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 lengthiest 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

(9,10). The current availability of effective pharmacologic and rehabilitative treatments thus makes effective psychotherapeutic management techniques especially valuable.

This paper discusses five syndromes that are commonly experienced by patients with schizophrenia—paranoia, denial of illness, stigma, demoralization, and terror of being psychotic—and describes psychotherapeutic management techniques that caseworkers and other mental health workers may find useful. Techniques are matched to syndromes to illustrate how they can be used, but not to imply that those techniques can be used only in addressing that particular syndrome. Because much of this kind of psychotherapeutic management takes place in day-to-day interactions and advanced psychotherapy training is not necessary, the term "caseworker," rather than "therapist," is used in the descriptions of the techniques and the examples.

Paranoia

In addition to showing florid paranoid symptoms, patients in a paranoid state may display more subtle signs, including excessive externalization of blame or responsibility. Symptoms that appear to be unrelated to paranoia, such as anxiety or insomnia, may be found on closer examination to be driven by a paranoid fear of attack, as the following case illustrates.

Case 2. Mr. B is a 24-year-old man with a three-year history of schizophrenia whose chief complaint is insomnia. He has a history of frequent moves with brief stays with relatives. When closely questioned by clinicians, he admits that the insomnia occurs only in one part of the city. Due to an elaborate delusional system, he feels in danger in certain neighborhoods and not in others.

The following psychotherapeutic management interventions are recommended for dealing with patients with paranoid states.

Nonthreatening body positioning. The caseworker places himself beside the patient rather than in the usual face-to-face position (11). Direct visual contact is avoided. Instead, both the caseworker and the patient look out together at the world that is deemed hostile by the patient. The side-by-side position tends to deflect the patient's paranoid fears away from the caseworker and improve the chances of forming a working therapeutic relationship.

Indirect speech content. The caseworker avoids speaking directly to the patient. Third-person pronouns (he, she, it, they) are used instead of first- and second-person pronouns (I, you), providing the verbal equivalent of side-by-side positioning. The purpose is to deflect the patient's paranoid projections away from one-on-one interactions with the caseworker and direct them toward external and more general issues.

Reciprocal emotional tone. Whenever possible, the caseworker's attitudes and emotional expressions should parallel those of the patient. When the patient expresses anger or frustration with a difficult situation, the caseworker also expresses anger and frustration. The goal is to help the patient feel understood by the caseworker. The patient's emotional state or beliefs are not interpreted or corrected (12). Instead, the caseworker's own emotional expressions reflect those of the patient.

Sharing mistrust. The intuitive approach with paranoid patients is to try to persuade them to be more trusting. The opposite strategy—in which the caseworker and the patient mistrust the world together—is often more useful. This technique is based on the assumption that patients in a paranoid state are overwhelmed by a mixture of real-life stresses and distress from psychotic symptoms (12) and that an immediate challenge to their world view would increase their difficulties. No attempt is made to correct or contradict the patient or to urge the patient to test reality.

This approach allows the caseworker and the patient to agree on something and opens the way for the caseworker to attempt to substitute a less paranoid, more benign, general explanation of events for the patient's more highly personalized paranoid one. The process is best done in a step-wise fashion, with the caseworker's suggestions only slightly less paranoid than the patient's explanation. The caseworker should carefully avoid collusion with the psychotic symptoms while attempting to find some aspects of the patient's paranoid belief system that may be credible. The goal, illustrated in the following case, is for the patient eventually to tell the caseworker, "Don't be so paranoid."

Case 3. Ms. C blames her most recent hospitalization on a police conspiracy to terrorize her. Rather than confront her by talking about the behavior that led to her arrest, the caseworker agrees that the police cannot be trusted and goes on to talk about his own outrage at the police beating of Rodney King. By the end of the conversation, Ms. C tells the caseworker to stop treating the police so unfairly.

Postponing psychoeducation. Psychoeducation in the management of schizophrenic disorders has been a major treatment advance (13). However, premature introduction of the medical model or symptom-based terminology in discussions with the patient may inadvertently increase 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 with the patient about paranoid or delusional symptoms. Until a sound alliance is formed, the caseworker should avoid the more traditional psychoeducational approach that teaches about illness and benefits of medication.

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

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 demoralization, 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.

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 disassociate 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 case worker'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.

Performative 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 ladened experience (14). Patients may more readily understand descriptors such as "psychotic symptoms" rather than "schizophrenia" and "suspiciousness" 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-deprecation may contribute to the development of depression.

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

Intervention to manage demoralization involves physical positioning, verbal and nonverbal communication, and normalizing the patient's experiences. Here the optimal physical position of patient and caseworker is face to face rather than the side-to-side position used with patients in paranoid states.

Maintaining a positive attitude. Many caseworkers who treat people with severe mental illness develop an attitude of hopelessness, and patients' attitudes may come to reflect those of the caseworker. To avoid a vicious circle of demoralization, caseworkers should strive to maintain morale and hope.

Admiring and approving statements. Verbal and nonverbal communication that conveys admiration and approval has special power when used sincerely by mental health professionals. However, in practice, caseworkers often emphasize patients' 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, caseworkers 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 unskillfully can backfire. Statements that are alleged to be admiring are frequently delivered in a degrading or sarcastic tone, especially by professionals who are accustomed to focusing on patients' psychopathology. Caseworkers may also be discouraged if the patient rejects the admiring statement. However, initial rejection of admiring statement is to be expected; the patient's disowning of approval suggests that the caseworker has succeeded in identifying an area of the patient's life that has important personal meaning.

Determining the origins of demoralization. Often caseworkers see a patient's demoralization as a natural response to schizophrenia. Although sometimes a result of the illness, demoralization often arises from specific issues that are unrelated to the illness or that existed before and were exacerbated by the illness. Whenever possible, the caseworker should move away from generic statements such as "I would feel that way too if I had schizophrenia" and attempt a more individualized understanding of the patient's demoralization.

The caseworker should note topics or themes that occur in patients' self-deprecatory remarks. In particular, personal issues unrelated to mental illness—for example, a male patient's self-attack because he showed tenderness, which he considers unmanly—should be distinguished 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 conventional expectations. The following case illustrates this point.

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

However, during a family interview, it becomes apparent that both Mr. F and his family believe that white-collar office work is the only legitimate vocational path. The caseworker encourages Mr. F to express his own interests, and he gradually reveals a preference for manual work. He is now able to maintain employment as a carpenter's helper.

Education about negative symptoms. Patients whose demoralization is driven by persistent symptoms can be helped by psychoeducation about the negative symptoms of schizophrenia. This background can help the patient understand that persistent 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 manifestations 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 follows 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 become indifferent to this problem. Indirect evidence of terror includes scattered or dissociated thoughts, volatile or inappropriate feelings or the absence of feelings, and unpredictable or contradictory behavior.

The psychotherapeutic management goal is to decrease the sense of terror and despair that comes from the awareness of being psychotic. The caseworker should ask the patient about being frightened and state that the caseworker would also be frightened under the same circumstances. Patients can find tremendous reassurance in the knowledge 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 extent 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 reassure 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 psychopharmacologic treatment. Psychotherapeutic management techniques should be undertaken in treatment settings in which psychopharmacologic 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. Coordination is particularly important when there is a differential diagnosis in which psychopharmacologic treatments are indicated, such as demoralized states versus postpsychotic depression.

Communication between staff. Caseworkers who use the counterintuitive 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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H&CP Service Offers Wide Range of Benefits

The Hospital and Community Psychiatry Service of the American Psychiatric Association makes a wide range of information and educational resources available to staff members of mental health facilities at an affordable cost.

Notable among H&CP Service benefits is *Hospital and Community Psychiatry*. Currently almost 8,000 mental health professionals are receiving their own *H&CP* subscriptions through their facility's service membership. These staff members also receive the *H&CP Service Update,* a quarterly newsletter highlighting service benefits. In addition, they have access to more than 200 titles in the service's video rental library at very low cost.

Other benefits include quarterly mailings as well as discounts on books, registration fees for the annual H&CP Institute, and psychiatric searches and placements. For more information, contact the H&CP Service, APA, 1400 K Street, N.W., Washington, D.C. 20005; telephone, 202-682-6173.