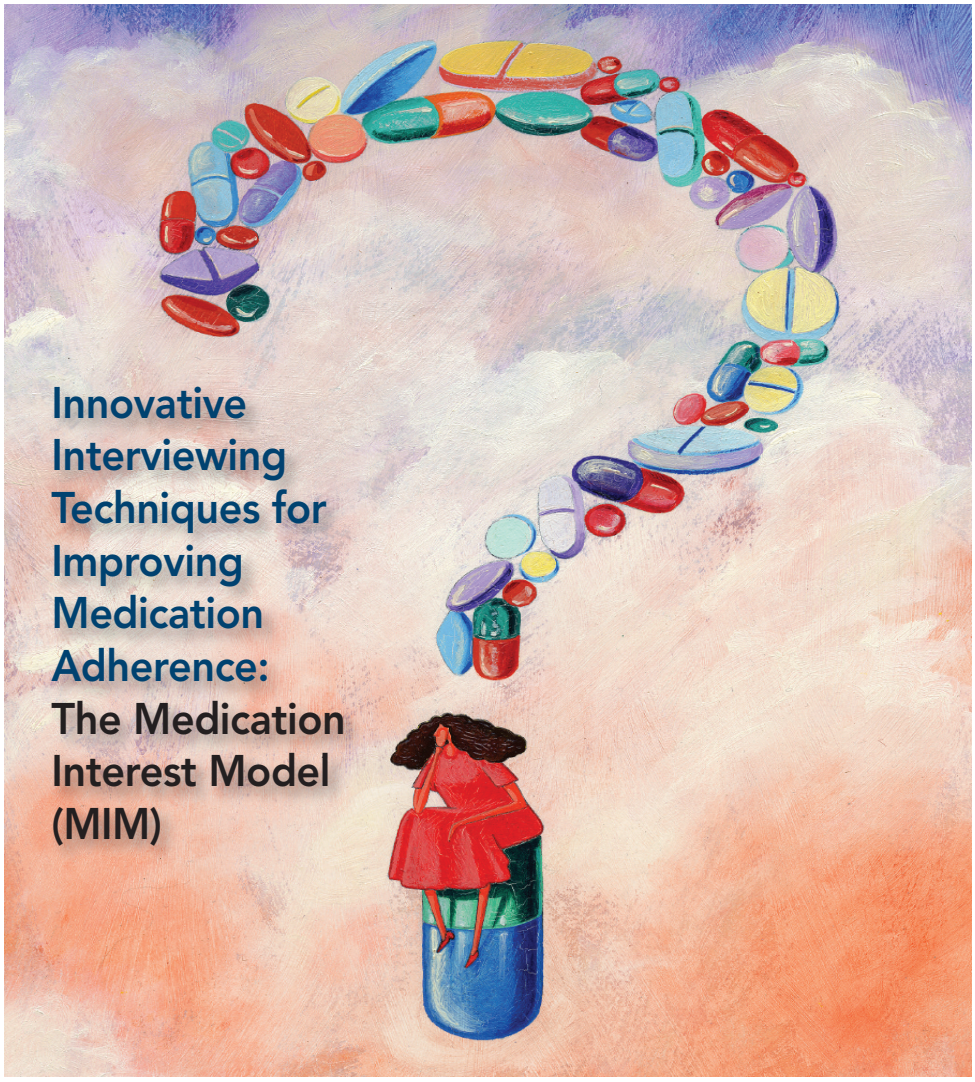
Enhancing Medication Interest and Medication Follow-through in the Treatment of Schizophrenia

A 3-Part Series



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Counseling Points™

Enhancing Medication Interest and Medication Follow-through in the Treatment of Schizophrenia

Innovative Interviewing Techniques for Improving Medication Adherence: The Medication Interest Model (MIM)

Continuing Education Information

Target Audience

This activity has been designed to meet the educational needs of practicing psychiatrists involved in the management of patients with schizophrenia.

Statement of Need/Program Overview

Psychiatrists caring for patients with schizophrenia are challenged by medication nonadherence, which plays a significant role in precipitating relapses of illness. Although all relapses cannot be prevented, appropriate pharmacologic and psychosocial strategies can be implemented to enhance medication interest and follow-through. This *Counseling Points*™ CME program is designed to educate psychiatrists about the latest interviewing, motivational, and management strategies in this area of medicine.

Educational Objectives

After completing this activity, the participant should be better able to:

- Describe the use of specific interviewing techniques for each step of the Choice Triad (the three psychological steps patients experience when choosing whether to use a medication).
- Identify the significance and impact on adherence of the three factors—efficacy, cost, and meaning—that patients use when weighing the pros and cons of a medication.
- Discuss the use of a specific interviewing technique—Testing the Waters—that can help transform nonadherence related to the patient's weighing of the pros and cons.
- Describe interviewing techniques that sensitively address the complexities of discussing adherence in difficult clinical situations, such as with medications that have dangerous side effects or with patients who have schizophrenia and are involuntarily taking medications.

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A statement of credit will be issued only upon receipt of a completed activity evaluation form and a completed posttest with a score of 70% or better. Your statement of credit will be mailed to you within three weeks.

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Enhancing Medication Interest and Medication Follow-through in the Treatment of Schizophrenia

Innovative Interviewing Techniques for Improving Medication Adherence: The Medication Interest Model (MIM)

Introduction

Choosing an antipsychotic and deciding whether its pros outweigh its cons is one of the most difficult decisions facing a person coping with schizophrenia. As illustrated in issue #1 of this *Counseling Points*™ series, compelling evidence shows that the road to health in schizophrenia is intimately related to medication adherence.

> *"Our words are as important a part of the pharmacopoeia as the medications themselves."*[1]
>
> *John F. Steiner, MD, MPH*
> *Director of the Colorado Health Outcomes Program*
> *University of Colorado*

Over the past 20 years, a model of interviewing called the Medication Interest Model (MIM) has been evolving, which is dedicated to the goal of improving medication adherence through the words that clinicians use when talking about medications with their patients.[2,3] In this issue, innovative interviewing techniques from the MIM will be described, which can be immediately applied to helping patients with schizophrenia make the complex decision of whether to try an antipsychotic or to stay on one.

The MIM postulates that two key components exist concerning the enhancement of medication adherence. First, the cornerstone of the process (the focus of this issue) consists of collaboratively working with patients so that the individual's personal interest in choosing and staying on a medication is maximized. The MIM emphasizes the importance of viewing adherence as beginning with patient choice. It provides a conceptual framework—the Choice Triad—and an expanding series of over 40 behaviorally specific interviewing techniques designed to sensitively explore the thought processes and emotional responses patients experience when considering the use of a medication. The second step of the model (the focus of our third and last issue in the series) emphasizes the importance of physicians and other clinicians (such as case managers) joining forces with patients, their families, and "natural supports" in the community to reduce the numerous external obstacles that can prevent patients from being able to "follow through" with their interest in taking antipsychotics, including both the advantages and potential problems associated with atypical antipsychotics.

Theoretical Framework of the Medication Interest Model (MIM)

With regard to patient choice, the practice of "choice" and the issue of "trust" often go hand in hand. From a patient's perspective, trust is often built based on how clinicians discuss various aspects of medication use, including topics such as the pros and cons of the medications, their mechanisms of action, and patient concerns about their side effects. Language counts.

Former Surgeon General C. Everett Koop wryly commented that, "The doctor-patient relationship can be restored, but it will take commitment by people on both sides of the stethoscope."[4] In many ways, patients determine who is on the other side of the stethoscope by the fashion—nonoppositional versus oppositional—in which clinicians discuss medications. This is especially true with conditions such as schizophrenia in which the issue of trust is of paramount importance.

The cornerstone principles of the MIM—such as the Choice Triad—and the practical application of its numerous interviewing techniques were first described by Shawn Shea in the book *Improving Medication Adherence: How to Talk with Patients About Their Medications*.[3] In this issue, a sampling of these interviewing techniques will be provided. These interviewing techniques, like all of the interviewing techniques of the MIM, are equally applicable to both serious psychiatric and medical disorders, from schizophrenia to diabetes.

The steps of the Choice Triad, which people navigate before deciding to take a medication, are described in **Table 1.**

Table 1. The Choice Triad[3]

People generally take medications because:

Step 1) They think that there is something wrong with them for which they personally want relief.

Step 2) They are motivated to try a medication because they believe that the medication has the potential to help bring them this relief (or perhaps prevent a serious future problem as with an antihypertensive agent or a vaccine).

Step 3) They personally believe that the pros of taking the medication outweigh the cons.

Each step of the Choice Triad is composed of a variety of psychological nuances of importance in understanding patient choice regarding medication interest. For example, during step 3—when weighing the pros and cons—the ultimate answer of the patient is often related to three belief sets arising from three questions. These belief sets and their corresponding questions are as follows:

I. Efficacy (Does this drug make me feel better?)
II. Cost (Is it worth it *to me* to take this drug?)
III. Meaning (What does it say *about me* that I *have* to take this drug?)[3]

With patients dealing with psychiatric illnesses, each belief set forms its own unique personalized continuum. For instance, concerning the "efficacy" of the medication, each patient has a personal belief about the extent to which a particular medication is "working." Some patients are convinced that the medication is helping a lot, while others are convinced that it is not helping at all. Many are in between. The closer the patient is to believing that the medication is not helping, the less robust his or her interest in staying on it will be.

Within each of the three continua used navigating the third step of the Choice Triad—"the weighing of the pros and cons"—multiple beliefs may vie for importance in the patient's final choice. With regard to the first belief set—efficacy ("Does this medication make me feel better?")—patients tend to weigh their symptom relief ("Got rid of my voices.") against the appearance of side effects ("Is causing my tongue to act strange."). With the second belief set—cost (Is it worth it *to me* to take this medication?)—the variables are not solely relegated to money, but also include hidden "costs," such as inconvenience of dosing and difficulty with procurement. The third belief set—meaning ("What does it say *about me* that I *have* to take this medication?")—can be filled with numerous disconcerting beliefs for patients suffering from schizophrenia, such as fears of addiction to the medication or the belief that the need for the medication is a reflection of personal weakness or stigma ("People think I'm crazy." or "I'm diseased.").

Where these three continua intersect may provide a surprisingly accurate indication that a patient is about to stop an antipsychotic. It is through the personalized weighing of these three sets of beliefs—forming the metaphorical scales for the patient's weighing of the pros and cons—that a given patient decides whether the *necessity* of the antipsychotic outweighs his or her *concerns* about it.

Enhancing the medication interest of a patient with schizophrenia lies in carefully uncovering the nuanced beliefs of the patient in each step of the Choice Triad. Beliefs that logically would block a patient's interest can then be gently transformed utilizing interviewing techniques unique to the MIM as well as other collaborative approaches embraced by the overarching framework of the MIM such as motivational interviewing.

A clinician can view the steps of the Choice Triad as metaphorical "toolboxes" from which the clinician can learn, easily remember, and organize a variety of interviewing techniques that may be of use when helping a patient with schizophrenia or another psychiatric disorder transform the medication concerns related to that particular step. Familiarity with the various interviewing techniques from each toolbox allows the clinician to creatively choose those techniques best suited for that particular patient's needs and which feel the most comfortable for that particular clinician (for all clinicians must develop their own styles, picking and choosing the most personally appealing techniques from the array available).

Historical Foundations of the Medication Interest Model (MIM)

The MIM draws from the historical efforts to maximize motivation through the effective development of therapeutic alliances built upon shared trust and collaborative goal setting. Bordin was one of the first innovators to address enhancing the therapeutic alliance, not only through the use of empathy, but through the use of collaboratively finding shared goals.[5] Prochaska and colleagues advanced the field by providing a four-step transtheoretical theory of motivation and its relationship to change (1. Pre-contemplation, 2. Contemplation, 3. Preparation, and 4. Action).[6,7] Similar concepts were developed in the field of solution-focused psy-

chotherapy, where the term "resistance" was discarded and specific interviewing techniques such as "the Miracle Question" were formalized.[8-13]

More specifically related to people coping with severe mental illnesses, such as schizophrenia, Mueser and colleagues have pioneered the importance of a collaborative approach both with patients as they learn to effectively self-manage their illnesses as well as with family members.[14-17] Jobes has delineated the power of collaborative interviewing with regard to suicide prevention.[18]

Arguably the greatest advance in the field of collaborative interviewing was the development of motivational interviewing by Miller and Rollnick for helping people with substance abuse become aware of their problems and motivating them toward recovery.[19] Miller and Rollnick's innovative work has been applied to a variety of arenas including exercise, dieting, wellness programs, and improving medication adherence.[20-21] The interlacing of collaborative interviewing models such as solution-focused interviewing, motivational interviewing, and the MIM has been described by Cheng.[2]

The MIM makes a concerted effort to transform single interviewing principles *into a variety of flexible interviewing* techniques.

To better understand how to more effectively use language to enhance medication interest, it is useful to delineate three terms: interviewing *principles*, interviewing *techniques*, and interviewing *strategies*. An interviewing principle is a guiding concept for approaching an interviewing task such as "moving with resistance." An interviewing technique (which often evolves from the application of an interviewing principle) is a behaviorally specific set of words (often a single statement or a single question) that has been operationalized and tagged with a name. An interviewing strategy is the sequential use of two or more interviewing techniques to address a complex interviewing task.

The MIM makes a concerted effort to transform single interviewing *principles* into a variety of flexible interviewing *techniques*, for interviewing techniques may be easier to learn, remember, and effectively employ (as well as easier to teach and test for competency) when compared with interviewing principles. Moreover, it is hoped that the behavioral specificity of the techniques of the MIM will facilitate their study both empirically and qualitatively so as to set a foundation for an evidence-based model of interviewing related to the enhancement of medication interest.

In addition, effective role-playing approaches have been developed for training clinicians to competency with regard to single interviewing *techniques* when they are behaviorally operationalized (e.g., Alan Ivey's "*micro*training") and for complex interviewing *strategies* when they too are behaviorally operationalized (e.g., Shea's "*macro*training).[22-24] Both microtraining and macrotraining are directly applicable to teaching clinical interviewing skills for enhancing medication interest in schizophrenia and other mental disorders. An example of the power of transforming a vague interviewing principle—such as "creating a collaborative relationship with the patient"—into a specific interviewing technique designed for a specific interviewing challenge with a patient coping with schizophrenia is provided below.

Starting with a Tough One: How Do You Introduce a Medication Where One of the Potential Side Effects is Death or a Serious Medical Syndrome?

Some medications carry a distinctively increased risk of death, as is seen with chemotherapeutic agents in oncology. In such instances, these potentially lethal side effects must be discussed openly with patients so that the patient can wisely weigh the pros and cons. In the treatment of schizophrenia, clozapine (which may lead to agranulocytosis) has just such a distinctive risk attached to its use. Although less striking in nature, some mood stabilizers also carry an increased risk of potential lethality such as carbamazepine (agranulocytosis), divalproex sodium (chemical hepatitis), and lamotrigine (Stevens-Johnson syndrome). How does one raise these issues in such a way that one is effectively applying the interviewing principle of "creating a collaborative relationship with the patient"?

One possible solution lies in an interviewing technique called "*Personalizing Risk*." Imagine a clinician who has been working for years with a patient whose schizophrenia has responded poorly to antipsychotics. The clinician is personally convinced that clozapine could be potentially life-saving (preventing suicide) and/or life-transforming. After explaining the pros and cons of clozapine effectively, including the potential for death, the clinician might use the technique illustrated in the box on page 7.

Clinical Interviewing Technique: **Personalizing Risk**

"You know, John, when thinking about using clozapine, one has to give a lot of thought to it, because of the dangerous side effect I mentioned. You and I have a pretty good relationship and have known each other for a long time now, and I think we trust each other. Considering the fact that every medication we've tried has failed, and this medication has a definite tendency to help when other medications have not helped with schizophrenia, if I was in your spot, I would absolutely take it myself. Not only that, but the risk of the bone marrow problem is very low, and we can carefully keep our eye out for it and take protective steps if any changes are seen. I feel very confident that this is a safe medication to use—so much so that I would give it to a member of my own family if they were in your spot. I wouldn't say that to you unless I meant it."

By personalizing the risk, based upon a genuine belief in the safe use of the medication by the clinician, one can see how an important, yet difficult-to-employ interviewing principle—"building a collaborative relationship with the patient"—has been transformed into an easily learned and utilized interviewing technique. This interviewing technique can also be of use when introducing other atypical antipsychotic agents, where the clinician needs to openly discuss potentially serious side effects such as the metabolic syndrome. For each step of the Choice Triad, the MIM has a toolbox full of such interviewing techniques from which the clinician can choose.

Sample Interviewing Techniques

Step 1 of the Choice Triad

As a patient navigates the Choice Triad, his or her belief in each step is not necessarily an "all or nothing" process. With regard to step 1—the patient believes that there is something wrong for which he or she wants relief—a patient's response may range from total endorsement of this belief to complete rejection. Depending upon where the patient lies on this continuum, different interviewing techniques may be more or less useful.

With a patient who has come to the conclusion that he or she has schizophrenia —sometimes after years of wrestling with the idea—the clinician's exploration of step 1 becomes more nuanced in nature. It is no longer whether the patient feels that there is something seriously wrong; he or she does. Instead, the emphasis now shifts to the equally important task of finding out from which symptoms the patient most wants relief at this moment in time.

To some degree, medical and nursing training teaches clinicians to treat diseases, but people generally take medications not so much because they have a disease but to get relief from the symptoms their disease causes. The difference in perspective is subtle, but it is real, with potentially telling ramifications for the building and maintenance of the ongoing patient/clinician alliance.

The trust that a patient with schizophrenia has in his or her psychiatrist, psychiatric nurse, or a case manager is often largely determined by how hard he or she thinks the clinician is working to provide relief from that individual's *self-identified* most pressing symptoms. Sir William Osler addressed this issue with his oft-quoted comment, "It is much more important to know what sort of patient has a disease than to know what sort of disease a patient has."[25] According to Osler's perspective, each patient views the impact and importance of his or her symptoms uniquely. A symptom that bothers one patient immensely may be perceived by a different patient as a mere nuisance. Consequently, one of the most effective ways to see what sort of patient "has the disease" is to find out what symptoms that particular patient views as his or her most pressing symptoms as in the following box.

Clinical Interviewing Technique: **The Target Symptoms Question**

"Of all of your different symptoms from the schizophrenia, which are the ones that you most want help with right now?"

Sometimes the answers to the "*Target Symptoms Question*" are surprisingly revealing and immediately useful in enhancing medication interest. Imagine a patient who, over the years, has come to understand both the positive and negative symptoms of his or her schizophrenia well. Dealing with much improved but still disturbing positive symptoms, such as denigrating hallucinations, a clinician might expect the patient's answer to the Target Symptoms Question to be along the lines of "Do something about my voices." Instead, the patient responds, "You know, Doc, I can handle the voices now. They are a lot better than they have been for years. But what I can't handle is having no energy. I want a job, and I want a job bad. But I don't have the energy to get one."

This patient's angst, caused by his negative symptoms, provides a wonderful window into what could prove to be the single most powerful motivator for this particular patient to stay on medication—belief that the medication could increase energy and lead to a job.

On the other side of the coin, if the patient perceives that his or her current antipsychotic is hurting his energy level ("it makes me drowsy"), the risk of discontinuing the antipsychotic may rise steeply despite its effectiveness in decreasing the patient's auditory hallucinations. The above patient's response may suggest the choice of an atypical antipsychotic that has greater efficacy for relieving negative symptoms or fewer sedating effects. When the clinician proceeds to share, "I would like to suggest a medication that may be particularly effective with helping with the low energy we sometimes see in schizophrenia," the patient will feel that he has been heard. Indeed, he has.

Sometimes the use of the Target Symptoms Question may uncover the unexpected presence of a second psychiatric disorder or syndrome. With a response such as the one given by the patient above, a clinician might decide to more aggressively search for underlying depression, which might respond well to the addition of an antidepressant.

Step 2 of the Choice Triad

Step 2 of the Choice Triad—the patient believes that a medication may help provide relief for what is wrong—is the gateway towards understanding patient motivation. Many times, one of the primary motivators for trying a medication is the belief that the medication may remove a highly noxious symptom. In schizophrenia, a wide range of symptoms can be distressing, including positive symptoms such as hallucinations, delusions, and agitation, and negative symptoms such as anergia and lack of motivation. But are there other motivators besides symptom relief?

A pediatrician in one of Dr. Shea's workshops highlighted the importance of this question. His answer regarding a nonpsychiatric disease, asthma, has many applications for psychiatric disorders from obsessive-compulsive disorder to schizophrenia.

In addition to wanting relief from the symptoms that their asthma had given them, such as acute attacks, many of his patients wanted back something the asthma had taken from them—the ability to play a sport or "feel normal" like the other kids who didn't have to use an inhaler in gym class. In many instances, whether one is talking about diseases from the non-psychiatric arena such as asthma and congestive heart failure or psychiatric illnesses such as schizophrenia, patients want back their dreams, their livelihoods, their peace of mind, and the confidence to pursue goals without becoming beset with self-doubts. The desire to recover these lost dreams can often provide an unusually powerful motivator that may help patients to tolerate surprisingly unpleasant side effects.

The pediatrician's interviewing tip, *The Inquiry Into Lost Dreams,* is illustrated in the box.

Clinical Interviewing Technique: **The Inquiry Into Lost Dreams**

"I find it useful with my kids with asthma to ask them this question or a variation on it: 'Is there anything that your asthma is keeping you from doing that you really wish you could do again?' What I find with this age group is that there is often a quick answer to this question, and the answer is often related to a sport—say football or soccer.

What I find to be so useful about this question is that it opens the door for adolescents, who by definition are prone to form oppositional relationships with adults, to tell me what they want me to do for them. They are calling the shots, not me. The opposition seems to dissolve away. Meanwhile, I gain a deeper insight into their motivation for seeking help from their asthma that goes beyond their desire for symptom relief. I might never have known this powerful motivator had I not asked. I can use this knowledge to enhance the adolescent patient's desire both to start a medication and to stay on it.

Although I never provide false hope, if I feel it is within reason I can use this newly uncovered information immediately to help shape a shared agenda with a comment like, 'Now I can't promise this, but I have had some very good luck with helping other students, with asthma like yours, to get back into sports. We have some great medications that can help with that goal. Once again, no promises, but I would like to work with you to see if we might be able to get you back out on that soccer field. How does that sound to you?'"

This useful interviewing technique can easily be applied in the field of psychiatry—"Is there anything that your depression is keeping you from doing that you really wish you could do again?" Imagine the power of this type of motivator for enhancing interest in staying on an antidepressant, if, say, a grandmother suffering from a severe depression answered with, "Yes, I'd really like to have enough energy to go visit my granddaughters in California," and she felt that her antidepressant, despite its side effects, offered her the single best chance of doing so.

In schizophrenia, The Inquiry Into Lost Dreams approach is generally employed long after patients have navigated step 1 of the Choice Triad. At this stage of recovery they believe, at least partially, that they have schizophrenia and are usually already on an antipsychotic. The question is: Will they stay on it?

The answers to The Inquiry Into Lost Dreams in patients managing schizophrenia can be diverse, including responses of a very practical nature, such as "I

want to be able to get a job," "I want to be able to go to college," "I just want to be able to move out of home and get my own apartment," "I just want to stay out of hospitals" to responses that poignantly remind us of the devastating damage to the soul that schizophrenia leaves in its wake, such as "I want to be able to hang out with my family again at Christmas. I just want them to like me again." Some of these lost dreams may be achievable and some may not. Those that the clinician believes are reasonable goals can be used as powerful personalized motivators for staying on an antipsychotic or mood stabilizer even when it may be necessary to tolerate some difficult side effects.

The clinician should be careful to avoid discouraging patients from pursuing ambitious goals that they are genuinely interested in attaining and dampening their enthusiasm, as such goals have the potential of being powerful motivators for taking medication.[26] If the patient states the desire to achieve a very ambitious goal, such as becoming a professor or an architect, rather than expressing skepticism, the clinician can demonstrate interest in this goal by seeking to understand why it is so appealing, and then consider some of the steps the patient could take towards achieving that goal, such as enrolling in school to complete a degree. Medication can then be discussed as something that could help the patient make those first steps towards the goal.

The Inquiry Into Lost Dreams is very fruitful for many patients, but some may have difficulty identifying concrete losses or changes they want to make in their life. When working with these patients, it can be useful to rephrase the question along the following lines: "If you didn't have schizophrenia, or you weren't experiencing these kinds of problems, what would you be doing? How would things be different?" Patients often respond to this kind of questioning with answers like "I'd have a job," "I'd have a girl/boyfriend," "I'd be married/have a family," "I'd have my own apartment," "I wouldn't have to depend on other people, I could take care of myself," and "I'd be able to enjoy life more." These responses provide hints to the changes patients would like to see and may lead to an increased interest in taking a medication that could lead to such changes.

Step 3 of the Choice Triad

As patients weigh the pros and cons, they weigh an internalized set of beliefs, sometimes containing a surprisingly large number of individual beliefs, varying from concrete cognitions that the patient could write down, to more evasive "gut feelings" that elude words. Robert Horne and John Weinman studied these belief sets.[27] They found that patients "weigh their beliefs about the necessity of the prescribed medication for maintaining health now and in the future" with their "concerns about the potential adverse effects of taking it."[27]

As mentioned earlier, three specific belief sets (efficacy, cost, and meaning) are addressed in step 3 of the Choice Triad that operationalize the concepts described by Horne and Weinman regarding how patients weigh the pros and cons of medications. Understanding these three belief sets may provide a clinician with a more valid read on any given patient's medication interest, potentially allowing the clinician to transform patient concerns before they become unfilled prescriptions.

As patients weigh the pros and cons, they weigh an internalized set of beliefs, sometimes containing a surprisingly large number of individual beliefs, varying from concrete cognitions that the patient could write down, to more evasive "gut feelings" that elude words.

All three aspects regarding the weighing of the pros and cons with regard to antipsychotics are complex and important in understanding a patient's interest in taking them. In this article, limited space only permits a brief investigation of the third component of step 3—the meaning to the patient of *having* to take the medication. With patients coping with schizophrenia, especially those in partial remission, the symbolic meaning of the medication often plays a major role in determining whether the patient will stay on the medication for the long run. Antipsychotics can inadvertently become symbols for "being sick" or "being crazy."

For a practical introduction to the many other interviewing techniques useful for transforming all three arenas of the weighing of the pros and cons for psychiatric medications, the interested reader is referred to the book that introduced the MIM, *Improving Medication Adherence: How to Talk with Patients About Their Medications*.[3] The MIM also encourages the use of motivational interviewing principles such as those described by Berger in the mnemonic READS (**R**olling with resistance, **E**xpressing empathy, **A**voiding argumentation, **D**eveloping discrepancy, and **S**upporting self-efficacy), for they are particularly effective in enhancing motivation related to step 3 of the Choice Triad.[28-30]

Testing the Waters

An illustration of a unique interviewing technique for exploring the question, "What does it say *about me* that I *have* to take this drug?" is called "*Testing the Waters*." Before describing the technique, it is necessary to explore the psychological paradox that creates the problem for which the technique provides a potential solution.

The problem is seen in patients who are in a substantial remission or even complete remission of their schizophrenia. It is even more frequently encountered with patients with bipolar disorder, schizoaffective disorder, and major depression, where total remission may be more common. Some of these patients, who may be intelligent, motivated for good health, well aware of the potential risks of their illness, and even vocal proponents of the usefulness of their current medications, sometimes suddenly stop taking them. Rapid exacerbation of their psychosis or mania often follows.

Peter Conrad's work regarding the symbolic meaning of antiseizure medications sheds light on this phenomenon.[31] Conrad discovered that patients who had their epilepsy in excellent control with minimal side effects would sometimes do exactly what euthymic patients with schizoaffective disorder or bipolar disorder might do—abruptly stop their medications. One of Conrad's patients describes the experience as follows:

"When I was young I would try not to take it…I'd take it for a while and think, 'Well, I don't need it anymore,' so I would not take it for, deliberately, just to see if I could do without. And then (in a few days) I'd start takin' it again, because I'd start passin' out . . . I will still try that now, when my husband is out of town . . . I just think, maybe I'm still gonna grow out of it or something."

A curious paradox unfolds when medications are effective in relieving symptoms. When a medication removes all symptoms, whether in bipolar disorder or a seizure disorder, the paradox is at its maximum. If a medication successfully removes all symptoms, it removes any ability for the patient to know whether or not the disease is still present.

So it is with patients managing schizophrenia, schizoaffective disorder, and bipolar disorder. All of these are illnesses in which, even when some symptoms remain, the presence of such symptoms can be easily consciously suppressed or unconsciously repressed, for what patient wouldn't want to be free of these illnesses? The reasoning behind why patients who are doing well may choose to abruptly discontinue their medications is no longer puzzling. It makes good sense. It is uncomfortable to not know what is going on inside one's body. And it is all too human to wish that such a devastating illness no longer exists. The urge "to test" is not the hallmark of "resistance," "opposition," or "lack of insight." It is the attempt to gain insight for some patients. In others, it is the attempt to gain freedom.

To pre-empt this problem, the interviewing technique mentioned earlier and aptly named "*Testing the Waters*" is described in the box.

Clinical Interviewing Technique: **Testing the Waters**

"Jim, you've been doing great on your medications now for over a year. It's wonderful that you have your schizophrenia (substitute whatever illness the patient is dealing with) in excellent control. Some of my patients tell me that after a while, they wonder whether or not they still have the schizophrenia or even need the medications. I think that is a natural curiosity. Do you ever have thoughts like that?"

Depending upon what the patient says (and how he or she says it), the clinician can gain insight as to whether the patient is preparing to try a unilateral and unannounced "medication-free trial." Sometimes the clinician can convince the patient that such a trial is not advisable. Such proactive questioning can prevent a major relapse and, in some instances, as when the return of suicidal ideation or violent behavior is a potential aspect of stopping the medication, even prevent a tragedy.

Another Tough One: Talking with a Patient About the Need to Initiate a Medication Involuntarily Against the Patient's Will

If ever there was a situation in which it might appear that the collaborative principles of the MIM cannot be applied, the involuntary forcing of a patient to take medication would appear to be one. Interestingly, it is one of the situations in which the principles of the MIM may be most helpful.

In such difficult situations, the clinician's language is impacting on the therapeutic alliance in two time frames: 1) the immediate relationship and 2) the longer-term relationship. In the immediate sense, even though a patient may be quite angry at the decision by the treatment team to force a medication, it is critical that the patient's perception is that the clinician is truly trying to help—the clinician and the patient

simply disagree on how to help or whether help is needed—and that the clinician is not acting from an oppositional stance. Such a belief can help secure the therapeutic alliance in later stages, when the patient is more stable and may be reflecting back upon the actions of the clinician.

The intensity of a patient's refusal to take a medication is sometimes fueled not so much by the fact that the clinician is forcing its use as it is by the patient's *perception* that the clinician is aggressively doing so from an oppositional stance. It is the patient's retrospective *perception* of the clinician's attitudes and motivations that often determines, in the long run (later in the hospitalization, during treatment as an outpatient, or upon a return admission), whether the patient will feel comfortable with the clinician's ultimate recommendations. The intensity of the patient's anger at the moment of involuntary administration is not necessarily a good indicator of ultimate cooperation. In regard to long-term medication interest, the proverbial adage, "it's a marathon, not a sprint," actually holds true.

The patient's perception may not be created so much by what the clinician says, but by how the clinician says it. As clinicians, we can hold opposing views from our patients without being opponents, depending upon the words we choose to share those views. Our words convey not only meaning, they convey relationship.

In the box below, this interviewing principle will be brought to life by a series of interviewing *techniques* woven into an interviewing *strategy*. Even though the interview strategy contains many steps, because each step is behaviorally specific, the strategy is ideally amenable to training to competency via the role-playing approach of *macro*training, which has been used to train clinicians to competence with even more complex interviewing tasks, such as the uncovering of dangerous suicidal ideation, planning, and intent.[24,32] This interviewing strategy is based upon an approach that was shared at one of Dr. Shea's workshops by Robert Becker, MD, the medical director of Greystone State Hospital in New Jersey.

Clinical Interviewing Technique:
Maximizing Alliance While Involuntarily Medicating

(This interview strategy will be laid out as a series of interviewing techniques)

1. **Clinician:** "I have an opinion about your situation and possible treatment here, but I'm not sure how much you will want to hear my opinion. However, it might be of value and perhaps get you what you want." (*Inviting a Request for Clinician Opinion*) [Patients will often ask for the hinted opinion.]
2. **Clinician:** "Before I share my opinion, I want to apologize because I'm afraid that what I have to say might upset you, and I don't want to upset you." (*Pre-emptive Apologizing*)
3. **Clinician:** "I also want you to know that I may be wrong. I don't think I'm wrong, but I have been wrong in the past." (*Acknowledgement of Fallibility*)
4. **Clinician:** "I hope that if you are upset, that we still can work together to help you to achieve your goals." [Then reiterate specific life goals that you have learned from the patient earlier, as well as emphasizing the goals of being discharged from the hospital and getting on with one's life.] (*Agreeing to Disagree*)
5. **Clinician:** "I think that you will be able to achieve [list whatever goals were discussed above] if you were to take a medication I have in mind." [Explain why.] (*Providing Opinion*)
6. **Clinician:** "Would you be willing to give the medication a try for awhile?" (*Making a Request*)
7. **Clinician (*if patient refuses*):** "I can understand your hesitancy. Let's look at the cons—and they are significant—and the pros in a little more detail." (*Openly Acknowledges the Cons and Reviews the Pros*)
8. **Clinician:** "I honestly feel that the medication will help, and that in the long run the pros will outweigh the cons. Please consider giving it a chance, because I really think it will help, and I don't want to have to force you to do anything you don't want to do. Would you be willing to at least try the medication to see for yourself?"
9. **Clinician (*if patient still says no*):** "Once again, I understand your hesitancy. I want to be very open with you. Our team feels so strongly that the medication is necessary for purposes of your safety [or perhaps the safety of others] that I have an obligation to give it to you by law. Let me explain the situation [describe legal situation as it pertains to your state]. I would much prefer that you try the medication voluntarily. Even if you don't and you still have to take it by law, you will have a choice on how. Your nurse will offer you the medication as a pill, which is by far the easiest way to take it [describe again the major pros of taking the medication]. If you don't choose to take the pill, then the nurse will need to give you a shot, which we would definitely like to avoid if possible. Let's see if we can work this out so you take the medication in the way that you feel is best for you even though you may not want to take it." (*Non-antagonistic Setting of Limits*)

The interviewing strategy *Maximizing Alliance While Involuntarily Medicating* will not work with every patient, but Dr. Becker has been pleasantly surprised, over the years, how often patients choose voluntarily to take the oral medications thus avoiding the complicated confrontations that sometimes ensue with forced intramuscular dosing. In addition, this interviewing strategy conveys a caring relationship that will probably not go unnoticed by the patient, setting a stage for future collaboration and making the best of a most difficult encounter.

Conclusion

The sharing of clinical interviewing tips among psychiatrists, nurses, case managers, and psychologists on a worldwide basis is at the heart of the MIM, for the model is designed to function as an ever-growing toolbox of interviewing techniques for improving medication interest in the treatment of schizophrenia and other serious illnesses In this regard, the Worldwide Web has provided a particularly effective pathway for such ongoing expansion of interviewing techniques, as reflected by the Web-based feature the "Clinical Interviewing Tip of the Month" and its archive first posted in 1999 and described in the literature in 2007.[33,34] At this website, clinicians share newly minted interviewing techniques for improving medication interest, as well as other aspects of clinical interviewing, such as suicide assessment and engagement techniques. By way of a computer metaphor, the MIM functions much like the operating system known as LINUX, which is constantly improved by input from designers unknown to each other. It is hoped that the input of clinicians from around the world will lead to ever-more-effective interviewing techniques for enhancing medication interest in the treatment of schizophrenia.

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Counseling Points™

Innovative Interviewing Techniques for Improving Medication Adherence: The Medication Interest Model

- Choosing an antipsychotic agent and deciding whether the pros of the medication outweigh the cons is one of the most difficult decisions facing a person with schizophrenia.
- The Medication Interest Model (MIM) has been evolving over the past 20 years. It is dedicated to improving medication adherence through the words that clinicians use when talking about medications with their patients.
- The Choice Triad , which is part of the MIM, consists of three steps:

  Step 1) Patients think that there is something wrong with them for which they personally want relief.

  Step 2) They are motivated to try a medication because they believe that the medication has the potential to help bring them this relief (or perhaps prevent a serious future problem).

  Step 3) They personally believe that the pros of taking the medication outweigh the cons.
- When navigating step 3 of the Choice Triad, patients weigh the pros and cons as they personally see them regarding the efficacy, cost, and meaning of taking the medication.
- The clinical interview technique "Personalizing Risk" can be used when introducing a medication where one of the potential side effects is death or a serious medical syndrome.
- The clinical interview technique "The Target Symptoms Question" can be used to reveal the symptoms of schizophrenia that are personally most troubling to a patient.
- The clinical interview technique "The Inquiry Into Lost Dreams" can be used to identify the goals and activities schizophrenia is preventing a patient from pursuing.
- The clinical interview technique "Testing the Waters" can be used to identify patients who are at risk for abruptly stopping a medication.
- The clinical interview technique "Maximizing Alliance While Involuntarily Medicating" can be used to transform a patient's resistance to having to take a medication for schizophrenia while enhancing the likelihood of a good long-term relationship.
- The MIM interviewing techniques can be adopted as described or adapted to each clinician's own personal style.

Counseling Points™

Innovative Interviewing Techniques: The Medication Interest Model

Continuing Medical Education Posttest

If you wish to receive acknowledgment for completing this activity, please complete the posttest by selecting the best answer to each question, complete the evaluation verification of participation, and fax to: (303) 790-4876. You may also complete the posttest online at www.cmeuniversity.com. On the navigation menu, click on "Find Posttests by Course" and search by project ID 5791. Upon successfully completing the posttest and evaluation, your certificate will be made available immediately to print online.

1. The Medication Interest Model (MIM) emphasizes the importance of viewing adherence as heavily dependent upon:
A) clinician opinion
B) patient choice
C) both of the above
D) neither of the above

2. The Choice Triad consists of:
A) three steps exploring the patient's medical history, family history, and allergic history
B) three steps defining how a patient decides to take or stay on a medication
C) three steps defining the patient's personal history of taking medication
D) all of the above

3. When navigating the third step of the Choice Triad—weighing the pros and cons—the patient develops a personalized opinion about which of the following?
A) Efficacy (Does this drug make me feel better?)
B) Cost (Is it worth it to me to take this drug?)
C) Meaning (What does it say about me that I have to take this drug?)
D) All of the above

4. According to the MIM, enhancing the medication interest of a patient with schizophrenia lies in carefully uncovering:
A) inappropriate patient beliefs about medications and confronting them
B) the nuanced beliefs of the patient in each step of the Choice Triad
C) both of the above
D) neither of the above

5. The interviewing technique called "Personalizing Risk" is specifically designed to be of assistance in introducing a medication to a patient:
A) for off-label use
B) that has potentially serious side effects such as death or a serious medical syndrome
C) that is of a different class than the medication he or she is currently taking
D) that is more expensive than the medication he or she is currently taking

6. The interviewing technique called the "Target Symptoms Question" asks the patient to self-identify which symptoms of schizophrenia he/she most wants help with at the current time and can help:
A) guide the choice of antipsychotic and other medications
B) uncover the presence of a second psychiatric disorder or syndrome
C) both A and B
D) neither A or B

7. The clinician should discourage patients with schizophrenia from pursuing ambitious goals, as failure can lead to lack of interest in continuing medication use.
A) True
B) False

8. The Inquiry Into Lost Dreams:
A) is counter-indicated with patients with schizophrenia
B) is difficult to learn and should primarily be used only by experienced clinicians
C) is only of use with patients suffering from schizophrenia
D) can uncover powerful personalized motivators for medication interest other than symptom relief

9. Conrad suggests that a curious paradox unfolds when medications are effective in completely relieving symptoms.
A) Patients don't know if their illness is still present
B) Patients are at risk for abruptly stopping their medication to test whether or not their illness is still present
C) Patients are at risk for hidden co-morbidities
D) Both A and B

10. The interviewing strategy called "Maximizing Alliance While Involuntarily Medicating" includes which of the following interviewing techniques?
A) Acknowledgement of Fallibility
B) Pushing Necessity
C) Agreeing to Disagree
D) Both A and C

Evaluation Form

Counseling Points™: Innovative Interviewing Techniques for Improving Medication Adherence: The Medication Interest Model

Project ID: 5791ES38

To assist us in evaluating the effectiveness of this activity and to make recommendations for future educational offerings, please take a few minutes to complete this evaluation form. *You must complete this evaluation form to receive acknowledgment for completing this activity.*

1 = Strongly Disagree 2 = Disagree 3 = Somewhat Disagree 4 = Somewhat Agree 5 = Agree 6 = Strongly Agree

To what extent do you agree with the following statements? *(Please circle the appropriate number on the scale.)*

- Identification of a patient's unfulfilled goals or dreams for the future can be powerful motivators in the Medication Interest Model (MIM) approach to enhancing medication adherence. 1 2 3 4 5 6
- The interviewing techniques of the MIM provide useful tools for enhancing medication interest among patients with schizophrenia..... 1 2 3 4 5 6
- I am confident in my ability to apply MIM-based interviewing techniques to assess interest in medication discontinuation by schizophrenic patients in remission. 1 2 3 4 5 6
- I am confident in my ability to apply MIM-based interviewing techniques to maximize the therapeutic alliance in a situation where a patient must be forced to involuntarily take medication. 1 2 3 4 5 6

Overall Effectiveness of the Activity

The content presented:

- Was timely and will influence how I practice..... 1 2 3 4 5 6
- Enhanced my current knowledge base..... 1 2 3 4 5 6
- Addressed my most pressing questions..... 1 2 3 4 5 6
- Provided new ideas or information I expect to use 1 2 3 4 5 6
- Addressed competencies identified by my specialty 1 2 3 4 5 6
- Avoided commercial bias or influence..... 1 2 3 4 5 6

Extent to Which Program Activities Met the Identified Objectives. *(After completing this activity, I am now better able to:)*

- Describe the use of specific interviewing techniques for each step of the Choice Triad (the three psychological steps patients experience when choosing whether to use a medication)..... 1 2 3 4 5 6
- Identify the significance and impact on adherence of the three factors—efficacy, cost, and meaning—that patients use when weighing the pros and cons of a medication..... 1 2 3 4 5 6
- Discuss the use of a specific interviewing technique—Testing the Waters—that can help transform nonadherence related to the patient's weighing of the pros and cons. 1 2 3 4 5 6
- Describe interviewing techniques that sensitively address the complexities of discussing adherence in difficult clinical situations, such as with medications that have dangerous side effects or with patients who have schizophrenia and are involuntarily taking medications. 1 2 3 4 5 6

Impact of the Activity

Name one thing you intend to change in your practice as a result of completing this activity:_____

_____

Please list any topics you would like to see addressed in future educational activities: _____

_____

Additional comments about this activity: _____

_____

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As part of our continuous quality improvement effort, we conduct postactivity follow-up surveys to assess the impact of our educational interventions on professional practice. Please indicate if you would be willing to participate in such a survey:

❒ Yes, I would be interested in participating in a follow-up survey.

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Posttest Answer Key

1	2	3	4	5	6	7	8	9	10

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