Cognitive–behavioural assessment and treatment of maladaptive help-seeking behaviour in a patient with schizophrenia

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Objective: Maladaptive help-seeking behaviour in psychiatric patients is a significant problem for public mental health services, yet it is not addressed in the mainstream literature. We present a report on the successful treatment of a person with schizophrenia who displayed this common dilemma for patients and clinicians.
Clinical picture: A 31-year-old man with borderline intellectual functioning had a 10-year history of schizophrenia marked by negative features. He frequently presented in crisis to public mental health services, the local hospital, and his general practitioner; this resulted in excessive use of services, including admissions.
Treatment: The patient was reassessed from a cognitive–behavioural perspective rather than a syndromal perspective. Specific behaviours were modified, cognitions were identified, challenged and restructured, and other service providers were provided with an alternative to admission or acute community care.
Outcome: At 24 months the maladaptive behaviour remains in remission.
Conclusions: Behavioural problems in persons with chronic schizophrenia may be effectively treated by reconceptualising the behaviour as distinct from the major diagnosis.
Key words: Cognitive–behaviour therapy, help seeking, schizophrenia.

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Help-seeking behaviour is virtually a prerequisite of treatment in any health setting and may be observed in one or more of several semi-independent categories. Help-seeking behaviour may occur in the context of: (i) genuine health problems; (ii) hypochondriacal concerns (where the distress precipitating the help-seeking behaviour is not the actual pathology); (iii) malingering or functional symptomatology; (iv) learned help-seeking behaviour, where no external reinforcement is readily evident, but rather the behaviour is associated with psychological sequelae of previous help-related experiences.

In the context of (genuine) health problems, clinical pathways are available for assessment and problem formulation. When health anxiety is suspected to be the underlying cause of the presentation (regardless of the patient's own beliefs) hypochondriasis pathways may be used [1,2]. Where secondary gain is suspected to be underlying the complaint, other guidelines are available [3,4]. No such guidelines are apparent with regard to learned help-seeking behaviour. We believe that this pattern forms a distinct clinical condition accounting for a significant percentage of health services consumed.

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WY, a 31-year-old man with a 10-year history of chronic schizophrenia characterised by prominent negative symptoms and with intellectual functioning in the borderline range, was referred to the first author for assessment of problems with depression and 'stress'. The characteristic feature of WY's presentation was his constant help-seeking behaviour, such that he was well known within the mental health service for his frequent attendance at the hospital emergency department, calls to the mental health service's Acute Care Team and unscheduled visits to his local community mental health centre or general practitioner. WY would typically present with complaints of depression and associated suicidal thoughts in addition to vague aggressive ideation towards others. Such presentations often resulted in WY's admission to inpatient psychiatric units or ongoing, intensive follow up by the Acute Care Team or community mental health staff. The impact of the various interventions was usually a rapid diminishing of expressed concerns, uninfluenced by the precise nature or duration of the intervention.

Costs to the health service were identified as occurring in the hospital emergency department, inpatient facilities, the Acute Care Team and the local community mental health centre. Also, general medical practitioner time and public health funds.

Cognitive–behavioural assessment

The specific behaviour in question was WY's frequent help seeking from health professionals during times of subjective distress. Behavioural analysis revealed that this usually occurred during periods of unstructured time without competing behaviours to occupy him.

Affective antecedents to WY's presentation included feelings of subjective distress, principally sadness and boredom.

Cognitive antecedents to WY's presentation included beliefs that contact with health professionals, especially mental health professionals, would provide relief. Further to this, WY experienced significant anxiety in relation to the thought disorder associated with his schizophrenia, principally confusion or ambivalence. At times of acute distress he believed that intervention from health professionals was necessary to appropriately assess his thought disorder and to treat the problems he associated with it. Assessment by health professionals quickly relieved WY's feelings of anxiety, boredom and sadness, as he believed that he was receiving appropriate treatment.

It is possible to conceptualise WY's concerns in terms of the central feature of hypochondriasis: 'an enduring tendency to misinterpret innocuous physical symptoms and signs as evidence of serious illness' [5]. This description needs to be modified in two ways to match the antecedents observed in WY's case. First, symptoms need not be 'innocuous'; they may be genuine and causally associated with a *bona fide* illness process not linked to hypochondriasis. Second, these symptoms may be psychological such as dysphoria, anxiety or thought disorder.

Behavioural antecedents for WY include his history of positive reinforcement in regard to presentation to health services. The nature of this reinforcement, non-specific reassurance and individual attention from a health professional leading to a subjective sense of relief, was a powerful reward for WY. This process was facilitated by his complaints of a significantly depressed mood, his statements that he intended to commit suicide and his vague aggressive ideation towards others and stated desire to attack them. These statements are a potent means of engaging health professionals, who are obliged to assess these ideas thoroughly, which resulted in long sessions with these health professionals and frequent admissions to hospitals. Since WY sought reassurance from many clinicians, it was hypothesised that the positive reinforcement from these professionals formed a variable ratio schedule. That is, some clinicians would show great concern possibly associated with hospital admission, while other clinicians would show significantly less concern. In the context of WY's beliefs, attention and reassurance from clinicians was a strong reinforcing event. This strong reinforcement delivered by a variable ratio schedule became a powerful mechanism for increasing the frequency of his behaviours. Occasional hospitalisation or intensive community care also served to confirm his beliefs that his concerns were valid and his actions were proper.

WY's case was conceptualised as that of a 31-year-old man with intellectual functioning in the borderline range and a 10-year history of satisfactorily managed schizophrenia, who had few activities and experienced significant anxiety in relation to his mental health. WY's help-seeking behaviour was reinforced by health services delivering a variable ratio reinforcement schedule of non-specific reassurance. This reinforcement provided a subjective sense of relief and a confirmation of his beliefs.

Treatment

The cognitive and behavioural factors associated with WY's maladaptive presentations occurred in the context of feeling 'lonely and bored' in addition to anxiety about his own mental health. Treatment therefore focused on WY's thought processes and behavioural repertoire, in addition to addressing environmental reinforcers. Particular attention was given to engaging WY in a collaborative therapeutic process via establishing rapport and a shared 'world view'. WY had been receiving clozapine for 1 year prior to his referral for clinical psychologist intervention; there was no change to his medication regimen throughout his psychological treatment and he continued to receive routine case management.

Alterations to environmental reinforcers

Health-care providers who had been previously accessed by WY, or who were likely to be accessed by him, were telephoned to discuss the formulation and a management plan for responding to presentations by WY. This was followed up by a written version of the formulation and management plan, which included the recommendations to immediately refer WY to the first author and to keep interviews brief and task-orientated.

Cognitive therapy

The cognitive intervention was tailored to suit his level of intellectual functioning and sociocultural background. Several of WY's dysfunctional beliefs about daily life and the people around him were explored. Collaborative efforts with WY produced a set of 'rules' for him to use to rebut these beliefs.

WY's schema concerning his help-seeking behaviours included the beliefs that health care services would 'fix me up' and his fear that 'something bad' might happen if he did not contact such services. When these beliefs were gently challenged, he was able to identify that he had never experienced anything seriously untoward when he did not contact health services and that the services primarily provided company and emotional support. Constructive alternatives to help-seeking behaviour were explored with WY, which generated a list of alternative and/or pleasant behaviours.

Behavioural therapy

Behavioural therapy consisted of involving WY in pleasant events scheduling, both as a means of redressing his episodes of low mood and to provide competing activities incongruent with help-seeking behaviour when feeling bored or distressed. This included visits to Buckingham House, a community program for people with chronic mental illness. WY began to visit Buckingham House 2–3 times per week, having previously avoided attendance.

Other pleasant events scheduled with WY included a list of activities such as calling a friend, going for a walk or going to church. This list of activities was collaboratively developed with WY, by examining strategies he already found helpful for relieving boredom and adding new strategies, influenced by Tarrier's (1993) model of enhancing basic coping strategies [6].

Outcome assessment

Shortly after implementation of the intervention WY began to reduce the frequency of his maladaptive use of health services; after several weeks this ceased altogether. He continued to attend activities at Buckingham House and appointments with the community mental health centre and 6 months later attained full-time employment in an assisted work program. At 24 months follow up WY continues to be employed full-time, attends Buckingham House when time permits and has accessed health services inappropriately on only one occasion.

Discussion

The salient features of the case of WY described here will be familiar to health professionals caring for persons with a chronic mental illness. The behavioural pattern observed often develops insidiously, frequently as the by-product of well-intentioned management plans designed by services operating as free agents. In addition to the benefits of improved clinical outcome from the approach described here, there is also a significant economic component, in service use, professional staff time and energy and staff morale. This is an area of potentially great importance in health-service delivery for people with chronic mental health problems.

The significant feature of the intervention described is the employment of the cognitive–behavioural model for a person who superficially appears to be

displaying a primary manifestation of schizophrenia. Following the clinical application of learning theory, a comprehensive cognitive–behavioural assessment was conducted, which did not *ipso facto* dismiss the content of the behaviour in question as an untouchable product of a psychotic disorder. The macro-form of the behaviour was conceptualised as a learned pattern; a micro-view had persistently missed the features of the behavioural pattern and focused on each presentation as a discrete event.

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