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Supportive Psychotherapy for a Patient with Psychosis: *Schizophreniform Disorder*

CLINICAL CASE

Ms. J is a 19-year-old single woman living with her parents and two younger brothers. She presented for psychiatric evaluation upon her parents' request and with whom she was accompanied to the initial appointment. She had recently been released from an inpatient psychiatric treatment center where she had undergone a nine-week stay including individual psychotherapy, pharmacological management, and group activities. At the initial appointment, Ms. J did not respond to many questions and deferred to her parents to give details of her mental health history.

She began to experience symptoms two years earlier when two significant events co-occurred. Ms. J received a traffic ticket at age 17 for speeding, and she lost driving privileges for one year; in addition, she asked a friend from school out on a date, only to find that her closest female friend had asked him out first. Shortly after these events, she became depressed, developed initial and middle

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insomnia, decreased appetite, decreased energy level, and decreased interest in band and sports. Her grades at school dropped and she ended the school year with a grade point average much lower than her normal performance. She was seen initially by a family practice doctor and subsequently by a psychiatrist, and she tried several antidepressants with minimal success. Over the next several months, the depression became more severe and she was unable to return to school in the fall of her senior year of high school. Ms. J also endorsed suspiciousness toward friends and police officers, stating to her parents on various occasions that individuals in their family were being followed throughout their community by police and that friends she had known for years "turned on me and made me fail out." She was not able to concentrate on school work despite the efforts of a private tutor, and eventually she put her education on hold. With increasing symptoms involving delusional themes, subsequent and consecutive medication trials of aripiprazole (Abilify®) and quetiapine (Seroquel®) were pursued, though unsuccessful. Ms. J complained of sedation and headaches, and discontinued both medications within days of starting them.

Ms. J was admitted to a psychiatric treatment center for nine weeks. Some improvement was noted, and during the hospitalization Ms. J did not exhibit the paranoia seen prior to her admission. Within two weeks after returning home, she refused to return to high school, and she made comments that the police in her community were "after" her, watching her every move. She had recently regained driving privileges and was again driving, which was the only activity that motivated her. She made comments on a regular basis about law enforcement monitoring her and she would frequently take alternate routes back to her house in an effort to avoid interaction with them. In reality she had not been pulled over by police since regaining her driver's license.

She was guarded and avoided questions regarding emotions or relationships. She talked extensively about her car, which her parents had purchased for her in an effort to provide a source of motivation and reinforcement for participating in family activities. The family later expressed concern that Ms. J was staying awake for 24 to 36 hours at a time researching the vehicle on the Internet, followed by long periods of sleep. She did not interact with the family, skipped meals, and was generally disruptive to the normal schedule and routine of the household. She preferred to sleep during daytime hours and research the car throughout the night. During this period she would frequently show up late for psychotherapy appointments, be extremely fatigued during sessions, and miss sessions altogether at times stating she had been "too tired" to wake up. Her relationship with all her family members became strained, and she had virtually no contact with friends from school. She was also aware that her perceptions of experiences did not match others' interpretations. She avoided interface with virtually everyone and became more isolative. With the constellation of disorganized thought processes, paranoid delusions, tactile hallucinations, and negative symptoms, including avolition and isolative behavior, Ms. J was diagnosed with schizophrenia, paranoid type.

THE ROLE OF SUPPORTIVE PSYCHOTHERAPY IN SCHIZOPHRENIA

While psychotherapy had been the gold standard for treatment of schizophrenia prior to the 1960s, the advent of neuroleptic (antipsychotic) medication diminished its role markedly.[2] However, the advances made in pharmacotherapy also enable patients with schizophrenia to function at a higher level, which in turn allows them to participate and benefit from psychotherapy in a way not possible previous to the use of antipsychotic medication. It is important to conceptualize the treatment of schizophrenia as being multimodal, by incorporating pharmacotherapy, psychotherapy, and community support technologies.

The efficacy of numerous types of psychotherapy in schizophrenia has been studied. In a comparison between insight-oriented and supportive psychotherapy, it was found that sicker patients not only tolerated supportive therapy better than insight-oriented therapy, but in addition, the outcome measures favored those receiving supportive therapy.[3] Cognitive behavioral therapy (CBT), the most studied psychotherapeutic treatment for schizophrenia, has also been compared in several studies to supportive therapy. In a study that examined the effect of these therapies at 24 months, both CBT and supportive

TABLE 1. Therapeutic value of the "real relationship" supportive psychotherapy

- Growth of interpersonal and social skills
- Improved reality testing
- Consensual validation
- Promotion of identification with therapist
- Enhanced patient self esteem
- Greater calmness in crisis

From Novalis PN, Peele R, Rojcewicz SJ. *Clinical Manual of Supportive Psychotherapy.* Washington, DC: American Psychiatric Presss, Inc., 1993:132.

therapy were found to have long lasting clinical benefits, with supportive therapy showing superiority on some measures, particularly in reduction of negative symptoms.[4]

Although the fundamentals of supportive psychotherapy are similar for most psychiatric conditions, the therapy of patients with schizophrenia presents unique challenges in the application of those fundamentals and necessitates specialized symptom-specific and illness-specific interventions.[1] A knowledge of the natural course of schizophrenia underlies successful supportive psychotherapy. The exacerbations of symptoms are basic to the disease process and will not be completely resolved despite pharmacotherapy, psychotherapy, or a combination of both.[1] Supportive psychotherapy, however, can play a key role in preventing exacerbations from further disrupting the patient's life. It is particularly important to understand the fluctuations of this illness in the context of risk assessment. For example, the risk of suicide is highest in the first two weeks following discharge from an inpatient hospitalization.[5] It is therefore imperative to provide supportive psychotherapy at this and other stressful times of transition. Studies have shown a three-fold reduction in the recurrence of homelessness in patients who had social skills training and supportive therapy during their transition from shelter to community housing.[6]

In supportive psychotherapy with a patient who has schizophrenia, the relationship between the therapist and patient is crucial. Recent studies have shown that patients with schizophrenia who develop a good alliance with their therapists, in comparison to patients who have not, demonstrate greater acceptance of treatment, better medication adherence, less total medication use, and better long-term outcome.[1] The better overall outcome is reflected by a variety of measures of psychopathology, cognitive functioning, ego functions, social functioning, and work performance. Patients may adjust their social deficits by learning from the therapist and modeling themselves on the therapist's behavior. The therapeutic advantages of the real relationship between patient and therapist are outlined in Table 1.

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PRACTICE POINT: Effectiveness of Supportive Psychotherapy in addressing symptoms commonly associated with schizophrenia (hallucinations, etc.)

By session 22, Ms. J shared further details regarding her feelings toward a friend she had known since fifth grade and whom she had asked out just before the symptoms of depression began. She described their close friendship and the many years their families had spent time together both at church and socially at their homes. They both had younger brothers who had been best friends as far back as she could remember. She had played intramural softball and had participated in band with the friend. While the two were part of a larger group of friends, as a couple they were virtually inseparable. She had felt sure her romantic feelings toward him were mutual, and in the

TABLE 2. Therapeutic responses to hallucinations

- Do not agree with the reality basis for the hallucination
- Examine the circumstances of the hallucination
- Interpret the occurrence (e.g., as a reaction to a blow to self esteem)
- Explain the mechanism again and again
- Try to treat the patient's condition with an increase in external stimuli
- Ask patient to drown out hallucinations with alternate noise
- Deemphasize the hallucinations and focus on positive matters

From Novalis PN, Peele R, Rojcewicz SJ. *Clinical Manual of Supportive Psychotherapy.* Washington, DC: American Psychiatric Press, Inc., 1993:138.

TABLE 3: Therapeutic responses to delusions

- Express mild questioning or skepticism
- If patient has any doubts whatsoever, begin to confront the delusion and to explore its formation
- If patient becomes non-delusional, further explore the process of delusional formation and possibly interpret content
- Offer consensual validation for elements of reality in the delusion
- Interpret the delusion as "poetic truth"

From Novalis PN, Peele R, Rojcewicz SJ. *Clinical Manual of Supportive Psychotherapy.* Washington, DC: American Psychiatric Press, Inc., 1993:139.

spring of their junior year of high school, she asked him out on a date. The friend originally thought she intended for the whole group to go to a movie, and when she clarified that she was asking him out on a date, the friend was caught off guard. Unbeknownst to Ms. J, he had agreed to date another girl from the group just that morning. It became an uncomfortable and clumsy conversation, which was a first for them. It ended quite awkwardly and they didn't talk one on one for several weeks, but he continued to date their mutual friend.

At this point, it is important to explore the rejection Ms. J experienced and its implications. When she expressed that she was "embarrassed" by the interaction, the therapist normalized this emotion, explaining that rejection is an experience common in everyone's life. It was pointed out to Ms. J that she invests herself in relationships, and it is her willingness to take risks that makes herself vulnerable at times. However, these are positive qualities that will serve her well and will eventually produce consistent and meaningful longitudinal relationships.

Work also was done to process the combination of stressors that had co-occurred, and the inception of the mental illness. Ms. J spoke of the genetic component and the fact that her mother had struggled with major depression for many years. She described the emotions she experienced when the possibility of developing schizophrenia had been discussed during the initial months of her depression. She discussed her fear of losing control of her symptoms, as well as her hesitancy to discuss her concerns about feelings of paranoia in psychotherapy. She had feared that sharing them with the psychiatrist would not only confirm everyone's suspicions that she was developing a severe and chronic mental illness, but more importantly that verbalizing the unusual experiences would make them occur more frequently. As a result, Ms. J was often guarded for several sessions at a time, leaving the therapeutic relationship strained. At this point, Ms. J's anxiety and fears were acknowledged, and she was encouraged to share her experiences despite concerns that the therapist would not "believe" her; the focus was on the affect, or her emotions regarding these experiences. When she began to express doubt that her friends would in fact turn on her or plot against her, the therapist could cautiously pursue the theme of questioning her own delusions. When this line of interpretation was accepted by Ms. J, the therapist could pursue the formation of the delusion from its origin, expanding on the history of the friendships in question.

Effective response to hallucinations, delusions, and ideas of reference is a major factor in the art of supportive psychotherapy. It is contraindicated for the therapist to agree with the content of the abnormal perceptions.[1] Such a false agreement can increase the patient's anxiety, further confuse her reality testing skills, and reinforce the psychotic content. A basic strategy is to convince the patient that who she "really is" is more worthwhile and attractive to the therapist than the identity provided by the hallucinations, delusions, or ideas of reference.

PRACTICE POINT: Supporting the Patient Who is Recovering from an Acute Psychotic Episode

In many instances, a delusional patient goes through three specific phases while recovering from an acute psychotic episode: 1) a delusional phase, with full belief in the delusions; 2) a double-awareness phase, in which the delusions co-exist with more accurate reality testing (i.e., the patient may question the

delusions, may simultaneously accept or reject them, or may conceal or try to suppress them); and 3) a non-delusional phase, in which no delusions or only residuals of delusions exist.[1] This sequence helps to determine appropriate timing for therapeutic challenging of delusions. See Tables 2 and 3 for therapeutic responses to hallucinations and delusions, respectively.

PRACTICE POINT: Countertransference Issues

Work with schizophrenic patients places the therapist in close contact with intense anxiety, primary-process thinking, projective identification, and an atmosphere of loss of ego boundaries.[1] It is important for the therapist to watch for several common countertransference issues when working with a patient with this type of symptom set. The therapist may develop unrealistic expectations for the patient, leading to disappointment or subtle pressure on the patient to improve. The therapist may have overly pessimistic expectations, settling for only minor changes in the patient.

In the case of Ms. J, time was spent collecting data on family relationships, as well as relationships with peers, to gain a fuller understanding of the capacity for bonds prior to the onset of mental illness. This assists the therapist in formulating realistic expectations for current functioning. While Ms. J was endorsing paranoid delusions, there were limitations in her capacity to relate to others, but there was significant improvement with alleviation of the symptom set. At this point, the therapist can confront suspiciousness toward friends who were previously trusted.

USING THE RECOVERY MODEL in treatment of schizophrenia, the clinician does not require that the patient have reduced need for medical, mental health, and social care; it is about experiencing improved quality of life and higher levels of functioning despite the illness.

Work with the schizophrenic patient can be extremely challenging and rewarding. The therapist should remain cognizant of the expected remissions and exacerbations associated with the illness, regardless of the expertise of the therapist. Some of the risks in providing supportive therapy to the patient with schizophrenia are outlined in Table 4.

A recurrent theme of loss and grief is common for patients with schizophrenia. Patients often feel isolated by their debilitating illness, and life goals they once had may no longer be attainable. Multiple exacerbations during the course of their illness are likely to evoke feelings of hopelessness and despair, feelings that are often shared by the therapist as doubts of successful treatment invade.[8] As a result of this countertransference, the therapist runs the risk of "burning out." However, if the therapist is

TABLE 4: Risks of using supportive psychotherapy in schizophrenia and strategies for minimizing these risks

RISKS	STRATEGY FOR MINIMIZING RISK FOR THE PATIENT
Dangers of inappropriate intensive psychotherapy	
	• Get to know patient's capacity for understanding, initially using limited or superficial interpretations
Increased depression, chance of suicide	
	• Build in safety by seeking feedback from patient; be able to offer extra support when needed
Premature termination	
	• Maintain appropriate distance; avoid overstimulation and intrusion into patient's life before such issues can be handled
COUNTERTRANSFERENCE PROBLEMS	
Unrealistic expectations	
	• Understand the course and prognosis of the illness, and become knowledgeable about cognitive deficits in schizophrenia
Overly pessimistic expectations	
	• Realize that pessimism may be a way of protecting yourself from doubts about your own competency; however, it can become self-fulfilling
Therapist burnout	
	• Avoid staking your reputation on any one patient

From Novalis PN, Peele R, Rojcewicz SJ. *Clinical Manual of Supportive Psychotherapy.* Washington, DC: American Psychiatric Press, Inc., 1993:153.

able to understand these feelings and utilize them to better empathize with the patient's experience of loss and grief, it will enable him or her to become a more effective therapist.[8]

In the case of Ms. J, feedback regarding her comfort level with various topics was sought over and over in the sessions during both exacerbations and remissions. At times, she felt certain questions were intrusive (e.g., when the therapist attempted to explore the rejection she experienced at the onset of the depressive symptoms). By building an alliance with the patient, the therapist encouraged Ms. J to discuss sensitive issues but only when she was comfortable in doing so.

CONCLUSION

Using the recovery model in treatment of schizophrenia, the clinician does not require that the patient have reduced need for medical, mental health, and social care; it is about experiencing improved quality of life and higher levels of functioning despite the illness.

Recovery in this sense does not mean the illness has gone into complete remission. It means that over time, through what for many is a long and difficult process, individuals come to terms with their illness by learning first to accept it and then move beyond it.[9] They learn to believe in themselves as individuals, learn their strengths as well as their limitations, and come to realize that they have the capacity to find purpose and enjoyment in their lives despite their illness. The recovery approach focuses upon the potential for growth within the individual. That potential can then be developed by integrating medical, psychological, and social interventions. The recovery model sees individuals with mental illness as active participants in the recovery process.

Supportive psychotherapy in the case of Ms. J will help her achieve "recovery" in whatever way she may define it.

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