

*"I know of no other book even in the same league."
Gerry Spence, Author of the NY Times Best-Seller *How to Argue and Win Every Time**

I AM NOT SICK I Don't Need Help!

How to Help
Someone with
Mental Illness
Accept
Treatment

10th
ANNIVERSARY
EDITION

Xavier Amador, Ph.D.

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Someone with
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**Vida Press, New York
2012**

I AM NOT SICK, I DON'T NEED HELP!

Xavier Amador

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Also available in other translations and as an ebook. On the web: www.VidaPress.com & www.LEAPInstitute.org

Amador, Xavier, 1959 -

I AM NOT SICK, I DON'T NEED HELP!

How to Help Someone with Mental Illness Accept Treatment.
10th Anniversary Edition / Xavier Amador.

ISBN-13: 978-0-9677189-3-4

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for
Enrrique and Lou-Andréa

Other books by Dr. Xavier Amador:

*I'm Right, You're Wrong, Now What?
Break the Impasse and Get What You Need*
(Hyperion, 2008)

Break the Bipolar Cycle
(McGraw Hill, 2007)

I Am Not Sick, I Don't Need Help! 2nd Edition
(Vida Press, 2007)

*Insight and Psychosis, 2nd Edition
Awareness of Illness in Schizophrenia and Related Disorders*
(Oxford University Press, 2004)

I am Not Sick, I Don't Need Help!
(Vida Press, 2000)

Being Single in a Couples' World
(Fireside Trade Edition, 1999)

Being Single in a Couples' World
(Free Press, 1998)

*When Someone You Love is Depressed:
How to Help Without Losing Yourself*
(Fireside, trade edition, 1997)

*When Someone You Love is Depressed:
How to Help Without Losing Yourself*
(Free Press, 1996)

A portion of the proceeds from the sale of this book are donated to the
National Alliance on Mental Illness

**To contact Dr. Amador and for information
on his books, LEAP trainings, and speaking schedule see
www.LEAPInstitute.org**

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Foreword

by Pete Earley (2nd Edition)

How would you feel, Dad, if someone you loved killed himself?

I was rushing my college age son, Mike, to an emergency room when he asked me that question. He was seeing secret messages in bumper stickers and experiencing rapid mood swings. When we reached the hospital, I felt a tremendous sense of relief. *The doctors there would know what to do!*

Four hours later, a doctor finally appeared and after briefly questioning Mike, declared there was nothing he could do to help him. Mike was convinced that he wasn't sick and he refused to take anti-psychotic medication.

Because the doctor did not believe Mike was an "imminent danger," either to himself or others, my son was turned away even though he was clearly delusional.

During the next forty-eight hours, Mike decompensated. Only another parent can really understand how agonizing it is to stand by and watch your child slip further and further into a mental abyss. I tried, of course, to intervene. I told Mike that his anti-psychotic medicine would help him think more clearly. But he told me there wasn't anything wrong with the way he was thinking. I tried to show him that he was having delusions, but he disagreed. Finally, I begged him to take his pills. "Please, please, just do it for me!" But he wouldn't. "I'm not sick," he kept repeating. After hours and hours of exhausting conversations, I demanded that he take his medication or leave the house. That threat only made the situation worse. Afraid of what might happen to him on the street, I backed down. The next morning, when Mike caught me spiking his breakfast cereal with his medicine, he became enraged.

Forty-eight hours later, Mike was in police custody. He had slipped outside one morning and broken into a house to take a bubble bath because he felt dirty. Luckily, the homeowners were out of town. It took six officers to subdue him. Mike was charged with two felony crimes.

Uncertain what to do, I contacted the National Alliance on Mental Illness (NAMI), the nation's largest grassroots mental health organization, and a volunteer there urged me to read Dr. Xavier Amador's book, *I Am Not Sick, I Don't Need Help!*

When I did, I was amazed. Just about everything that I had done to help Mike had been wrong. Rather than calming the situation, my actions had driven a wedge between Mike and me. I had not Listened to him, not Empathized with him, certainly not Agreed with him and finally had not formed a Partnership with him. Those are the four guiding principles behind LEAP, an acronym that Dr. Amador has coined to help teach parents and others how to better communicate with their mentally ill loved ones. When I was arguing with Mike, I had felt frustrated and overwhelmed. In Dr. Amador's book, I found a simple-to-understand blueprint for parents, siblings, children, and friends to follow. While I was reading Dr. Amador's book, I also realized I was not alone. Others had faced the very same situation that I had encountered with Mike.

I discovered that Dr. Amador's advice came from years of experience as a clinical psychologist. His academic and professional credentials were impressive. He had served as a professor of psychiatry at Columbia University, as Director of Research at NAMI, and Director of Psychology at the New York State Psychiatric Institute. He had worked as an NBC News consultant, appeared on countless television news shows, been quoted regularly in the media, and had been called on by the National Institute of Mental Health, Veteran's Administration, and U.S. Justice Department for advice. Dr. Amador also had served as an expert witness in high-profile cases, including the Theodore Kaczynski "Unabomber" trial, the Elizabeth Smart kidnapping, and the Zacarias Moussaoui "Twentieth Hijacker" case.

But it was another tidbit from Dr. Amador's background that really caught my eye. His brother, Enrique, has schizophrenia. This was important to me, because it meant Dr. Amador not only had professional experience, but also a personal stake in his research. One of the reasons why he had developed LEAP was to help him find ways to better understand his own brother.

Eventually, my son was sentenced to two years of probation and during that period, Mike followed the rules. He attended therapy, participated in group sessions and took his medication. But several months after Mike's court-imposed sanctions ended, signs of his illness began to resurface. I was stunned when I discovered that Mike had stopped taking his medication. Despite everything that we had gone through, he had, once again, quit taking his pills. My first impulse was to confront him. *How could you do this again? Haven't you learned anything?* But my wife reminded me of Dr. Amador's book. Using LEAP,

she was able to work out an agreement that soon had him back on his medication and into treatment.

In this new edition, Dr. Amador updates his groundbreaking book. He explains how “unawareness” of a mental illness is a *symptom* brought on by the disease. It is *not* a choice that an ill person makes. He gives practical advice about how families and doctors can bridge the gap created by the federal Health Insurance Portability and Accountability Act (HIPAA) that frequently prevents loved ones from being informed and involved in treatment. He summarizes state commitment laws, using simple-to-understand terms to explain the legal complexities. Since releasing his first book, Dr. Amador has delivered more than 300 lectures and conducted hundreds of LEAP workshops. He has taken information from those sessions and added it to this edition. These include model scripts that suggest specific phrases to use and NOT to use. Being able to refer to these passages is much like having Dr. Amador in your hip pocket.

The needs of every individual who has a mental illness are unique. But regardless of that person’s specific problems, the basics that Dr. Amador teaches help readers improve their communication skills, help develop trust, and help turn combative situations into cooperative ones.

One night while Dr. Amador was autographing books, a man approached him empty handed. He had left his dog-eared copy at home, he explained, but had stood in line anyway because he wanted to shake the hand of the doctor who had, as he put it, “given me my son back.”

I feel the same way.

=====

Pete Earley is the author of *Crazy: A Father’s Search through America’s Mental Health Madness*. He is a former investigative journalist for the *Washington Post* and the author of several *New York Times* best-selling books.

Preface to the 10th Anniversary Edition

Xavier Amador (2012)

Why write a tenth anniversary edition? Was it because, like many people, I like round numbers? I remember my tenth birthday like it was yesterday. I was so proud to turn “10” and I suppose I am proud or, more precisely, humbled that *I Am Not Sick* has turned ten years old. This little book, which started out as a labor of love, continues to grow in its reach to family members, doctors, nurses, therapists, law enforcement officers and policy-makers. To my surprise, it has been translated into French, Spanish, Hungarian, Chinese and Japanese (more translations are in the works). As much as I do see the appeal of round numbers, their symmetry and the ease with which they can be memorized, I did not revise this book simply because ten years have passed since the publication of the first edition. I wrote it because ten years of experience and new science have been acquired and many more people are asking for even more information on the nature of the problem of poor insight, anosognosia, treatment options and how they can help someone with mental illness who is convinced there is nothing wrong with them.

For owners of previous editions you might, at first glance, think the book is merely one-third longer—there are seven new chapters. But as you read, you will discover that previous chapters have all been revised. My goal was to update the research and to be even more practical and detailed in the advice I give on how to engage someone with mental illness *who does not understand he or she is ill*. You will learn several new LEAP tools—I now call the specific communication techniques users of LEAP employ “LEAP tools” (you will see why when you read the first chapter on LEAP). In addition, in this new edition, I report on recent research conducted on LEAP, opportunities

for training in LEAP and about new research that points to the importance of ensuring persons with schizophrenia, related disorders and bipolar disorder are involved in treatment and adhering one hundred percent, or as close to that goal as possible, to the medications prescribed. In this new edition, I also make the case for why doctors should be assessing insight and diagnosing anosognosia, or poor insight, whenever they assess a patient with schizophrenia, schizoaffective, bipolar or related disorders. Knowing whether the person believes he or she is ill is critical to treatment planning.

It was nearly thirty years ago (in 1981) that I first learned how my natural instinct to confront denial of illness head-on led to disaster. My brother had just come home after his first hospitalization for schizophrenia. The medicine he had been given brought him back to the reality I knew, but within a day of his getting home, I found the pills in the garbage can. Naturally, I asked him why he'd thrown them out.

"I'm okay now. I don't need it anymore," he explained.

Since this ran counter to everything he was told in the hospital, I made a point of reminding him. "But the doctor said you're probably going to have to take this medicine for the rest of your life. You *can't* stop taking it!"

"He didn't say that."

"Sure he did! I was at the family meeting, remember?" I countered.

"No. He said I had to take it while I was in the hospital."

"Then why did he give you a supply of medicine to take home?" I argued, trying to prove him wrong.

"That was just in case I got sick again. I'm fine now."

"No. That's not what he said."

"Yes, it is."

"Why are you being so stubborn? You know I'm right!" I said.

"It's my business. Leave me alone."

"When you got sick, it became everyone's business. And besides, I'm worried."

"You don't have to worry about me. I'm fine."

"You're fine now, but you won't be if you don't stay on the medicine."

"That's not what the doctor said!"

"Then let's call him and I'll prove it!"

"I don't want to talk about it! Just leave me alone," he said as he walked away.

With every dose of "reality" I tried to give him, Henry countered with more denials. And with every go-round we both became angrier and angrier.

I thought he was being stubborn and immature. My accusations and threats to prove him wrong made him angry and defensive. My natural instinct to confront his denial was completely ineffective and made things worse. We got caught in a cycle of more confrontation and denials (what I call the *denial dance*), which pushed us farther apart. The end result was always that he walked away angry. And then he would relapse and end up back in the hospital.

In 1989, when I first started doing research on the problem of denial, there were fewer than ten studies in the research literature. When the first edition of this book was published, there were more than one hundred. When the 2nd edition was published four years ago, there were just over two hundred. Today, there are close to three hundred! The avalanche of new research on the nature of the problem and how we can best help persons who say "I'm not sick, I don't need help!" continues. We have learned a great deal which I will tell you about in the pages ahead.

One final note. Over the last ten years, I have given several hundred talks and workshops on the problem of denial and

the solutions offered in this book (i.e., LEAP). LEAP seminars have been presented all over the United States, in many cities in France, Belgium, Australia, New Zealand, the United Kingdom, Hungary, Portugal, Turkey and Spain.

Because of the demand, my colleagues and I started a training and research institute aptly named “LEAP Institute” (see *www.LEAPInstitute.org* for information and free resources). We have learned a lot about what works and what doesn't. Over the past decade, I have learned much from our experience with thousands of patients, families and therapists all over the world, and from the new research. *These* are the reasons, and not the number ten, that I felt a new edition was needed. I am very excited about how much more practical and informative this new book is and hope that you will feel the same.

I end here with a quote from my foreword to the first edition: “After my lecture [about the research on poor insight] I was surrounded at the podium for nearly two hours, speaking with family members who wanted advice and a greater understanding of why their loved ones refused to accept help. The yearning of these people to learn more and to talk to someone who understood their frustration was enlightening. I was also struck by the realization that the scientific advances with which I was so familiar hadn't yet reached many of the people who would benefit most from what has been learned. That is why I wrote this book.”

This realization, that many clinicians and family members had not yet learned of the research related to this problem, is nearly as true today as it was ten years ago. Tens of thousands are now informed, but given the scope of the problem of poor insight, millions more have not yet benefited from the science you will read about the pages ahead. My hope is that this book will finally close that gap between science and practice.

**I AM NOT SICK
I Don't Need Help!**

Introduction

If you are reading *I Am Not Sick, I Don't Need Help!* it is probably because you have a loved one or are treating a patient with serious mental illness who is in “denial” and, most likely, is not taking the medication he or she needs to prevent a flare-up of the condition and to recover. Or, if he is taking it, he is not doing so regularly. You’ve tried various strategies that haven’t worked and you’re seeking information about how you can help him or her to get help.

The first part of this book provides information about the nature and scope of the problem you are about to tackle. Some of you may be tempted to skip this section and go directly to the chapters on LEAP (Part II of this book) — a communication strategy designed to win the trust of persons with mental illness who lack insight for the purpose of becoming a “friend” whose advice they will follow (e.g., to accept treatment, supportive housing and other services). I have no problem with that and encourage you to do so if your situation is urgent. Or, if the situation is even *more* urgent, you may want to turn directly to Part III, where I provide practical guidance about when and how to secure “assisted treatment” (inpatient or outpatient involuntary treatment). In my mind, skipping ahead would be an appropriate use of this book. If you do that, however, I strongly urge you — after things have settled down — to go back and read the three chapters that make up Part I.

The information in Part I is vital for several reasons. First, it will help you to understand what the newest research has shown about the causes of what may seem to you nothing more than pure stubbornness on the part of the person you are trying to help. Too often, people with these disorders feel that we (I am speaking both as a therapist and as a family member) are their enemies. From their perspective we are adversaries and detractors — definitely

not allies. Meanwhile, we scratch our heads and wonder why they seem unable or unwilling to accept the help we offer. In this context, it is not surprising that the relationship often becomes adversarial. However, once you understand that the mentally ill person's refusal to accept treatment typically results from a brain dysfunction that is beyond his control, you will see why you shouldn't take it personally or blame him for what appears to be deliberate denial.

Countless times following lectures I have given to professional and lay audiences (family members and consumers/patients), someone will come up and tell me that knowledge of the new research has helped to alleviate guilt. Just as often, I am told that this information helps to diminish blame and anger directed toward the mentally ill person who is refusing help. If you are feeling angry and blaming the person you are trying to help (both common and natural feelings), you will be much less effective in what you are trying to accomplish, and your task will be an unhappy adversarial endeavor rather than a positive collaboration.

Just as importantly, however, you will learn why it's so important for you to keep trying. The research indicates that the sooner someone receives medication, the better his prognosis, the less frequently he will be hospitalized, and the shorter his hospital stays will be. It's often difficult to maintain your resolve when you are dealing with someone who wants no part of what you are offering, so knowing just how vital treatment is will help you to persevere.

Once you know the nature of the problem and why you so urgently need to address it, you will be better prepared to understand and implement the new approach to dealing with poor insight and treatment refusal described in the second part of the book. The techniques you will learn—LEAP—are not only informed by the research on insight and medication adherence

you will already have read about, but are also based on the results of recent *placebo controlled studies* and on my own clinical experience working with patients and families and supervising other therapists.

I can't guarantee that LEAP will definitely eliminate medication (and service) refusal in the person you're trying to help, but I can promise that if you faithfully follow the guidelines I give, they will help lower tension, increase trust and greatly increase the likelihood that the person you are trying to help will follow your advice. And if my previous experience and the published research are any indication, chances are very good that you can make a very positive difference.

During the time you are working on the problem, you may face the difficult dilemma of countless other family members and therapists: whether or not to force medication by using the psychiatric commitment laws in your state. Doing this can sometimes be a vital part of the treatment process, but it is most effective when it is done in a way that ultimately strengthens your alliance with the mentally ill person rather than destroying it. The third part of this book focuses on the question of when to "commit or not commit" someone to hospital or outpatient treatment¹ against his or her will. You will learn not only the nuts and bolts of how to seek commitment to the hospital, but also how to cope with the difficult feelings this kind of intervention raises for everyone involved. My main goal is to show you how to deal with the accusations of betrayal you will likely encounter and the guilt you may feel and, most importantly, how to use the commitment itself to build trust and a sense of teamwork with the very person you forced into treatment.

Too often, inpatient treatment is crisis-driven and, hence, short-sighted. You can, however, build upon the trust and

1. Many states now have outpatient commitment laws. In select cases, these laws allow family members and clinicians to seek a court order to medicate mentally ill persons against their will without requiring hospitalization.

gains you have achieved after the person is discharged from the hospital, and I'll be providing you with strategies for doing just that.

Finally, Part IV of the book ties it all together. You learn, in a brief chapter, the theoretical and scientific basis of LEAP, about other forms of psychotherapy that have been found to be effective in lowering symptoms and how the research argues strongly for a revision of how we diagnose schizophrenia, bipolar disorder and related illnesses. In short, I argue that we must assess and document whether the person has awareness of his or her illness so we can design a treatment plan that makes sense (LEAP or Motivational Interviewing rather than asking them to fill a prescription they are certain they do not need).

In the last chapter, I tell you about Henry's death. More accurately, I tell you about his life and his relationships with his girlfriend, friends, caseworker and his younger brother—me. My intention is for you to draw inspiration and motivation from this chapter as LEAP saved our relationship and gave us many years of joy and hope. In this chapter, I hope to share with you something about Henry's remarkable selflessness.

The final section is a concise summary of all the major interventions described in the book. It is quite literally a LEAP "cheat-sheet" in that it will help you to easily remember the essential tools to convince someone in "denial" to accept treatment and services and, more importantly, to accept your friendship and support.

Finally, I encourage all family members to investigate and become involved with one of the family advocacy groups and consumer organizations I list in the Resources section (e.g., NAMI). There are many reasons to do so, not the least of which is to feel less alone and more supported in your quest to better the life of your mentally ill relative. These organizations will also help you to feel less ashamed and embarrassed about having a

mentally ill person in your family. These feelings are unwarranted and will only hinder you in your attempts to help your loved one.

For too many years I was ashamed about my brother, who had schizophrenia. Despite knowing that he suffered from a brain disorder and that I had nothing to feel ashamed about, I avoided such organizations and kept his illness a secret from my colleagues. It was only after talking with people like myself that I was able to stop feeling ashamed. Because of my own experience, I would certainly understand if you don't feel that you are ready to attend any kind of meeting or conference about mental illness. It is ironic and sad that the instinct not to talk about family problems keeps many of us from receiving the support and information we need to solve those problems.

However, you can benefit from such organizations even if you still feel hesitant about getting involved. You don't have to attend a single meeting to learn from their websites or request other literature offered by these groups. I have learned much from these organizations and have found great comfort in knowing not only that there are many other families like mine but also that there are forces at work to change mental health laws, fund research, and improve treatments.

For therapists who read this book, I aim to give you hope that you can reach your patients/clients with serious mental illness who don't think they're ill and refuse your help. Whether you are a mental health professional or a family member, this book will help to dispel the despair that sometimes makes you want to turn your head and look the other way. It will give you renewed hope that you can make a big difference.

3

The Root of the Problem: New Research on Anosognosia (Ã-nõ'sog-nõ'sê-ã)

"This is not surprising, since the brain, the same organ we use to think about ourselves and assess our needs, is the same organ that is affected in schizophrenia and bipolar disorder."

E. Fuller Torrey, commenting on the high prevalence of poor insight in persons with serious mental illness.

(Schizophrenia and Manic Depressive Disorder, 1996, page 27)

Sitting around the table with me were two nurses, a therapy aid, a social worker and a psychiatrist. We were in the middle of our weekly clinical team meeting discussing whether or not we thought Matt was well enough to be discharged from the hospital.

"His symptoms have vastly improved," began Maria, his primary nurse. "The hallucinations have responded to the medication. He's calmer and no longer paranoid."

"Both his mother and father are ready to have him come home again," added Cynthia, Matt's social worker, "and Dr. Remmers has agreed to see him as an outpatient."

"Sounds like we've got all our ducks lined up in a row." Dr. Preston, the team leader, capped the discussion and scribbled a note in Matt's medical chart.

"Only one thing troubles me," Cynthia interjected hesitantly. "I don't think he's going to follow through with the treatment plan. He still doesn't think there's anything wrong with him."

“He’s taking his medication,” I observed.

“For now. But he’s really stubborn and so defensive. I don’t think that will last more than a week or two after he hits the sidewalk.”

I had to agree with Cynthia’s prediction, but I didn’t share her view as to *why* he wouldn’t take his medication on the outside.

“What makes you say he’s defensive?” I couldn’t help asking.

Nearly everyone around the table burst out laughing, thinking I was being facetious. “No, really, I’m serious,” I said.

The resident assigned to the case, Dr. Brian Greene, jumped into the discussion.

“Well, he doesn’t think there’s anything wrong with him. As far as Matt’s concerned, the only reason he’s here is because his mother forced him into it. The man is full of pride and just plain stubborn. Don’t get me wrong—I like him, but I don’t think there’s anything else we can do for him as long as he’s in denial. No one’s going to convince him that he’s sick. He’s just going to have to learn the lesson the hard way. He’ll be back before he knows what hit him.”

Dr. Preston, recognizing that Matt’s discharge was a forgone conclusion, ended the discussion saying, “You’re probably right about that and about the fact that there’s nothing more we can offer him here. When he’s ready to stop denying his problems, we can help. Until then, our hands are tied. Brian, you’re meeting with Matt and his parents at three o’clock to go over the plan. Any questions?” After a moment’s silence, Matt’s medical chart was passed around the table for each of us to sign off on the discharge plan.

.....
“All I need to do is get a job. There’s nothing wrong with me.”

During the first few years of my brother’s illness (before I went to graduate school to become a clinical psychologist), I

often thought he was being immature and stubborn. Asked about what his plans were after being discharged from yet another hospitalization, he ritually answered, “All I need to do is get a job. There’s nothing wrong with me.” His other stock answer was, “I am going to get married.” Both desires were natural and understandable but unrealistic given his recent history, the severity of the illness, and his refusal to accept treatment. Someday, perhaps, he would realize his desires, but it was very unlikely unless he was actively involved in the treatment recommended by his doctors.

It was exasperating to talk to Henry about why he wasn’t taking his medication – having limited experience with the illness, the only reason that I could think of for his adamant refusal was that he was being stubborn, defensive, and, to be frank, a pain in the rear. I was lucky that I thought of my brother only as being stubborn because, like many children of people with serious mental illness, Anna-Lisa often wondered if her mother didn’t love her enough to want to get better. It took her mother’s suicide to educate Anna-Lisa about what was really happening. And, for myself, it was only after I started working in the field, and met many more people with serious mental illness, that I stopped giving such theories much credence. It just never made sense to me that the pervasive unawareness and odd explanations given by people like Matt and my brother could be explained simply as having an immature personality or a lack of love.

But you don’t have to take my word for it. Let’s look at the research for a more objective answer to the question of what causes poor insight and refusal to accept treatment.

Research on the Causes of Poor Insight

I have considered three possible causes of poor insight in the seriously mentally ill. First, it could stem from *defensiveness* – after all, it makes sense that someone who is seriously ill would

be in denial about all the potential and promise for the future that has been taken by the disease.

Or perhaps it's simply the result of *cultural or educational differences between the mentally ill person and the people who are trying to help him*. Differences in subculture and values are often blamed. For example, Anna-Lisa always believed that her mother's poor insight wasn't denial so much as a preference for the interesting and fantastic world her illness provided her—when she was symptomatic, the world was a magical place filled with adventures to be had and mysteries to explore. As a result, Anna-Lisa never wanted to question her mother's delusions, because she feared that by talking about them, she might take them away and somehow cause her mother even more pain.

The third possible cause is that poor insight into the illness stems from *the same brain dysfunction that is responsible for other symptoms of the disorder*. Historically, psychoanalytic theories predominated to explain poor insight in schizophrenia. The literature is rich with case studies suggesting that poor insight stems from defensive denial, but the question had never been tested in controlled studies until recently.

.....
Everyday defensiveness is not responsible for the gross deficits in insight that are so common in these patients.

Two of my doctoral students, Chrysoula Kasapis and Elizabeth Nelson, took different approaches to this question in their thesis research. Dr. Kasapis examined the overall level of defensiveness in the patients she studied, while Dr. Nelson looked at the issue of stigma.

Neither approach to the question found anything of significance. Highly defensive patients were generally no more likely to have poor insight than those with little or no defensiveness. Similarly, how stigmatizing patients perceived their symptoms to

be had little effect on insight into their illnesses. Everyone gets defensive from time to time and some are more prone to denial than others – the same holds true for people with serious mental illness. However, “everyday” defensiveness is not responsible for the gross deficits in insight that are so common in these patients.

Cultural differences between the examiner and patient may also play a role in the mislabeling of someone as having poor insight. In other words, a patient may be well aware of most, if not all, aspects of his mental illness, but his subculture might label it something else. Consequently, he would not use the label “mental illness” to describe himself. He might say instead, “I have a nervous problem,” or, in the case of religious beliefs such as those common to some Caribbean countries, “I am possessed by evil spirits.” The subculture of the afflicted person needs to be considered in any study of insight.

.....
It's ironic, but many patients with poor insight into their own illnesses are excellent at diagnosing the same illness in others!
.....

Related to the issue of cultural influences is the question of patient education. Has the patient ever been told that he or she has an illness? If so, has he or she been taught how to identify and label symptoms of the disorder? In my experience, most patients with poor insight have been told about the illness they have, yet either claim they haven't been told or adamantly disagree, claiming that their knowledge is superior to that of the doctors making the diagnosis. It's ironic, but many patients with poor insight into their own illnesses are excellent at diagnosing the same illness in others!

The answer to the question of whether half of all people with serious mental illness don't know they are ill because they have no information about the illness is actually obvious when you step back for a moment. If you had heartburn that was bad enough

for a friend or relative to convince you to see your family doctor, who then diagnosed the problem as heart disease and explained that the pain was angina, you would stop referring to the pain as heartburn and start calling it angina. You would respond by making an appointment with a cardiologist and canceling your next visit with the gastroenterologist.

Why, then, do so many people with schizophrenia and bipolar disorder fail to do this? Why do they persist in calling their pain “heartburn” despite all evidence to the contrary?

A Concept of Self that is Stranded in Time

In our paper published in 1991, my colleagues and I proposed that poor insight in people with serious mental disorders is a consequence of, to coin a phrase, “a broken brain.” We came to believe that pervasive lack of insight and the accompanying illogical ideas offered to explain being hospitalized stemmed from neurological deficits. At that time, we hadn’t yet considered a neurological hypothesis to explain poor insight in bipolar disorder, but we felt there was good reason to believe that what we were seeing in patients with schizophrenia was a consequence of brain dysfunction rather than stubbornness, defensiveness, or ignorance about mental illness in general. The fact is that the brain circuitry responsible for recording and updating self-concept is not working properly in such patients.

For instance, *my* self-concept includes the following beliefs about my abilities: I can hold down a job; if I went back to school, I would be a competent student; I have the education and experience to be a therapist; and I am generally socially appropriate when I interact with others.

What are some of the beliefs you hold about yourself and your abilities? Do you believe that you can hold down a job? What if I told you that you were wrong, that you were incapable of working and might never find employment unless you swallowed some

pills I had for you? And that you would have to take those pills for a very long time, possibly for the rest of your life?

What would you say to that? Probably the same thing my brother once said to me when I told him he would never hold down a job again unless he took his medication faithfully: “You’re out of your mind!”

You would likely think I was joking, and after I convinced you that I was dead serious, you would come to believe I was crazy. After all, you *know* you can work—it’s an obvious fact to you. And, if I involved other people, including relatives and doctors, you might start to feel persecuted and frightened.

That is *exactly* the experience of many with serious mental illness whom I have interviewed. Their neuropsychological deficits have left their concepts of self—their beliefs about what they can and cannot do—literally stranded in time. They believe they have all the same abilities and the same prospects they enjoyed prior to the onset of their illnesses. That’s why we hear such unrealistic plans for the future from our loved ones.

If a Man Can Mistake his Wife for a Hat...

If you have never talked to someone who has suffered a stroke, brain tumor or head injury, what I have just said might seem difficult to believe. If so, I recommend that you read *The Man Who Mistook His Wife for a Hat*, written by the neurologist Oliver Sacks (also the author of the book upon which the movie “Awakenings” was based). Dr. Sacks has the gift of being able to describe, in vivid detail, the inner life of people who have suffered brain damage.

Writing about the case which gave title to his book, Dr. Sacks described a man who had cancer in the visual parts of his brain and noted that when he first met Dr. P., this music professor couldn’t explain why he’d been referred to the clinic for an evaluation. He appeared normal—there was nothing unusual

about his speech—and he displayed high intelligence. As the neurological evaluation proceeded, however, bizarre perceptions emerged. When asked to put his shoes back on, he delayed—gazing at his foot with intense but misplaced concentration. When Dr. Sacks asked if he could help, Dr. P. declined the offer and continued looking around. Finally, he grabbed his foot and asked, “This is my shoe, no?” When shown where his shoe actually was, he replied, “I thought that was my foot.”

There was nothing at all wrong with Dr. P.’s vision—it was the way his brain was constructing and categorizing his perceptions that was disturbed. Later, when he was sitting with his wife in Dr. Sacks’s office, he thought it was time to leave and reached for his hat. But instead of his hat, he grabbed his wife’s head and tried to lift it off, to put it on. He had apparently mistaken his wife’s head for a hat! When giving talks about poor insight in serious mental disorders, I often like to say, “If brain damage can cause a man to mistake his wife for a hat, it is easy to imagine how it can cause someone to mistake his *past self* for his *current self*.”

In the late 1980s, I worked extensively with neurological patients, administering psychological tests designed to uncover the deficits caused by their brain damage. I couldn’t help noticing the similarities between the neurological syndrome called *anosognosia* (i.e., unawareness of deficits, symptoms, or signs of illness) and poor insight in persons with serious mental illness. Anosognosia bears a striking resemblance to the type of poor insight we have been discussing. This resemblance includes both symptomatic and neurological similarities.

For example, patients with anosognosia will frequently give strange explanations, or what neurologists call *confabulations*, to explain any observations that contradict their beliefs that they are not ill. One 42-year-old man I evaluated had been in a car accident and had suffered a serious head injury that damaged tissue in the right frontal, parietal, and temporal lobes of his brain, leaving

him paralyzed on the left side of his body. When I met with him about a week after the accident, I asked if he could raise his left arm for me, and he answered “yes.” When I asked him to do it, he lay there expressionless, unable to move his paralyzed arm. I pointed out that he had not moved his arm. He disagreed. So I asked him to do it again while looking at his arm. When he saw that he could not move his arm, he became flustered. I asked him why he did not move it, and he refused to answer at first. When I pressed him, he said, “I know this is going to sound crazy, but you must have tied it down or something.”

Anosognosia has been with us for as long as our species has enjoyed the benefits of consciousness. More than 2,000 years ago, L.A. Seneca, writing on the moral implications of self-beliefs, described what appears to be a case of anosognosia following hemianopia (blindness caused by brain damage): “*Incredible as it might appear...She does not know that she is blind. Therefore, again and again, she asks her guardian to take her elsewhere. She claims that my home is dark.*” How could someone not realize she was blind? And why, when faced with the evidence, would she seek to explain away the blindness?

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*When one's conception of who one is gets stranded in time,
 one can't help ignoring or explaining away
 any evidence that contradicts it.*

The man who had been paralyzed in the car accident could not understand that he could no longer move the left side of his body. It didn't fit with what he believed about himself (that his arm and leg worked fine), so he couldn't help trying to explain away any evidence to the contrary. He was just like the blind woman who did not understand that she was blind, and more easily believed an alternative explanation than the truth (e.g., the house was dark). Every day, someone with a serious mental illness utters similar

explanations to buttress his belief that there is nothing wrong with him. When one's conception of who one is gets stranded in time, cut off from important new information, one can't help ignoring or explaining away any evidence that contradicts it. As a result, many chronically mentally ill persons attribute their hospitalizations to fights with parents, misunderstandings, etc. Like neurological patients with anosognosia, they appear rigid in their unawareness, unable to integrate new information that is contrary to their erroneous beliefs.

One final similarity between neurological patients with anosognosia and the seriously mentally ill involves the patch-like pattern of poor insight. Pockets of unawareness and awareness often coexist side by side. For example, the anosognosia patient may be aware of a memory deficit but unaware of paralysis. Similarly, we have seen many patients with schizophrenia who are aware of particular symptoms while remaining completely unaware of others.

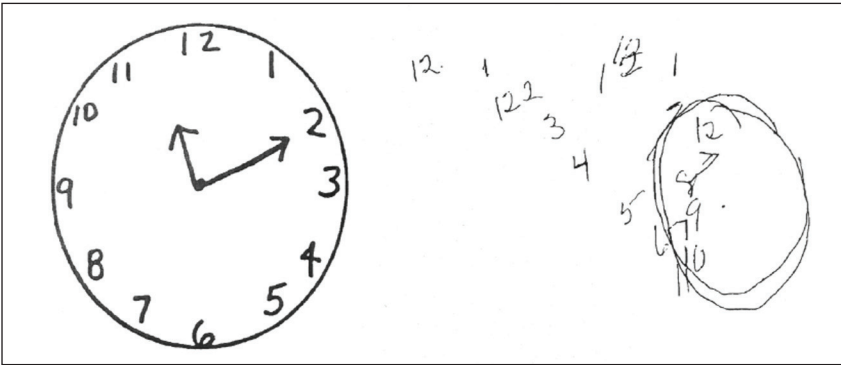
Damage to particular brain areas can result in anosognosia. Studies of anosognosia, therefore, provide a practical starting point for hypothesizing about the brain structures responsible for insight in persons with serious mental disorders. Neurological patients with anosognosia are frequently found to have lesions (i.e., damage of one kind or another) to the frontal lobes of their brains. Interestingly, research has shown that these same areas of the brain are often dysfunctional in people with serious mental illness.

In one study of neurological patients at Hillside Hospital in Queens, New York, conducted in collaboration with Dr. William Barr and Dr. Alexandra Economou, I compared patterns of unawareness in three groups of patients suffering damage to three different regions of the brain. This study was funded by the Stanley Foundation and had as one of its goals identifying the brain dysfunction most likely to produce awareness deficits. As

expected, patients with frontal lesions were more likely to show problems with insight into their illnesses than patients with left posterior damage. Let's look at an example.

George, a 71-year-old man who had suffered a stroke, was asked to draw the clock on the left side of the figure that appears below. Before drawing the clock, he was asked, "Do you think you will have any difficulty copying of this picture?"

George was instructed to use the following 4-point scale to answer the question: 0 = no difficulty, 1 = some difficulty, 2 = much difficulty, and 3 = cannot do. He answered "0" and said he would have no difficulty. The right side of the figure shows the drawing he made after exerting great effort.



More striking than his inability to recognize that the stroke had left him unable to perform such a simple task was what happened next. When asked if he'd had any difficulty drawing the clock, he answered, "No, not at all." Further questioning revealed that he could not see or comprehend the differences between his clock and ours.

When it was pointed out to him that his numbers drifted past the circle, he became flustered and said, "Wait, that can't be my drawing. What happened to the one I drew? You switched it on me!" This is an example of a *confabulation*. Confabulations are the product of a brain "reflex" that fills in gaps in our

understanding and memory of the world around us. Almost everyone confabulates a little—you’ve heard people stop in the middle of recounting something that happened to them and say something like, “Wait, I was lying. I don’t know why I said that. It didn’t happen that way!” This is an example of an instance when someone realizes he has confabulated and corrects himself.

Confabulations are “constructed” memories and/or experiences that are especially common in people with brain dysfunction. However, in such individuals, we don’t usually observe self-correction, because they don’t understand the need for correction. George wasn’t lying when he said I had switched the drawing on him. It was the only thing that made any sense to him, so for a moment, he believed that was what had happened.

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*He was operating under beliefs that were linked
to his past self rather than his current self.*

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In his book *The Principles of Psychology*, William James wrote: “Whilst part of what we perceive comes through our senses from the object before us, another part (and it may be the larger part) always comes from our own mind.”

There are few better examples of James’s insight than the one I have just given you. George “saw” his drawing using his sense of vision. But his perception of the clock—the image of the drawing that was processed in his brain—was something altogether different from what his eyes saw. George had a concept of himself, a *self-schema*, that included the belief that he could easily copy a simple drawing of a clock. You have the same belief as part of your self-schema. You might not consider yourself artistically endowed, but you believe that you could produce a reasonable facsimile of the drawing if asked to. In a sense, this belief was stranded in George’s brain, disconnected from his visual senses and left unmodified by the stroke he had

suffered. He was operating under beliefs that were linked to his *past self* rather than his *current self*. He *saw* the numbers drifting outside his lopsided circle, but he *perceived* the numbers to be in their proper place inside a symmetrical circle. Our brains are built to order, and even help construct, our perceptions.

Here is a simple example of what I am talking about. Answer this question: What letter appears in the box you see to the right?



If you answered “E” you saw what the majority of people who are given this task see. But in reality, you did not *see* the letter E. What you saw is a line with two right angles (a box-like version of the letter “C”) and a short line that is unconnected to the longer one. You likely answered “E” because you *perceived* the letter E. The visual processing and memory circuits of your brain “closed the gap” between the lines so you could answer the question.

To prove that poor insight in serious mental disorders is neurologically based, however, my colleagues and I needed more than observed similarities with neurological patients. We needed testable hypotheses and data that were confirmatory. Knowing that patients with schizophrenia frequently show poor performance on neuropsychological tests of frontal lobe function, we hypothesized that there should be a strong correlation between various aspects of unawareness of illness and performance on those tests.

Dr. Donald Young and his colleagues in Toronto, Canada, quickly tested and confirmed our hypothesis. They studied patients with schizophrenia to examine whether performance on neuropsychological tests of frontal lobe function predicted the level of insight into illness, and the result showed a strong association between the two. Of particular note is the fact that this correlation was independent of other cognitive functions they tested, including overall IQ. In other words, poor insight

was related to dysfunction of the frontal lobes of the brain rather than to a more generalized problem with intellectual functioning. Taken together, these results strongly support the idea that poor insight into illness and resulting treatment refusal stem from a mental defect rather than informed choice.

But just as one swallow does not make a summer, one research finding does not make an indisputable fact. The next step in determining more definitively whether poor insight into illness is a consequence of frontal lobe dysfunction is to replicate the findings of Young and his colleagues in a new group of patients.

As it turns out, the finding that poorer insight is highly correlated with frontal lobe dysfunction has been replicated many times by various research groups (see table below). The list of replications I give here will undoubtedly be added to by the time you read these words, as I am aware of yet unpublished results that also confirm the hypothesis.

Repeated replications by independent researchers are infrequent in psychiatric research, so the fact that various researchers have found essentially the same thing as Young and his colleagues speaks to the strength of the relationship between insight and the frontal lobes of the brain. A few studies have not found this relationship, but in those cases methodological flaws in the design of the research are likely the reason.

Executive (frontal) dysfunction and poor insight

- Young et al. *Schizophrenia Research*, 1993
- Lysaker et al. *Psychiatry*, 1994
- Kasapis et al. *Schizophrenia Research*, 1996
- McEvoy et al. *Schizophrenia Bulletin*, 1996
- Voruganti et al. *Canadian Journal of Psychiatry*, 1997
- Lysaker et al. *Acta Psychiatr Scand*, 1998

- Young et al. *Journal of Nervous and Mental Disease*, 1998
- Bell et al. Chapter in: *Insight & Psychosis*, Amador & David, Eds. 1998
- Morgan et al. *Schizophrenia Research*, 1999a & 1999b
- Smith et al. *Journal of Nervous and Mental Disease*, 1999
- Smith et al. *Schizophrenia Bulletin*, 2000
- Laroi et al. *Psychiatry Research*, 2000
- Bucklet et al. *Comprehensive Psychiatry*, 2001
- Lysaker et al. *Schizophrenia Research*, 2003
- Drake et al. *Schizophrenia Research*, 2003
- Morgan and David (review) in *Insight and Psychosis*, 2nd Edition (Oxford University Press, 2004)

There is also an emerging body of literature linking poor insight in schizophrenia and other psychotic illnesses to functional and structural abnormalities in the brain, usually involving the frontal lobes. A review of these brain-imaging studies (e.g., using MRI, CT and PET scans) can be found in *Insight and Psychosis*, Amador XF and David AS (Editors), Oxford University Press, 2005.

The research discussed above, and other newer studies that link poor insight to structural brain abnormalities, lead us to only one conclusion. In most patients with schizophrenia and related psychotic disorders, deficits in insight and resulting non-adherence to treatment stem from a broken brain rather than stubbornness or denial.

If you are dealing with a mental health professional who is holding on to the outdated idea that severe and persistent problems with insight are a consequence of “denial” (i.e., a coping mechanism), ask him or her to look at the “Schizophrenia and Related Disorders” section of the *DSM-IV-TR*, page 304:

Associated Features and Disorders

“A majority of individuals with Schizophrenia have poor insight regarding the fact that they have a psychotic illness. Evidence suggests that poor insight is a manifestation of the illness itself rather than a coping strategy... comparable to the lack of awareness of neurological deficits seen in stroke, termed anosognosia.”

Now, if the person you are trying to educate is extremely resistant and also a careful reader, he or she may say something like, “Yes, but I also see that Dr. Amador was the co-chair of this section of the *DSM*, so he just wrote what he already believes. It doesn’t prove anything!” If that happens, have the person read the introduction to the last revision. He will learn that every sentence in this version of the *DSM* had to be *peer-reviewed* before it was added. Peer review in this context involved other experts in the field receiving the proposed text along with all the research articles that supported the changes my co-chair and I wanted to make. *All changes had to be supported by reliable and valid research findings.* So, although the field has been slow to give up outdated theories about poor insight in these disorders (thinking it’s denial rather than anosognosia), we are making progress.

New Research on Anosognosia

I have been invited to guest-edit a special edition of the National Institute of Mental Health’s journal *Schizophrenia Bulletin* focused on “Poor Insight in Schizophrenia.” This special issue is slated to appear in late 2011. I thought it would be helpful to readers of this book to provide a brief summary of some of the most recent research implicating brain dysfunction as the root cause of unawareness of illness. Below is a brief table listing some of those studies.

Authors	Year	Journal	Results
Young et al.	1998	<i>The journal of nervous and mental disease</i> , 186(1), 44-50.	Lack of illness awareness is related to defective frontal lobe functioning as indexed by neuropsychological measures.
Laroi et al.	2000	<i>Psychiatry Research</i> , 2000 Nov 20; 100(1):49-58	Deficits in the Wisconsin Card Sorting test which is a measure of executive, or frontal lobe functioning were significantly correlated with poorer insight into illness.
Keshavan et al.	2004	<i>Schizophrenia Research</i> , 70, 187-194.	Deficits in insight may be related to a generalized dysfunction of neural networks involved in memory, learning, and executive functions.
Aleman et al.	2006	<i>British Journal of Psychiatry</i> , 189, 204-212.	Neuropsychological dysfunction, specifically impairment of set shifting and error monitoring, contributes to poor insight in psychosis.
Pia & Tamietto	2006	<i>European Archives of psychiatry and clinical neuroscience</i> , 60(5), 31-37.	Lack of insight in schizophrenia may occur as a neurological disease per se following brain damage that seems related to frontal lobe areas.
Shad et al.	2006	<i>Schizophrenia Research</i> , 86, 54-70.	Lack of insight is correlated to lower scores on neuropsychological measures that assess executive functions such as The Wisconsin Card Sorting Test (WCST).
Sartory et al.	2009	<i>Schizophrenia Bulletin</i> , 35 suppl.1, 286.	Lack of insight correlated with verbal recognition performance Lack of awareness is best accounted for by poor verbal recognition performance.

Anosognosia versus Denial

Often I am asked the question: “How can I know whether I am dealing with anosognosia versus denial?” There are three main things you should look for:

1. The lack of insight is severe and persistent (it lasts for months or years).
2. The beliefs (“I am not sick,” “I don’t have any symptoms,” etc.) are fixed and do not change even after the person is confronted with overwhelming evidence that they are wrong.
3. Illogical explanations, or confabulations, that attempt to explain away the evidence of illness are common.

Ideally, you would also want to know if neuropsychological testing revealed executive dysfunction. But regardless of whether the problem is neurologically based or stems from defensiveness, or both, the most important question is: How can you help this person to accept treatment? That is the focus of the rest of this book. Remember, the cause of the severe and persistent “denial” may be less important than how you choose to deal with it.

One last thing. Many people despair that they will never be able to help their loved ones if the denial is, in fact, a symptom of their illnesses. You may be feeling that way right now. The rest of this chapter is for you.

A Broken Brain Is Easier to “Fix”

The bottom line to all of this research is that, more likely than not, a broken brain is creating barriers to insight and acceptance of treatment in the mentally ill person you’re trying to help. But that is no reason to despair. There are two immediate ways in which you can use this knowledge to benefit your loved one and yourself.

First, when faced with the frustration of trying to convince him or her to get help, remember *the enemy is brain dysfunction*, not

the person. This shift in your thinking can go a long way toward lowering your level of frustration, increasing your effectiveness, and building a collaborative relationship with the person you are trying to help. Secondly, this knowledge can be used to rekindle hope that you will be able to help your loved one accept the help that's being offered.

Hope? As I said before, if you're like most people, reading the results of the research I reviewed above may have left you feeling more pessimistic (or confused) than optimistic. After all, brain damage is irreparable, isn't it? If poor insight is another symptom of brain dysfunction, then what is there to hope for?

A common myth is that personality traits like stubbornness or defensiveness are far easier to fix than deficits caused by brain damage. In fact, however, it is far more difficult to change a person's personality than to teach him how to compensate for some forms of brain dysfunction. So, although the notion that brain dysfunction can cause poor insight may at first lead you to feel powerless, it is actually grounds for renewed hope.

Rehabilitation is possible following many types of brain damage, 1) because some brain cells can be repaired and 2) more often, because functions can be re-routed to other, undamaged parts of the brain. In such cases, doctors carefully assess the deficits caused by the lesions and create a plan to compensate for the loss of ability. This is the usual practice following strokes, brain tumors, head injuries, and other causes of central nervous system damage. In fact, rehabilitation specialists are trained specifically for this task, which is frequently referred to as *cognitive remediation*.

This approach is highly relevant to the task of helping the seriously mentally ill individual develop awareness of his or her illness and the new skills needed to become willing and active participants in treatment. In the chapters that follow, you will learn how to evaluate the nature and severity of the awareness

deficits your loved one has, and to devise a plan for helping him compensate for these deficits. With this method, you can help him develop the kind of insight he needs to cope effectively with the illness and accept treatment. The good news is that accomplishing this can be much easier than you might think.

Part II

How to Help Using LEAP

*"You can't always get what you want.
But if you try sometime,
you just might find,
you get what you need!"*

Mick Jagger and Keith Richards
The Rolling Stones, *Let it Bleed*, 1969

4

The Right and Wrong Approach

“Tell me one last thing,” said Harry. “Is this real? Or has this been happening in my head?”
Dumbledore beamed at him...“Of course it is happening in your head, Harry, but why on earth should that mean it is not real?”

J.K. Rowling, *Harry Potter and the Deathly Hallows*, 2007, page 723

Dr. Karen Holloway sighed and said, “Michael’s back,” as she walked toward where I was sitting in the nurse’s station. “I need you to go to the E.R. and do his admission,” she added.

“Michael Kass?” I asked, incredulous.

“Afraid so,” Karen replied, a bit amused by my surprise. “Get used to it, Xavier. Some patients are stuck in the revolving door, and Michael’s one of them.”

This was 1988 and Karen was the chief resident at the hospital in New York City where I was an intern. To this day, she remains one of the more compassionate, bright and level-headed clinicians with whom I have ever had the pleasure of working. The diagnosis of “Revolving Door Patient” was not one she made lightly or without compassion.

Michael Kass had been discharged from the hospital only six weeks earlier after a one-month hospitalization. When he left, he was no longer hearing voices. His delusions still lingered, but he felt little pressure to talk about them, and he was scheduled to receive follow-up treatment in one of our outpatient clinics.

Judging by Karen's comment, I guess I hadn't hidden my disappointment and surprise that he was back so soon. I took the stairs two at a time, eight floors down, to the Emergency Room—no use waiting for the overburdened elevators—and walked to the door labeled "Psych ER." Behind this door, sequestered from the rest of the ER service, was a suite of five rooms with four patient bays to the left and the nurses' station to the right. As I entered, I took a quick right and ducked into the nurses' station—I didn't want Michael to know I was there until I'd had a chance to talk to the triage nurse. The report I got was frustrating to hear.

After leaving the hospital, Michael had gone home to live with his parents but had not shown up for his first outpatient appointment. His parents, in their late sixties, hadn't known that Michael hadn't gone to see his doctor. They'd asked about his appointment, but he hadn't wanted to talk about it. They'd called the clinic, but no one would tell them whether or not their 35-year-old son had kept his doctor's appointment. They also hadn't known that after the one-week supply of medications he'd been given when leaving the hospital had run out, he'd never had the prescription refilled.

I spent about twenty minutes looking at his old chart, which the triage nurse had ordered up from medical records. Then I stepped out of the nurses' station and greeted my new-old patient.

"Hi, Michael, how are you?"

"Dr. Amadorafloor! What are *you* doing here?" he answered, *clanging*⁶, laughing, and talking a mile a minute. "You've got to get me out of here! I was minding my own business—I wasn't hurting anyone—and the police got it all wrong. Get me out of here, okay? You've got to get me out because..."

I tried to interrupt. "Michael, Michael, hold on, wait up a minute!"

6. A feature of thought disorder, a frequent symptom of psychosis, that involves word associations based on rhyme.

"I'm not supposed to be here. They'll find me here if I stay. Gotta go, gotta get out, okay?"

"Michael, try to slow down and tell me what happened. Okay?"

"I'm telling you what happened. I'm not supposed to be here," he shot back, clearly annoyed with me.

It took almost an hour to get through the checklist I was trained to use. I completed a *mental status exam*⁷, evaluated his current symptoms, and listened to his version of what had happened and why he was in the Psych ER. Excusing myself while he was again pleading with me to get him out, I escaped to the nurses' station once again, to write down what I had learned.

Michael was once again hearing the voices of government agents who were commenting on his every move. While we were talking, I asked him what the voices were saying and he repeated, "He is sitting on the bed, talking with that doctor. He can't escape us now." Given the voices he was hearing, it isn't surprising he'd developed the delusion that some secret federal agency was monitoring his movements and planning to assassinate him.

I noted in his chart the re-emergence of the hallucinations and exacerbation of the longstanding delusion about government agents persecuting him. I also noted that he was not currently suicidal or homicidal, that his "insight into illness" was poor, and a number of other observations I had made while interviewing him. My written recommendation was to restart the antipsychotic medication he'd been on when he was discharged six weeks before and to admit him to our inpatient psychiatric unit "for stabilization." Then I went back to see Michael, told him my recommendation, and asked him to sign himself into the hospital for a couple of weeks.

7. A cornerstone of psychiatric assessment, the mental status exam involves an assessment of the clarity of consciousness, memory, attention, emotion, thought process, insight into illness, and various symptoms of mental illness.

He refused, saying, “The only thing wrong with me is that I’m going to get killed if I stay here any longer!”

Since he had been found hiding in a subway train tunnel and had struggled with the police when they extracted him, I thought we had a fairly good case for an involuntary admission. When he was found, he hadn’t eaten or bathed in several days and he had made camp dangerously close to an active track, explaining to police that “they [the federal agents] would never think to look for me here.” I called Dr. Holloway – she agreed, and the appropriate papers were signed to admit him against his will for 72 hours. If he didn’t want to stay after the 72 hours, and if at that time we felt he was still a danger to himself because of his mental illness, we would take him before a mental health court and try to get a judge to order thirty days of involuntary treatment.

When I explained the plan to Michael, he understandably went ballistic. He was terribly frightened and felt certain that he would be killed if he stayed in the hospital. However, after accepting medication by injection, he calmed down considerably and was moved upstairs to the psychiatric ward.

Unless something was done to engage Michael in treatment, this hospitalization would be nothing more than a band-aid.

Though we had resolved the current crisis, unless something was done to engage Michael in treatment, this hospitalization would be nothing more than a band-aid. He would be “stabilized” and discharged with prescriptions he would never fill and an appointment he would never keep because, as he put it, “I am not sick! I don’t need medicine – I need protection from the feds!”

The Wrong Approach

I was using the medical model with Michael, which, in most cases, is the wrong approach to take for dealing with the long-term

issue of poor insight and refusal to take medicine. The medical model is supposed to work, more or less, in the following way: Once the diagnosis and treatment are decided upon, the patient is informed of both. If the patient refuses, and if he fits the legal criteria for an involuntary admission to a hospital, the doctors take charge. In some cases, medical doctors operating under a benevolent paternal ethic are able to order treatment against a person's wishes. Like a parent who knows what's best for her child, the physician can take control by admitting the person and treating him against his will. We abide by similar, though less dramatic laws every day (e.g., laws that require seatbelts; mandatory rabies inoculation of pets; motorcycle helmets; those that prohibit drunk driving, etc.).

My next task, under this model, was to educate Michael about his illness and the need for treatment. If you are reading this book, you know that when it comes to individuals like Michael, education about their illness does not translate into their gaining insight. And, indeed, that is what happened over the two-week period Michael was in the hospital.

I told him all about delusions and hallucinations and confronted him about his "denial" of the illness. I explained to him the nature of the problems he had and why he should accept the treatment being offered. As during his previous hospitalization, once he became more stable, he readily agreed that he would take the medication when he left the hospital. When I told him I thought he was just saying that so he could get out of the hospital, he sometimes sheepishly admitted to the lie and told me there was nothing wrong with him except the fact that people wouldn't leave him alone. But most often he would stick to the party line and say, "I know the medication helps me and that I need to take it." Ironically, as some of his symptoms responded to the medication, he got better at consistently feigning allegiance to the doctor's orders.

For people with serious mental illness who are unaware of their illness, this traditional approach rarely works. It rests on the mistaken assumption that the patient has come to see the doctor because he feels he has a problem and wants help. It assumes a collaborative approach from the start—the doctor as an ally, not an adversary.

Although the details might differ, Michael’s story of hospitalization, followed by outpatient noncompliance, worsening illness and readmission to the hospital, is all too typical. So was my inadequate response to the bigger problem of what would happen to him when we were done with him (again). I was operating under a medical model that focused on the tasks of diagnosis and treatment. This is the wrong approach when dealing with someone who has, for many years, consistently argued that there is nothing wrong with him and doesn’t need help. It’s not a bad approach for the short term, but it’s mostly worthless over the long term because the “patient” doesn’t see himself as a patient.

.....
If you can imagine something like this happening to you, then you have some idea of what it is like for someone with a mental illness to have a delusion and anosognosia.

An analogy might be useful to help you understand why this is so. Imagine I told you that that you did not live where you live. You might laugh and tell me to stop joking around. But what if I produced a restraining order from a court that ordered you to stay away from what you told me was your home address?

Taking it further, let’s say you live with other people, perhaps members of your family, and you saw that they had signed off on this court order. What would you think? Then, imagine that you then called them to ask why they’d signed off and they said something like, “You seem like a nice person, but if you keep

coming around here we are going to call the police. You don't live here, and we don't want to press charges, but we will if you put us in that position. Please stop calling us. You need help!"

If you can imagine something like this happening to you, then you have some idea of what it is like for someone with a mental illness to have a delusion and anosognosia.

Stay with the analogy and imagine you went home only to be arrested by the police. The nice people at your address did not want to press charges, so the police took you to the ER. Would you be receptive to my advice that you should take psychiatric drugs for your "delusion" that you live where you *know* you live? I doubt it. I have done this role play countless times and the answer is always "No!" When I ask why, my role-play partner usually laughs and says, "Because it's the truth. I know who I am and where I live!"

That's what it's like for a person with a serious mental illness to have a delusion *and* anosognosia. The medical model will not win this person's trust or cooperation. Like you or me in this situation, once the person is out of the hospital and on his own, he will not take medicine. If you can see the situation from that person's perspective, it makes sense, doesn't it?

The Right Approach

In my experience, it is often easy to change an adversarial relationship into an alliance and long term engagement in treatment. It takes focused effort, but it isn't hard to do once you learn the main lessons. The hardest part is putting aside your preconceptions and remembering that no amount of arguing has previously changed your loved one's opinion.

My best advice to you is to stop trying to convince him he is ill. When you accept your powerlessness to convince him you know the answer to the penultimate question (is he, or is he not mentally ill), you will begin to open doors you didn't even know

existed. Remember, if you had truly succeeded in convincing your loved one he has a mental illness, you would not be reading this book. The first step, therefore, is to stop arguing and start listening to your loved one in a way that leaves him feeling that his point of view – including his delusional ideas and the belief that he is not sick – is being respected.

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.....

Professor Dumbledore’s answer to Harry Potter’s question, quoted at the start of this chapter, is exactly right. For all intents and purposes, your loved one’s experience is very real indeed. To him, he is truly *not* sick.

If you can relate to your loved one in this way, you will be much closer to becoming his ally and working together to find the reasons *he* may have to accept treatment – even though he is not sick. You don’t have to agree with his reality – the “realness” of his experience – but you *do* need to listen and *genuinely* respect it.

My colleagues and I have helped many patients accept treatment for a wide range of problems they feel have nothing to do with mental illness: e.g., to relieve the stress caused by the conspiracy against them; to help them sleep; to get their families “off their back”; to lower the volume on the voices being transmitted by the CIA, etc.

Even so, I don’t expect you to immediately embrace this idea. Most people find it counter-intuitive and even a little scary. Others like the concept of stepping back from the debate about whether or not the person is ill but are not sure about how it is going to help. Let me start addressing these concerns by describing my approach and the science behind it.

Motivational Enhancement Therapy and LEAP

Anyone who has dealt with denial in a loved one knows that it can't be fixed simply by educating the person about the problem he doesn't believe he has. Such attempts are futile because the "patient" doesn't see himself as a patient. And, research shows that confrontation and group "interventions" rarely work. In fact, contrary to what most people believe, "interventions" often do more harm than good!

So what *does* work? Motivational Enhancement Therapy (MET) is a science-proven method that helps people in denial accept treatment. It was first developed more than 20 years ago for professionals like me who were working with substance- and alcohol-abusing patients. Unfortunately, despite its proven effectiveness for engaging people with substance abuse problems in treatment, few therapists are trained to use it with patients who have serious mental illnesses. This needs to change, as there is plenty of research to support using MET with such individuals.

In 2002, the *American Journal of Psychiatry* published a review by Dr. Annette Zygmont and her colleagues of studies published over a 20-year period aimed at improving medication adherence in schizophrenia. The researchers found that "... although interventions and family therapy programs relying on psychoeducation were common in clinical practice, *they were typically ineffective* [with respect to improving adherence to treatment]...*Motivational techniques* [on the other hand] were common features of *successful programs*." By "motivational techniques," the authors meant the main elements of MET.

.....
*I realized almost immediately that the specific
communication skills and strategies we were teaching
therapists could be learned by anyone.*
.....

Relying on the same evidence base reviewed by Dr. Zygmunt and her colleagues, Dr. Aaron T. Beck (considered by many to be the “father” of cognitive psychology) and I developed a form of MET we called “Medication and Insight Therapy” (MAIT) for an inpatient research study to be used with people who have serious mental illness.

At the time (mid-1990s), we taught this method only to therapists. But I realized almost immediately that anyone could learn the specific communication skills and strategies we were teaching. I felt it was more a communication style than a complicated therapeutic intervention and came to believe that you don’t need an M.D., M.S.W., or Ph.D. to use the main elements of this therapy effectively. Consequently, I developed a lay-friendly version that can be taught to family members, individuals in law enforcement and mental health professionals alike.

Listen-Empathize-Agree-Partner (LEAP) method

The result was the Listen-Empathize-Agree-Partner (LEAP) method. Over the past ten years, since the publication of the first edition of this book, I have taught LEAP to thousands of people across the country and overseas. Although the focus of my LEAP workshops was to show family members and health providers how to convince someone with serious mental illness to accept treatment, people at every seminar have commented on the usefulness of this method across a range of problems. That has been my experience as well.

So whether or not you believe your loved one has anosognosia for mental illness, or simple denial of illness, LEAP can help.

5

Learning to LEAP

When I was five years old I wanted to be Batman. It's true that Superman, Spiderman and the Hulk were also appealing, but for me they were all a distant second to the "caped crusader." It wasn't his mask and ears, which I remember thinking looked goofy—it was that amazing "Bat Utility Belt." I had to have a Batman costume for Halloween—nothing else would do—and I still remember how I felt when I strapped on that belt for the first time. I had the power to do good—I could conquer all evil, set things right and live to tell the tale.

The best thing about Batman was that he was a regular person. He did not have superpowers—it was his tool belt that set him apart. There were many high tech tools in his belt, but my favorite was the grappling hook, attached to a dental-floss-thin rope, that he used to walk up the sides of buildings. With those tools, there was no wall he could not climb, no obstacle he could not overcome. There was no enemy he could not defeat.

I want you to imagine that you, too, have a tool belt. It can be made of any material you like, stylish (Dolce and Gabbana) or purely functional (Craftsman). Imagine it is full on the left side with all the tools we use when relying on the medical and psychoeducational approaches (e.g., making a diagnosis, educating the person about his diagnosis, giving him his prognosis and prescriptions for treatment, reality testing about delusions, etc.). These tools are highly effective when we are dealing with persons who have insight and want our help—ideal for persons who identify themselves as patients or consumers.

Now, I want you to imagine that your tool belt is empty on the right side. Loops, hooks, and pockets all lay open and ready to

receive the tools you will need to help someone accept treatment even though he does not believe he is ill. I'm going to provide you with the tools to fill that side of your belt. They will serve you well, but you'll have to practice using them.

The first and most important tool you will put in your belt is the focus of next chapter – the *Reflective Listening Tool*. But you will also learn how not to “buy into delusions” while listening without judgment and how to *delay giving your opinion* when asked potentially deal-breaker questions like, “So, do you think I'm sick and should take this medicine?” I will also explain all the reasons you should delay answering such questions and how to choose the right time to give your opinion, and provide a tool for *giving your opinion* in a manner that allows your loved one to save face, retain dignity, not feel betrayed and most importantly, *stay in the conversation and not walk away*.

.....
*To make all this happen you have to put your goal of convincing
 your loved one he is sick high up on a shelf,
 at least for the time being.*

I think you will find that LEAP's effectiveness for dealing with someone in denial or with anosognosia is immediately intuitive. Once you learn the basic principles, it simply makes sense that it will work far better than what you've been doing all along. The core tools are *Listening* (using “reflective” listening), *Empathizing* (strategically – especially about those feelings you've ignored during your previous arguments about your loved one's being sick and needing treatment), *Agreeing* (on those things you can agree on and agreeing to disagree about the others), and ultimately *Partnering* (forming a partnership to achieve the goals you share).

More often than not, the first aim of LEAP is to repair the damage done to the relationship by your (or other's) previously

adhering to the medical model and taking the “doctor knows best approach.” The second task is to help your loved one find *his own reasons* to accept treatment. To make all this happen you have to put your goal of convincing your loved one he is sick high up on a shelf, at least for the time being.

.....
Listen with only one goal: to understand the other person's point of view and reflect your understanding back to him
.....

The cornerstone of LEAP is reflective listening. It is also the one feature of the method that immediately turns down the volume on everyone's anger, builds trust, and mends fences. The reason is that you listen with only one goal: to understand the other person's point of view and reflect your understanding back to him. You don't comment on what he said, point out ways in which you think he's wrong, judge, or react in any way. (Sounds easy until the person starts talking about the fact that there's absolutely nothing wrong and he doesn't need treatment!)

Listen

Reflective listening is a skill that needs to be cultivated—it doesn't come naturally to most people. To succeed, you will need to learn to *really* listen and not react to what your loved one feels, wants, and believes. Then, after you think you understand what you are told, you need to reflect to him or her, in your own words, your understanding of what you just heard.

The trick is to do this without commenting, disagreeing, or arguing. If you succeed, your loved one's resistance to talking with you about treatment will lessen and you will begin to gain a clear idea of *his* experience of the illness and the treatment he doesn't want. When you know how your loved one experiences the idea of having a mental illness and taking psychiatric drugs, you will have a foothold you can use to start moving forward.

But you will also need to know what his hopes and expectations are for the future, *whether or not you believe they're realistic*. If you can reflect back an accurate understanding of these experiences, hopes, and expectations, your loved one is going to be much more open to talking with you. More importantly, he is going to be much more open to hearing what you have to say.

Empathize

The second tool for your tool belt involves learning *when* and *how* to express empathy. If there were a moral to each technique, the one for empathizing would go something like this: *If you want someone to seriously consider your point of view, be certain he feels you have seriously considered his. Quid pro quo*. That means you must empathize with all the reasons he has for not wanting to accept treatment, even those you think are “crazy.” And you especially want to empathize with any feelings connected to delusions (such as fear, anger, or even elation, if the delusion is grandiose). But don't worry – empathizing with how a particular delusion makes one feel is *not* the same as agreeing that the belief is true. This may seem like a minor point, but, as you will learn, the right kind of empathy will make a tremendous difference in how receptive your loved one is to *your* concerns and opinions.

Agree

Find common ground and stake it out. Knowing that what *you want* for your loved one is something *he does not want* for himself can make it seem as if there is no common ground. You want him to admit he's sick and accept treatment. He doesn't think he's sick, so why in the world would he take medicine for an illness he doesn't have? To avoid coming to an impasse, you need to look closer for common ground and for whatever motivation the other person has to change. Common ground always exists, even between the most extreme opposing positions.

.....
*You will now be able to present the idea that
medication might help him to achieve his goals.*
.....

The emphasis here is on acknowledging that your loved one has personal choice and responsibility for the decisions he makes about his life. When you use the *Agreement tool*, you become a neutral observer, pointing out the various things you *do* agree upon. If invited, you can also point out the positive and negative consequences of decisions your loved one has made. That means refraining from saying things like, “See, if you had taken your medication, you wouldn’t have ended up in the hospital.” Your focus is on *making observations together* – identifying facts upon which you can ultimately agree. Rather than making an observation or statement about what happened, you ask a lot of questions, such as, “So what happened after you decided to stop taking your medication?” “Did the voices quiet down after you stopped?” “After you stopped taking the medication, how long was it before you went to the hospital?”

If you have been using reflective listening and empathy, your loved one is going to feel that you are an ally rather than an adversary, and getting answers to such questions will be a lot easier than it may sound. When you put aside *your* agenda for the time being, you can find a great deal of common ground. For example, if the answer to the question about what happened after the medicine was stopped was, “I had more energy but also I couldn’t sleep and got scared,” you can agree with that observation without linking it to having a mental illness.

At this point in the process you will know the motivations your loved one has to accept treatment (e.g., “sleep better,” “feel less scared,” “get a job,” “stay out of the hospital,” “stop people from bothering me about being ill,” etc.) that may have nothing to do with the belief he or she has a mental illness. You will know

what his short and long term goals are because you will have talked about them together. And, with this knowledge, you will now be able to present the idea that medication might help him to achieve *his* goals. I can't emphasize this enough—*your suggestions should have nothing to do with the notion that your loved one has a mental illness.*

Partner

Forming a partnership to achieve *shared* goals is the last and, in my experience, the most satisfying tool you will use. Once you know the areas where you can agree (e.g., staying out of the hospital, getting a job, going back to school, getting an apartment, etc.), you can now collaborate on accomplishing those goals. Unlike the previous techniques, this one involves both of you making an explicit decision to work together, to become teammates striving for the same goal. *You* may call the prize “recovery from illness,” while your loved one calls it “getting a job,” but the names are irrelevant to arriving at a shared plan of action that will, more often than not, involve accepting treatment and services.

6

Listen

In my LEAP seminars, I always ask, “Why would anyone want to listen to you if he felt you had not first listened to him? Quid pro quo.”

This important psychological principle—which is the cornerstone of my method for breaking an impasse—is far from new. More than 2,000 years ago, the Roman poet Publilius Syrus said, “We are interested in others when they are interested in us.” Psychologists who are expert in conflict resolution and marriage and family therapy have written about this fundamental principle for decades. Dale Carnegie, author of the 70-year-old best-seller *How to Win Friends and Influence People* writes, “Philosophers have been speculating on the rules of human relations for thousands of years, and out of all that speculation, there has evolved only one important precept. It is not new. It is as old as history. Zoroaster taught it to his followers in Persia twenty-five hundred years ago. Confucius preached it in China twenty-four centuries ago. Jesus taught it among the stony hills of Judea nineteen centuries ago. Jesus summed it up in one thought—probably the most important rule in the world: “Do unto others as you would have others do unto you.”

More recently, the authors of *Getting to Yes*, *The 7 Habits of Highly Effective People*, *Good to Great*, *How to Argue and Win Every Time* and other insightful observers of human relations have all emphasized this same fundamental principle of persuasion. But despite the ancient lineage and popular dissemination of this simple and logical truth, it is too often overlooked when we are lured into an “I’m right, you’re wrong” situation and end up thrashing around like a fish caught on the end of a line, certain that if we try just hard enough (i.e., speak more loudly or repeat our

position once again), we will win. And sometimes we do succeed in bending the other person to our will, but not without doing some damage. Listening with genuine curiosity and respect is the key to not getting stuck in this trap and opening the other person to caring about your opinion.

It was 7:30 a.m. and morning rounds had begun on the ward where I worked as an attending psychologist. The entire day shift was seated in a circle around the room. Doctors, nurses, social workers and assorted students were, or soon would be, repeating this ritual on inpatient psychiatric wards all over the country.

The chief of the unit, a psychiatrist, called the meeting to order and then Marie, the head nurse, took over. She began by reviewing how each patient had fared the night before. When she came to Samantha, a 40-year-old single woman with chronic schizophrenia, she paused and sighed before beginning. "Samantha Green, stable on six milligrams of Risperdal. She slept well last night and is ready for discharge today. Jo Anna," she asked the senior social worker, "do you want to fill everyone in on the discharge plan?"

"Sure. It's a real gem," responded Jo Anna sarcastically. "Samantha is going back to her parents' house and has an outpatient appointment with her doctor set for a week from today. Mr. and Mrs. Greene are picking her up at noon and she's walking out the door with a one-week supply of medication."

"You don't sound too pleased with the plan," I commented.

"It's nothing personal," she replied, knowing that Samantha and her parents also had an appointment with me for a family meeting. "The plan is all right—it's Samantha I'm not pleased with!" She paused, and then added, "Look, we all know what's going to happen. Call me cynical, but I'll bet you ten dollars she stops taking her medication before the end of the month and she'll be back here before you know it. She needs long-term hospitalization, not another trip through the revolving door."

Samantha had been admitted to the hospital four times in the past year. Each episode of illness had been triggered when she secretly stopped taking her medication. Her parents would notice her talking to herself and start to worry that she was not taking her pills. Her mother would then ask if this was so, and Samantha would invariably deny it, even though she had not taken them for weeks. By the time the truth came out, it was usually too late and she needed to be hospitalized.

To my ears, Jo Anna's lack of faith in Samantha, her parents, and in me was neither cynical nor insulting. Given Jo Anna's experience and perspective, she would have been foolish to expect anything more than she did. However, if Jo Anna had known what I knew, she might have shared my optimism for Samantha and her family.

I knew why Samantha didn't want to take psychiatric drugs. It had taken some effort to uncover the true reasons, but with that knowledge and a good idea of what Samantha wanted out of life, I knew I could help her stay on her medication, in treatment, and out of the hospital. But Jo Anna and the rest of the hospital staff hadn't learned what I had, because they were focusing on other things.

In the climate of managed care and increasing advances in drug therapies for serious mental illness, mental health professionals working in hospitals have become increasingly specialized. Psychiatrists evaluate health and symptoms and order medications. Psychologists working on inpatient wards typically perform psychological assessments and, less often, do therapy. Nurses dispense medications, monitor patients' health and safety, and provide education about the treatments received. Social workers evaluate the patients' discharge needs and make arrangements for outpatient treatment and residence. As a psychologist working with the seriously mentally ill, I know a good deal about the medications used to treat the disorder but

I don't prescribe them. My job is different—understanding the person and how the illness has affected his sense of self and goals is one of my areas of focus. And that is why I was optimistic about stopping the revolving door Samantha was stuck inside.

Unlike the others, I knew how Samantha experienced being ill and what she thought about the drugs we were “pushing” on her. I also had a clear understanding of what it was she wanted out of life, and that knowledge had helped me to get her to agree to a trial of the medication as an outpatient. Unlike the other times she'd been hospitalized, she was not agreeing to take the medicine to placate us so she could get out—she was agreeing to continue (for a time) to see if it could help her achieve one of her goals. In other words, I had been doing a lot of listening, and what I had learned gave me a foothold with Samantha and reason to have hope.

Building a Treatment Agreement

The cornerstone of building a treatment agreement that will work and outlast your direct involvement is cut from the quarry of your loved one's sense of who she is, what she believes she is capable of doing, and what she wants out of life. Unless you know its shape, color, texture, and strength, you will be unable to build on this foundation. Each stone you lay will topple and fall to the ground unless you have listened and learned about her experience of these things. Specifically, you want to ask about her:

- beliefs about having a mental illness
- experience and attitudes about medication
- concept of what she can and cannot do
- hopes and expectations for the future

In the next three chapters, I will show you how to put your knowledge of these areas to practical use. But before we get there, you have to know your loved one's answers to each of these questions. And, because serious mental illness often changes the way people communicate with one another and what each person wants to talk about, there are some common pitfalls you'll need to avoid. The best way to do that is by learning how to use *reflective listening*.

Reflective Listening

We all know how to listen. But I'm not talking about "everyday listening." I'm talking about *reflective listening*, which is very different.

.....
*When you're doing it right, you're asking a lot of questions.
You sound like a journalist conducting an interview.*
.....

Reflective listening has, as its sole purpose, understanding what the other person is trying to convey and then communicating that understanding back without commenting or reacting in any way. It is an active, rather than passive process—your role is purely that of a listener who wants to get it right. When you're doing it right, you're asking a lot of questions. You sound like a journalist conducting an interview.

I'll give you an example of how and why something that seems so simple doesn't come naturally.

All my life, people have told me I am a naturally good listener. As a psychotherapist, I pride myself on my ability to listen and understand other people's experience. But everything I thought I knew about listening was put to the test the first few times I tried to converse with people in denial about having a serious mental illness.

I was 23 years old when I took a job as a psychiatric technician

(a.k.a. nursing aide) on an inpatient psychiatric ward at the University of Arizona Medical Center. My brother Henry's first psychotic episode had occurred less than a year before, and despite his rambling speech and crazy ideas, I could still understand him. My experience with my brother had given me a lot of confidence. *I have listened to many bizarre things, I thought. I can do this.*

As a psychiatric technician, I was responsible for assessing, among other things, how agitated, depressed, elated, suicidal or dangerous my patients were. I was also charged with determining whether my patients were following the prescribed treatment plan. Every conversation had a hidden agenda.

My very first admission evaluation was with Barbara, a 42-year-old woman who was in the throes of a grandiose delusion and irritable manic episode. She was talking a-mile-a-minute about her power to read minds, her supernatural abilities, the alien implant in her brain that had given her these powers, and the fact that she didn't need to be in the hospital. And she was very angry about being there.

With a bright red, hospital-issued clipboard on my knee, I diligently started with the list of questions that were printed neatly in rows on the evaluation form. "Can you tell me why you came to the hospital?"

"Can you tell me why *you* came to the hospital?" She mimicked me with disdain, effectively humiliating me for being a rookie.

I quickly countered, trying to recover my composure. "I am sorry. You were brought here by your husband. That's right, isn't it?"

"I am sorry. You were brought here by your husband. That's right, isn't it?" she echoed sarcastically.

Stating the obvious, I said, "It sounds like you don't want to talk right now. I am sorry, but I have to get through these questions." I pleaded with her, despite the fact that I was feeling even more humiliated and was also starting to get angry.

"I don't give a shit about your f__king questions!"

"I'm sorry, but I really do need to get through these questions."

"Grow up, little boy. You better realize who you're dealing with here. You don't know what you've gotten yourself into and you are in way over your head. Way over your head. Maybe I'll have your head. I could, you know. It's as easy as snapping my fingers or blinking an eye or squashing the wings of a butterfly!" She shouted in rapid fire before bursting into hysterical laughter.

My agenda was moot, my face a bright shade of red. I know, because she made a point of telling me as I was excusing myself and trying to walk—not run—out the door. I was scared and angry. I went to the nurses' station and plopped down next to Nancy, the charge nurse.

"You got that done fast," she said incredulously.

"Not really. I didn't get much done at all."

"She wouldn't answer your questions?"

"No. All she did was mimic my every word and threaten me."

"Threaten you?!"

"Not exactly. At least not in reality. She was threatening me with her God-like delusional powers."

"Well, it seems like she may not be able to answer these questions right now. What did you learn about her from just sitting in the room?"

"Well, she's angry and doesn't want to be here. She's in denial. She's manic, irritable, and grandiose. And she doesn't want to talk to me. Maybe someone else should give it a shot."

"No. She's your patient. I just gave her some medicine—give her a couple of hours to calm down a little, then try again. Only this time, don't bring in the admission form. Start by asking her if there's anything she would like to say. Let her talk about why she thinks she shouldn't be here and see where it goes. Ask her questions about that. That seems to be where she's at. Look for an opening to tell her you're sorry she's here."

“God knows I’m sorry she’s here!” I said, joking, and feeling better.

I saw the wisdom in Nancy’s advice. I followed her suggestions and ultimately learned quite a bit about Barbara. But it took putting my agenda on the back burner for me to listen to what she was feeling about being forced to be a “mental patient” in a psychiatric hospital. As a result, I was able to get my form filled out. Some questions were not answered, but the essentials were covered. (I will tell you more about Barbara later. But for now, I want to focus on the other elements of reflective listening.)

.....

To do it right, you have to drop your agenda. Your only goals are to understand what your loved one is saying and to convey that understanding.

.....

It’s hard to listen reflectively in the face of all the distracting “noise” of psychosis, especially if you are pursuing an agenda and trying to follow a timetable. To do it right, you have to drop your agenda, as I did with Barbara. *Your* only goals are to understand what your loved one is saying and to convey that understanding.

This is very hard to do at first, but it’s not impossible and actually gets quite easy once you “unlearn” your natural bad habits. Reflective listening is a skill and, as with any skill, once you know the basic principles, all you need to do is practice to get it right. To start, here are seven guidelines for reflective listening:

Seven Guidelines for Reflective Listening

1. *Make it Safe*
2. *Know Your Fears*
3. *Stop Pushing Your Agenda*
4. *Let it Be*
5. *Respect What You’ve Heard*
6. *Find Workable Problems*
7. *Write the Headlines*

1. Make it Safe

During the first few years he was ill, Henry never wanted to talk to me about the medicine he was prescribed. He didn't *feel safe*. As you will learn later on, my brother and I argued a lot for many years, going round and round on the issue of whether or not he was sick and needed to take medicine. This happened because we got into what I call the *denial dance*, which creates pessimistic expectations about talking.

Let me tell you about one of my first experiences with this.

My brother had just come home from the hospital and was doing well. The medication obviously helped him, but within a day of his getting home, I found it in the garbage can. Naturally, I asked him why he'd thrown it out.

"I'm okay now," he explained. "I don't need it anymore."

This ran counter to everything he was told in the hospital, so I made a point of reminding him. "But the doctor said you're probably going to have to be on this medicine for a rest of your life. You *can't* stop taking it!"

"He didn't say that."

I countered with, "Sure he did! I was at the family meeting, remember?"

"No, he said I had to take it while I was in the hospital."

"Then why did he give you a bottle of pills to take home?" I argued, *trying to prove him wrong*.

"That's just in case I get sick again. I'm fine now."

"No, that's not what he said."

"Yes, it is."

"Why are you being so stubborn? You know I'm right!" I said.

"It's my business. Leave me alone."

"When you got sick it became everyone's business. And besides, I'm worried."

"You don't have to worry about me. I'm fine."

"You're fine *now*, but you won't be if you don't stay on the medicine."

"That's not what the doctor said!"

"Then let's call him and I'll prove it!"

"I don't want to talk about it! Just leave me alone," he said as he walked away.

With every dose of "reality" I tried to give him, Henry countered with more denials. And with every go-round, we both became angrier and angrier. I thought he was being stubborn and immature. My accusations and threat to prove him wrong made him even angrier and more defensive. My natural instinct to confront his denial was completely ineffective and only made things worse. We got caught in a cycle of confrontation and denial that pushed us further apart and, not surprisingly, left my brother feeling that it was not safe to talk with me about these issues. The end result of conversations like this was that he walked away. The dance always ends in avoidance.

Henry said it best after one of our early arguments. "Why should I talk about this? You don't care about what I think. You're just going to tell me I'm wrong and need to see a shrink!"

It wasn't until I was in training to become a psychologist that I finally understood that my brother wasn't simply being stubborn. Armed with more knowledge and experience, I reflected on how I had talked to him and realized I had played a big role in getting him to stop talking and start sneaking (e.g., when he secretly threw his medicine in the garbage while claiming he was still taking it).

I made him feel unsafe. He knew that if he said he wasn't sick and didn't need medication, I was going to argue with him. Sometimes I did it gently, but as the years wore on and he became what mental health workers call a "frequent flyer,"

I was often harsh in my confrontation of his denial. Once, I even planned an intervention involving several family members and Henry's social worker. We all, gently but powerfully, told him he was in denial. One by one we told him he had schizophrenia and needed to take psychiatric drugs to get better.

Now imagine if that happened to you (assuming you do not have schizophrenia, which was exactly Henry's point of view). Imagine that this conversation followed on the heels of dozens more like it. Would you really be interested in explaining, once again, that there was nothing wrong with you and you didn't need medicine? No. Better to walk away or, if you can't, shut up and pretend to agree in order to get the conversation over with quickly.

.....
"I am sorry for not listening to you. I understand why you don't want to talk about this anymore."
.....

So how do we make it safe to talk? First, set aside a special time. It can be over a cup of coffee, a walk, on top of a Ferris wheel! Anywhere. What matters is how you introduce the conversation.

If you've had arguments in the past, you need to apologize and acknowledge that you made your loved one feel unsafe. You can say something like, "I am sorry for not listening to you. I understand why you don't want to talk about this anymore." And then normalize his reaction to you by saying something like, "If I were in your shoes, I would feel the same way." When you apologize for jumping in with your opinion (which I call *reactive* listening) and admit you would feel the same way he does, you make it safe to talk.

But there's more. You have to promise *not to do it again*. "I want to hear more about why you hate the medicine and I promise I won't do anything but listen and try to get a better understanding of your view on this. I promise not to give my opinion."

You might be thinking, “Wait a minute! How can you help someone in denial if you are not going to tell him the truth? Don’t you have to help him see the problem and the solution?” Yes, you do. But not yet...and not in the way you think.

Advice is a funny thing. It can be perceived as either welcome or unwelcome, disrespectful, insensitive, and patronizing. What determines how the advice will be received? Here’s an example.

Women who have been pregnant often complain about how complete strangers walk up to them and give them unsolicited advice. Sometimes it’s humorous; usually it’s irritating. But almost always, they ignore the free advice because it was uninvited and felt intrusive.

And yet, *every* woman I have talked to about this experience admits that she had at least one friend or relative whose counsel she sought and listened to. *That’s* the difference between *solicited* and *unsolicited* advice. Advice that has been requested carries far more weight than unwelcome advice. So, when you promise to *not* give your advice because your main goal is to listen and learn, you gain instant credibility. And I guarantee, as strange as this may sound, that you will be asked for your opinion far sooner than you would like.

So apologize for not listening well enough, promise you will listen without comment, and *keep the promise*. To succeed, you will need to discover why you have been afraid to listen in this way, because if you don’t, the same fears that kept you from reflective listening in the past will trip you up going forward.

2. Know Your Fears

Whenever I teach reflective listening to a new group of people I am reminded how much more similar than different we all are. On the outside, all sorts of differences jump out at me—the man in the business suit sitting near the one in the “Guns Don’t Kill People, People Kill People!” T-shirt and torn jeans; the large, loud

woman and the meek, diminutive one. People of all shapes, sizes, religions, races, and politics come to LEAP seminars because they all have a deep desire to help a loved one who is in denial. They also have the same fear about taking that first step, the fear that, “I will make it worse if I listen the way Dr. Amador says I should.”

During these seminars, I define reflective listening just as I did above. Then I ask for a volunteer. Recently, I did this role-play with Gwen in Halifax, Canada. Her job, as I explained it to her, was simply to listen to me as I role-played a delusional patient, and then reflect back what she had heard.

She looked confident as I began the role-play. Speaking fast and sounding very angry and scared, I said, “Look, Gwen, I am not sick, there’s nothing wrong with me. I’m not taking that medicine because it will kill me. It’s poison. If you want to help me, then help me with the people upstairs.”

“What about the people upstairs?” she asked, without reflecting back what I had just said.

“Every night at eight o’clock, they walk across the floor of their apartment to the bathroom. I hear them flush the toilet and I know what they’re doing! I’m no fool! They’re communicating with the group that’s trying to kick me out of my apartment. They’re the same people who have been trying to kill me!”

Gwen, who had been nodding as I explained the problem, answered, “So it sounds like the people upstairs are disturbing you. They’re making a lot of noise?”

Seeing that she was done, I asked the audience, “Did Gwen reflect back what I said?” Immediately numerous hands shot up. One after the other, they described how she had not. They saw what Gwen could not see in the moment – although she had responded in the form of a question, as I had recommended, she had not reflected back a single thing I had said. The closest she came was mentioning that I was “disturbed” by the people upstairs. In fact, however, I wasn’t disturbed. I was scared and

angry and it had nothing to do with their being “noisy” neighbors. The noise didn’t bother me—it was their use of the toilet as a signaling device that had me upset!

The audience was able to see that she had not reflected back what I had said, but they didn’t do much better themselves when several of them tried their hand at it. Like Gwen, they omitted mentioning the “crazy” facts. The closest anyone came was acknowledging that the toilet flushing was a signal to the other people in the building who wanted “me” evicted. But they all avoided talking about my denial, my belief that the medicine was poison, and the stranger, more paranoid delusions (the conspiracy of fellow tenants who were planning my murder).

After reassuring my volunteers that I used to make the same mistakes with my brother before I learned reflective listening, I modeled the correct way to do it. Playing the role of the listener now, I said, “So, Xavier, tell me if I got this right. You’re not sick and don’t need to take the medicine. What’s worse, the medicine is poison. And the thing you want my help with has to do with your neighbors. Every night at eight o’clock, your upstairs neighbors walk into their bathroom and flush the toilet to signal other people in the building. These are the same people who have been trying to kick you out and also kill you. Do I have that right?”

Not even halfway through saying this, I could see several people squirming in their seats, shaking their heads, and frowning. “I know that many of you are very uncomfortable with what I just said. What makes you so uneasy?”

“You’re reinforcing the denial!” one man practically shouted.

“You can’t tell this guy his medicine is poison. He’ll never take it!” Gwen added.

“What else worries you?” I asked the group.

“You worsened the delusion; now you’re going to get drawn into it. He’s going to want you to do something about his

neighbors,” another man offered. A woman, who I knew to be a social worker, raised her hand. “This goes against everything I was taught. You can’t collude with a delusion like that. You’ll reinforce it!”

I turned to the group. “Was anyone feeling okay about what I did?” An elderly woman in the front row raised her hand.

“I thought it was fine,” she said. “He’s going to want to talk with you because you are talking about what’s important. He doesn’t believe he’s crazy and thinks people are trying to kill him, for gosh sake!”

“So why do you think the rest of them are so uncomfortable with my reflecting all that back to him?” I asked.

She slowly turned around to look at the audience, then, turning to face me again, she said simply, “They’re chicken,” and sat back down. After the laughter subsided, I thanked my unexpected accomplice and elaborated on her wise observation.

When you're facing someone who rigidly holds irrational beliefs, you gain nothing by disagreeing.

First, I never agreed with his beliefs about being sick, the medicine, or the paranoid ideas. By prefacing and ending my statements with questions (“Tell me if I got this right” and “Do I have that right?”), I was free to use my patient’s own words. In no way did I challenge his beliefs. Why should I? He’s delusional!

Rather, I showed him, through my actions, that I wanted only to listen to him and understand. I have never talked anyone out of a delusion and, to my knowledge, I have never talked anyone *into* one either. The point is, when you’re facing someone who rigidly holds irrational beliefs, you gain nothing by disagreeing. More importantly, you lose that person’s willingness to talk about the problem.

There are, however, a few pitfalls you have to watch out for. One is when the person asks, “So it sounds like you agree with me. Do you?” Or the flip side of the same coin: “Why are you acting like you believe me?” Actually, these questions offer an important opportunity, which I’ll talk about in the following chapter. For now, I ask that you trust me – and for the time being, focus on uncovering what *your* fears are.

3. Stop Pushing Your Agenda.

I know your agenda is to help someone you’re worried about. And you have specific ideas about how the help should come. But because the person in denial is already expecting unwelcome advice for a problem he doesn’t believe he has, you need to keep this agenda to yourself!

When reflectively listening, the only stated agenda you should have is your desire to listen and learn. When a person trusts that you will not pontificate about what he should and should not be doing, he will be more apt to agree to talk about certain “hot” topics (e.g., his refusal to seek professional help).

Agreeing on an agenda is easy if you follow the lead of the person in denial. This is how I was finally able to engage Barbara. What she wanted to talk about was how furious she was for being forced into the hospital when she wasn’t mentally ill. If the person you’re trying to talk to is upset about having to take medicine, ask him about his *feelings*, not about the medicine or your belief that he should take it. You can say, “I’d like to understand why you hate taking your medicine. Would you mind talking with me about that? I promise I won’t pressure you or bug you – I really just want to understand how you feel about it.”

Try it once with any hot topic and see what happens.

4. Let it Be.

If the discussion turns into an argument and you feel the denial dance coming on, stop! If your loved one becomes accusatory, saying something like, “You don’t care about me, all you’re thinking about is yourself,” just let it be. Don’t fan the flames.

Sometimes mental illness creates “thought disorder,” making it especially difficult for others to follow the person’s train of thought. It’s annoying and frustrating. When talking with someone who has thought disorder, or disorganized speech, be careful that you don’t inadvertently impose order on the chaos, because usually you will get it wrong. In other words, let it be and focus on listening *differently* instead of on trying to impose order. Listen for the feelings behind the words and reflect back the emotion. When you understand the underlying emotions, you will discover what the person cares about most and what motivates him.

5. Respect what you’ve heard.

When you make it a point to communicate your understanding of what you’ve just heard without reacting to it, you convey your respect for the other person’s point of view. You also deflate anger. When you echo what you’ve heard without comment or criticism, you stop the denial dance dead in its tracks. Think of it this way: Would you really be interested in hearing the opinion of someone you’ve been arguing with if you felt he or she hadn’t listened to your views?

6. Find Workable Problems.

Everyone in denial or with anosognosia, knows he has at least one problem. The problem is *you* and everyone else who is telling him he needs help!

He will have other problems you can uncover as well. Understanding how the person in denial sees himself and his beliefs about what’s not working in his life is the key to unlocking

the isolation and building a relationship with someone who recognizes he is in trouble and needs help. A relationship with someone who can lead him to that help is the only way he'll find it as long as he is unaware of the illness.

Consequently, you first need to learn what *he* thinks the problem is. How does *he* define it? And what does *he* say he needs to fix it? Without understanding what he thinks is wrong and needs to change, you will be powerless.

For example, my brother never agreed that he had schizophrenia, but he did think that being forced into a psychiatric hospital again and again was a big problem. I couldn't have agreed with him more. Once you find a problem you can work on together (e.g., Henry and I agreed that avoiding another hospitalization was a good thing), you have common ground and leverage. It is also vital that you find out what he wants out of life – in the short term and long term – without being judgmental. You need to find out what it is that is most important to *him*.

7. Write the Headlines

I started out by telling you that to do this right, you need to approach your loved one the way a journalist would. That means not only asking questions without injecting your criticism or other opinions, but also discovering a theme and figuring out what the “headlines” are. So, after a conversation in which you've been reflectively listening, think of the front page of a newspaper and literally write down the headlines. If you can, write them down in front of the person (I will give you examples of how to do this later), so that you know you are both on the same page about what's important to him.

So what are the “headlines”? The headlines are the problems the mentally ill person believes he has (not the problems you say he has) and the things that motivate him to change (those that are most important to him). Ultimately you are going to work

together on the problem as he defines it, but link it to the help you believe he needs. And you will do this by harnessing what motivates him.

To illustrate these listening guidelines, I offer the following two examples from families I have worked with. The first is a good example of how *not* to listen while the second provides an excellent lesson on how to do it right. Both examples are drawn from my work supervising therapists in training on an inpatient psychiatric ward. Because my students typically bring video tapes of their sessions with families to our supervision meetings, I can comment on both the therapist and the family members' listening skills.

Ineffective Listening

It was 3 o'clock and Dr. Brian Greene, a second-year resident in psychiatry, was meeting with Matt Blackburn and his parents. Matt is the 26-year-old man who lives at home with his parents I first told you about in Chapter 1.

As you may recall, he was admitted to the hospital believing he was a close confidant of the U.S. President. He also believed that God had chosen him as His special messenger to world leaders, that the CIA was trying to assassinate him, and that his mother was trying to sabotage his mission (this last belief was not entirely delusional).

When he was admitted to the hospital, he was also hearing voices and had thought disorder (rambling disconnected thoughts strung together so that when he spoke it was often difficult to make sense of what he was saying). After two weeks of treatment at Columbia, his speech was more cogent and the voices had quieted down a bit thanks to the medication he had received. He still had the same delusional beliefs, but the drugs helped relieve the pressure he felt to act on them (e.g., go to Washington to meet with the President).

The meeting was called by Dr. Greene to discuss what Matt would do after being discharged from the hospital. “Mr. Blackburn, Mrs. Blackburn,” Brian said to each as he shook their hands, “Please come in and have a seat.” Matt was already seated at the end of a long table in the patient dining room.

His mother circled the table to reach her son and bent down to give him a kiss. Mr. Blackburn immediately sat down in the nearest chair, which was also the farthest from Matt, and started asking questions of Dr. Greene. “I know we’re supposed to be talking about Matt’s discharge, but don’t you think he needs to stay here longer? I don’t think he’s ready to come home yet.”

“There’s really nothing more we can offer him here, Mr. Blackburn,” Brian answered. (In truth, it probably would have helped Matt to stay another week, but his insurance had run out.)

“Well, I don’t think he’s ready and neither does his mother!”

“Hold on,” Mrs. Blackburn said, “I didn’t say that exactly. Of course, we want you to come home,” she said, directing her last comment to Matt. “We’re just worried about what’s going to happen next.”

Seizing the opportunity, Brian began. “Matt has an appointment later this week with a doctor in our outpatient clinic. He has enough medicine with him to last until that appointment, and the hospital’s day program has accepted him. He can start there as soon as the doctor has seen him.”

“This is exactly what I was afraid of,” said Matt’s father to his wife. Then he turned to face Brian and added, “I don’t want to be negative, Dr. Greene, but he’ll never go to that appointment and he won’t go to this day program you’re talking about. He doesn’t think there’s anything wrong with him. We need a better plan than this. Matt won’t take his pills and he doesn’t like hanging around the people in these programs. He says they’re all crazy!”

“Matt, what do you have to say about all this?” Brian rightly asked.

He responded loudly, while looking down at the table. "I said I'd go. I'll go!"

"That's what you promised us before, Matt," said his father in a kinder tone. "But when we get home, you disappear into your room and you don't go anywhere."

"It's different this time. I'll go! I just want to get out of here and get a job and my own place."

"Are you sure you'll go?" his mother asked, looking worried.

"Yeah, Mom, don't worry, I'll go. I really will. Okay?"

Matt's father didn't look convinced, but his mother and doctor looked, if not convinced, at least relieved by what they had just heard.

Let's review the seven listening guidelines I gave above.

1. Did They Make It Safe?

Brian and Matt's family did set aside a special time to talk but did not make the conversation "special" in the way I described above. There was no acknowledgment of their differing views and no apology for previous attempts to convince Matt he was in denial and mentally ill. No one explained that he or she wanted only to hear Matt's views on the discharge plan. And no promise was made to refrain from giving unsolicited advice.

Instead, the old argument was immediately raised by his father and the battle lines drawn. The result was that Matt got defensive and then did what you and I would have done had we, like Matt, been through this a hundred times before. He lied and said he would go to the appointment. He lied to get his parents and his doctor off his back and to get released from the hospital.

2. Did They Know Their Fears?

On the surface, Matt's father and mother both appeared to be in touch with the fear they felt going into this conversation. But they were not. They were aware of their fear that their son would continue his career as a "frequent flyer" or revolving-door patient—but they had no awareness of the specific fear they had about this conversation, which was that they would make things worse if they didn't make their views known once again.

Although she did it more gently than her husband, Matt's mother also laid down the battle lines. She wanted her son to stay in the hospital longer. She made it very clear she thought he was still very sick. Both parents, and Dr. Greene for that matter, felt compelled by their fears to once again tell Matt, *as if hearing it once again would make a dent in his denial*, that he was ill and needed professional help. And yet, all three knew that Matt was not going to follow up with the clinic appointment.

They could have talked about that with Matt directly. But to do that they would have had to make it safe for him to talk, not let fear rule the conversation and stop pushing their agenda.

3. Did They Stop Pushing Their Agenda?

Matt was about to leave yet another hospitalization, and his parents and doctor knew he would not follow through with their recommendations because he never had before. But that didn't stop the three of them from pushing their hopeless agenda anyway.

Dr. Greene wanted to communicate the details of the post-hospital treatment plans and "seal the deal" so to speak (even though he admitted to me later that he knew Matt would never follow through with the plan as it had been presented to him). Matt wanted to leave the hospital and was willing, if that's what it took, to take medicine for the time being. How long he was willing to stay on the medicine was never determined because

Matt did not trust his doctor or parents enough to be forthcoming and reveal what his true feelings were. Mr. Blackburn openly predicted that his son would stay on the medicine for less than one week while Brian naively hoped that Matt would be willing to follow doctor's orders for months to come.

Mr. Blackburn was pursuing an agenda, which was trying to convince Brian to hold Matt in the hospital longer. And although Mrs. Blackburn was focused on the same agenda, she was preoccupied with her guilt and with not wanting to hurt or anger Matt.

What was Matt's agenda? No one asked, so we really don't know, although I found out later.

4. Did They Let It Be?

Matt was not offering his opinion or saying he would not take his pills. At least not directly. So there was little in the meeting for his doctor and parents to react to. But his parents were reacting to things Matt had said and done in the past. His father was angry from the start, not only because the hospital was discharging his son, whom he felt was too ill to come home, but also because he didn't believe Matt was telling the truth. When Matt said he'd go to his appointment and take his medicine, his father reacted essentially by calling him a liar ("That's what you promised us before, but when we get home you disappear into your room and you don't go anywhere."). Although more subtle, Matt's mother also reacted to his reassurances with disbelief.

5. Did They Respect What They'd Heard?

No one echoed back to Matt what they understood him to be saying. Matt's views on whether he was ill and needed treatment were not respected. There was at least one missed opportunity. When Matt said, "This time is different," his doctor or parents could have replied, "So, Matt, I want to understand. You're

saying this time is different. Is that right?" If such a question had been asked, not with anger or sarcasm, but with genuine curiosity, Matt would have answered yes, his defenses would have dropped a notch, and he would have told them something very important. This time really *was* different for him. He truly did not want to come back to the hospital ever again, certainly not the way he had this time (his parents had called the police, who brought him to the hospital against his will).

And if they had echoed back what they heard and Matt had felt they truly understood, a problem they all shared could have been identified. They could have worked together *to keep him out of the hospital*.

From Matt's perspective, his parents were the reason for his hospitalization. From theirs, it was the mental illness. But they all agreed that no one wanted him to end up in the hospital again (even the insurance company would have agreed to that). This was a missed opportunity to help Matt drop his defenses and turn down the volume on everyone's anger.

Let me give you a feel for what I am talking about. Brian was Matt's doctor, and I was Brian's supervisor, so sometimes I met with the two of them together. During one of these meetings, Matt had described the terror he felt when the police brought him to the hospital. He had never felt so scared before and he never wanted to feel that way again. And he had grown tired of being hospitalized again and again. I asked him why he thought his parents had called the police, and he answered, "Because they think I'm sick."

"But that doesn't tell me *why* they would put you through this."

"They think I'm sick and need to be in the looney bin, that's why."

"Let me ask the question differently. What's motivating them to do this to you? Do they hate you?"

"No."

"Do they want to hurt you?"

"I don't know. I don't think so."

"Then why would they call the police on their son?"

"They're afraid, I guess."

"Matt, let me see if I have this right. Your parents called the police to bring you to the hospital against your will, not because they hate you or want to hurt you, but because they're afraid. Do I have that right?"

"Yeah. That's it."

"What are they afraid about?"

"They're afraid I'll get hurt."

"Now, I know you disagree with them on this, but before we talk about that, let me see if I am following you so far. Your parents were afraid you would get hurt so they wanted you in the hospital to keep you safe. Is that right?" He nodded. "What does that tell you about how your mom and dad feel about you?"

"They love me."

"So you have a big problem here, don't you? How do you convince your parents to stop throwing you in the hospital? I mean, you can't convince them to stop loving you, can you?"

"No," he said smiling.

"Then what?"

"I can't convince them there's nothing wrong with me. You guys have all brainwashed them!" We both laughed at his reminder that people like me – doctors – were at the root of his problem.

"No. And they can't convince you that you're sick. So there you are. What could you work on together?"

"I guess reassuring them so they don't get scared and call the police."

"How can you do that?"

"There's nothing I could do to convince them."

“Nothing?”

“Well, no...not nothing. I could take the medicine.”

“But if I understand you, you’re not sick. Why would you take medicine if there’s nothing wrong with you?”

“To keep them off my back!” he said laughing.

This conversation, though valuable, would have been priceless had Matt had it with his parents. But because they were afraid and unable to echo what they heard, they missed a chance to find common ground with their son and work on the problem they all agreed Matt had (i.e., hospitalizations against his will were bad). By redefining the problem so that it was no longer about the question of whether or not he was sick and needed help, and clarifying that he knew his “misguided” parents were motivated by love, Matt could have translated the impossible problem he had into one that was workable.

6. Did They Find Workable Problems?

When it came to defining the problem, Matt, his parents, and Dr. Greene were talking apples and oranges. Matt saw the problem as his parents, the police who listened to them, and the shrinks who had convinced his mother and father he was ill. His parents and Dr. Greene saw the problem as Matt’s being stubborn, immature, and defensive—he was not taking any responsibility for the illness he *clearly* had. On the other hand, Matt and I had easily found at least one workable problem. We agreed that the only problem anyone would be willing to work on with him was how to keep him out of the hospital.

Identifying a problem we could work on together opened up a way for us to work as allies rather than adversaries. After his parents left, I briefly met with Matt and Dr. Greene and said: “Well you know it’s your choice, Matt. You know what I think, and I can’t force you to do something you don’t believe in. I wouldn’t want to do that even if I could, unless, of course,

you were in danger, which you're not in right now. I respect your right to make this decision for yourself. I know you told Dr. Greene and your parents that you would stay on the medicine. But if you change your mind, and if I had to guess I'd guess you will since you don't believe you're sick, I hope you will pay close attention to what happens next. It's your life. Don't just have an opinion about the medication—prove to yourself whether your opinion is right or wrong."

"I already said I'd take the pills!" he responded defensively, probably because I was implying that I didn't believe the reassurances he'd given Dr. Greene and his parents.

"Okay, I will take you at your word. But I have to say that if it were me, I wouldn't take the medicine." Seeing that Brian looked mortified by what I had just said, I asked him, "Dr. Greene, do you have something to say? You look like you might have a different view on this."

"Well, I don't think you really meant that if you were in Matt's shoes you wouldn't take the medicine."

"That's exactly what I meant." Brian frowned and seemed to be searching for words when Matt saved him by asking me, "So, you don't think I need the drugs?"

"I didn't say that. What I said is that if I were *you*, I wouldn't take them after I leave the hospital. Matt, you don't believe you have a mental illness and you feel strongly you shouldn't be taking medicine for an illness you don't have. That sounds like common sense to me. Who would take pills if they didn't think they needed them? What would be the point? If I believed those things I wouldn't be planning on taking the medicine when people were no longer looking over my shoulder. If I were in your shoes, I would say what it took to get out of here and then follow my own compass. Isn't that really where you are? You can tell me and you will still go home today. It won't change a thing."

"I would never do that," Matt said facetiously, a smile spreading across his face. I smiled back as we both recognized and shared the truth of what he would do once the door closed behind him.

"Hypothetically then, if you do stop taking the medicine, ask yourself these three questions: What stays the same? What gets worse? What gets better? Write it down like we've been doing while you were here. You know what I mean?"

"Yeah. The pluses and minuses."

"Exactly. So you know what I'm talking about?"

"Yeah. It's my life. I hold the key and it's up to me to decide."

"Right. Now, you've decided you really don't want to take the medicine, right?"

"Yeah," he admitted sheepishly. "But I will anyway. Everyone wants me to, so I will."

"Well, I don't know if everyone wants you to, but you know my opinion. I hope that you will. But if you decide to stop, I want you to know I respect that this is your life and your right."

"Yeah, but you'll think I'm stupid."

"No, I won't. But I might think you made a bad decision if you made an uninformed decision."

"You're the doctor, you would know."

"That's not what I meant. You are in the best position to be the expert on this issue. Be a scientist. Think of this as an experiment. Collect the data. Don't jump to conclusions one way or the other. Just pay attention to what happens when you're not taking the medicine. Ask people you trust how you seem when you're off medicine. Think you'd be interested in doing that?"

"I don't know. I already know the answer."

"Well, it seems everyone else already thinks they know the answer, too, and most of them disagree with you. Here's your chance to prove them wrong."

"I'll try to keep an open mind."

"That's all I'm suggesting. Anything else you want to talk about before we stop? Any feedback for me?"

"No, I guess not."

"Well, good luck." I stood up, extended my hand, and added, "I hope I never see you again."

"Same here," Matt replied. We both laughed as we shook hands. If I saw Matt, it would be because he was back in the hospital. Keeping him out of the hospital and in his life was something we both wholeheartedly agreed upon.

7. Did They Write the Headlines?

No one appeared to pay attention to the headlines, much less write them down. Of course, writing down what Matt had to say would have been awkward in this situation because his doctor and parents had never practiced this technique with him. It's true that Brian often took notes during their sessions, but they were almost entirely about symptoms he was observing. He rarely recorded Matt's subjective experience of the problem (his parents, the police, and the "shrinks") or statements that revealed what was important to him, what motivated him (staying out of the hospital, getting a job and a place of his own). But it would have been easy to ask, "Is it all right with you if I write down what you're telling us is most important to you?"

Effective Listening

Dr. Ivan Kohut, a third-year resident in psychiatry, was meeting with Vicky, the 45-year-old woman with manic depression you heard about in Chapter 2. Her husband Scott was also present. Vicky had spent the last two weeks in the hospital following a manic episode during which she took her two children on a three-day "road trip" to Mount Desert Island National Park in Maine.

The first night of the trip was especially disturbing because Scott had no idea where his family had gone until Vicky called him at 11:00 p.m. to explain that she wanted their children to experience the same spiritual awakening she was having. God had instructed her to take them to the top of Cadillac Mountain because it was the highest point on the East coast, and had told her that once they were there, he would come to them.

Having gone through two previous manic episodes with Vicky over the course of their marriage, Scott figured out what was happening much more quickly than he had in the past. During the phone call, he begged her to come home, but she refused, and when he told her he thought she was becoming sick, she abruptly hung up the phone. Scott immediately called the police in the area she had phoned from, but they told him there wasn't much they could do except to "keep an eye out for her car." They suggested he call the National Park Headquarters in Maine.

With the help of Vicky's psychiatrist, Scott was able to convince the park rangers to intercept his wife when she arrived. He then flew up to Maine, and after much cajoling and threats of commitment, he got her agreement to return to New York and go to the hospital.

From both Scott's and Vicky's perspective the drive back was nightmarish. The children, as children often do, were unconsciously running interference by misbehaving. Their fights and tantrums, together with Vicky's rapid-fire speech and grandiose proclamations, made for an excruciatingly long drive home.

After greeting the couple, Ivan sat down and began by asking, "What would the two of you like to talk about today? I have two things I'd like to put on our agenda. How about you, Vicky?"

"When do I get out of here? That's the only thing I'd like to talk about."

"Okay. Scott, how about you?"

"Well, I have the same question. And I also want to talk about her medications."

"Anything else? Either of you?"

"No," Vicky answered quickly.

Scott thought a minute, then said, "I suppose not. Maybe more will occur to me as we talk."

"Good. My two agenda items are similar," said Ivan. "I want to report on how I think Vicky is doing and then ask her how she feels about the discharge plan. So that's basically three items: One, when does Vicky get out of here; two, my view on how she's doing, and three, Vicky's opinion of the plan we put together for after she leaves. If it's okay with the two of you, I'd like to get the second item out of the way first."

Vicky and Scott both nodded their approval.

Addressing Vicky, Ivan said, "I think you are doing much better than when we first met two weeks ago. Back then you were sleeping about two to four hours a night, your thoughts were racing, your speech was pressured, you were euphoric, extremely irritable, and you had some unusual thoughts about God and supernatural abilities you felt he had given you. Right now your sleep is back to normal, your thoughts aren't racing, and your speech isn't pressured. You don't need me to describe your mood. How would *you* describe your mood over the last week?"

"Kind of constricted. I'm not as happy and I don't get irritated so easily. I'm not depressed."

"Do you miss the happy feeling?"

"You know I do, Dr. Kohut! Wouldn't you?"

"Absolutely." Noting the smile on her face, he added, "But it looks to me like you can still feel happy. It's the extreme happiness, the high, that's gone. Yes?"

"That's true," she answered.

“So, in a nutshell, I think you’re ready to go home the day after tomorrow.”

Vicky looked surprised. “Why didn’t you tell me that this morning when we met?”

“I suppose you don’t remember, but I told you I had to discuss it with the team first. I wanted everyone’s input. We generally make these decisions by consensus, and the consensus is that you’re much improved and can go home. Scott, any opinion about this?”

“Not really. I expected it. I see that she’s getting back to normal. But I guess I’m not clear on what happens next. What can we do to keep this from happening again?”

“Good segue to the last item on our agenda – what happens next with respect to your treatment.” Ivan addressed Vicky once again. “I’d like to see you in the clinic once a week for the next couple of months, and then maybe drop down to once a month. I don’t want to change anything about the medication you’re taking right now. I’d like to see how you do over the next couple of weeks, then re-evaluate and discuss if we should make any adjustments. What are your thoughts about what should happen next?”

Vicky laughed and asked, “Does it really matter? Everyone thinks I should stay on medication.”

“Of course, it matters!” Scott replied, a little irritated and defensive.

“You’re the boss here, even if it doesn’t seem that way now,” Ivan added.

“What are you talking about?” asked Vicky.

“I am talking about the fact that what your husband and I think you should do doesn’t amount to a hill of beans compared to what *you* think you should do. If you believe that the medications have done their job and want to stop taking them, you will. I can’t stop you and neither can your husband.”

"Then why am I here? I don't *feel* like the boss."

"That's because you lost a lot of control when the bipolar disorder you have flared up. It caused you to do things that worried a lot of people and motivated them to take control away from you. But now you've got the illness under control again and you're back in the driver's seat."

"If that's true, then I don't want to take these drugs for more than a month or two."

"So, if I understand you, you don't want to take these drugs for more than two months at the most. Right?"

"Yes."

Scott interrupted. "Wait a minute! That's how she got into this mess in the first place. Every doctor she's seen, including you, has told us she will very likely have to stay on these medications for the rest of her life."

"If she doesn't want to have another flare-up, yes, that's true. That is my opinion. Also, the medications will help to keep her from becoming depressed again. I'm not contradicting myself. I'm saying something else. It's Vicky's choice, not yours or mine. But the choices you make," he added, looking at Vicky, "will have consequences."

"You make it sound so ominous," she replied.

"I think the consequences of stopping your treatment will be very negative. You know what my professional recommendation is and what your last psychiatrist felt. You know what your husband and your family would like. But what you believe is what you will ultimately do. And I have to respect that. But I am curious about one thing. Why don't you think you will need the medications? Just this morning you told me they've been very helpful over the past few weeks. Were you just 'yessing' me or did you really mean it?"

"I meant it. They've done their job. But I'm better now."

"So you see yourself as cured of bipolar disorder."

"Well, I'm not sure I have manic depression. But whatever was going on, yes, the medications helped calm me down. So, yes, the problem is solved. Why would I want to be on these drugs for the rest of my life when the problem doesn't exist anymore?"

"So what you're saying," Ivan began, "is that you had some kind of problem, not manic depression, that the drugs helped you with. And now that the problem is solved, you don't want to keep taking the medication. Right?"

"Right."

"Want my opinion on what you just said?"

"I already know it."

"Actually, it may surprise you."

"Shoot."

"What you propose is certainly possible," Ivan said to the couples' surprise. "How about we make a deal. If you decide, six months from now, that you still want to go off your medications, we can give it a try. But I won't have any part of it if we're not meeting regularly."

"Why would you do that? You already told me you think I have to stay on these medications forever."

"Because your opinion is the only one that ultimately determines whether or not you stay in treatment. I am willing to work with you to prove what you believe even though I don't believe it. I have only two requirements: that you see me regularly, and that you keep a daily diary during the time we're lowering your dosages."

"Why a diary?"

"So you have a record of how you were thinking and acting during the time your medication was lowered. It will also help you to pay attention to the consequences, not only for you but for your family."

"I would be willing to do that," Vicky replied.

“Okay, then let’s write the deal down so we all remember. You will stay on the medications for another six months. If at that time you still want to discontinue the drugs, we do it together,” he said aloud as he wrote down his words. Then he added as an afterthought, “I’d like to include Scott in some of those meetings as well if that’s okay.”

“Sure,” she answered.

“And if we go that route, you will keep a daily diary. We can talk more about what I’d like you to record—cross that bridge when we come to it. Do I have it right? Is this what we agreed to?”

“Yes,” both Vicky and Scott replied.

1. Did They Make It Safe?

Did Ivan make it safe for Vicky to talk? Yes. He made it clear that he wanted to hear Vicky’s views on the treatment and was actually reluctant to tell her his views, which she already knew. She understood she could talk about her belief that she was not sick and didn’t need medicine without her doctor contradicting her. She also knew that Ivan would keep her husband from jumping down her throat. Ivan made it clear that her opinion was the only one that really mattered at the moment. It was more important than his and Scott’s opinion.

2. Did They Know Their Fears?

Scott got nervous and went on the attack for a moment when Ivan acknowledged, without argument, Vicky’s desire to stop taking the medicine. Otherwise, Scott did a great job of listening passively as his wife and doctor discussed her views on the problem and what she needed. In previous meetings, Ivan had worked with Scott to help him recognize where he was powerless and where he had power. Where he was powerless was in convincing his wife she had manic-

depression and needed to be on medication for the rest of her life. He hadn't succeeded in four years, and Ivan helped him to recognize what was obvious—he wasn't going to suddenly succeed now by continuing the argument. Where he had power was in repairing their relationship so that she would feel he was once again her ally, on her team, and that they were working on the same problems together.

Ivan was clear about his fears and understood that he had nothing to lose by listening to Vicky's views. He knew he would not harm her by allowing her to be honest, by not contradicting her views without her permission (he always asked her if he could give his opinion before he gave it), and by actively listening.

3. Did They Stop Pushing Their Agenda?

Not only did they agree on an agenda, but over the course of their conversation Ivan repeatedly checked back with Vicky and her husband to ensure that there wasn't anything else either of them wanted to talk about. The main agenda was understanding Vicky's views and working with how she experienced all this.

4. Did They Let it Be?

Ivan did not react emotionally to Vicky's statement that she wanted to stop taking medication. Neither did Scott, except during the one brief moment when his fears caught him off guard. Neither Ivan nor Scott jumped in with their opinions to refute Vicky's statement that she was no longer ill and planned to stop taking the medication. They let her opinions stand. They respected her point of view. When Ivan *did* offer his opinion, he empowered Vicky by first asking if it was okay with her for him to tell her what he thought.

5. Did They Respect What They Heard?

Ivan did this repeatedly, often rephrasing things Vicky had said to ensure that he “got it right.” He prefaced his reflective statements by indicating that he just wanted to be sure he understood her correctly (“Let me see if I got this right?”), used her words without comment or criticism, and then asked her if he’d understood correctly. He acknowledged that he understood and genuinely respected her point of view.

6. Did They Find Workable Problems?

Vicky felt that the medications were a short-term treatment, like antibiotics for an infection, rather than a long-term treatment, like insulin for diabetes. The good news is that Vicky had some insight, though nowhere near as much as her family and doctor would have liked. She understood that the drugs helped her when she had symptoms but didn’t understand that the drugs could prevent the symptoms from returning when she was feeling well.

Although Ivan understood that statistically it was highly unlikely she could stop without getting sick again, there was a very, very small chance that she could. He also understood that until the day Vicky “owned” the treatment, until she found a reason that made sense to *her* to stay on the medicine, she never would. Her problem, which he was willing to help her with for the time being, was taking the medicine. But he would work with her on this only if she stayed in therapy with him, allowed Scott to come to some of the sessions, and took responsibility for tracking what happened when she stopped taking the medicine.

By agreeing to work with her on the problem as *she* defined it, he kept her in therapy and on the medication for a longer period of time than if he had insisted the treatment was “a life sentence,” as she had once described it. He also laid the foundation for her discovering reasons to continue in treatment.

7. Did They Write the Headlines?

Ivan not only wrote down what they had agreed to do about the medications but asked permission to do so before starting. This was important because it emphasized Ivan's wish to collaborate rather than pontificate. By asking, he also underscored that Vicky would be in charge after she left the hospital. He wasn't afraid to acknowledge his own powerlessness.

By doing that, he reminded Vicky that the choice to continue treatment was hers, as was the responsibility for the consequences that would follow her decision. The "headlines" were that she wanted off the medications and that she understood they helped her when her thoughts were racing, when she wasn't sleeping, and when she got tired out (these were the things she saw as problems even though she didn't think she had an illness).

In summary, listening is an active process. It involves asking many questions and not reacting to what you are hearing. You should think of yourself as a scientist trying to unravel a mystery. Your task is to gain a clear idea of what *your loved one's* experience of the illness and treatment is. Once you know how he experiences the idea of having a mental illness and taking psychiatric drugs, you will have acquired vital knowledge you need in order to build a treatment agreement.

The Danger of Listening Reflectively

Very likely, the person you are listening to reflectively and without judgment will make the mistake of thinking you believe what he is telling you (about not being sick, not needing medications, or the CIA conspiracy). He may ask you to help him catch the CIA in the act or talk to his parents so he can go off medications since you seem to agree he doesn't need them.

I touch on this problem at various points in this book—it's why most people are afraid of reflective listening—but let me

introduce you to two new tools: *The Delaying Tool* and the *Three A's For Giving Your Opinion* that will allow you to use reflective listening without falling prey to these traps. I will talk about these both again later, but let me lay it out for you here concisely.

The Delaying Tool

You want to delay giving your opinion about controversial topics (delusions, desire to not take medicine, etc.) for as long as possible to preserve the alliance you are building, delay the hurt your answer will cause, and perhaps most importantly, shift the locus of control to the person who is asking for your opinion. After all, when you give it, he has no one to blame for hearing your point of view but himself, especially if you have delayed giving it because you have been genuinely reluctant to do so.

So, in terms of learning to LEAP, the longer you are able to delay giving your opinion, the more the other person will have experienced you as respecting his and, therefore, the more obligated he will feel to respect yours (or at least hear you out). If he has to solicit it, the more in control he will feel and the less defensive he will be when he hears it. The harder he has to work for it, the more it will matter when you finally do give it. For these three reasons, your opinion will have more weight.

When you delay, try the following: first *honor the question* by promising to answer, *attempt to change the topic* and *ask permission* to do so. Here are some examples that include all three elements (the promise, the diversion and the request for permission to change the topic):

- I promise I'll tell you whether I think you are sick. But first, if it's OK with you, I would like to hear more about _____. Would that be all right?

- I will answer your question about the CIA. Can I ask you to give me some more details about what happened last night first? Would that be OK?
- You've asked me many times whether I think you're delusional. I promise to answer, but if it's OK with you, before I tell you what I see, could you tell me more about _____?
- I promise to answer your question about whether you should stop taking medicine. Before I do, I want you to know that I think your opinion about this is far more important than mine. So can you tell me all the reasons why you want to do that?

The “A” Tools for Giving your Opinion

Sometimes, even after you've listened and empathized, the other person won't ask you what you think. This is rare in my experience, and if it happens to you, I want you to consider two possibilities. One is that you have not used the tools you've learned as effectively as you could...and the other is that the person likes talking so much that he simply isn't interested in what you have to say. If it's the latter, you can ask if he or she would be interested in hearing your perspective. You can say something like, “After listening to you, I have a much better picture of your views on this. Can I tell you what *I* think?”

I've never heard of anyone who has used the listening and empathy tools receiving a “no” in answer to this question, and I don't believe you will either. But whether you have been asked for your opinion repeatedly and delayed giving it, or you have had to offer it because the person doesn't ask, despite being cooled down and feeling listened to and respected, the *way* you deliver your opinion will determine whether it throws more fuel on the fire or continues to douse the flames. If you want to get past the impasse, there are three new tools you now need to add to your tool belt. I often use all three of them together, but sometimes you need only one or two to get the job done. I call these my “A” tools—it makes

them easier to remember and they are powerful tools you can use whenever you're arguing or negotiating. I like to think of these tools as soft, like felt or a goose-down pillow. Sometimes I think of them as airbags. In other words, they are tools that help to soften the blow and save lives – or at least relationships.

The “three A’s” are *apologize*, *acknowledge*, and *agree*.

APOLOGIZE

Apologizing may be the last thing you think you need or want to do at this point. After all, the other person has been asking you (probably more than once) what you think. You're only doing what she's asked. In fact, you may think that if you need to apologize for anything it would be for having delayed so long – but that's not the way it works.

Keep in mind the reason you delayed in the first place: because you're aware that when you *do* give your opinion, it's likely to damage the trust you've so carefully been building. When you finally admit that you still don't agree, the other person is likely to be disappointed, to feel somehow betrayed, and to get angry all over again. So what you need to indicate is that you understand all this and *apologize*, because you do truly wish what you believe didn't make her feel that way.

I'm *not* suggesting you apologize for the opinion you're about to offer (e.g., “Yes I think you may have bipolar disorder...”), but for the feelings it might engender. You're not saying you're sorry you feel this way, but rather that you're sorry that what you have to say may make him or her feel upset. What you might say is something like, “Before I tell you what I think about this, I want to apologize because what I think might feel hurtful or disappointing.”

Understanding that difference ought to make the process easier for you. If you still feel unable to apologize, you're probably still too angry, and you need to take a few deep

breaths, step back – if only for a moment – and think about why you’re doing this in the first place.

When you *do* apologize, just be sure that you *don’t* use the word “but,” as in, “I apologize if this is going to upset you, *but*, I think...” I mentioned this before but want to emphasize it here again because it is so important.

People who are in a disagreement typically stop listening when they hear the word “but.” It’s as if you had pushed a button on a remote control and shut off their hearing aid. Not only are they incapable of hearing you – but the most likely outcome is that you’ll just revert to “butting” heads all over again.

ACKNOWLEDGE

What is it that you need to acknowledge? Certainly not that you still think you’re right (although, ultimately, that’s more or less what you’re going to be saying). Rather, you need to acknowledge that you’re not infallible and you might be wrong – even though you clearly don’t think so. (And you’re *not* going to say *that!*) So, after you apologize, say something like, “Also, I could be wrong about this. I don’t know everything.”

When you do that, you are, first of all, indicating that you are flexible. If you can be flexible, you’re more likely to trigger some flexibility in the other person. If you’re rigid and dogmatic, you’re equally likely to trigger that. Remember that LEAP is all about *giving* in order to *get*.

Acknowledging that you could possibly be wrong is also a way to convey respect because you are not insisting that you are wise and the other person is ignorant. It’s the same principle Benjamin Franklin wrote about in his autobiography:

“I made it a rule to forbear all direct contradiction to the sentiment of others, and all positive assertion of my own. I even forbade myself

the use of every word or expression in the language that imported a fix'd opinion...for these fifty years past no one has ever heard a dogmatical expression escape me."

If it worked for Benjamin Franklin, who broke many seemingly insurmountable impasses, it can work for you.

AGREE

I've already said that you're not going to be agreeing with the other person's opinion. So what is this about?

Here, you're going to ask her to agree that you disagree. In other words, you'll be indicating that you respect her opinion and hope that she'll respect yours. "I hope we can just agree to disagree on this. I respect your point of view and I won't try to talk you out of it. I hope you can respect mine."

.....

Using the "three A's" is far easier than it might appear at first glance. When my brother Henry asked me if I thought he had schizophrenia, I said: "I'm sorry because this might hurt your feelings. I want you to know I could be wrong. I don't know everything, but yes, I think you might have schizophrenia. I hope we don't have to argue about this – I respect your opinion on this and I hope you respect mine. Let's just disagree on this."

Did you see any or all of the "three A's"?

Here is a shorter example. "Should you take the medicine? I'm sorry I feel this way and I could be wrong, I just hope we can agree to disagree on this. Yes, I think you ought to try it for at least a few months and see how it goes."

The point is to be genuinely humble, help the person save face, and preserve the relationship you've been building. Remember, you will win on the strength of your *relationship* rather than on the strength of your argument.

7

Empathize

A few years after he first became ill, my brother and I were talking about one of his medications, Haldol. He hated Haldol (a.k.a. haloperidol) because it made him feel “stiff” and “groggy.” As I listened to his complaints, I understood for the first time some of the frustration he felt about taking these medications. I recall saying something along the lines of, “I can see why you don’t like these drugs. They make you feel stiff and groggy.” The conversation stands out in my mind because for the first time, we were calmly talking *about the medication* and listening to one another, instead of arguing.

Usually our conversations on this topic were a disaster. I would hold my ground and pontificate about why he should take the medications prescribed for him and about how immature it was of him not to accept the fact that he was ill. Brothers can often be that way, but after working for a year as a therapy aide on an inpatient psychiatric ward, I was beginning to learn how important it was to listen. As I listened, I couldn’t help beginning to empathize. I loved Henry, and when someone you love is in pain, it’s hard not to empathize. Learning to listen led to empathy. And my empathy ultimately resulted in my brother showing a real interest in *my thoughts* about the illness he felt he did not have and the medications he was sure he did not need.

.....
These are among the most important feelings to connect with because they are the feelings that drive people with mental illness away from their loved ones and therapists.
.....

When you feel empathy and convey it, your loved one will likely feel understood and respected. When you convey that you understand how your loved one is feeling, his or her defensiveness will decrease and openness to your opinion will increase. If you have listened reflectively to your loved one's experience of his illness and the prescribed treatment, you will naturally begin to empathize.

Communicating empathy can be tricky when you're talking to someone who has a psychotic illness, however. Many people worry that they should not empathize with certain feelings, such as anger about being forced to take medicine, fear of treatment, or feelings connected to delusions when, in fact, these are among the most important feelings to connect with—because they are the feelings that drive people with mental illness away from their loved ones and therapists.

Conveying empathy

You must first learn what it is you should be empathizing with. The short answer is “any *feeling* your loved one is willing to reveal.” But there are certain feelings that are particularly important for you to understand. Whether they are rational (“I am so tired of everybody telling me I am sick!”) or irrational (“The C.I.A. has implanted microchips in the capsules so they can track me!”), you want to be sure to empathize with:

- **Frustrations** (about pressure from others to take medication and about personal goals that have not been met).
- **Fears** (about medication, being stigmatized, and failing).
- **Discomfort** (attributed to medications, such as gaining weight or feeling groggy, slowed down, less creative, stiff, etc.).
- **Desires** (to work, get married, have children, return to school, stay out of the hospital, etc.).

A magical thing happens when you combine reflective listening with empathy. Your loved one will ask you what you think! I can almost guarantee this will happen.

For example, remember the conversation I had with Matt and his doctor? Matt, who everyone knew didn't think he was mentally ill, had just insincerely promised to take his medicine when he left the hospital. And I said, "Okay. I will take you at your word. But I have to say that if it were me, I wouldn't take the medicine." He opened up to me then and was more honest about not wanting to take the drugs. When he did that, I focused on empathizing with his feelings about taking them. I said, "You sound angry that everyone is pushing these drugs on you. Are you?" He agreed, then eventually asked me, "So, you don't think I need the drugs?"

You saw my answer to that question, but what you didn't know was that the time was ripe for me to give him my opinion. He was about to leave the hospital, and it was my last chance to talk with him. Most of the time, however, when someone asks my opinion about a delusion, about whether I think he's mentally ill or needs medications, I delay answering.

For example, one patient was convinced that his mother was poisoning his food. I listened and empathized, and he then asked me if I believed it was actually happening. Our conversation about this began with my saying, "So, if I understand you correctly, you mother has been poisoning your food. Do I have that right?"

"Yes!"

"How do you feel about that?"

"Are you serious? How would *you* feel?"

"I would feel, and I think anyone would feel, scared and angry," I replied.

"So, do you believe it? Are you going to do something about it?" he asked.

I didn't answer his questions at that point, although I did later. I delayed answering as long as I could. I will get to the reasons for that and explain how you can delay answering without frustrating the questioner. For now, however, the take home point is: *Listen and empathize and you will be asked your opinion.* And that is ultimately what you want to have happen – because an opinion that has been asked for carries far more weight than one that is forced on a person who is arguing with you.

Dolores

Dolores, who has had schizophrenia for nearly 20 years, told me that she didn't need medication or a day treatment program because there was nothing wrong with her. What did Dolores feel she needed? More than anything else, she wanted a job. She was frustrated that she did not have a job and also with her family, who told her she couldn't work. Her family was being reasonably pessimistic. The fact is that Dolores had been unable to keep a job for more than a few days at a time and she had been employed only a handful of times over the past twenty years.

By the time I met her, Dolores, like many individuals with serious mental illness who don't know they're ill, had been hospitalized many times – in her case, two to four times per year. Although she almost always signed herself into the hospital voluntarily, she would do this only after receiving tremendous pressure from her family. When I talked with her about what she planned to do when she left the hospital this time, she told me simply, "Get a job."

If you were her therapist and discussing her plans, you might be tempted (as I was early in my career) to focus on the irrationality of the idea. After all, she had a long history of poor adherence to her medication regimen – there was no reason to believe that her longstanding pattern of unemployment was about to change. You might understandably think that talking about

her reluctance to stay in treatment would be more beneficial than encouraging or agreeing with her irrational plan for herself. The problem was that Dolores had absolutely no interest in talking about drugs, day treatment programs, or doctors' appointments. Would you want to talk about those things if you weren't ill?

So, instead of going that route, I began our talk about her plans for the future by empathizing with what she was feeling at that moment. "You want to get a job when you leave?"

"I'm going to work on Wall Street," she answered quickly.

"Why Wall Street?" I asked, ignoring how far-fetched her plan was.

"I want to make a lot of money. I need to have my own money."

I reflected her statement back to her. "It's important to you to have your own money and you can do that by working on Wall Street. Is that right?"

"Yes, I hate having to ask my family for money."

"How come?"

"It makes me feel like a child. My little sister [who was in her 30's at the time] is a stockbroker and you should see her house. I'm the big sister. I should be making money too!"

I checked to see if I understood her feelings and, at the same time, communicated my empathy. "It sounds like asking for money makes you feel embarrassed or even a little humiliated. Am I right about that?"

"It does. Wouldn't you be embarrassed?" she asked.

"Yes, I think I probably would feel that way." Sensing an opening, I added, "Can I ask you something?"

"What?"

Careful not to add to her humiliation and raise her defenses, I asked, "Why do you think you haven't worked very much?" (Note that I *didn't* ask, "Why is it you've only worked about twelve days in your entire adult life?")

She quickly answered, "Because I'm always in the damn hospital!"

"Is being in the hospital keeping you from work?"

"I'm angry about being in the hospital so much. I want to get on with my life and I can't if I'm in a damn hospital."

"So it's much more than frustration you feel. It makes you angry. Yes?" I asked, nodding my head.

"Very angry," she answered, more calmly this time.

Pushing ahead, I asked, "How do you feel about the fact that it's been hard to find work?"

"Sometimes I want to scream!"

"That sounds infuriating. Is it?"

"No. It's frustrating," she said, correcting my misperception.

"So it's frustrating. Sorry I got that wrong."

"That's okay."

During this brief exchange, I empathized with Dolores's feelings of *humiliation*, her deep *desire* to work, and her *frustration* with being unable to work. Did you notice that nearly everything I said was in the form of a question? That is how you should do reflective listening. Also, by making a statement about my understanding of her feelings and asking if I had it right, I was able to make sure I understood what she meant when she said she wanted to scream. I communicated my empathy for what she was feeling and allowed her to be in control of the conversation.

Also, by asking questions instead of commenting on what she had to say (e.g., "What you're planning isn't realistic..."), I learned what was important to Dolores, what was uppermost on her mind, and how she was feeling. I created a window of opportunity, which I later used to discuss what role, if any, she felt treatment might play in what she wanted to accomplish (i.e., staying out of the hospital and working on Wall Street).

Whenever you want to facilitate change in another person, you must first become his friend (i.e., someone he trusts).

Whenever you convey empathy for another person's experience, he feels understood, respected, and more trusting. Because you understand the other person's point of view and how he feels about his situation, there is nothing to argue about. Consequently, he becomes less defensive and more open to hearing your perspective. And, more often than not, he will ask either: "So do you believe me?" Or, "Why are you acting like you believe me? You don't believe me, do you?"

These questions are opposite sides of the same coin—a coin you want to handle carefully as it is vital to where you want to go.

How to handle the "Do you agree with me?" question

Delay answering questions about delusions, having a mental illness, or the need for medication as long as you can. There are two reasons to do this—so that you preserve and build on the good relationship you have been creating with reflective listening and empathy. Up to this point, the person feels that his or her opinion is respected and honored. In fact, he feels so certain of your respect for his opinion that he has made the mistake of thinking you probably agree with him. Therefore, when you do give your opinion, it will probably hurt and make the person defensive.

The longer you wait, the more experiences he will have of your listening to him without disagreeing or essentially telling him he's "crazy," which is just how many persons with mental illness will hear your opinion unless you pay close attention to how you give it.

The second reason to delay has to do with the two ways one can give an opinion. I mentioned them in the previous chapter. By making the person ask for your opinion, you make him responsible for having to hear it.

Think about it. If you asked me over and over again whether I thought you were mentally ill and needed medication, and I

didn't seem very eager to tell you, you'd have no one to blame but yourself for having coerced me into giving it. Try to remember:

- Only give your opinion when it has been asked for.
- An opinion that has been asked for carries more weight than an unsolicited opinion.
- It is important to avoid or delay giving your opinion.

So, how can you delay giving your opinion on these matters that are so important to your loved one? In the space below, I want you to write down something you could say to delay giving your opinion on the question, "Do you think I am mentally ill and need to take medicine?"

.....

.....

Read what you wrote and imagine it was being said to you. How would you feel about it?

The trick to delaying is first to honor the question by promising to answer it. By doing that, you empower the person by asking his permission to delay answering and you make the point that *his opinion is more important than yours*. It is not as complicated as it sounds. Here are some examples:

- "I promise I will answer your question, but, if it's okay with you, I want to wait and listen to you some more first, okay?"

- “I will tell you, but I would rather keep listening to your views on this because I am learning a lot about you I didn’t know. Can I tell you later what I think?”
- “You know, your opinion is the most important opinion in this room, not mine. I would like to learn more before I tell you what I think, if that’s all right with you.”

I once had a patient say to me, “But you’re the doctor! Your opinion has got to be more important than mine.” I disagreed and I told him so. “When we’re done talking and you walk out this door, you are in the driver’s seat. Your opinion is what will determine what you do and where you go, the choices you make, not mine. So your opinion is far more important than mine.”

By saying this, I was empowering him while humbling myself. More important, it was coming from my heart. I believed it. As you can imagine, this made me and my opinion a lot less threatening to him than I or it would have been otherwise.

.....
When you feel the time is right, you want to give your opinion.

At some point, when you feel the time is right, you want to give your opinion. Earlier in the book, I told you about the research that indicates how a special kind of relationship can influence someone’s willingness to take medicine. That relationship is one in which the mentally ill person feels that his opinion is respected, trusts the other person, and believes that this other person thinks taking medicine is a very good idea. Well, now is your chance to give your opinion. But, for the same reasons you delayed giving it, do it with humility while empowering your loved one. Never give your opinion without first using what I named the “three A’s.” I described them earlier, but they are so important. Many readers tell me they missed them when reading this book, so I list them here again:

Apologize – “Before I tell you what I think about this, I want to apologize because it might feel hurtful or disappointing.”

Acknowledge fallibility – “Also, I could be wrong. I don’t think I am, but I might be.”

Agree to disagree – “And, I hope that we can just agree to disagree on this. I respect your point of view and I will not try and talk you out of it. I hope you can respect mine.”

This, too, comes quite easily once you practice it a few times. Try it out with someone in a role-play before using it with your loved one. Practice it in other situations. It will disarm the person you are about to disagree with when you say something like, “I am sorry because my answer might upset you and I realize I could be wrong. I just hope we can agree to disagree. I think _____.” Don’t use the word “but” as in, “But, I think...” People who are in a disagreement typically stop listening when they hear the word “but.”

If your loved one gets defensive after you give your opinion, don’t argue. Just apologize for disagreeing. You might even say something like, “I wish I felt differently so we didn’t have to argue about this.” But I have found that, by the time I give my opinion when using LEAP, I rarely encounter defensiveness.

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The Surprise

I'm sure you remember that one of the first things I told you, way back at the beginning of this book, was that your goal was *not* to get your loved one to admit he or she was sick but to get him to follow his statement "I'm not sick" with the statement "But, I could use some help." In other words, the techniques I've been teaching you are not aimed at getting the person who is mentally ill to gain insight into being ill; they are directed specifically at getting him to find reasons to accept treatment despite what he believes.

If you've reached the point where your patient or loved one has made that commitment, what you want to do now is make sure *you* don't revert to old bad habits like giving your opinion without first asking if the other person wants to hear it. You need to maintain and build on the collaborative dialogue you've begun, and while you may be tempted to remind the mentally ill person that "doctor knows best," or even worse, "father knows best," you've got to remember that those so-called wise words aren't going to make one bit of difference to the one you're trying to help. In fact, they will more than likely just blow up the bridge you've so carefully been building between you.

But you know all that already, right? So what's the surprise? The surprise is that when people with a serious mental illness are in treatment and when they have the kind of relationship I've been trying to help you build with them—one that allows them to feel their point of view is respected and to trust you—they *will* begin to develop insight.

Remember Vicky, whose interview with Dr. Kohut you read in Chapter 6? Initially, Vicky continued to believe she was "cured"

of bipolar disorder but agreed to continue taking her lithium on a trial basis for six months and then, if she decided to go off it, to do so in conjunction with her doctor. She was able to make this commitment because Dr. Kohut had allowed her to understand that she was, ultimately, the one in charge of whether or not she would take the medicine—by doing that, he won her trust and showed her that he honored and respected her feelings. After a while, Vicky was also able to see what happened when she lowered her dose or discontinued her medication, and she gained true insight into the relationship between taking the medication and remaining asymptomatic. When she recognized that without the lithium she was getting “worn out” again, she *asked* to be put back on medication.

And then there was Dolores, who kept losing jobs because she was holding conversations aloud with the voices in her head. At first, Dolores didn't see any relationship between her getting fired and going off her medication. In fact, she initially believed that the medication was *making* her hear voices. It took a long time, and several more hospitalizations, but Dolores did gradually come to have some insight into the fact that when she stopped taking medication she talked to herself more, and that this was likely to make people think she was “nuts.” Like Vicky, she developed insight into how medications helped her with a problem she was having. Vicky didn't call the problem “bipolar disorder”; she called it getting “worn out.” Dolores's problem, as she saw it, wasn't having hallucinations; it was talking aloud to herself. Nevertheless, both these women developed insight into how the medications helped them with their problems as *they* saw them. The surprise, then, is that over time people *do* begin to redefine their problems as mental illness, whether or not they define mental illness in exactly the same way you do.

In psychology, we call this the “change paradox.” When you stop pushing someone to change, often they find reasons to

change all on their own. I think that is what happened not only with Vicky and Dolores but also with other patients who have benefited from the kind of relationship I've been talking about while taking their medications. Given the room to explore their situation with someone they trusted and who did not preach or tell them they were sick, they were able to develop insight. First the insight was about positive outcomes linked to taking medicine and then later, into having a mental illness.

We know today, right now, that building a respectful and trusting relationship is the key to helping someone with poor insight accept treatment for mental illness.

I think the anecdotal evidence is pretty compelling, but there are also scientific studies to show that developing the kinds of relationships I've been talking about can and does ameliorate lack of insight in patients with serious mental illness. In a study by Dr. Roisen Kemp and her colleagues, published in the *British Journal of Psychiatry* in 1998, the researchers found that medication adherence and insight improved over an 18-month follow-up period after only six sessions of MET. (Remember, LEAP is based on MET, which seeks to create a collaborative relationship with the person in "denial.") This is one good example of how building the mutually respectful and trusting relationships we have been talking about can help with both adherence and insight. And, as I mentioned in Chapter 10, new research on medication may also help in our battle against anosognosia. Regardless of what happens with the research on medication, however, we know today—right now—that building a respectful and trusting relationship is the key to helping someone with poor insight accept treatment for mental illness.

Whether you are a family member or a mental health provider, what this means is that when you create a nonjudgmental

and trusting relationship, the person you are trying to help will find reasons to be in treatment, and over time, develop insight about having a mental illness. It may take a year or two of staying in treatment, but the pay-off over a lifetime is incalculable.

As you go forward, however, you need to remember that you are a member of the team. You need to be strong and well rested. If you do more than you should, you will lose motivation and risk “burnout.” Burnout is a term used by mental health professionals to describe the feeling of complete exhaustion that comes from having been immersed in other people’s problems for too long. Exhausting yourself will only make you less effective and your loved one or patient feel like a burden.

If you are a family member, I want to add one final word from one family member to another. You are in a unique position to help your loved one learn how to cope with mental illness. You knew your loved one before the illness struck, which means that you also know the core person who is often eclipsed by symptoms of the disease. When someone who is seriously mentally ill feels that you see him for who he is, and not just for the diagnosis he has been given, he will be open to learning from you.

The Surprise for Henry and Xavier

Henry never developed insight into being mentally ill. But the last time I saw him, in the days following our mother’s funeral, I can’t tell you how much comfort I received from him – it was more visceral than verbal. I know he felt the same. Yes, we talked, but our shared battles, betrayals and ultimately our reconciliation, made possible by our respect for each other, was something we felt in our bones.

On the drive back to his house, on our last night together, my brother told me he felt I saw him for who he was. Henry was very kind, smart, funny, insightful (about most things), and creative. Yes, he was a pain in the ass (and I to him) during the

early years of his illness when we argued about whether or not he was mentally ill and needed treatment. But I was to blame for that more than he. Henry was able to laugh at life. I saw him and liked him and he knew that.

I learned a lot from my brother—a man most people gave a wide berth to because of his explosive eruptions into laughter for no apparent reason and his conversations with the voices only he heard. He taught me how to throw a baseball, ride a bicycle, and the power of humility. When we were growing up, he brought humor and magic into my life (like the time, when I was five, that he convinced me I had just missed Santa Claus flying by our window). More recently, he taught me about compassion, patience, perseverance and most importantly, forgiveness. I feel very fortunate, as you will read in the next section, that we had a strong friendship for many years before he died.

LEAP would not exist if not for Henry Amador. It was not my creation alone or that of my collaboration with Aaron (Tim) Beck, M.D. and other colleagues and patients. More than anyone else, Henry helped me to develop LEAP and without it, I am sure we would have lost many years of closeness, laughter and love.

In the next, and last, section of this book I give you the details of where LEAP comes from theoretically, a summary of recent research on cognitive behavioral therapy for schizophrenia (which LEAP draws on in part) and a review of recent research on the link between violence and poor adherence. I next make an argument for why we must include anosognosia in our diagnostic manual, not only for schizophrenia, but for other psychotic disorders.

Finally, I tell you the end of Henry's story. Perhaps "end" is not the correct word because I believe that with every copy of this book that is read, his story will continue to unfold—and his compassion, empathy and kindness will help others reach people with serious mental illness and bring them back to their families.

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Henry

On April 23, 2007, while standing on a sidewalk and helping a woman put her groceries on a bus, my brother Henry was hit by a car and died at the scene. There's a videotape of what he did, taken by the bus company, though I don't yet have the strength to watch it.

That was so like him. Although often lost in delusional thoughts and distracted by hallucinations, he was aware of people around him, especially those in need, and he cared.

That was not what he or I had planned for. When I first wrote about this, only two months after his death, I was much too close to my loss and mourning to know what good could possibly come from it all—but I had to trust that someday something would.

Saying Goodbye Twice

Standing at the lectern, looking out at the people who had come to Henry's funeral, I was struck once again by what a full life he had had. His friends filled the church, prompting several of my family members—who had had very little contact with Henry after he became ill 25 years before—to say things like "I had no idea he had this many friends!" and "I never knew his life was so full."

As they met and spoke to more and more of his friends over the course of that day and the next, some in my family expressed deep remorse and sadness that they had missed out on so much of his life. I didn't feel that sadness because I had not—my brother and I were very close and loved each other's company immensely. Henry was my hero.

The reason I had this relationship with Henry while others in our family did not is *not* because I am a better person; I am no saint. The reason is that after he first became ill, I was somehow able to mourn who he had been before, while most of my brothers and sisters (there are nine of us) seemed unable to.

At first, I know we all felt it—it was impossible to accept that he was no longer there in the way he had been. Handsome, kind, and loving with a magical sense of humor, he would never become the person we all had envisioned he would—a loving husband and father, a responsible caregiver and successful man.

When he became ill with schizophrenia, we all longed for the “old Henry” and made little room in our hearts for the “new Henry.” He had the same problem.

For the first five years of his illness he, like us, was stuck on the plan he had had for the future, and he became depressed that what he had planned now seemed impossible to attain. Prior to becoming ill, he had always worked, gone to university and had girlfriends. That was over now. Not until he had mourned his old vision for the future did he discover that the core of the old Henry was still there and realize that new plans needed to be made.

The last year of his life he was especially happy. This is not some wishful revisionist delusion on my part—it is confirmed by all that were close to him. He had many friends; he worked odd jobs with his friend “Pops,” and his girlfriend Mary had become a big part of his life.

Mourning when mental illness strikes

The research is clear on the importance of mourning. By mourning what has been lost, you open your eyes to all that is still there. Moreover, you open your eyes and heart to new possibilities.

In a review of the research on literature we published in the spring of 2007 in the *Annals of General Psychiatry*, my colleagues

and I found that people with schizophrenia who had successfully mourned were less likely to feel suicidal. Studies of family members of people with schizophrenia have found that those relatives that who have mourned the loss of the way things used to be are less likely to be critical of their mentally ill loved ones, and feel less burdened and stressed.

Some research findings are intuitive – they just make sense. This is one of those instances. I saw that same transformation in my brother and experienced the improvement in his hopefulness about his future and our relationship. I've seen it repeated time and again in the patients and families I have worked with this last 25 years.

Closing one door opens another

It is like any other major change in life. When you mourn, you feel sad because you are saying goodbye to what was and what you hoped would be. But by doing this, you feel at peace – and even happy – as you say hello to what is and what *can* be. I have counseled many families and also consumers on the importance of going through this process. Families that successfully mourn are able to let go of their anger at their loved ones. They learn to separate the illness from the person. Communication gets healthier, and even the course of illness can improve because of the lessened tensions between family members.

But I never before experienced the stark truth of this wisdom so completely as I did when my brother died. Now that he is gone, I find I have no regrets.

I cherish countless good memories of him. I remember our nearly constant laughter together, his helping me build an outdoor fireplace in my home which crackled with flame and heat for my family earlier this evening, his giving me permission to write about him, the pride he felt in me and I in him, and so much more.

I recall our many conversations, how often he would ramble and it would be hard for me to listen. Despite all, he would always end by saying, “You’re my baby brother, and I love you.”

After Henry became ill, many things changed. But not the fact that he was smart, handsome, kind, and loving. Or how he could make me laugh—splitting-your-gut laughter—in any situation, even at our mother’s funeral! He usually did it with kindness and reverence for the feelings of other people—except for those rare instances later in life when the illness got the best of him. Because he felt less inhibited, he was far funnier than he was prior to becoming ill and he knew it.

Many people have written to me to offer their condolences, to share their good memories of Henry, and to wisely say how lucky I was to have him as my older brother. They are right.

But they left out one vital thing, a lesson I learned anew as I reflected on the seemingly insurmountable task of saying goodbye to him all over again. I was especially fortunate that I was able to mourn after he first became ill—to say goodbye to what I had hoped for—so that during these past 25 years, I could laugh with him, make new good memories with him, and realize just how lucky I was to be his “baby brother.”

Henry worked with me to get well and our relationship was a good one. He helped many people through his example, his influence on my thinking, and his willingness to let his story be told in my books and articles. We will never know how many lives he saved and how many people with poor insight he helped to recover.

I have received many letters from kind souls telling me he had that impact—I am sure there are many more who have not written.

I have much to be grateful for.

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LEAP®

QUICK START GUIDE

LISTEN

Reflectively
to:

Delusions
Anosognosia
Desires

Repeat back what you've heard without comment, defensiveness or contradiction. We resist reflecting back many important things our patients tell us because:

- *We fear it will make it worse (i.e., delusions, insight, attitudes, medication, etc.)*
- *We do not want to be asked to do something we cannot.*
- *We worry about injuring the therapeutic alliance.*

Delay giving your opinion:

"I promise I will answer your question. If it's alright with you, I would like to first hear more about _____. Okay?"

"I will tell you what I think. I would like to keep listening to your views on this because I am learning a lot I didn't know. Can I tell you later what I think?"

"I will tell you. But I believe your opinion is more important than mine and I would like to learn more before I tell you my opinion. Would that be okay?"

When you finally give your opinion, use the "three A's":

APOLOGIZE: "I want to apologize because my views might feel hurtful or disappointing."

ACKNOWLEDGE FALLIBILITY: "Also, I could be wrong. I don't know everything."

AGREE: "I hope that we can just agree to disagree. I respect your point of view and I hope you can respect mine."

LEAP®

QUICK START GUIDE

EMPATHIZE

Strategically
express empathy for:

Delusional beliefs
His desire to prove he is not sick
His wish to avoid treatment

Normalize the experience.

AGREE

- Discuss only *perceived* problems/symptoms
- Review advantages and disadvantages of treatment
- Reflect back and highlight the *perceived* benefits

Agree to disagree.

PARTNER

Move forward on goals you *both* agree
can be worked on together.

About the Author

Dr. Amador is an internationally sought-after speaker, clinical psychologist, professor at Columbia University, Teachers College, in New York City, the Director of the LEAP Institute and author of eight books.

In 2010, Dr. Amador and his LEAP program were featured in the PBS's NOVA series, *This Emotional Life*. Dr. Amador's expertise has made him a regular contributor to the Today Show and a featured guest on ABC's Good Morning America, Prime Time Live, CBS This Morning, NBC Nightly News, 60 Minutes, CNN, Dateline, ABC's World News Tonight, Fox News, *The New York Times*, *The Wall Street Journal*, *USA Today* and many others.

Dr. Amador has been a consultant to numerous companies and government agencies including the National Institute of Health.

His forensic cases include: the Unabomber, PFC Lynndie England, the Elizabeth Smart kidnapping, and the trials of Zacarias Moussaoui and accused 9/11 co-conspirator Ramsi bin al Shibh. Dr. Amador has over 25 years experience working with adults, families, and couples. He lives in New York.

Previously, Dr. Amador was a professor in the Department of Psychiatry at Columbia University, College of Physicians & Surgeons; on the Board of Directors of the National Alliance for the Mentally Ill (NAMI); Director of Research at NAMI; and the Director of Psychology at the New York State Psychiatric Institute.

Dr. Amador has published over 100 peer-reviewed scientific papers, and many other publications that have been translated into more than 20 languages.

Dr. Amador was co-chair of the last text revision of the Schizophrenia and related disorders section of the *DSM IV-TR* (often referred to as the "Psychiatrists' Bible").



LEAP® (Listen-Empathize-Agree-Partner®) shows clinicians, family members, and law enforcement professionals how to quickly gain the trust of someone who is angry or paranoid. It gives you the tools you need to persuade someone in “denial” about mental illness to accept treatment and/or voluntarily comply with your requests. It grew out of Dr. Xavier Amador’s:

- Successful struggle to convince his brother Henry, who was diagnosed with schizophrenia, to take the medications prescribed for him.
- Twenty-five years of hands-on clinical experience with patients who lacked insight.
- Experience gained from hundreds of LEAP seminars involving tens of thousands of clinicians, family members, and law enforcement.
- Twenty-five years of clinical research supported by the NIMH, Stanley Research Foundation, American Psychiatric Association and NARSAD.

Since the book *I Am Not Sick, I Don't Need Help!* was published, thousands have learned LEAP from the author and LEAP Institute faculty worldwide.

**For more information, please visit
www.LEAPInstitute.org**