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Motivational Interviewing in a Patient With Schizophrenia to Achieve Treatment Collaboration: A Case Study

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A B S T R A C T

Medication nonadherence decreases the success of clinical treatment and the efficient use of resources, thereby creating a barrier to effective health care. In this report, we describe the achievement of treatment collaboration through motivational interviews (MI) in a patient with treatment-resistant schizophrenia. In this case study, we conducted six MIs during which we asked open-ended and reflective questions, established empathy with the patient, and developed discrepancies, leading to ambivalent feelings being revealed. We used the importance, confidence and self-efficacy ruler. The MI method can be used to ensure continued treatment effectiveness, to increase patient awareness about the disease and benefits of treatment, and to increase patients' self-efficacy.

Medication nonadherence in patients diagnosed with schizophrenia may result in the deterioration of psychotic symptoms, a five-fold increase in the risk of relapse, lengthened hospital stays, comorbid substance abuse, increased suicidal and homicidal tendencies and violent behavior (Herings & Erkens, 2003; Hunt, Bergen, & Bashir, 2002; Leucht et al., 2003; Valenstein et al., 2004). Although medical treatment plays an important role in schizophrenia, nonadherence to prescribed medication is a widespread problem (World Health Organization, 2003). According to the results of the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) study, 74% of patients with schizophrenia discontinued their treatment within 18 months of initiation due to side effects, lack of benefit from medication or other causes (Lieberman, 2005). In a cohort of patients experiencing the first episode of psychosis, 40.9% of the patients were adherent to treatment, 39.3% were nonadherent and 19% had insufficient adherence during the first year of treatment (Coldham, Addington, & Addington, 2002). Further, in a study comparing adherence evaluations from 100 patients taking neuroleptic medications and their treating physicians, 27% of the patients and 30% of the physicians rated patients' medication adherence at 50% or less (Kampman, Lehtinen, & Lassila, 2001). Kozuki and Froelicher (2003), in their study on medication nonadherence in 132 patients, found that 24.2%, 18.2% and 56.1% of the patients had adherence, partial adherence and complete nonadherence, respectively, for the 3 weeks preceding hospitalization.

For patients followed in a psychiatry clinic, the reasons for rehospitalization were rejection of recommended treatment (46.7% of patients), exacerbation of symptoms (32.6% of patients), intolerable side effects of medications (12% of patients), and not taking medications in 8.7% of patients. These findings underscore the main reasons for rehospitalization for medication nonadherence in patients with schizophrenia (Kelleci, Doğan, Ata, & Ve Ark, 2011). In a study performed by Duman, Kocaman, Üçok, Er, and Ve Ark (2006), nonadherence to medication and medical check rates were found at 57% among schizophrenia patients (Duman et al., 2006). Dilbaz, Karamustafalıoğlu, Oral, Önder, and Çetin (2006) determined that patients' long-term medication nonadherence rate was 25%, and during the acute phase it was found to be 51% (Dilbaz et al., 2006). It was reported that denial of illness, stigma, side effects of drugs, and difficulties related to using drugs were the main reasons given for both long-term and acute nonadherence.

The reasons for medication nonadherence are many and include the following in patients with schizophrenia: lack of insight or insufficient insight about their disease(s); psychopathology at a psychotic level; fear related to medication use; intolerable disease course; undesirable side effects; difficulty due to the complexity of adherence for a given treatment regimen; insufficient social support; financial difficulties (i.e., cannot afford medication); lack of information about treatment or misinterpretations of treatment; environmental factors in the hospital or residential neighborhood; pre-existing negative attitude (on the part of patient, families or friends) toward medications and mental diseases; perceived difficulties of medication use; conflicting

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cultural beliefs; and lack of knowledge (or misconceptions) about the disease(s) and its (their) management (Dolder, Lacro, Dunn, & Jeste, 2002; Joanna Briggs Institute, 2006; Vanelli, Burstein, & Cramer, 2001). Rettenbacher et al. (2004) observed that the quality of the therapeutic relationship between patients and health care personnel influenced medication adherence. Medication adherence improves in cases of patient-care provider relationships in which patients are encouraged to participate in their treatment, which in turn strengthens the relationship itself. Therefore, patient autonomy is important. When patients reject the use of medications, collaboration can be achieved by offering alternatives to avoid harm (Aronson, 2007; Bell, Airaksinen, Lyles, Chen, & Aslani, 2007; Wahl et al., 2005). Nonadherence results in increased levels of admission to psychiatric clinics, arrests due to violent episodes, low levels of satisfaction with life, and increased substance abuse (Ascher-Svanum et al., 2006; Drymalski & Campbell, 2009; Weiden, Kozma, Grogg, & Locklear, 2004).

Various programs and interventions are available to increase medication adherence in patients with schizophrenia. These include the following: psycho-education, cognitive–behavioral interventions, family interventions, psychosocial skills education and compliance therapy (Dilbaz, 2011; Joanna Briggs Institute, 2006).

Previous reports document that a good relationship between health staff and patients is required to strengthen adherence and that models directed toward the individualization of care are necessary for improvements in medication adherence (Clinical Practice Guidelines, 2005; Çobanoğlu et al., 2003; Possidente, Bucci, & McClain, 2005). MI is an emerging nonpharmacologic approach to increase such adherence.

MI interventions are based on individual-centered counseling, cognitive–behavioral therapy, social–cognitive theory, the health belief model and the trans-theoretical model (Miller & Rollnick translated by Karadağ and Ögel, 2009). This approach is intended to achieve behavioral changes by expressing empathy and helping individuals resolve discrepancies in behavioral changes (Miller & Rollnick translated by Karadağ and Ögel, 2009). At these interviews, the feelings and opinions of individuals are investigated, and their internal motivation improves. Counselors create an atmosphere that facilitates, but does not force, change.

Graeber, Moyers, Griffith, Guajardo, and Tonigan (2003) reported that MI reduced alcohol intake in patients with comorbid schizophrenia and alcohol abuse. In a randomized study, Kemp, Hayward, Applewhaite, Everitt, and David (1996) utilized MI in patients with psychosis and found that the experimental group had significantly higher medication adherence and insight about their disease. After using MI and a cognitive–behavioral approach in their patients with comorbid schizophrenia and alcohol and substance abuse and offering psychoeducation counseling to the patients' families, Barrowclough et al. (2001) observed a reduction in the symptoms of schizophrenia and alcohol and substance abuse and improved general function. Therefore, some investigators posit that health care personnel should be better trained in MI (Barwick, Bennett, Johnson, McGowan, & Moore, 2012; Tay, 2007).

According to psychopharmacology guidelines developed by the American Nursing Association and the Turkish statute regarding psychiatric nurses' duties, authorizations and responsibilities (ANA, 1994; issued in the formal governmental newspaper in 2011), nurses are required to understand the classifications and the expected and unexpected effects and side-effects of drugs and symptoms of drug toxicity. According to the guidelines set forth in Turkey, nurses should attempt to identify such effects, involve patients and their families in treatment plans, collect data about patients' prior medication use and educate patients (and families when involved in care) about the benefits and harms of a given treatment in Turkey (Fortinash, 1996; Resmi Gazete, 2011). Naturally, nurses should know about and implement MI to involve patients in their treatment and continue treatment collaboration with patients (Fortinash, 1996). Motivating patients to achieve a change in their behavior and responses is an important nursing function. In this case study, the aim was to improve treatment collaboration through the use of MI in a patient with treatment-resistant schizophrenia.

METHODS

In this case study, we examined the process of enhancing treatment collaboration through the use of MI in a patient diagnosed as schizophrenic and resistant to treatment. Patient Ö.N. was followed in the Schizophrenia Outpatient Clinic of Dokuz Eylül University Hospital. He was selected as a case study for MI due to his ambivalence toward medication as well as his resistance to changing medication-taking behaviors (i.e., nonadherence to the prescribed medication regimen). In this context, a scale and a questionnaire were used to assess his medication adherence. The Morisky Medication Adherence Scale was developed by Donald E. Morisky, and its validity was studied in 1986 by Morisky, Gren and Levine. The scale is composed of four questions that evaluate medication adherence. Questions are answered by patients as yes/no. If all questions are answered as “No”, the patient is assessed with a high degree of adherence; if one or two questions are answered as “Yes”, the medication adherence level is at a medium degree; if three or four questions are answered as “Yes”, the medication adherence is classified at a low degree (Morisky, Green, & Levine, 1986). The Drug Attitude Inventory was prepared by researchers. It consists of twenty-eight questions and three categories: regular drug use, attitudes toward medication-resistance, and knowledge about medication. Before the interview was conducted, information about the interview process was expressed to the patient. Oral and written informed consent was obtained from the patient to conduct MI and to audio record the interviews.

The researcher is a PhD student in the psychiatric nursing department and is certificated on MI techniques. The researcher participated in a 20-hour course, including supervision on MI from an MI specialist.

In addition to attending interviews, Ö.N. regularly attended doctor's follow-up visits in the schizophrenia outpatient clinic for his treatment. The researcher conducted MI for approximately 45 minutes to 1 hour, on a one-to-one and face-to-face basis once a week for 6 weeks in the nursing department classrooms between March 10 and May 8, 2014. Each interview was structured in accordance with the principles of MI. After each interview, the counselor and the researcher evaluated the content of the interview and requested advice from an experienced specialist.

Case Presentation

Ö.N. was male, 22 years old and a university student. He stopped attending his university classes at the end of the first academic year due to his inability to focus on his studies. The patient did not take his prescribed medications regularly and was unwilling to take them on his own. In fact, he only took medication under the supervision of his parents.

Ö.N. was first hospitalized at his parents' and his request in 2009. His parents noted that he became progressively introverted; he did not get out of bed, speak or open his eyes, he remained in one position for an unusually long time after being placed in that position by someone else. The patient spoke haltingly, had a negative attitude, was diagnosed with psychotic depression and initiated treatment. As his symptoms were not completely eliminated, his treatment was changed. When he was hospitalized for the second time at his own request, he complained of fatigue, opposition, unhappiness, and introversion, and he exhibited decreased self-care, decelerated movements and impaired function. The patient stared into space, stood motionless and was unable to speak. Doctors determined his final diagnosis to be schizophrenia.

After discharge, he regularly attended doctor's follow-up visits in the schizophrenia outpatient clinic and was prescribed antidepressant, anxiolytic and antipsychotic drugs.

Before starting motivational interviews, the researcher evaluated the patient's mental status. He had hallucinations in which he received messages from the television, noticeable thought blocking/alogia, considerable psychomotor retardation and the flat affect; he answered the questions without any additional dialog.