“I Don’t Need Help”

A relationship-focused approach to treatment resistance for providers adapted from the LEAP Model.

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Objectives

By the end, participants should be able to:

- Reframe “refusal” and “non-compliance” as meaningful engagement data.
- Define anosognosia and distinguish it from intentional denial.
- Use LEAP: Listen, Empathize, Agree, Partner.
- Apply LEAP to a post-PRTF transition case with medication refusal, family conflict, and missed care.
- Leave with wording that can be used immediately in direct interventions, calls, staffing, and provider collaboration.

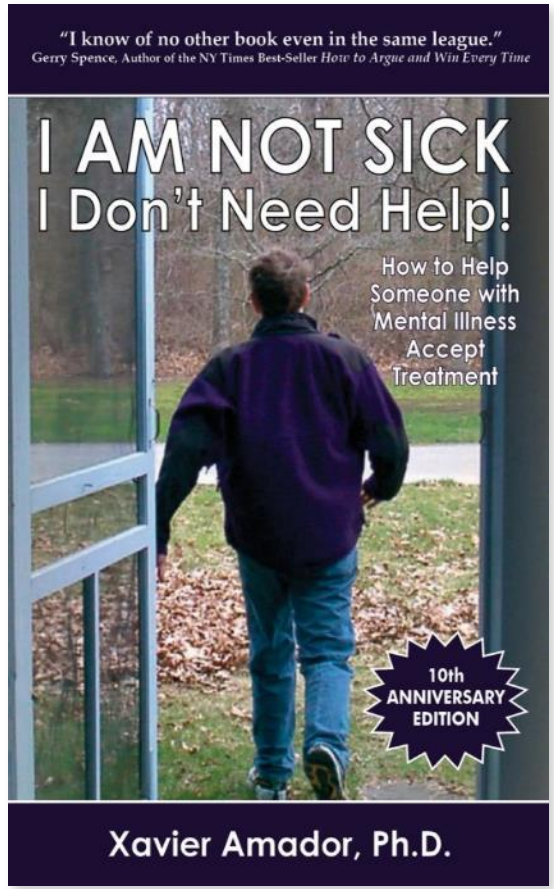
Training Stance
Relationship first. Safety always. Treatment goals come after trust and shared priorities.

Case Study Anchor
Introduce the case early, revisit it during each LEAP step, and close with role-play.

Primary Source & Adaptation Note

Where the core LEAP content comes from

- Primary source
  - Dr. Xavier Amador's book: I Am Not Sick I Don't Need Help! How to Help Someone Accept Treatment.
  - This training adapts the book's LEAP concepts for Community Providers, Care Management and provider-facing engagement conversations.
- Adaptation boundary
  - This deck is a training adaptation—not a substitute for the book, formal LEAP certification, clinical judgment, crisis protocols, or legal requirements.
  - Citations appear in speaker notes and the final reference section.
- Key source statement: LEAP = Listen, Empathize, Agree, Partner, with the goal of building relationships that lead to treatment engagement and progress.



Agenda

01—

Case Study

02—

Anosognosia and treatment resistance

03—

LEAP model: Listen, Empathize, Agree, Partner

04—

Putting it all together and key take aways

Case Study: Post-Acute Transition

De-identified training example for LEAP practice

- **Member Profile:** 19-year-old; recently discharged from third acute hospitalization in three months diagnosed with bipolar disorder and ADHD; history of multiple involuntary hospitalizations.
- **Current supports / legal context:** Lives with grandmother. Grandmother was guardian before age 18; member is now the member's own guardian.
- **Engagement Concerns:** Agrees to medication prescribed while at hospital but quickly after returning home refuses medication: "I'm fine. I don't need that." Enrolled in services at local CMHC however often no-shows individual therapy, case management, and medication management appointments. Avoiding care manager outreach calls. Grandmother contacts crisis services weekly due to member's threatening behaviors and escalations.
- **Recent Escalation:** LEO contact at home after argument with grandmother; neighbor reportedly heard yelling/screaming and loud thuds. LEO transported member back to ER for screening.

Why This Matters

Resistance is not the end of the conversation. It is information about where the relationship needs to begin.

The Reality for Providers and Care Managers

Seen as behavior

- Missed appointments
- Avoids outreach
- Refuses medication

May reflect distress

- Fear, trauma, mistrust, prior harm, autonomy needs, or lack of insight

Common trap

- Correction → persuasion → pressure → more disengagement

LEAP reframe

- Curiosity → Respect → Trust → Opening for Collaboration

Practical Meaning

Slow down your agenda before trying to move the plan forward.

What treatment resistance may mean

Move from “why won’t they?” to “what is this protecting?”

Fear

Fear of side effects, hospitals, loss of autonomy, or being controlled.

Trauma / system harm

Previous coercion, placement disruption, involuntary care, or feeling unheard.

Mistrust

Belief that providers, family, or systems do not understand or respect member priorities.

Anosognosia

Neurological lack of awareness of illness—may make insight-based arguments ineffective.

What is Anosognosia?

It's neurological, not denial. Frontal-lobe changes keep the brain from updating its self-image, and insight can come and go.

Plain-language definition

A person may be unaware of a mental health condition or unable to perceive it accurately.

Why arguments fail

If the person cannot update their self-image, "proof" may feel like criticism, control, or betrayal.

BH provider implications

Do not make acceptance of diagnosis the entry ticket to help. Lead with listening and partnership.

Don't say

"Does not accept s/he has an illness"

"Refuses to acknowledge…"

"Denies s/he has…"

Do say

"Cannot comprehend s/he has an illness"

"Is unaware s/he has…"

"Unable to see or understand…"

Traditional Approach vs. LEAP

Same clinical concern. Different relational strategy.

TRADITIONAL CM APPROACH	LEAP APPROACH
• Educate / correct	• Listen first
• Push compliance	• Validate feelings
• “You need treatment”	• Find agreement
• Reality-test too early	• Partner around goals

What is LEAP?

Listen • Empathize • Agree • Partner

Developed by Dr. Xavier Amador

Relationship-focused communication for people who resist treatment because of lack of insight or mistrust

Primary source for this training

I Am Not Sick I Don't Need Help!: How to Help Someone Accept Treatment.

Goal

Create relationships that lead to treatment and services—not demand agreement on diagnosis first.

Core principle: relationship before change

The common trap
Insight → Treatment → Relationship

“If the member understood, the member would comply.”

The LEAP sequence
Relationship → Trust → Engagement → Treatment

“Start with connection; build toward shared action.”

Relationship is the intervention
You do not win on the strength of your argument; you win on the strength of your relationship.

L = Listen

Reflect without correcting or arguing

Goal

Understand the member's reality and convey that you understand it.

Try

"What I hear you saying is..."
"Did I get that right?"
"Tell me more about that."

Avoid

Correcting, debating, "but actually...", or moving prematurely to education.

Case application

Member: "My grandmother is old and always on my case about the bipolar thing... I don't think I have it."
CM: "You feel like people keep putting a label on you that does not match how you see yourself. Did I get that right?"

E=Empathize

Validate feelings without reinforcing inaccurate beliefs

Validate emotion

“That sounds frustrating.”

“I can see why you’d be tired of people bringing it up.”

Do not validate delusion

Empathize with fear, anger, shame, exhaustion—not factual accuracy of the belief.

Case application

“It sounds like you felt backed into a corner and needed a way to blow off steam.”

Why it matters

Feeling understood lowers the need to defend. Once the emotional temperature drops, collaboration becomes possible.

A = Agree

Find common ground—or agree to disagree

Agreement does not mean endorsement

You can agree on goals without agreeing on diagnosis, medication, or who is “right.”

Case agreement options

“We both want fewer police calls.”

“We both want you to have more control.”

“We both want things calmer at home.”

Agree to disagree language

“We may see the bipolar diagnosis differently. I’m not here to force that conversation today. Can we focus on what would help you sleep better and have fewer blowups with your grandmother?”

P = Partner

Collaborate around member priorities first

Partnering focus
Ask what matters: sleep, independence, fewer arguments, work/school, staying home.

Small next steps
One therapy text-back. One provider question. One sleep/stress goal. One warm handoff.

Case partnership

“Would you be open to one call where we only talk about sleep and stress—not meds?”

Partnering keeps autonomy visible

“You get to decide what you do. My job is to help you have options that keep you safe and out of crisis.”

Case formulation: what are we hearing?

Separate safety needs from engagement strategy

Risk / safety signals

- Recent LEO contact
- Escalating conflict at home
- Loud thuds / punching bag explanation
- Medication non-adherence
- Missed therapy and avoided CM calls

CM stance

- Stay curious
- Continue outreach
- Prioritize safety
- Ask permission
- Partner on what matters to member

Possible meaning

- Autonomy push after age 18
- Diagnosis disagreement
- Shame or mistrust
- Fear of being controlled
- Lack of insight / anosognosia

Important boundary

LEAP does not replace crisis protocols, required reporting, safety planning, or provider notification when immediate safety concerns are present.

Before / after script

Same concern, lower defensiveness

Old response

Member: “I’m fine. I don’t need meds.”

CM: “You were hospitalized multiple times and need to take them. If you keep avoiding therapy this will get worse.”

Likely impact: member defends, ends call, avoids future outreach.

LEAP response

Listen: “You do not see bipolar as fitting you.”

Empathize: “That sounds frustrating when people keep pushing it.”

Agree: “We both want fewer arguments and no more police calls.”

Partner: “Could we talk about sleep and stress first?”

Practical tools for Care Managers

DO MORE OF THIS; AVOID THESE TRAPS

Do

- Slow down the agenda
- Ask permission before giving an opinion
- Validate emotion first
- Use “help me understand…”
- Focus on member goals and immediate quality-of-life concerns
- Summarize and check accuracy

Avoid

- Arguing facts
- Reality-testing delusions early
- “You have to…” language
- Threats unless required for safety/legal reasons
- Making diagnosis acceptance the entry point
- Power struggles with family present

Why LEAP fits Care Continuum

Engagement is the work before the work

Where it helps

- Level of Care transitions
- High-risk BH populations
- Foster care / family systems
- Individuals with repeated crises
- Individuals who are hesitant or resistant to services

What it supports

- Individual/Provider Trust
- Provider collaboration
- Attendance at follow-up
- Medication conversations
- Crisis prevention planning

How to document

- Member-stated goals
- Strengths and barriers
- Permission-based education
- Agreed next steps
- Safety actions taken

Key Takeaways

1

Resistance ≠ defiance. It may be fear, trauma, mistrust, autonomy, or lack of insight.

2

Anosognosia is a real lack of awareness; insight arguments may not work.

3

Relationship is the intervention. Trust opens the door to change.

4

LEAP is repeatable: Listen, Empathize, Agree, Partner.

Closing reflection: What is one conversation you can approach differently tomorrow?

References & Source Notes

Primary sources used to update this deck

- Primary: Amador, X. I Am Not Sick I Don't Need Help! How to Help Someone Accept Treatment.
- LEAP Institute: LEAP method, relationship-first language, evidence-based program description, and book list.
- XavierAmador.com: book overview and table of contents listing anosognosia and LEAP steps.
- NAMI: anosognosia definition, lack of awareness/lack of insight, and treatment implications.
- NAMI Georgia: LEAP steps and practical communication guidance.
- MINT: motivational interviewing communication style, autonomy, reflections, and avoiding confrontation.
- SAMHSA/GovInfo: recovery-oriented, person-centered behavioral health, shared decision-making, and respectful communication.
- Attached SHP template, user outline, and user-provided de-identified case study.

Full source URLs are included in speaker notes. Generated visuals are cited in speaker notes where used.

Thank You

Questions / discussion

sunflower health plan