The Frontline Reports column features short descriptions of novel approaches to mental health problems or creative applications of established concepts in different settings. Material submitted for the column should be 350 to 750 words long, with a maximum of three authors (one is preferred), and no references, tables, or figures. Send material to the column editor, Francine Cournos, M.D., at the New York State Psychiatric Institute, 1051 Riverside Drive, Unit 112, New York, New York 10032.

An Integrative Treatment for Patients With Persistent Auditory Hallucinations

Hallucinations-focused integrative treatment uses multiple modalities to maximize control of persistent auditory hallucinations. The approach is a directive style of single-family therapy that integrates selective motivational interventions, training in coping skills, and cognitive-behavioral therapy with medication, psychoeducation, and rehabilitation. The intervention uses 20 one-hour sessions over nine to 12 months. Crisis intervention is available around the clock.

The intervention

The motivation module includes several components. A focus on disease and on medical institutions is replaced by one on consumer needs and demands. Symptoms and behavior are relabeled positively. Medication noncompliance is recast as a request for medication adjustment. Resistance is no longer explained in psychiatric terms but viewed as consumer complaints for which the adjustments should be made. With use of motivational interviewing, interventions are accommodated to the patient's degree of awareness of the illness. Hallucinations are accepted as a reality for which the patients are responsible.

To enhance patient responsibility the patient selects the timing and order of therapeutic interventions. Compliance is reinforced by adjusting the duration and frequency of sessions according to principles of operant conditioning.

Coping training teaches patients and relatives a repertoire of skills for anxiety management, for distracting the patient's attention from the voices, and for focusing attention on the voices when nececessary. Graduated exercises are followed by practice. Daily monitoring of the characteristics of the voices, contextual aspects, and coping and its effect is pivotal in constructing a coping strategy.

Cognitive-behavioral therapy interventions focus on precipitating events, on emotional, cognitive, and behavioral actions or reactions, and on the reactions of others. False beliefs are challenged. Patients and relatives are encouraged to elicit new ideas and solutions. Psychoeducation focuses on symptoms and on problem solving.

In family treatment, joint sessions with the patient and relatives are preferred. Relatives are given credit for their endurance and sympathy for unsuccessful attempts to work with the patient; feelings of guilt are neutralized. Relatives monitor their feelings, cognitions, and behavior toward the patient, and patients in turn monitor their relatives' reactions. Data from these sessions are used to train relatives in positive labeling and in selectively reinforcing the patient's coping behavior, self-care, and daily activities. Data from continuous monitoring help participants evaluate the effectiveness of their training.

The usual rehabilitation domains are covered, although rehabilitative tasks are reframed as coping strategies for beating the voices. Tasks are divided into small steps. The need for support in accomplishing them is determined, and possible failures are anticipated and countered with coping behavior. Relatives are instructed in selective reinforcement. For each task, participants monitor endeavors, time investment, and the effect of and their satisfaction with activities.

Medication is provided according to guidelines of the Dutch Psychiatric Association, which are similar to those of the American Psychiatric Association.

Evaluations

The effectiveness of hallucinations-focused integrative treatment was tested in two naturalistic studies between 1994 and 1996, one with 40 adults with therapy-refractory hallucinations and the other with 14 adolescents. Diagnoses were made according to *DSM-IV*; the majority of the patients had schizophrenia. Assessments were conducted with the Auditory Hallucinations Rating Scale for assessing hallucinations; the Groningen Social Disabilities Schedule, which uses a 4-point scale to measure eight social roles of work, social relationships, participation in society, and self-care; and the Positive and Negative Syndrome Scale to measure psychopathology. Satisfaction with therapy was measured on a 5-point scale, with 5 indicating very satisfied.

Half of the adult patients completed treatment. At the end of treatment, 20 percent of the 40 adults, or 40 percent of those who completed treatment, reported continuous freedom from auditory hallucinations for three months. Sixty-four percent of the adolescents reported the same. Two-thirds of the adult group reported that hallucinations neither interfered with daily activities nor caused them anxiety. Among the adolescents, only one reported considerable anxiety. Of 12 adolescents who reported interference with daily activities at baseline and nine who reported interference with thinking, one in each group retained these complaints after treatment.

Forty percent of the adults and 79 percent of the adolescents reported improvements in their daily activities; 57 percent of the adolescents showed substantial improvement in work or study activities, and smaller percentages in both groups reported improvement in contacts and relationships.

Satisfaction with the intervention was high in both groups, with nearly

80 percent rating their satisfaction as 4 or 5 on the 5-point scale. Dropout rates were below 10 percent.

Most patients attributed their improvement to coping training and insight. At a follow-up assessment of the adult group four years later, 60 percent of the adults had retained their gains, and 30 percent showed even further improvement. Ten percent had relapses but were still functioning better than before treatment; nevertheless, social handicaps and anxiety were still severe, requiring further treatment. A follow-up assessment of the adolescents was not conducted. A randomized controlled trial comparing hallucinations-focused integrative treatment with usual care is in progress.

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Resident Education in Community Psychiatry: A Model of Service-Learning

In 1995 the Health Professions Schools in Service to the Nation launched a program of community-based education called service-learning. The foundation of this innovative form of education is the development of a partnership between health professions schools and the communities in which they are located. The aim is to achieve a collaborative balance between serving the identified unmet health care needs of the community and meeting defined educational objectives for the student or resident, such as embracing a personal ethic of service, cultivating critical thinking skills, and promoting a context for reciprocal learning.

Training psychiatric residents to be more knowledgeable about and responsive to the health care needs of the underserved is an educational goal of the University of Florida's community psychiatry program. Models of service-learning, integrated into the curriculum of the community psychiatry program, offer the opportunity to achieve this end. Upper-level psychiatric residents have the opportunity to engage in a service-learning experience by volunteering to work in an inner-city, shelter-based psychiatric clinic for the homeless mentally ill population in Jacksonville.

The University of Florida's community psychiatry program partnered with the Northeast Florida Area Health Education Center, an organization committed to training health care professionals to treat medically underserved populations, and approached the administration of the I. M. Sulzbacher Center for the Homeless, located in downtown Jacksonville. The purpose of the preliminary discussions was to determine the need for psychiatric care among those who frequent this large, 300-bed center for homeless persons. In these initial meetings it was made clear that access to mental health care and addiction services among the local homeless population was a profoundly unmet need. Hence the University of Florida's psychiatric clinic for the homeless was developed under the direction of the department's community psychiatry program, beginning in June 2000.

The clinic was designed to operate one full day each week in conjunction with the primary care clinic already established at the center. On clinic days, some 15 to 20 patients are seen for initial psychiatric evaluation, follow-up assessments, or medication management. During the first ten months of operation, over 650 clinic visits by homeless persons seeking mental health care were recorded.

Using the principles of service-learning, a balance between service and learning is emphasized. To promote a personal ethic of service among residents, participation in the clinic is voluntary. Upper-level residents are informed of the community need, the design of the clinic, and the minimum service commitment of two months. The department supports the resident's involvement but does not require participation. In addition, a faculty member is present throughout the clinic day and reviews each patient's chart with the resident. This interaction fosters critical reflection on community-specific issues such as lack of accessible health care for the poor, the local causes of homelessness among persons with mental illness, and the apparent obstacles in the community for those attempting to break the cycle of homelessness.

Finally, an emphasis on reciprocal learning is achieved through ready access and close proximity to the case managers and shelter providers who are intimately involved in the day-to-day needs of persons referred to our clinic. These individuals serve as informal faculty and teachers for the residents.

Preliminary feedback has been uniformly positive from both the psychiatric residents and the community. Commitments by the residents to staff the clinic are secured many months in advance. The homeless center has approached the department to determine whether the clinic can be held more than a single day each week. Long-term evaluation will include measuring the knowledge and attitudes of the residents through self-assessment tools and obtaining feedback from the center staff to ensure that identification of and response to the heath care needs of the homeless clientele is ongoing and appropriate.

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