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A comparison of treatment adherence in individuals with a first episode of psychosis and inpatients with psychosis

Alicia Spidel [a,*], Caroline Greaves [b,c], John Yuille [d], Tania Lecomte [a]

[a] University of Montreal, Canada
[b] BC Mental Health & Addiction Services, Canada
[c] The University of British Columbia, Canada
[d] Forensic Alliance, Canada

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ABSTRACT

In predicting treatment compliance in individuals with severe mental illness, research has focused on variables such as substance abuse, personality, history of child abuse, and symptomatology, although these relationships have not been investigated in great detail in individuals at the onset of mental illness. To better understand these correlates of treatment compliance, two samples were examined: a sample of 117 individuals presenting with a first episode of psychosis and a more chronic forensic sample of 65 participants recruited from a psychiatric hospital. These samples were investigated for service engagement in terms of violence history, substance abuse, symptom severity, psychopathic traits and history of childhood abuse. Linear regressions performed for the first episode sample revealed that childhood physical abuse was the strongest predictor of poor service engagement, followed by problems with alcohol, a history of physical violence, any history of violence and higher psychopathic traits. Linear regression revealed for the forensic group that a lower level of service engagement was most strongly predicted by a history of childhood abuse and a higher score on the Brief Psychiatric Rating Scale (BPRS). Results are presented in light of the existing literature and clinical implications are discussed.

1. Introduction

Psychosis is a serious mental illness that can have dramatic consequences to the individual who suffers from it. Although there are many types of treatment, traditional medication remains the most prescribed (Nemade & Dombeck, 2009). Despite recent advances in antipsychotic medications (Rosenheck et al., 2000), they often cause side-effects, causing people suffering from psychosis to often reduce, or stop taking their prescribed antipsychotics. Recent research has found that many factors contribute to failure to take medications as prescribed, called non-compliance or non-adherence (Davis, Chen, & Glick, 2003). In those suffering from psychosis it has been estimated that non-compliance rates are roughly 40% for complete non-compliance and that partial non-compliance rates are around 75% (Fenton, Blyler, & Heinssen, 1997; Lacro, Dunn, Dolder, Jeste, & Leckband, 2002; Young, Zonana, & Shepler, 1986). In addition research from the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) study found that medication non-compliance was due, in most part, to side effects from the medications (Weiden, 2006). Among patients with schizophrenia, non-adherence to maintenance treatment with antipsychotic medication is associated with a greater number of clinic and emergency room visits and more psychiatric hospitalizations (Terkelsen & Menikoff, 1995; Valenstein et al., 2002; Weiden & Olfson, 1995). Problems with treatment adherence among psychiatric patients can encompass a variety of behaviors, including (1) taking medication regimens incompletely, (2) discontinuing medications altogether, (3) failing to attend the first outpatient appointment after psychiatric hospitalization, (4) missing other scheduled appointments, (5) dropping out of outpatient follow-up altogether, and (6) failing to complete assignments or recommendations related to prescribed psychosocial interventions. In inpatient psychiatric settings, treatment non-adherence may also include failure to follow the structure of the unit and refusal to participate in a group therapy program. As such, improving adherence to treatment with antipsychotic medication in patients with psychotic disorders is a complex task; more information on factors or profiles of individuals affecting adherence is warranted (McDonald, Garg, & Haynes, 2002; Zygmunt, Olfson, Boyer, & Mechanic, 2002).

1.1. Treatment compliance

A common perception among clinicians and laypersons is that non-compliance with medications is a direct result of disease processes in schizophrenia (Fenton et al., 1997). However, noncompliance rates for

* Corresponding author at: Université de Montréal Bur. C-358, 90 Avenue Vincent d'Indy, Montréal, QC H2C 3J7, Canada.
E-mail address: aliciaspidel@aim.com (A. Spidel).

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schizophrenia have been found to be in the mid-range of those that are reported in other common medical disorders (Fenton et al., 1997). Medication noncompliance rates of 55 to 71% have been reported for patients with arthritis (Berg, Dischler, Wagner, Raia, & Palmer-Shevlin, 1993), 54 to 82% for patients with seizure disorders (Shope, 1988), 20 to 57% for patients with bipolar affective disorder (Elixhauser, Eisen, Romeis, & Homan, 1990), and 19 to 80% for patients with diabetes (Friedman, 1988). Researchers have further found that compliance is lowest when the illness is chronic and the consequences of stopping treatment are not seen immediately (Fenton et al., 1997). In disorders sharing these features, as is the case with psychosis, adherence declines with time (Blackwell, 1973).

1.2. Compliance and substance use

Although there is evidence that treatment non-adherence in those who suffer from major mental disorder is linked to substance abuse, a history of violence and/or psychopathic traits, most studies have been done with individuals in forensic psychiatric settings, often presenting with chronic symptoms. Furthermore, most studies that have looked at treatment adherence have focused on medical treatment alone. In studies with dual-diagnoses patients (suffering from both a major mental illness and substance abuse) it was found that people who adhered to their medication regime experienced fewer stressful life events and had a lower severity of psychiatric symptoms (Magura, Laudet, Mahmood, Rosenblum, & Knight, 2002). On the other hand, the medication non-adherers not only had the opposite profile, but also appeared to have an increased risk for substance abuse (Olfson et al., 2000). In a sample of people with schizophrenia, Cohen and Henkin (1995) found that those who dropped out early from treatment were more likely to have a co-occurring personality disorder, to have aggressive or labile affect and to have a less stable form of illness. Ries et al. (2000) found that dual-diagnoses patients (suffering from both psychosis and substance abuse) were less likely to engage in treatment but responded faster and better to psychiatric treatment than clients who were non-substance abusers.

1.3. Compliance and violence

Several studies have looked at the relationship between treatment adherence and violence in those with a major mental disorder. Elbogen, Van Dorn, Swanson, Swartz, and Monahan (2006) investigated such an issue in a U.S. sample of 1011 adults receiving outpatient treatment for a psychiatric disorder. They found that community violence was inversely related to treatment adherence, perceived treatment need, and perceived treatment effectiveness. Violence that is committed by individuals with psychosis has become an increasing cause of concern for clinicians, policymakers, and society in general (Monahan & Steadman, 1983; Mulvey, 1994; Torrey, 1994). Accordingly, many strategies have been developed to manage this risk including the strengthening of risk assessment procedures (Borum, Swartz, & Swanson, 1996), and efforts to improve treatment compliance (Dvoskin & Steadman, 1994). The legal system has also been looked to as a way to improving treatment adherence (Geller, 1990; Hiday & Scheid-Cook, 1991; Swartz et al., 1995) through interventions such as court-mandated treatment or involuntary outpatient commitment. This is the case as it has been found that those who are less compliant with medication are more likely to be violent (Torrey, 1994). Therefore it is hoped that by increasing compliance it will also decrease violence by these individuals (Buchanan & David, 1994; Torrey, 1994).

1.4. Compliance and psychopathy

Unlike major mental illnesses, the presence of personality disorder as an additional factor potentially impacting treatment adherence has received little attention in the literature, particularly in those presenting a first episode of psychosis. This is of concern given the high rates of personality disorders in these populations. One personality type that is particularly important in those who are incarcerated is psychopathy. Thornton and Blud (2007) concluded upon reviewing research on psychopathy and treatment that there was a general pattern of those with higher psychopathic traits leading to poorer short term responses to treatment which they defined as less participation, poorer motivation, and less likelihood of completing treatment. Of particular interest here is the research that has found that in those with schizophrenia non-compliance is associated with greater psychopathy scores (Hoge et al., 1990; Kasper, Hoge, Feucht-Haviar, Cortina, & Cohen, 1997). In addition, the comorbidity of schizophrenia and psychopathy was found to be higher among violent patients than among nonviolent patients. The findings of this study demonstrate that psychopathic personality traits are associated with some of the violent behavior in some patients with major mental illness and that non-compliance is an issue.

1.5. Compliance and history of childhood abuse

There is now substantial evidence linking child sexual abuse and child physical abuse to a range of mental health problems in childhood (Spataro, Mullen, Burgess, Wells, & Moss, 2004). Child abuse has also been shown to be associated with most adult disorders, including: depression, anxiety disorders, PTSD, eating disorders, substance abuse, sexual dysfunction, personality disorders and dissociative disorders, as well as suicidality (Bushnell, Wells, & Oakley-Browne, 1992; Fergusson, Horwood, & Lynskey, 1996; Kendler et al., 2000; Mullen, Martin, Anderson, Romans, & Herbison, 1993). Researchers have found high prevalence rates of childhood sexual abuse and childhood physical abuse in clients with psychiatric disorders. A review of the literature (Read, Van Os, Morrison, & Ross, 2005) found that 69% of female inpatients and 59% of male inpatients with psychosis have suffered from a history of childhood abuse. Moreover several studies have suggested a causal link between child abuse and psychotic symptoms, particularly in terms of auditory hallucinations as being linked to sexual abuse (Read, Agar, Argyle, & Aderhold, 2003). More recently Varese et al. (2012) conducted a meta-analysis to examine the association between childhood adversity and trauma (sexual abuse, physical abuse, emotional/psychological abuse, neglect, parental death, and bullying) and psychosis outcome from January 1980 through November 2011. These researchers found a significant association between adversity and psychosis across all research designs, with an overall effect of OR = 2.78 (95% CI = 2.34–3.31).

1.6. Compliance with first episodes

There is some literature that looks specifically at first episodes. What is known with first episode and treatment adherence is that less than 50% take their medication as prescribed (Birchwood & Spencer, 2001) and less than one-third engage in relapse prevention treatments (Spidel, Lecomte, & Leclerc, 2006). The problem is particularly severe in the case of first episode clients since the absence of treatment adherence, psychosocial and pharmacological, can lead not only to relapses but also to more severe symptoms, violence, heightened suicidal risks and increased risk for homelessness and drug overdoses (McGlashan, 1996; Pepper & Ryglewicz, 1984).

1.7. Compliance — chronic and first episode samples

Some similarities between more chronic patients and first episodes with psychosis have been found. In a study by Lecomte et al. (2008), profiles of poor-adherers or low service engagement were especially linked to childhood trauma, as well as worst symptoms and poor alliance. Males with histories of legal problems were also more prevalent (Lecomte et al., 2008). These are similar to findings in several