THE IMPORTANCE OF THE SOCIAL ENVIRONMENT IN THE TREATMENT OF MENTALLY RETARDED ADULTS WITH PSYCHIATRIC DISORDERS: AN OUTREACH TREATMENT PROGRAMME

A. van Minnen and C. A. L. Hoogduin

Introduction

Due to their biological impairments, mentally retarded persons are for a large part dependent on their social environment (Edgerton, 1967; Helsel and Matson, 1988; Reiss, 1985; Reiss and Benson, 1985). Therefore, negative social-environmental conditions, such as frequent relocations (O’Connor, 1983; Reiss, 1985; Reiss and Benson, 1985), limited social support (Burchard et al., 1991; Reiss and Benson, 1985; Reiss and Trenn, 1984; Rosen and Burchard, 1990), and limited social integration (Burchard et al., 1991; Reiss and Benson, 1985; Rosen and Burchard, 1990), can play an important role in the development and continuance of psychopathology (Burchard et al., 1991; Carr and Durand, 1985; O’Connor, 1983; Reiss and Benson, 1985; Romer and Heller, 1983).

Frequent relocations may cause disruption in social life (O’Connor, 1983; Reiss, 1985) and may cause a relocation syndrome (Cochran et al., 1977; Cohen et al., 1977; Heller, 1982.). A relationship has been reported between limited social support of mentally retarded persons and depression (Reiss and Benson, 1985; Laman and Reiss, 1987) and furthermore, limited social integration may result in loneliness and a sense of inferiority (Edgerton, 1967; Reiss, 1985; Reiss and Benson, 1985).

Treatment of mentally retarded persons with psychiatric disorders requires therefore explicit attention to social-environmental conditions. In the Netherlands, an outreach treatment programme has been introduced for mildly mentally retarded adults with severe behavioural disorders. Treatment of patients is handled by an outreach team in the patient’s own living situation, which can be at home with their parents as well as in institutions, group homes or shelter homes. Examples of the treatment were also given in an earlier

*Dr. A. van Minnen
Psychologist, Department of Clinical Psychology, University of Nijmegen, P.O. Box 9104, 6500 HE Nijmegen, The Netherlands.
Tel. 0031 (0) 24 3612154, Fax. 0031 (0) 24 3615594

Prof. Dr. C. A. L. Hoogduin
Psychiatrist, Department of Clinical Psychology, University of Nijmegen, The Netherlands.

* For Correspondence
publication (Van Minnen et al., 1993). Maguire and Piersel (1992) showed that a treatment option that seems similar to the outreach treatment approach, a mobile intensive treatment, is very successful and efficient. In a controlled study, the outreach treatment appeared to be at least as effective as the standard treatment in the hospital with regard to psychiatric symptoms and admissions to hospital (Van Minnen et al., 1997). What is more, outreach treatment costs were significantly lower. Another advantage of the outreach treatment programme is that, through this form of treatment, relocation to a specialised clinic is not necessary and all persons that are important in the daily life of the patient can be actively involved in the treatment programme.

The two following case histories illustrate how the outreach team works, and emphasise the influence of the social environment on the problems of the patient.

Case 1

Paul is a mildly mentally retarded man (IQ 52), 29 years old. He is suffering from Williams’ syndrome, a congenital disorder, characterised by mental retardation, a characteristic facial structure, postnatal growth deficiency and supravalvular aortic stenosis.

Since he was eleven years old, he has been living in a shelter home. When he was 26, he was sent away from the shelter home on account of severe aggressive behaviour, and moved in with his parents again. On behalf of aggression and conflicts at home, he was admitted to an institution for the mentally retarded two years later.

Paul is described as a robust young man, who can be helpful and friendly, but reacts irritated when he doesn’t get what he wants.

The reason for calling the outreach team to help was the severe aggressive behaviour: Paul assaulted two of his group leaders so severely that they were hospitalised for their injuries. The aggression of Paul is described by the group leaders as unpredictable which causes a lot of anxiety about possible repetition of severe assaults. His medication is flufenazine, 25 mg depot once a month, dexamethasone, 0,5 mg twice daily and haloperidol, 5 mg three times a day.

A member of the outreach team went to the unit where Paul lives. After a diagnostic phase, which included intelligence tests, observation in his living group, an interview of his family and dossier study, the following working hypothesis was formulated: Paul’s loquacy, friendliness and strong ability to make interpersonal contacts, characteristics of Williams’ syndrome, make him appear more intelligent than he actually is, and there is constantly the danger that his capacities are overestimated by others. Furthermore, it appears that his severe aggressive behaviour is preceded by too much control and especially interruptions of his compulsive behaviour (e.g. moving ashtray, prolonged tapping off the ashes from his cigar, order all kind of things). The aggressive behaviour may be considered as a reaction of frustration of this compulsive behaviour.

During the diagnostic phase, the group leaders received the advice from the outreach team therapist not to interrupt Paul in his compulsive behaviours and to avoid conversations requiring insight. Furthermore, the haloperidol was decreased, while the remaining medication was maintained.

The treatment plan, based on the above working hypothesis, consisted of
three phases. In the first phase the unit where Paul lives was rearranged. An extra sitting corner was created where Paul can sit apart from his groupmembers. Furthermore, the dining table was expanded, so that Paul has more room to eat. Through these rearrangements, his groupmembers could not touch Paul anymore and so paid little attention to his compulsive behaviour, which was exactly the goal: to decrease control and the interruptions of his compulsive behaviours. In this first phase there were regular time-outs, a reaction of the group leaders to every possible threat of aggressive behaviour of Paul. On advice of the outreach team therapists, time-outs were only given after a real aggressive or destructive action of Paul.

In the second phase his daily activities were adapted. Three times a day Paul received short individual orders, which he could carry out independently, with the goal to enlarge his sense of autonomy.

In the third phase a behaviour regulation system was implemented with the goal to assure for Paul positive social interaction and reinforcement and to structure the demands put on him in order to approach him on a level appropriate to his capacities.

The case was closed after seven months with good results. After the first phase of the outreach treatment programme, no more aggressive behaviour and no more time-outs had taken place. His total score on the Psychopathology Inventory for Mentally Retarded Adults (Matson et al., 1984) had dropped from 18 to 4. Furthermore, there was a repairment in the relationship between Paul and his group leaders. He is now described as a sociable and adjusted man. Paul himself said that he now felt more at home and never wants to leave the unit.

The outreach team therapist made 10 visits to the unit concerned. This therapist took care of the development of the treatment plan, the implementation of it and supervised the treatment process. Furthermore, he stimulated and motivated the group leaders to continue with the treatment programme.

Discussion

The treatment of Paul was mainly focused on those aspects that preceded and led to the severe aggressive behaviour. After observation, the aggressive behaviour was no longer unpredictable and inexplicable, but was seen as a response to various stimuli. The interactional problems between group leaders and Paul played an important role in causing and continuing the problems. With relatively simple interventions in the social environment, the aggressive behaviour could be prevented.

Case 2

Henk is a mildly mentally retarded man (IQ 74), 24 years old. He is living with his parents. For three years he has been suffering from an obsessive-compulsive disorder: washing his hands until they bleed, staying for hours on the toilet, using large amounts of toilet paper and taking showers for many hours. Furthermore, he needs a lot of time for getting out of bed, eating and going to bed, and he has a disturbed day-night rhythm. The behaviour of Henk causes an untenable situation for the family: His parents don't get any sleep and there are a lot of conflicts between Henk and his father.

Eventually the outreach team were called for help. A therapist of the outreach team visited the family. Soon it became apparent that there were no possibilities for the outreach team to treat Henk in this
family situation: Henk’s parents were emotionally not capable of supporting Henk during treatment and Henk himself was not motivated towards any form of treatment.

To end this crisis situation, the outreach team elected to separate Henk and his parents by moving Henk to a supervised independent living situation. The necessary condition to make that new situation work was for all involved (including outreach team, parents and other caregivers) to form a stable support network for Henk, with the underlying philosophy: optimal respect for Henk’s own territory.

Henk was assigned an apartment, where he could live the way he wanted, except for some basic rules: he had to take a shower once a week, he had to eat properly and he was not supposed to cause any trouble for the neighbourhood. A manual was produced which contained task division concerning Henk’s primary needs, such as food, drinks, hygiene and social contact. Henk could decide himself whether he wanted more autonomy in every respect, if he proved capable of that.

In the beginning of this programme, his disturbed day/night rhythm caused the main problems: he went to bed in the morning, and opened the door for persons only after repeatedly ringing the doorbell. However, when he noticed that persons of the network left after ringing only once, he made sure he was awake. The detachment of Henk and his parents was also a difficulty. To deal with that, Henk was allowed to call on professional caregivers only in case of problems.

Slowly, Henk began to develop initiative of his own: for instance, he invited people in to his home, travelled by train independently and took an extra sandwich if he wanted to. After half a year, a treatment plan was made for his obsessive-compulsive disorder which was made up of four phases: The first phase consisted of developing a therapeutic relationship in order to reduce Henk’s anxiety for treatment. The second phase consisted of letting Henk recognise and acknowledge his fears. In the third phase the emphasis lay on motivating Henk towards a behavioural therapeutic approach. Finally, in the fourth phase a behavioural therapeutic approach was carried out by means of exposure and response prevention. In all phases it was important to have low expectations and few demands in order to keep Henk motivated.

At this moment, the last phase of the treatment is still continuing. The obsessive-compulsive disorder of Henk has not yet been dealt with. What has been achieved, however, is that Henk lives on his own and that the whole family found a balance that is satisfactory; an important basis for further treatment.

Discussion

Characteristic of treatment by the outreach team is that the social support network of the patient is involved in the treatment programme. The above treatment was in the first place aimed at the entire family. The independent living situation, with supervision, resulted in the fact that the parents were relieved of the burden of care. Besides that, Henk learned to take more responsibility for his behaviour, through which he became accessible to treatment for his obsessive-compulsive disorder.

Closing Remarks

It seems clear that social-environmental factors can play an important role in the lives of mentally retarded persons.
Negative social-environmental conditions can cause or maintain severe disorders.

Advantages of the outreach treatment approach are, in respect to the social environment, that patients can stay in their own living situation, relocations are not necessary, the social support network system stays intact or can be extended, the social support network can be involved in the treatment and support patients during treatment, attention can be given to the environmental factors that may influence the problem behaviour and social integration can be stimulated. Research showed that the burden on the family and carers did not significantly increase during the outreach treatment (Van Minnen et al., 1997). Furthermore, the promotion of positive social-environmental factors may contribute to an increase of self respect, independence and skills of mentally retarded persons, with the result that the chance of development of new psychiatric disorders can be decreased. That makes the outreach treatment programme not only curative but also preventive in nature.

Summary

In this article the importance of involving social environmental factors in the treatment of mentally retarded persons with psychiatric disorders is stressed. An outreach treatment approach, in which patients are treated in their own home environment, explicitly focuses on the social environment of patients. Two case histories illustrate the influence of social environmental factors on psychiatric disorders and the outreach treatment programme.

Acknowledgement

We would like to thank Ley Peeters and Huub Smedts for the treatment of the patients and their comments on an earlier draft.

References


