Discussion and conclusions

If a decrease in total BPRS score of 15 percent or more is taken as the criterion for clinical effectiveness of clozapine, 70 percent of the patients in the study group had a clinically effective response within six months after starting the medication. The study group showed improvement in both positive and negative psychotic symptoms, and most achieved higher levels of patient privileges after treatment with clozapine.

Although positive and negative symptoms of psychosis were not completely alleviated, the frequency and intensity of such symptoms decreased dramatically. Improvement was noted in social interactions, grooming, daily living skills, anomalous functioning, and diminished aggression. As a result of these improvements, 70.5 percent of the patients on clozapine achieved a level of patient privileges that had been achieved by only 3.7 percent of patients before treatment.

In addition to clozapine’s direct effect on dopamine receptors, the reduction in the symptoms of movement disorders associated with discontinuation of typical antipsychotics may have contributed to patient improvement. Akathisia can be a source of anxiety and depression, and akinesia may be manifested as a be

Patient Identification of Street Identification of Street Skills for a Psychosocial Training Module

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Various skills training modules have been developed to teach psychiatric patients behaviors that are necessary to daily interpersonal and instrumental goals. Studies show that patients who participate in social skills training increase their repertoire of interpersonal behavior (1), decrease severe symptoms (2), and are not hospitalized as often as patients who do not participate (3).

However, despite these social skills, most patients are vulnerable to the risks of urban life. Severely mentally ill patients have higher rates of victimization and commit more misdemeanor crimes than the general population (4,5). Hence, a psychoeducational module that teaches street skills—practical abilities to recognize and respond to risky situations—would help patients cope with some of the major pitfalls of living in the city.

Identification of skills to be included in this training module is not a easy task. Perceptions of social problems and their solutions are culturally bound and therefore not always comprehensible to individuals.
of different ethnic subgroups (6). Clinicians who develop skills training modules are frequently from the white middle class and may not recognize problems or solutions specific to the socioeconomic class of patients they treat. This may be especially true for street skills, given the significant differences between poor and middle-class neighborhoods.

Goldfried and D'Zurilla (7) developed a behavioral-analytic method that is useful in constructing a skills training module based on the unique experiences of the subgroup of interest. We used this method to assist psychiatric patients in identifying street skills that are effective for handling victimization. Ironically, although psychiatrically disturbed patients who are surveyed may be able to identify interpersonal skills that should be included in a training program, the cognitive and intellectual deficits characteristic of their illness may diminish their ability to put those skills into practice.

We hypothesized, however, that psychiatric patients could generate a reliable and meaningful list of problem situations and responses. Further, we expected that differences in intellectual levels and presence of psychotic symptoms would not diminish the reliability and quality of patients' responses.

Methods

Subjects. Twenty-one patients enrolled in a partial hospitalization program in Chicago were informed of the purpose and procedures of the study and agreed to participate. Patients had previously received DSM-III-R diagnoses of schizophrenia or schizoaffective disorder (N = 11), major depression (N = 6), bipolar disorder (N = 2), or other major psychiatric illness (N = 2) by faculty at the department of psychiatry at the University of Chicago. Subjects had lived in the Chicago metropolitan area for at least three years.

Two measures of cognitive functioning were used. For assessment of intellectual ability, subjects completed the vocabulary subtest of the Wechsler Adult Intelligence Scale, Revised (WAIS-R). The correlation of the subtest with overall IQ ranges from .82 to .87 (8). For assessment of level of thought disorder at the time of the study, subjects also completed three items from the expanded version of the Brief Psychiatric Rating Scale (BPRS) (9): unusual thought content, disorientation, and conceptual disorganization.

Raters who conducted the BPRS interviews had been trained previously to a minimum agreement of 80 percent for the presence of symptoms. Subjects' responses for were coded for thought disorder by two independent raters using criteria from Andreasen's Scale for the Assessment of Thought, Language, and Communication (10). Examples of those criteria include derailment, tangentiality, and autistic logic.

Procedures. Subjects were asked to report their opinions about and experience with crime. They were told that their responses would provide the content for a street skills training module. After providing information about their experience with being a victim of crime or being arrested, subjects completed survey instruments that corresponded to the three phases of behavioral analysis—situational analysis, response enumeration, and response evaluation.

Questions pertaining to situation-
al analysis included requests for specific information about past experiences with crime—for example, “Tell me what happened each time you were a victim of crime”—or requests for speculation about urban problems in general, such as “In what kind of situations do you think people might unwittingly participate in a crime?” In the response-enumeration phase, subjects were asked to consider the list of situations generated in the first phase and to name effective responses to each problem. In the third phase, response evaluation, subjects discussed the responses to reach a consensus about the effectiveness of each coping behavior. Information was collected from the patients as a group during a class scheduled specifically for the purpose of developing this module.

Results
Five of the 21 patients who participated in the study were either hospitalized or left the program before data collection was complete, so the number of subjects who completed specific tasks varied. The mean±SD age of subjects was 36.6±14.4 years. Subjects’ mean±SD years of education was 17.7±2.1. The group comprised more males (67 percent), African Americans (67 percent), and single adults (80 percent). Ninety percent of the subjects received public assistance. Eighty-three percent had been victims of crime. The median number of lifetime victimizations was 1.5. Far fewer subjects had been arrested; the median number of arrests was 5.

Situational analysis. Patients generated 60 different situations in response to a question about victimization, 34 situations in response to a question about avoiding arrest, and 13 situations in response to a question about other issues to be included in the street skills module. To check patients’ reliability in identifying situations, appropriate responses were compiled in a checklist and subjects were asked to select the most relevant situations twice during a two-week period. Test-retest correlations representing the number of endorsed items related to victimization, criminal arrest, and other street skills were high: .74, .86, and .64, respectively (p<.01). The top 25 percent of items endorsed by patients for the three questions were viewed as defining relevant street situations. Two independent judges determined that these items yielded the eight different situations summarized in Table 1.

The appropriateness of patients’ responses did not seem to be diminished by formal thought disorder. According to findings from the BPRS, 50 percent of the subsample of patients met criteria for severe conceptual disorganization. However, only one patient generated any confused responses, as determined by judges using criteria from the Scale for the Assessment of Thought, Language, and Communication (inter-rater reliability was 90 percent). Unlike quality of patients’ responses, quantity of responses was correlated with thought disorder, with patients who had a high level of thought disorder providing fewer responses.

The total number of situations generated during the open-ended phase of the situational analysis was found to be significantly correlated with the sum of the three BPRS items (r=-.60, p<.05) and patients’ intelligence, as measured on the WAIS-R subtest (r=.63, p<.05). Results of a multiple regression analysis showed that the variance of quantity of response was predicted by the BPRS and WAIS-R scores independently (R=.81).

Response enumeration. The eight situations generated from the situational analysis were used to prepare 20 open-ended questions for the response enumeration. Patients generated a total of 14 coping responses to victim-related questions, nine responses to arrest-related questions, and three responses to questions about other street skills.

An analysis of the responses using criteria from the Scale for Assessment of Thought, Language, and Communication revealed no disorganized responses by patients in the response enumeration phase. No significant correlations were found between the number of responses to survey questions in the response enumeration and BPRS scores. Similarly, quantity of responses was not found to be correlated with scores on the vocabulary subtest of the WAIS-R.

Response evaluation. Patients rated the relevance of the items generated in the open-ended response enumeration phase on a 5-point scale from least to most relevant. The resulting ratings were used to pare the set of responses down to a manageable number of street skills that other patients might acquire through skills training. The street skills, or coping responses, for each problem situation are summarized in Table 1.

Discussion
Crime situations and coping responses relevant to severely mentally ill patients were identified using strategies developed by Goldfried and D’Zurilla (7) for identifying the behavioral content of interpersonal domains through the eyes of a target clinical population. The crime-related situations generated in this survey had a definite urban flavor, targeting trouble spots such as bus terminals, subway trains, and deserted neighborhoods. Of interest is that coping responses identified by patients tended to be more preventive than reactive. For example, patients recommended avoiding situations in which arrests might result rather than providing suggestions about how to navigate the criminal justice system after having been arrested.

The quantity of responses correlated with the patients’ level of intelligence and psychosis; patients with more symptoms of thought disorder and less intelligence produced fewer responses to test items. This finding may represent a deleterious effect of the impoverished thinking characteristic of patients with negative symptoms. However, quality of responses did not seem to be diminished by formal thought disorder.

Besides identifying responses to urban crime that are relevant to patients, the study confirmed the usefulness of Goldfried and D’Zurilla’s method for describing the relevant content of skills modules (1). This method can also be used to validate the content of other types of training modules for psychiatric patients, including modules on activities for daily living, conversational skills,
assertiveness, and problem solving. Moreover, the behavioral analysis method may be used to identify other areas in which patients may encounter problems, perhaps including difficulties that are not readily apparent to clinicians whose socioeconomic sphere is different from that of their patients.

References

Factors Involved in Failure to Keep Initial Appointments With Mental Health Professionals

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The large number of patients who fail to keep their initial appointments with mental health professionals has long been recognized as a major and costly problem (1). Studies generally report rates of missed initial appointments ranging from 20 percent to 60 percent (2,3). Research indicates that patients who miss their initial appointment differ from those who drop out after the initial appointment (4) and have a lower rate of rebooking their appointments (5).

Although failure to keep initial appointments is recognized as an important problem, it has not been studied consistently because of several inherent difficulties. Often the only contact that patients who do not keep first appointments have with a mental health facility is a physician referral or a telephone self-referral. As a result, the ability to gather information on these patients is significantly constrained. Some studies have followed up on patients who missed initial appointments (6,7), but such studies are less common because of the additional difficulties in recontacting patients. As a result, no author has published more than one or two studies in this area. Individual researchers have usually employed their own methodologies and looked at different aspects of the problem; thus replicated findings are limited.

This brief review attempts to integrate these disparate studies. The analysis is divided into three parts that mirror the three (nonexclusive) foci within this research: characteristics of patients who miss their initial appointments, follow-up of these patients, and attempted methods of lowering the rate of missed initial appointments. Because of the large number of negative or unreplicated findings, this overview focuses on the few replicated positive results using representative studies.

Major research findings

Patient characteristics. A variety of patient and appointment characteristics have been investigated to determine if they affect the rate of missed initial appointments. Although some variables are unique to a single study, numerous variables have been reported in several studies and allow for some generalizability. These variables can be divided into three groups: demographic, clinical, and clinical practice.

Most demographic variables, such as race or marital status, have failed to differentiate between patients who keep their initial appointment and those who do not. The one possible exception is age. Younger prospective patients may be less likely than older prospective patients to attend their initial appointment (8–10).

Clinical variables related to the patient seem to have somewhat more predictive ability. Patients with specific presenting complaints, such as obsessive thoughts and frigidity, appear more likely to attend the initial session than those with vague complaints, such as personality problems (2,8,11). Also, research suggests that a previous history of mental health contact decreases the probability that the patient will keep the initial appointment (4).

Of more interest to most clinicians is what aspects of their practice affect the probability that a patient will keep the first appointment. Such

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