

Chapter 2

Early Intervention & The Difficulties Around Ambiguous Presentation

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1. Rationale

This case study is presented as an example of the difficulties a therapist encountered when dealing with a young adult whose clinical presentation was unclear and ambiguous and who was reluctant to engage in therapeutic interventions.

2. Reason for Referral

Abdul (1) was a nineteen-year-old Asian man who was in a psychiatric inpatient rehabilitation unit and was being cared for by a multi-disciplinary team, of which I was a part. It was at his Care Programme Approach (CPA) that I first met Abdul who had been readmitted to the unit. The meeting consisted of Abdul, his parents and the multi-disciplinary team. It soon became apparent that there was conflict between the parents and their son, and this was confirmed at the second CPA that took place four weeks later. He was very withdrawn, monosyllabic in his responses and unwilling to engage in much verbal contact. The team and myself were in agreement that psychological intervention may assist him in expressing his feelings and to address any concerns that he may wish to discuss, such as his low mood, family relationships and the reasons for his being in the unit.

3. Background Information

Background information on Abdul was obtained in a fragmented manner, as both he and his family were reluctant to share personal material, except around factual matters, such as his schooling. He was the middle of three children with a brother 10 years older than himself who was successful in his career. It was reported that he had good relationships with them. His father, aged 70, had a prosperous business, and his wife, aged 60, had divided her time between assisting in the business and taking care of the children and home.

(1) The patient's name and identifying details have been changed in order to protect his identity.

At the age of three, Abdul was sent to Pakistan to live with relatives for three years during which time he had no direct contact with his parents. The reason for this separation remained unclear, and it is significant that this only emerged during the course of my intervention. It also transpired that his father had previously been married and had four children whom Abdul had never met and who were never referred to.

Abdul had attended a Roman Catholic school as both his parents were of that faith, and he described his school years as “fine”. He obtained 10 GCSEs with good grades and went on to do his A Levels. However, he dropped out before completing the first year and he had never been employed. His social and interpersonal skills were appropriate, and his general functioning and understanding were of above average ability.

The team were informed that the family were attending family therapy, but neither Abdul nor his parents would provide information about it except that they had been referred two years prior because of the patient’s behaviour (i.e. his parents reported that he was difficult and unmotivated), and that they discussed some family issues. The older brother was not included in the sessions as he lived outside the country.

Five months prior to my meeting Abdul he had been admitted to an acute mental health ward under Section 2 of the Mental Health Act (1983) after displaying what was described as bizarre behaviour. In the past year he had broken his brother’s computer, smashed the mirror on his father’s car, and poisoned the vegetables he mother was growing. More recently, he was agitated with poor eating and sleeping patterns, and he had put his fist through a window. It was this incident that prompted his father to take him to hospital for an assessment. According to his family, there had been a gradual increase of what they referred to as their son’s “strange behaviour” over the past three years culminating in the events described above.

The admitting doctor noted that Abdul’s mental state on admission was difficult to assess, as he was ambiguous and unresponsive in his answers. He was orientated to time, place and person, and no evidence of delusions or hallucinations were found. However, he would smile inappropriately and make the occasional comment such as “I cannot breath through my sex organs”. Abdul remained on an acute ward for a 9-week period before being transferred as an informal patient to the rehabilitation unit. He remained there for two months and was discharged. A few weeks later his father took him to Pakistan and, according to his father, he began to “act strangely” and say ‘silly’ things. No concrete evidence of what this meant could be ascertained only that he would be vague and laugh inappropriately, so his father returned to the UK and Abdul was re-admitted to the rehabilitation unit, which is where I met him.

4. Assessment

This assessment was based on my initial interview, my participation in CPA and team meetings, and consulting his case notes. Abdul presented as a physically well-developed and polite young man who was withdrawn and uncommunicative. During the initial assessment he would make eye contact, but offered very little information. Most questions were responded to with “I don’t know”, or he would wait a long period of time, ask me to repeat the question, only to say “I don’t know” or “I can’t agree with you”. He was not impolite or discourteous, but he would stare at me, smile and respond in a disinterested, slightly mocking and challenging manner. Surprisingly, when asked if he wanted to engage in individual psychotherapy he said that he did, but when this was pursued all he would say was “I’ll try it” or “ok”. On the occasions when he answered in sentences, and based on his responses in the CPAs, it was obvious that he was a young man of average or above intelligence whose language skills and comprehension were competent and who could express himself with no difficulty when he chose to.

He denied any personal or family problems but I observed in the CPAs that his father would interrupt when his son was speaking or state that if his son did not co-operate with everything we suggested then he would disown him. His parents expressed anger and frustration with him, and

they frequently became openly rejecting and critical of him. His reaction to this would be to remain silent and distant in a passive way.

He reported that he had had no relationship, heterosexual or homosexual, and he noted that he had no friends. His explanation of this was that he lacked confidence, he was shy and he had nothing much to offer in conversation. Most of his interactions were with his immediate and extended family or family friends, which would not be an uncommon occurrence within his cultural context. When this was explored with him, he only partly agreed and noted that both his siblings had friends outside of the family context, and that his brother's girlfriend was not from their circle. Initially, he said this was "fine" for him, but it later emerged that having friends and a girlfriend was his greatest wish.

Abdul remarked that he had used cannabis since the age of 15 but the quantity and frequency were unclear as he was non-committal. The possibility existed that he wished to be seen as having used a large quantity of drugs which may have been motivated by a rebellion against his parents or wanting to establish credibility with his peers.

5. Diagnostic Uncertainty

There was much debate around Abdul's diagnosis. He had originally been given a diagnosis of Simple Schizophrenia (Diagnostic and Statistical Manual [DSM-IV], 1994) and later a differential diagnosis of a Drug Induced Psychosis (DSM-IV, 1994). There was no evidence of positive psychotic phenomena, the nursing staff on the hospital ward and in the rehabilitation unit had not reported any first rank symptoms or behavioural disturbances, and his beliefs, thought processes, level of functioning and interactions were stable and coherent. However, he may have been presenting with early signs of a psychotic illness, such as depressed mood, restlessness and social withdrawal, that are often mixed and difficult to categorise (Birchwood & Tarrier, 1994; Initiative to Reduce the Impact of Schizophrenia [IRIS], 1999). These factors created a division in the team regarding his diagnosis, with some opting for the diagnosis of simple schizophrenia and others believing there was a stronger affective component coupled with personality traits mainly of the passive-aggressive, dependent and avoidant types (DSM-IV, 1994). There was agreement that a mood component was present which required intervention, and an acknowledgement that the team would be required to tolerate and work with the uncertainty until a clearer picture emerged.

The Beck Depression Inventory (Beck, Rush, Shaw, & Emery, 1979) was administered and he obtained a score of 48 that fell within the severely depressed range. (He refused to complete an end of treatment inventory so no comparative score is available). The validity of his responses on this measure was questionable as he was observed to approach the task in a disinterested manner. However, one could not ignore his high score and he was regarded as a potentially high suicide risk for he was young, male, socially isolated, unemployed, he had no friends or peer group, his relationship with his parents was poor and he lacked confidence in himself (Centre for Clinical Outcomes, Research and Effectiveness [CORE], 1998). When asked about feelings of depression or suicidal thoughts he always denied any presence of them.

6. Formulation

Abdul showed no evidence of first rank psychotic symptoms except for his unusual comments at times (such as, "my blood is cold"), there were no observations or reports of him responding to

auditory or visual hallucinations or being preoccupied or distracted, and there was no evidence of his being agitated or aggressive. His insight appeared to be limited, though at times there was evidence of a greater understanding of himself. His view of himself and his belief in his abilities were poor, he was lacking in confidence and he perceived the world to be a critical and unsupportive environment.

His expressed range of emotions was restricted, his mood appeared low and his communications were devoid of detail. His interactions with others were always controlled and appropriate, and he presented as quiet and withdrawn. He had been socially and academically primed but it appeared that his emotional and sexual development had lagged behind (Bowlby, 1977, 1980; Bretherton, 1990; Crittende, 1990; Libet & Lewinsohn, 1973).

Abdul was in a conflictual relationship with his parents that appeared to include adolescent issues, such as difficulty in individuating from his parents (Bowlby, 1977, 1980; Erikson, 1963,1968). Observation of family interactions revealed that both parents were authoritarian and rigid in their approach, and unrealistic in their expectations of their son. For example, they expected him to be engaged in full-time employment on discharge from the unit. He seemed unable to verbally express his thoughts and feelings around this conflict so he was using dysfunctional means by which to relate them, namely through physically damaging his family's property and assuming a passive and non-verbal stance. This, he acknowledged, evoked annoyance and frustration in his parents.

The working hypothesis was that underlying his objectively depressed and withdrawn demeanour was anger and sadness. His family system had disallowed him to individuate or to develop a firm sense of his individual identity (Erikson, 1963; 1968). He had few positive beliefs about himself, and himself in relation to others, which research has shown to be contributing factors in depression (Beck, 1976; Bowlby, 1969, 1977, 1980; Crittende, 1990; Gerlsma, Das, & Emmelkamp, 1993; Main, Kaplan, & Cassidy, 1985; Stern, 1991). The strained and critical relationship with his parents, and his social isolation, meant that he had no positive or rewarding response from his environment and he lacked a confiding relationship with another adult (Lewinsohn, Weinstein, & Alper, 1970; Williams, 1992). This, combined with his being unemployed and having a low level of self-esteem, were all vulnerability factors for developing a severe mental illness and being regarded as a high suicide risk (Brown, 1986; Brown & Harris, 1978; CORE, 1998; Gut, 1989; Kaplan, Sadock, & Grebb, 1994; Osipow & Fitzgerald, 1993; Rippere, 1995).

Although his diagnosis was unclear, a mood component appeared to be present, whether it was within a context of a psychotic illness or an affective one. There was the possibility that the psychotic-like symptoms were transient (through the use of drugs), or were the early signs of a psychotic illness. There was also the possibility that his symptoms were being used in a manner that would allow him to utilise the 'mental illness' label as a means of avoiding dealing with his feelings of depression and anger (Salzberger-Wittenberg, 1970). These varying hypotheses mitigated against any precise formulation, but the case did highlight the type of uncertainty and complexity that is encountered in this more specialist area of work.

7. Therapeutic Considerations

Abdul was lacking in motivation, he was unwilling to engage or communicate in a manner that was conducive to exploring issues, he denied any depressed feelings or problem areas, and he showed limited insight into his situation. An approach based on the IRIS model for early intervention in psychosis (1999) was used. This model (i.e. Initiatives to Reduce the Impact of Schizophrenia [IRIS], 1999) is a 'working' model based on the principles of a therapeutic approach rather than on a specific theory of mind (such as Beck, 1967). It focuses on developing a broad therapeutic alliance with the client (and family, if appropriate), who is presenting with prodromal or first rank symptoms of a psychotic illness either for the first time, or who has had only a few episodes of the illness in the past. The therapeutic approaches suggested include, for example, suggestions on maintaining continued contact with difficult to engage clients, supporting family member, addressing treatment compliance issues and so forth, rather than on intervention techniques (such as identifying negative cognition and automatic thoughts). It was developed by clinicians and researchers working in the field of psychotic illnesses and was derived from their experiences with clients, families and services. It accommodates ambiguous presentations, and it emphasises both the importance of ongoing attempts to engage the patient and the development of a gentle, non-confrontational therapeutic relationship. In addition, the principles of intervention allow the therapist to work in a less structured and more flexible manner, without the constraints of a set model of working (IRIS, 1999). Early intervention work for both psychosis and depression (whether part of a prodromal syndrome or a disorder in its own right) could also assist in reducing the negative impact of such disorders (IRIS, 1999). A further motivation for offering therapy was to use the therapeutic relationship in a positive and adaptive manner (IRIS, 1999; Raue & Goldfield, 1994; Safran & Muran, 1995) for his developing a relationship with someone outside of the family unit could be beneficial in its own right (Baker, 1993; Jones & Pulos, 1993).

8. Treatment Plan

The client was given weekly sessions at the rehabilitation unit. The frequency and length of the sessions were adjusted according to his needs and capacity to sustain engagement. Ongoing discussion, observation and feedback between myself and the multi-disciplinary team were required due to the nature of the unit.

9. Intervention

Each week Abdul would arrive for his session being polite and 'compliant'. However, once he sat down in the chair he assumed his non-verbal, non-committal persona. He would stare at me in silence with a face that showed no emotion, give unashamed and large yawns whilst continuing to look at me, and refuse to say anything more than "I don't know" or "fine". He never expressed a wish to terminate the sessions, nor did he refuse to attend or leave the unit prior to them. Attempts to explore issues with him were thwarted and it soon began to feel as if he was testing me at every turn. His determined and mocking passivity and his avoidance of dealing with anything was unremitting

What was particularly concerning was his unquestioning keenness to accept the label of being mentally ill for it seemed as if it gave him the unfortunate opportunity to remain passive and

disengaged. It also gave him the chance to indirectly express his anger with his parents and to curtail their criticisms of him by blaming his behaviour on his 'illness'. On the occasions when I would comment on his behaviour he would look me in the eye and say "It's my illness" in order to test my response. It seemed that Abdul was engaging with me as he did with his parents, and that he perceived therapy as a battle of wills. In psychodynamic terms, his response was one of transference (Salzberger-Wittenberg, 1970) and my response to this difficult situation required self-reflection and thought (Salzberger-Wittenberg, 1970) for his passive-aggressive stance sometimes evoked enormous irritation in me. Consequently, I was cautious so as not to make sharp comments or treat him (in an unhelpful way) like a rebellious child.

At the end of every session, regardless of its content or process, he would unfailingly say something along the lines of "thanks, it was nice talking to you". At first I thought this might be indicative of positive change, but my optimism was soon replaced with a feeling of uneasiness that he might well be mocking me. I sometimes wondered whether his coming for therapy was part of a plan - he would comply with everything, assume the role of being mentally ill, enjoy being provided for and thereby not have to change.

I soon began to shift the therapeutic emphasis and to take a more reflective approach by interspersing the stares, silences and yawns with comments on what I thought might be taking place for him. This shift seemed necessary and appropriate as a means of moving away from the sessions becoming a 'battle of wills' and as a way of providing a more conducive situation if we were to address the very thing he so much wanted but did not know how to obtain - a relationship.

This approach, over time, began to elicit a few more responses from him and he would, on occasions, tell me if he agreed or disagreed with me. I would reflect on his wanting me to do the work in the sessions, that his refusal/reluctance to engage in any communications that extended beyond a phrase or sentence was a way of stopping me from getting to know him, but also a way of protecting himself from criticism, and that his half-smiles were a way of letting me know that he was listening even if he was not responding.

On one occasion, after about three months of his remarkable ability to continue in the same non-committal, unemotional and supposedly disengaged manner, having asked a question and whilst waiting for an anticipated response I said "It's not a trick question". For the first time, in spite of his efforts to contain himself, his façade was momentarily cracked and he laughed spontaneously. For a few minutes thereafter he continued to laugh in a genuine and warm manner. I too laughed and the last few minutes of the session were spent in silence with him smiling and laughing at himself. I think it was this incident that brought about a major shift in our therapeutic relationship.

His determination to not engage in any reciprocal 'conversation' was unremitting, and his responses were, by this stage, completely predictable, but what was different was that he could now come into the sessions and spontaneously start them by giving me a few facts about what had taken place during the week. At times he would even comment on how he felt about them. His willingness to agree or disagree with my reflections improved and on occasions he would contribute to them. He occasionally expressed insight into his behaviour and wishes, notably around his wanting a girlfriend and friends and, over time, he felt more able to discuss his increasing desire to live away from the family home. He was also more verbal in his complaints about being tired and disinterested in activities or work schemes, and he was eager to let me know that his only wishes were to be rich, to have a girlfriend, to be allowed to sleep all day and to get his own flat. These symptoms are common to depression (DSM-IV, 1994) and early signs of psychosis (IRIS, 1999) but they are also common and typical adolescent responses (Erikson, 1968).

The staffs' observation of him outside of the sessions revealed a part of him that was being more communicative and engaged than had previously been noted. He had formed a strong attachment to the unit's chef; he would chat to him, go shopping with him and help him in the kitchen (though he insisted on telling me that he only did it because he had to, and that it meant nothing).

Continuing to engage with him was not always an easy task but there did seem to be a value in my accepting and working with what seemed like adolescent defiance and opposition, and his emotional immaturity. His passivity was being discussed and challenged but was not being responded to in a critical or rejecting manner. The aim was to be able to think about it and address it. It frequently felt as if he wanted to push me to the point where I too would criticise and reject him, so that he could then make me responsible for the ending of therapy and repeat what he seemed to have experienced at home (as referred to in the theoretical formulation).

In contrast to his behaviour in the sessions, within the unit he was almost the ideal patient. He always returned from leave at the agreed time, he carried through with any tasks requested of him, and other than needing some encouragement to attend the in-house groups, to get off his bed or to change his clothes, he never posed any specific management problem. The main issue was that even though his affect was not blunted in the usual way that it presents in people who have a psychotic illness or are more severely depressed, he still seemed sad and lonely, and he showed little motivation to move forward in his life.

The therapy continued for 5 months, at which time the team felt that he was ready to be prepared for discharge to a small partly supervised hostel, though this would take a number of months. This decision coincided with my telling him that I was to be leaving the unit in 6 weeks time. When I told him of my leaving, his immediate response was one of shock and he blurted out "I'm going to miss you. I'm going to miss our talks", and for a while thereafter he seemed uneasy but he refused to talk about it. When I later followed up on the two issues of leaving, my leaving and his leaving, things began to change. I had commented that even though it was something positive for him to be thinking of moving on, he might also be feeling a sense of loss at losing the companionship of the staff and 13 other clients and the security and the encouragement that he had received over a relatively long period of time. It would also mean that he would be leaving the chef who had become an important person in his life. In addition to this, our sessions would be coming to an end a lot sooner than his moving on. His response was that he had not thought of these things and that what I had said was true.

Over the following 6 sessions, prior to termination, his behaviour began to change. During the sessions he would ask to end early, he would look at the clock whilst I was talking to him, his tone of voice was often irritable, he began to smirk rather than smile, and it seemed that for the first time his anger was being shown in a more direct manner. Whereas in the past he would give the impression that he was tolerating my comments and boundaries he now seemed to be more hostile and dismissive of me. He would say, with a smile/smirk on his face, "I'm so happy these sessions are ending - it's such a relief that I wouldn't have to come to any more - they're a waste of time", or "I've really got nothing to say, can I go now". I continued to comment on what I thought might be happening for him, but he mostly refused to engage in any real discussion about it, and it was only in the final session that he briefly acknowledged the sessions being of some benefit.

10. Evaluation

I have often wondered, both throughout the intervention and whilst writing it up, whether I was

being as stubborn as he was by persevering as I did! Did I collude with his passive compliance by continuing the therapy? Should I have been more challenging or brought it to a close and informed him that the responsibility of it ending was a consequence of his unwillingness to engage in a more collaborative manner? However, the IRIS model (1999) of intervention comments on similar difficulties and encourages the continuation of engagement wherever possible. In the light of this, I do believe that the therapeutic relationship and the intervention was of some benefit to him evidenced by the small shifts in therapy and the greater ones in his relationships with others within the unit. Nevertheless, my leaving him (by leaving the unit) may have partly undermined my initial intention of providing him with a relationship that would not involve being rejected.

In conclusion, I feel that my ambivalence about the intervention possibly reflected his about living his life in a different way. It was about making a choice, and my choice was to not disengage because of his ambivalence even if the process of continued engagement was often frustrating and difficult. As a professional, I think that systems or services (and the professionals within them) sometimes struggle to tolerate ambivalence and frequently draw people in or push them out as a means of coping with uncertainty.

11. Discussion

Difficult to engage clients have received more attention over the past decade through a variety of approaches, such as Linehan's Dialectic Behavioural Therapy (1993), Sainsbury Centre for Mental Health's Keys to Engagement (Sainsbury Centre for Mental Health [SCMH], 1998) and the National Service Framework (Department of Health, 1999). These initiatives place a strong emphasis on the process of engagement, with the rationalisation that one (or services) cannot work with a client who has disengaged from services, or, as in Linehan's model (1993) with someone who is no longer alive (i.e. has committed suicide).

Engaging clients covers both concepts of those who are reluctant or resistant to arrive for sessions, as well as those who struggle to participate in the actual process of the therapy (i.e. they attend the sessions but do not engage in the work being done), such as with the client presented. Whereas the main focus in this case study was on developing a therapeutic relationship in which he could experience a reflective and uncritical relationship, alternative models and interventions could have been implemented. For example, utilising techniques from a more structured approach, such as asking him to keep a thought diary which could be discussed in the sessions (Beck, 1976, 1983). Another intervention model could have been Linehan's Dialectical Behavioural Therapy (1993). An example of a technique from this model would have been to facilitate his learning the skill of 'mindfulness' (Linehan, 1993) which is the process of paying attention to the task at hand, such as breathing, eating, washing and so forth, in a purposeful and non-judgemental manner, in order to develop his awareness of, and attention to, his daily life experiences.

In conclusion, there are usually a number of different models and techniques with which one can approach a clinical case, and the choice of treatment modality is frequently determined by the clinician's preferred method of intervention. However, it is often helpful to re-evaluate that choice in light of the outcome of treatment and the advantage of hindsight.

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