Psychotherapeutic Management Techniques in the Treatment of Outpatients With Schizophrenia

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Successful outpatient treatment of schizophrenic disorders largely depends on the patient's ability to form a treatment alliance with mental health professionals. However, even in the context of competent pharmacotherapy, symptoms of schizophrenia often persist under this alliance. The authors review five common syndromes occurring during the course of treatment of patients with schizophrenia that interfere with the therapeutic alliance: paranoia, denial of illness, stigma, demoralization, and terror from awareness of having psychotic symptoms. Mental health clinicians can use specific psychotherapeutic management techniques for these symptoms. Examples of these techniques include "sharing mistrust" for paranoid patients, providing patients who deny their illness with alternate points of view, making admiring and approving statements to demoralized patients, and normalizing experiences of stigmatized patients. The techniques do not require advanced psychotherapy training and can be used, with ongoing supervision, by bachelor's-level mental health workers.

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Despite increased attention to development and implementation of services for outpatients with schizophrenia, little has been written about training caseworkers and other mental health workers in basic strategies for interacting with these patients (1,2). Specific and sometimes counterintuitive techniques are needed to work successfully with patients with schizophrenia (3,4), and, as May (5) suggested, clinicians may need to make a distinction between formal psychotherapy and "what is therapeutic for the psyche."

Formal psychotherapy may be defined as a series of regularly scheduled sessions at which a patient meets with the same person, identified as a psychotherapist, at least once a week for at least 30 minutes. Psychotherapy is currently not commonly used with patients with schizophrenic disorders. Rather, a broader concept of psychotherapeutic management is used instead.

Psychotherapeutic management, as defined by May (5), involves understanding how psychopathology affects psychological issues as they pertain to the remedial management of individual patients. Clinicians may use psychotherapeutic management techniques to help patients identify and deal with current life problems, to work with family members and others in the community, and to enhance appropriate nursing care, social casework, milieu therapy, and goal-directed occupational therapy and rehabilitation.

In the course of their treatment and rehabilitation, patients with schizophrenia may interact with many different mental health workers for brief periods of time, which presents numerous opportunities for psychotherapeutic management, as the following case vignette illustrates.

Case 1. Ms. A is discharged from an inpatient psychiatric unit to a day program after an acute exacerbation of schizophrenia. She had been homeless before her hospitalization but has been accepted in a residence under the condition that she continue in day treatment. On the first day at the residence, she meets her new residential worker, who gives her a tour of the place. The next morning she is introduced to the driver of the van she takes to the day program at the community mental health center. At the center, the receptionist asks her to fill out an intake slip, and she is interviewed by an intake worker. She has a 15-minute meeting with the psychiatrist and then goes to a life-skill group and a woodworking group. At the end of the day, she takes a van, driven by another driver, back to the residence. Overall, Ms. A has been exposed to at least eight mental health workers. Except for the intake interview, the longest encounter was 15 minutes.

The lion's share of patients' interactions with mental health workers occurs with nonmedical staff members (6,7), who are rarely instructed in psychotherapeutic management techniques. In our opinion, nonmedical staff can learn and apply these skills. Formal training in psychotherapy is not necessary and, in some cases, may be counterproductive (8).

Improvements in the therapeutic alliance resulting from the skillful use of psychotherapeutic management techniques can enhance patients' compliance with medication, decrease rates of dropout from treatment, and facilitate rehabilitation.
along with the caseworker to attempt to substitute a more benign, less paranoid, general symptom, a neurologic deficit, or a psychological defense. Psychotic illness are usually easy to treat, and the paranoia lessened, no attempt should be made by the caseworker to identify, correct, or argue about the patient's resistance to psychoeducation (14). Patients in a paranoid state may not be able to tolerate psychoeducation because they tend to deny the existence of a psychotic illness and blame others for their difficulties. Until the patient is strengthened, and the paranoia lessened, no attempt should be made by the caseworker to identify, correct, or argue about the patient's resistance to psychoeducation (14). Patients in a paranoid state may not be able to tolerate psychoeducation because they tend to deny the existence of a psychotic illness and blame others for their difficulties. Until the patient is strengthened, and the paranoia lessened, no attempt should be made by the caseworker to identify, correct, or argue about the patient's resistance to psychoeducation (14).

Denial of illness

Denial and lack of insight into psychotic illness are usually easy to recognize, but their causes are complex and difficult to identify (15,16). Denial may arise as a psychotic symptom, a neurologic deficit, or a psychological defense. Psychotic symptoms such as paranoia, delusions, or grandiosity lead to loss of insight and therefore often present as

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denial of illness (17). Neurologic deficits associated with frontal lobe abnormalities found in patients with schizophrenia may manifest as denial (18). As a psychological defense, denial may arise as an adaptive response to overwhelming loss, interpersonal conflict, or threats to the patient's dignity.

In managing denial, the case manager first determines whether the patient is experiencing an acute psychotic episode. If so, hospitalization or an adjustment in the patient's neuroleptic medication should be considered. Denial that arises from chronic delusions that are not responsive to medication may be addressed using psychotherapeutic management (19). The following techniques are recommended for addressing denial.

Avoiding overzealous attack on denial. When the patient's denial of illness is chronic and seems unrelated to relapse, the caseworker should consider whether the denial should be addressed at all. Denial of illness may not be harmful if the patient is otherwise doing well and is compliant with treatment. Patients with schizophrenia who deny their illness may see themselves as having more purpose in life, may be more optimistic (20), and may have fewer affective symptoms (21) than patients who do acknowledge having a mental illness. The following case illustrates some of these issues.

Case 4. Mr. D is a 23-year-old graduate of an Ivy League college who was psychotic for two years before finally accepting treatment and medication. He had been referred to a day program and was compliant with his medication regimen despite never acknowledging that he needed treatment. His psychosis was in remission, and he was more cooperative and socially appropriate than he had been in years. However, during a psychoeducation session, it is brought to his attention that the medication he is taking is the reason he is doing so well. Unfortunately, this intervention backfires. Mr. D stops taking the medication to demonstrate that his recovery has nothing to do with that intervention.

Because denial of illness may be adaptive, it should be addressed only if patients show maladaptive behavioral responses that increase the risk of relapse—for example, medication noncompliance—or if patients underestimate their limitations, which can increase the risk of humiliation or physical injury.

Providing alternative explanations. Denial should be addressed indirectly. The caseworker starts by helping the patient acknowledge the existence or at least the possibility of different points of view. The techniques are similar to those used in cognitive therapy but are modified for use with the patient with schizophrenia (22).

The process can be broken down into four steps. The first step is to recognize the patient's point of view, which is likely to be highly learned, overdetermined, and cherished by the patient. For example, if the patient says, "I'm not sick, it's my parents who are sick and making up these stories about me," the caseworker holds off from disagreeing. Instead, the caseworker assumes that denial is a reasonable response from the patient's point of view and acknowledges the patient's beliefs without colluding with them.

In the second step, the caseworker assesses whether the patient realizes that people can have legitimate differences in viewpoints and opinions, that the patient's beliefs constitute only one point of view, and that people can disagree with each other without being personally offended by the disagreements. One approach is to discuss nonthreatening topical issues, such as recent political events, sports, and music, to illustrate that different opinions are acceptable and a part of life. Then the caseworker can mention that it is acceptable to hold different points of view about the patient's own life situation or need for treatment.

In the third step, the caseworker for the first time directly addresses the patient's denial. The caseworker suggests alternative explanations but leaves the patient a way to disagree without getting into a power struggle. The caseworker should understand why it is necessary for the patient to take the position of denying the symptoms. Alternate points of view must be introduced respectfully. The caseworker may broach an alternative explanation by pointing out the experience of others and asking if this experience may also be true for the patient.

In the fourth step, after the patient's denial abates, the caseworker should prepare for the patient to experience setbacks, including de-moralization, a sense of failure, or despair. The most striking example is development of suicidal despair during the period when the recently psychotic patient is regaining insight (23). Patients' setbacks are often triggered by personal difficulties, such as repeated rejections in finding a romantic partner. When the patient becomes aware of the role of symptoms in such personal difficulties, the caseworker should discuss with the patient how apparent defeat sometimes represents real progress. Often the hidden success is the willingness and courage to face situations in which rejection or relapse may be possible, as the following case illustrates.

Case 5. Mr. E is a 43-year-old man living with his elderly parents who has a longstanding delusion about a previous scholastic setback. He joins a day hospital program and begins to take medication for the first time. After two months on a low-dose neuroleptic, his symptoms markedly improve. He drops out of the day program to seek employment but has trouble with job interviews.

When Mr. E is readmitted to the day program, both he and the caseworker feel like failures. The caseworker feels like a failure because Mr. E dropped out of the program to get a job. Mr. E feels like a failure because it was necessary for him to return to the day program. However, when looked at from a long-term perspective (years instead of months), the process was a striking success. Despite Mr. E's inability to get a job, in many ways he was doing better than ever. He was more motivated to remain in the day program and to continue in what eventually became a completely successful work rehabilitation program.

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Stigma

Many patients will not admit that they feel stigmatized because they view such a statement as a "confession" of having a mental illness. Thus the patient's feelings of stigma or humiliation are often presented indirectly and must be inferred from the patient's behavior. Some obvious markers of stigma include an extreme reluctance to join treatment programs that are highly visible or that are attended by many patients in a group setting, an aversion to being seen with other patients, and a desire to dissociate from all mental health caretakers. Such a patient may be willing, even eager, to accept treatment in settings that are considered "medical" rather than "psychiatric."

Stigma may also present in more subtle ways. It can lead to substance abuse, because having psychotic symptoms is often seen as normal in the context of "getting high" (24). Stigma may also be the underlying cause of unrealistic expectations and seemingly foolish attempts to overreach vocational goals, illustrated by the example of a very poorly functioning and symptomatic patient who signed up for prelaw exams. Stigma can explain the commonly seen paradoxical situation of the patient who denies having an illness but voluntarily takes antipsychotic medication. Stigma may have its greatest effect on patients who had good premorbid functioning, who come from more affluent socioeconomic backgrounds, and whose families have trouble accepting the diagnosis (25).

The main interventions include acknowledging the stigma, normalizing the patient's experiences, supporting self-esteem, and helping the patient save face.

Normalizing behavior and attitudes. Stigmatized patients tend to assume that all their relationship difficulties and life struggles result from being mentally ill. This attitude in turn fosters greater stigma and isolation. They may idealize the lives of "normal" people without recognizing that these people also experience many problems in life. Normalizing the patient's experiences as much as possible can be very helpful in reducing stigma.

Self-disclosure. The caseworker may use self-disclosure judiciously to normalize patients' experiences and allow patients to compare their frustrations with those of someone else (26). Concrete examples from the caseworker's own life—trouble with authority, experiences of failure—can be used to assure patients that not all of their difficulties come from illness. Self-disclosure works better than more general statements with patients with schizophrenia, who may have difficulty learning from abstract statements.

The caseworker should observe the following two precautions in using self-disclosure. First, the caseworker should not trivialize the patient's real-life difficulties that result from having a mental illness by comparing them to relatively minor setbacks. For example, the caseworker's getting a mediocre grade in a course is not comparable to the patient's dropping out of school because of mental illness. Second, the caseworker should avoid disrupting boundaries by disclosing socially taboo or overstimulating topics such as sexual issues.

Performativc speech. Performative statements are those that derive their power simply from being made, providing that they are made by the right person under the right circumstances (25). A minister saying "I pronounce you man and wife," in a proper marriage ceremony is an example of a performative statement. If the patient does not acknowledge the caseworker as an authority, the caseworker can arrange for a performative statement to be made by another mental health professional, for example, the caseworker's supervisor. The following case shows how performative statements can be used in normalization.

Case 6. A 48-year-old man with a 30-year history of refractory psychosis was admitted around the Christmas holidays after making a very serious suicide attempt. He told the occupational therapist that the reason he wanted to die was that he couldn't stand being psychotic, especially when "everyone on the street is normal and having such a good time during Christmas." The occupational therapist replied in a definitive tone, "Life around Christmas is not like a Hallmark Christmas card. Everybody has problems with holidays!"

Saving face. Blunt or direct use of psychiatric terms and diagnoses may backfire when used with stigmatized patients. Just as discussions of other difficult medical diagnoses may be handled tactfully, psychoeducation may need to be modified to meet the patient's level of tolerance for hearing the diagnosis, which is often an emotionally laden experience (14). Patients may more readily understand descriptors such as "psychotic symptoms" rather than "schizophrenia" and "susceptibility" or "sensitivity" rather than "paranoia."

It is also helpful to find a face-saving way to explain humiliating events. For example, someone brought in to the hospital by the police in handcuffs after walking naked in the streets may accept an explanation such as "You know, being naked is upsetting to many people" rather than "You're sick right now, you know, walking outside naked is bizarre."

Demoralization

Many patients with schizophrenia show a marked pattern of self-deprecation, evidenced by expressions of self-loathing or worthlessness or attribution of their psychiatric symptoms to past failings or moral weakness. Often this pattern is most noticeable in the postpsychotic phase of the illness (27). The guidelines presented here assume that the demoralized patient does not have a depressive syndrome or neuroleptic-induced akinesia that would be better treated using appropriate somatic therapies (28).

Demoralization often is a function of identification with societal or familial expectations, such as those for achieving higher educational goals. Not meeting these expectations often generalizes to other aspects of the patient's self-esteem. For example, a patient who has to drop out of college because of schizophrenia may go on to deprecate all of his remaining intellectual gifts. In
such cases the patient's self-depreca-
tion may contribute to the develop-
ment of depression.

Self-deprecatory patients tend to
to comment negatively on their perfor-
ance and not to blame others. Such
patients are frequently reluctant to
disclose to the caseworker any feeling
of stigma, low self-esteem, or self-de-
rejection because this disclosure is
felt to be a further defeat.

Intervention to manage demoral-
ization involves physical positioning,
oral and nonverbal communication,
and normalizing the patient's
experiences. Here the optimal phis-
cal position of patient and case-
worker is face to face rather than
the side-to-side position used with
patients in paranoid states.

Maintaining a positive atti-
ude. Many caseworkers who treat
people with severe mental illness de-
velop an attitude of hopelessness, and
patients' attitudes may come to re-
fect those of the caseworker. To
avoid a vicious circle of demoraliza-
tion, caseworkers should strive to
maintain morale and hope.

Admiring and approving state-
ments. Verbal and nonverbal com-
munication that conveys admiration
and approval has special power when
used sincerely by mental health pro-
fessionals. However, in practice,
caseworkers often emphasize pa-
tients' psychopathology rather than
their strengths. Caseworkers may
have difficulty finding admirable
qualities in patients and should
avoid trying to convey admiration
until it is sincerely felt. To develop
sincere admiration for patients, case-
workers may find it helpful to recall
that patients must have significant
inner strengths to keep on going
with life despite their disabilities.

However, admiring or approving
statements used unskilfully can
backfire. Statements that are alleged
to be admiring are frequently de-
ivered in a degrading or sarcastic
tone, especially by professionals who
are accustomed to focusing on pa-
tients' psychopathology. Casework-
ers may also be discouraged if the pa-
tient rejects the admiring statement.
However, initial rejection of admir-
ing statement is to be expected; the
patient's disowning of approval sug-
gests that the caseworker has suc-
cceeded in identifying an area of the
patient's life that has important per-
sonal meaning.

Determining the origins of de-
morailization. Often caseworkers see
a patient's demoralization as a natu-
ral response to schizophrenia. Al-
though sometimes a result of the ill-
ness, demoralization often arises
from specific issues that are unre-
lated to the illness or that existed
before and were exacerbated by the
illness. Whenever possible, the case-
worker should move away from
generic statements such as "I would
feel that way too if I had schizo-
phrenia" and attempt a more indi-
vidualized understanding of the pa-
tient's demoralization.

The caseworker should note top-
ics or themes that occur in patients' self-deprecatory remarks. In par-
cular, personal issues unrelated to
mental illness—for example, a male
patient's self-attack because he
showed tenderness, which he con-
siders unmanly—should be distin-
guished from self-depreciation about
having a mental illness. Examples of
the latter would include remarks by a
patient who is a college graduate but
who can do only menial work. Some
cases of demoralization that initially
seem to be a reaction to being ill are
actually reactions to familial or con-
ventional expectations. The follow-
ing case illustrates this point.

Case 6. Mr. F is a high-function-
young man who has successively
lost jobs in a bank, an insurance of-
(office, and a secretarial agency. The job
losses are puzzling because he is
responsive to neuroleptics and com-
pliant with his medication, is not
acutely psychotic, and has sufficient
intellectual and social skills. He con-
tinues to have residual psychotic
symptoms manifested as delusions of
being controlled, but they do not
seem to interfere with his function-
ing in other areas.

However, during a family inter-
view, it becomes apparent that both
Mr. F and his family believe that
white-collar office work is the only
legitimate vocational path. The case-
worker encourages Mr. F to express
his own interests, and he gradually
reveals a preference for manual work.

He is now able to maintain employ-
ment as a carpenter's helper.

Education about negative symp-
toms. Patients whose demoralization
is driven by persistent symptoms can
be helped by psychoeducation about
the negative symptoms of schizo-
phrenia. This background can help
the patient understand that persis-
tent negative symptoms are thought
to be a result of a brain disease. With
this understanding, patients and their
families can come to see what was
considered laziness, tiredness,
and lack of enthusiasm as manifesta-
tions of the disease process.

Terror
Many patients are terrified when
they realize that they can no longer
experience or maintain coherent
mental functioning. What often fol-
lores is a desperate search for normal
mental functioning combined with
an attempt to hide this struggle from
others.

Terror is a common syndrome,
but because patients often cannot
verbalize their terror, caseworkers
may find it easy to ignore or may be
come indifferent to this problem. In-
direct evidence of terror includes
scattered or dissociated thoughts,
volatile or inappropriate feelings or
the absence of feelings, and unpre-
dictable or contradictory behavior.

The psychotherapeutic manage-
ment goal is to decrease the sense of
terror and despair that comes from
the awareness of being psychotic.
The caseworker should ask the pa-
tient about being frightened and
state that the caseworker would also
be frightened under the same cir-
stances. Patients can find tremen-
dous reassurance in the knowl-
edge that someone else recognizes
the patient's sense of terror without
its having to be explained. Perhaps
the greatest difficulty facing the
caseworker is to understand the ex-
tent of the patient's desperation
while at the same time not becoming
overwhelmed by it.

Reassurance. Reassurance is a
measure that is obvious but often
overlooked. The caseworker can reas-
sure the patient that fear is a normal
reaction to the psychotic experience
and that the experience, although
terrible, can be treated. The case-
worker should avoid false cheerfulness, which the patient will recognize as feigned.

Companionship. Although patients may not be able to reciprocate verbal communication, the caseworker's companionship can be very helpful in reassuring the patient, as the following case illustrates.

Case 7. A 23-year-old acutely psychotic woman remains largely mute and unresponsive despite trials of three antipsychotic medications. Although she worsens whenever anyone tries to talk to her, it is noted that she seems less frightened in the quiet presence of others. Accordingly, a mental health worker is assigned to sit quietly with her three times a week. By the third week she glances at him, and by the fifth week she begins to describe her fears. After recovery from the episode, she describes a terrifying sense of aloneness with her psychosis that, according to her, was largely relieved when the mental health worker began sitting with her.

In the presence of the terrified patient, the caseworker should remain slightly to one side and avoid staring at the patient. An air of quiet confidence is also needed because anxiety is contagious. Little should be said except occasional reflections about what the patient must be experiencing. The caseworker may try such descriptive words such as "wandering," "aimless," "frightened," "bewildered," or "vulnerable" to see if the patient can acknowledge any of these states. These attempts to describe the patient's inner experience and make contact with the withdrawn and frightened patient are best rendered by combining these descriptions with short empathic statements about how awful or frightening the patient's experience must be.

Leaving the patient alone. At the same time as offering companionship, the caseworker should avoid intrusive emotional reaching toward the patient. Some caseworkers may feel that if they are quiet together with the patient, the patient may experience the worker as indifferent or hostile. However, some emotional distance is helpful because excessive verbal interventions or interpersonal closeness can increase the patient's anxiety and exacerbate psychotic symptoms.

Cautionary notes

The psychotherapeutic management techniques outlined in this paper should be used in the context of ongoing supervision. Like any treatment intervention, these techniques may give rise to complications. The following issues may be particularly problematic.

Coordination of psychotherapeutic management with psychopharmacological treatment. Psychotherapeutic management techniques should be undertaken in treatment settings in which psychopharmacological treatment is considered the primary treatment for psychotic disorders. Medication management should be reviewed regularly by a psychiatrist skilled in the management of schizophrenic disorders. Whenever possible, the psychiatrist and the caseworker should coordinate psychopharmacological and psychotherapeutic management through ongoing communication.

Communication between staff.

Caseworkers who use the countemotional techniques, such as sharing mistrust, should communicate with other staff members about the rationale and goals of the psychotherapeutic management interventions. Staff communication is necessary to ensure that the caseworker has the support of the treatment team and is not perceived by other staff members as colluding with the patient or sabotaging the recommended treatment.

Misuse of psychoanalytic principles. Analytically oriented psychotherapy is generally not effective in the treatment of patients with schizophrenia (29,30). (Drake and colleagues [8] have reviewed the dangers of analytically oriented psychotherapy in the treatment of schizophrenia.) Mental health workers may misguidedly apply outdated psychoanalytic theories of psychosis or perhaps draw on their own experiences of being a patient in a psychoanalytically oriented psychotherapy.

A common example of misuse of analytic principles is making a psychodynamic interpretation of supposed unconscious motivations when the patient is acutely psychotic. The following case illustrates the danger of this approach.

Case 8. A student therapist receiving psychoanalytically oriented psychotherapy attempts to explore an acutely psychotic patient's "feelings of anger towards her controlling brother." He advises the patient that she harbors hidden rage against the domineering brother and suggests that she "get her anger out." The patient does just that, by smashing and breaking her hand against the office wall.

Boundary violations. The dangers of violations of the boundaries between clinician and patient are well known (31). Some techniques described in this paper, such as self-disclosure or making admiring statements, may be viewed as boundary crossings in some treatment settings and may be contraindicated in the treatment of patients with other disorders.

For example, even limited self-disclosure by a caseworker may worsen the symptoms of patients with borderline personality disorder who unconsciously seek to eroticize the interaction. Psychotherapeutic management techniques may be used with patients with schizophrenia in ways that do not constitute boundary violations: self-disclosure can be limited to problems at hand, and admiring statements may be made without seductive overtones.

Conclusions

Psychotherapeutic management involves applying the understanding of psychopathology and basic psychological principles in day-to-day interactions with patients. It differs from psychotherapy in that it is less structured and less circumscribed in time and can be done by any mental health worker who interacts with the patient.

This paper has underscored the importance of teaching psychothera-
peutic management techniques to mental health workers and paying attention to psychotherapeutic management of patients with schizophrenia treated in outpatient settings. Psychotherapeutic management techniques may be beneficial in developing an alliance with paranoid patients, negotiating treatment issues with patients who deny their illness, and reducing the terror and stigma that accompany a psychotic illness. However, psychotherapeutic management, no matter how skillfully used, is not a substitute for psychopharmacologic treatment and should be used in conjunction with an appropriate psychopharmacologic treatment plan. Skillful psychotherapeutic management can increase the likelihood that pharmacologic and rehabilitative treatments will be successful.

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