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Therapeutic Communication with Psychotic Clients

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Abstract With the current emphasis on evidence-based practice, the significance of the social worker–client relationship as a prerequisite to client goal attainment has been de-emphasized. This is particularly problematic with regard to practice with psychotic clients, with whom practitioners often have difficulty establishing therapeutic relationships. The purposes of this article are to examine the communication deficits of persons with psychotic disorders and, with an extended example, to describe five intervention guidelines for social workers toward the goal of developing positive working relationships with them.

Keywords Clinical social work · Psychotherapy · Psychosis · Mental illness

Introduction

Social work practitioners face particular challenges when working with psychotic clients, as it is often difficult to develop positive and facilitative relationships with them (Hewitt and Coffey 2005). When a client is psychotic, his or her language and perceptions are difficult to comprehend. In the example below, Elliot, who has schizoaffective disorder, describes how he is troubled:

> I'm the type of person who, when I have a problem, it all comes undone. So if I have a small problem it's like waiting for the sun to go down, like it's gonna just explode, and come undone, and there are parts I just have to clean up in the morning. A lot of people my age, they're waiting for the sun… it's like Japan, land of the rising sun, it's like they've been out for so long they're just waiting for a new day to dawn. I'm not like that, people are not like that, some of them don't know it's a fantasy. Sometimes I don't know, or forget whether I should talk about my friends who have screwed up, if it's important to go over those things, or if I should focus on happier things. It can be important… I have a lot of issues.

Much of the practice literature is focused on what social workers can do with psychotic clients *after* they have stabilized, often with the assistance of medication, and can communicate in more conventional ways. It is this author's contention, however, that psychotic clients can and should be engaged in working relationships even when the active symptoms are prominent, as they may retain or experience recurrences of psychotic ideation throughout the intervention. The purposes of this article are to examine the nature of communication of persons who are psychotic and to outline principles for social workers to engage them in a working relationship. These principles can help social workers to reduce a client's psychotic symptoms and then proceed with a longer-term therapeutic endeavor toward helping the client develop improved social functioning skills.

Non-Specific Aspects of Clinical Intervention

A major development in the social work literature during the past 15 years has been the search for, and establishment of, evidence-based practice guidelines for intervention (e.g., Nutley et al. 2009; Roberts and Yeager 2004; Thyer and Wodarski 2007). This movement is based on several

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assumptions, one of which is that clients who share a certain type of problem, challenge, or disorder have enough in common that they are likely to respond to the same range of interventions. While there is certainly merit to the search for evidence-based practice guidelines, "technique" is not the only variable that accounts for client outcomes, regardless of diagnosis. In fact, five factors that influence treatment outcomes have been identified as client factors, extra-therapeutic events, relationship factors, expectancy effects, and intervention technique (Spaulding and Nolting 2006). That is, outcomes depend on a combination of nonspecific and specific effects.

The value of therapeutic relationships is widely acknowledged but is still the subject of debate within the helping professions (Furman 2009). Some practitioners believe that the relationship is both necessary and sufficient for client change, while others assert that therapeutic technique is more important. Hewitt and Coffey (2005) conducted a meta-analysis of studies on the significance of the therapeutic relationship with clients who have schizophrenia and concluded that clients who experience an empathic, positive, and facilitative relationship have better outcomes. Additionally, Miller et al. (2005) concluded from their literature review that the two elements of the therapeutic alliance and the practitioner's ongoing attention to the client's attitude about the intervention account for positive outcomes more than anything else. They estimated that client characteristics (the nature of problems, motivation, and participation) account for 40% of clinical outcome, and the quality of the therapeutic alliance accounts for an additional 30%. The practitioner's guiding theory or model accounts for 15%, and the remaining 15% is a placebo effect.

Frank and Frank (1993) engaged in a worldwide study of the determinants of positive outcomes for persons who seek the assistance of helping professionals. They concluded that the following features were common to all positive outcomes:

- The client enters into an emotionally charged relationship with the provider, and perceives that person to be competent and caring.
- The provider has confidence in whatever theories and techniques he or she utilizes.
- Interventions are based on a rationale that is understandable to the client.
- Interventions require the active participation of the provider and client, both of whom believe them to be a valid means of improving functioning.
- The client is provided with opportunities for learning and success experiences.

The remainder of this article will elaborate on these nonspecific, relationship-based factors in intervention with psychotic clients toward the goals of symptom reduction and enhanced social functioning.

Defining Psychosis

There is no single definition of psychosis, but it can be understood as a mental state in which external reality has a diminished meaning for an individual or is perceived in a distorted way (Campbell 2004). The *core* of psychosis is characterized by thought blocking, thought deprivation, poverty of thought, and loose associations. The violation of boundary conditions is also an essential feature of psychosis, as the distinction between reality and fantasy, or the self and world, become blurred. The *periphery* of psychosis, or the ways in which the core disorder is manifested, may include hallucinations (auditory, visual, tactile, olfactory, somatic), affective impairments (flat, blunted, social withdrawal, non-communication, anhedonia, passivity, ambivalence), delusions (persecution, thought broadcasting, thought insertion, thought withdrawal, being controlled, being the focus of external events, somatic distortions, grandiosity), and loose speech (tangential responses, circumstantiality, loss of a goal, or seemingly purposeless and illogical associations) (American Psychiatric Association 2000).

By definition, psychosis is not "rational", understood as thinking that is based on accurate perceptions of external evidence, is life preserving, and keeps one directed toward personal goals (Ellis and McLaren 1998). Even in psychosis, however, the person makes some rational observations and choices (Taylor 1997). But it is the relative absence of rational thinking in psychosis, and the social worker's inability to comprehend the client, that makes relationship development difficult.

The Experience of Psychosis

Psychotic ideation may be evident in many disorders, both medical and psychiatric, including schizophrenia, schizoaffective disorder, delusional disorder (thought disorders), major depression, and bipolar disorder (mood disorders), among others (American Psychiatric Association 2000).

Thought Disorders

The thinking and perceptual distortions in psychosis result from neurological changes, the origins of which are not clear. These include disruptions in the person's short-term memory (Keefe 2000) and information processing capacity, which are related to impairments in stimulus filtering (Cadenhead and Braff 2000). The overload of normally inhibited

externally and internally generated stimuli leads to the person's misinterpretations of words and events. There is also impairment in executive functions, which normally allow a person to plan, organize, follow sequences, and think abstractly (Palmer and Heaton 2000). Emotionally salient topics intensify the level of disorganization in psychotic discourse, further inhibiting one's ability to reason or channel emotions (Rosenbaum and Sonne 1986). The ways in which these deficits become evident are described below.

The perceptual field in persons with schizophrenia features a loosening of the "common sense" visual context (Uhlhaas and Mishara 2007). Whereas a person's normal visual field is characterized by coherence, with objects perceived in meaningful relationship to one another, the loosening of perceptual schema separates fragments from the larger context. The individual perceives partial elements of a scene without grasping their natural relationships to each other (and therefore the scene's overall meaning). The emergent delusion consists of the person's elaboration of a new context for the unexplained, overly salient perceptual fragments. There is an ongoing relationship between social isolation and the development and persistence of delusions, because such isolation reinforces misperceptions of the internal lives of others. Auditory hallucinations are in turn the result of mental processes that are experienced as detached from their internal source. The perceptual difficulties associated with psychosis are also manifested by abnormal speech patterns characterized by poverty of content, derailment (poor connection and tangential responses to questions), circumstantiality (wandering and over-detailed messages), and loss of goal (the original point is lost) (Harvey 2000).

An example may illustrate this process. A socially isolated client with schizophrenia lost himself in religious fantasies, based on fragmented perceptions of his actual family background. Without the ability to attend to the many internal and external factors (variables) that contributed to these perceptions, and in the context of his terrible loneliness and anxiety, he constructed a "sensible" story that he had been sent to earth by God, doomed to suffer in isolation for the betterment of mankind. He had the "gift" of being able to interpret evil messages hidden in popular music (a topic of actual interest to a small segment of his society) and took on as his mission the warning of others that they were being brainwashed by Satan.

Below is another example of a confused communication from Elliot about conflict with his family:

> I'm heading toward the wilderness. I understand what it means to go south. I'm just naturally heading out of town. Sometimes I have to go to town, and it's not a big deal because I never plan to stay. I'm perpetually working to get out of town. My family is always trying to get to town, and I'm trying to get out of town. Going into town is always exciting for me. Most people go into town, they see subways, they see New Japanese, and they're stuck there for a week. They have to get work done. I'm in and then out. I don't spend money there. It's a different attitude.

Mood Disorders

In major depression and bipolar disorder, a person's thinking style and language is at the mercy of his or her uncontrollable moods (Goss 2006). When depressed, the client's thinking is slower than normal and lacking in focus. During the experiences of hypomania and mania, the person's elation brings on an influx of verbal tendencies. In hypomania, a moderate amount of elation may actually sharpen cognitive abilities, but speech and thought begin to degenerate into psychosis during mania. Manic persons cannot complete thoughts because the affective rush propels them in different directions, as evidenced in the following example from Sara, a client who was expressing resentment of her successful younger brother, a computer engineer:

> They're actually making computer chips out of sand from the beach. That's two huge work issues; organic versus sustainable. Like, you can't rip down the rain forest, but you can extract plants from it. Well, why are you allowed to go in if you aren't allowed to touch anything? But organic, a lot of men argue, "What is inorganic?" A problem to a psychologist is some idiot did heroin and fused both halves of his brain together; how do you get them apart? You can't open it up. It's like a person, you can't open him up.

Unfortunately for the social worker, efforts at verbal intervention make little impression on the actively manic client. Appropriate behavioral limit-setting is required to keep the client and others 'safe', and only when the manic episode remits can the social worker engage the client in relationship-based intervention (Fava et al. 2005). Still, as a mood episode stabilizes, remnants of disordered thinking may persist. Over the course of bipolar disorder a person may develop mild to moderate problems with attention, learning, memory, and executive function (Burdick et al. 2007).

Section Summary

While the presentation of psychosis presents challenges for the social worker, it also provides opportunities. The client feels rejected by others in part because he or she feels marginalized and discounted. Any attempts by the social

worker to show genuine acceptance of the client will be perceived and eventually welcomed. Further, while the client's bizarre ideas and associations become emotionally charged, he or she does not completely lose an understanding of social conventions (Arieti 1974). Much of the intervention involves helping the client to place perceptual fragments into a wider, more cohesive context. It represents an attempt to help the client explore his or her biography in a way that can incorporate more "factual" perceptions into delusional ones (Roberts 1997).

The interventions described below represent an effort to integrate neurological and psychodynamic principles. They accept the neurological basis of psychosis but also value the application of psychodynamic (relationship) interventions for helping clients develop improved attachments toward others and an awareness of the social contexts that can facilitate their goal attainment.

Intervention Guidelines

There is a rich history in the psychotherapy literature on the importance of relationship development with clients who have psychotic disorders. Frieda Fromm-Reichmann (1952) was among the first psychoanalysts who determined that a strong relationship can be established between the client with schizophrenia and the practitioner, and that this is a prerequisite for more intensive intervention. She was aware of the limitations of the person with schizophrenia to make a "full" recovery, and acknowledged that the client's continued reliance on schizoid defenses was appropriate. Lewis Hill (1957) later agreed, saying that the client with schizophrenia's ongoing but adaptive use of schizoid ways of living is an appropriate goal.

Elvin Semrad (1955) demonstrated through his charismatic use of self that empathic connection with psychotic clients is critical for their improvement. He asserted that psychotic symptoms are best understood as a defense against intolerable feelings of loss or failure, and that the emotional connection between client and practitioner can help mitigate the client's ongoing need for those defenses. Rather than getting preoccupied with treating symptoms, practitioners need to help clients feel what has previously been unbearable, and then find ways to solve their life dilemmas. Sullivan (1947) wrote that a lengthy interpersonal relationship is required to shed light on the psychotic client's difficulties in living, because the client cannot communicate his way of life well. The client's sense of reassurance is related to the social worker's being perceived as an expert in interpersonal relations.

Weiden and Havens (1994) outlined five obstacles that interfere with therapeutic alliance development with clients who have schizophrenia. These include paranoia, denial of the illness, stigma, demoralization, and terror from the experience of symptoms. Intervention strategies that can help to ameliorate these symptoms include empathizing with the mistrust of paranoid clients, providing clients in denial with alternate points of view, making affirming statements to demoralized clients, and normalizing the experiences of stigmatized clients.

In "A Safe Place" Havens (1996) characterized the worker-client relationship as a sanctuary that attempts to hold in a nurturing balance the client's conflicting desires for solitude and society. Countering the patient's expectations of contempt is therefore a first principle of forming effective relationships. To further this idea of the worker's affirmation of the client, Rapp (1998) describes the effective social worker-client relationship in case management practice as purposeful, reciprocal, friendly, trusting, and empowering. Engagement is a conversational and concrete process. Pacing is important, as is a strengths-based assessment.

Sustainment

What follows here is a summation of the ideas introduced above. The social worker/client relationship is the sustaining link between the client and external world, and provides the client with an environment of safety. When it is positive, the client becomes aware that the social worker appreciates the threads of meaning in his or her fragmentary statements (Cox 1997). It is the client's cautiously trusting response to being understood that facilitates his or her movement in the direction of personal integration and more adaptive functioning.

The social worker "sustains" and enhances the client's sense of self through verbal and non-verbal interventions; by listening actively and sympathetically, conveying a continuing attitude of good will, expressing confidence and esteem, realistically reassuring the client about the potential for goal achievement, and offering environmental support (Goldstein 1995). Through these interventions the social worker promotes a confiding relationship and instills in the client a sense of the worker's competence and caring. The social worker's presence becomes an antidote to the client's alienation, enhances morale, inspires the expectation of help, and creates a setting where constructive confrontation can eventually take place. Within this relationship the client comes to appreciate the significance of internal and external limits in pursuing goals, improves reality testing, and experiences learning and enhanced self-esteem. The client may develop an attachment to the social worker, although conventional evidence of this bond may not be readily apparent.

In the following statement, Elliot expresses his faith in the relationship with the social worker:

> Does counseling help? Not in the sense of my daily life. But it helps with my routine. If I have a problem I know I'll have an answer when I'm here, so I can make a note, a mental note, so if I have some work to get done, if I have something to say, and it's intense, I can say it in a scientific manner, and use my psychology, I trust that this is a real outlet. I've learned from experience that a degree is useful to have, and it reinforces that there is an answer. Where science is cold, a scientific person will not be offended by a scientific answer.

The social worker cannot initially comprehend what the psychotic client is saying, and any quick attempts at interpretation may amount to "free association" on the practitioner's part. The sustaining social worker thus does not rush to interpret the client's comments (suggesting "this" really means "that"), but accepts the client's statements with curiosity ("this" means "this", but perhaps also "that"). This patient acceptance of the client's presentation allows for the development of Semrad's (1955) empathy, Fromm-Reichmann's (1952) valuing of relationship over intellectual comprehension, and Havens' (1996) conveyance of acceptance. In turn, as emphasized by Sullivan (1947), even if the client becomes confused trying to understand what the social worker means, his or her perception as an "expert" will encourage the client's trust.

The patience required for sustainment may work against agency policies that encourage the use of active interventions early. The social worker may feel pressured to be "productive" in terms of establishing concrete goals and objectives. As public funding for mental health interventions is always limited, such administrative structures as managed care, capitated funding, and utilization review practices tend to enforce a more rapid movement through the care system than is practical for many clients with psychotic disorders (Mechanic 2008). Yet, the possibility of eventual success may be diminished by quick interventions, as the client may not become engaged in the process.

The remaining intervention guidelines are adapted from Dilks et al. (2008).

Expand the Client's Perspective

Therapeutic communication with psychotic clients requires that the social worker gradually perceive the meaning of the client's seemingly bizarre statements. Toward that end, the social worker gradually encourages the client to elaborate on his or her thoughts regarding areas of concern. The social worker gradually anchors the client's statements and beliefs in social contexts that run counter to the client's sense of isolation (Sullivan 1947). That is, the social worker first attends to the *context* of disclosure, offering feedback as a representative of the "outer" world, while seeking to understand the client's inner world and *content* of disclosure. The social worker does not argue against the reality of a client's delusions, but rather explores the feelings behind them, and slowly begins to adjust his or her "this means this" sustaining responses to include other possibilities (perhaps "this means that").

As an example of this process, the social worker's response to Elliot's confusing statement is included below. It is important to emphasize that the social worker was only able to formulate his idea of the meaning of Elliot's statement (anxiety about being scrutinized by others) after spending several sessions getting to know him.

> Elliot: Eye color… when I was in college eye color got really important, I can talk about it. Apparently in adolescence your eye color can change, but it doesn't permanently change. My eyes look green sometimes when they were brown my whole life. And some people are really overly intense with eye color, in college, and eye contact is intense, so when you start making eye contact… I'm comfortable with you, but some teachers are really big on it. It's not like high school where you can really get out of order, and I really have a bad reaction to staring. And I can be intimidating because I'm an athlete. My personality is, I'm the kind of person who can bring up an eye contact discussion. But you can't' do that everyday in class.
>
> The social worker: I get the impression, Elliot, that it's hard for you to be around other people, especially strangers. They might look you in the eye, and intrude on your space, and make you nervous. It seems like when people try to get physically close to you, or talk to you, you get uncomfortable.

Process Distress

The social worker regulates the emotional pace of therapy by structuring the conversation to minimize the possibility of the client becoming overwhelmed by negative feelings. With the social worker's acceptance and support the client can stand back from distressing experiences, memories, or concerns such that he is no longer overwhelmed by emotion when speaking about them (Semrad 1955). The client's modulated distress can then become the object of sustained discussions.

Elliot: My mom, brother, and dad are all into sweets, desserts and stuff like that, and I'm not. Things that are nice look sweet. A lot of things that look nice are not sweet, like bananas, that have a lot of vitamins, and jam has a lot of sugar. So they tend to walk all over me at times. They'll gang up on me to get what they want. They'll let me go hungry, it's a dissention problem. Here I can just spill my guts. My parents don't like it, nobody believes me. Here I can just say it, and I won't hear "just let it go". Whatever I say in here, it's just a topic. I can decipher feelings, and I don't want to feel people getting confused.

The social worker: So you can't relate to your family very well. They often seem to be on a different page than you are, so to speak. And it seems to upset you that you feel so isolated, and maybe sometimes you wonder if something is wrong with you because of this. But Elliot, you have a right to your feelings; everyone does.

Facilitate New Understanding of Situations

The sharing of views between social worker and client can move the client toward considering alternative conclusions regarding his or her perceptions. The social worker's filling in perceptual gaps makes available to the client new possibilities for assessing and reacting to his or her concerns. The process is founded on the worker's repeatedly observing and empathizing with the client's experiences (Rapp 1998). If the client trusts the social worker, he or she will consider this input and reconsider the nature of his or her experiences, opening up possibilities for functioning differently in the social world.

Elliot: I keep getting into trouble with the police. There are a lot of shady characters in my neighborhood, and I'm pretty sure they're selling drugs. I see these people all the time, just hanging out. So I call the police. But last week the police wound up coming to my house again, and complaining to my dad that I was causing trouble. But I'm in the neighborhood most of the time, and other people aren't, so I see what goes on better than most people. And there's a police officer living just two doors down. I think he moved into monitor the crime situation. Lately I've been filing my reports with him, but that guy called my dad, too.

The social worker: Elliot, you've told me you haven't actually seen these people dealing drugs. Maybe they're just people who are hanging out. If they look suspicious, it doesn't necessarily mean that they're doing anything wrong, you know?

Introduce Possibilities for Action in the Social World

This is a "summary" strategy that involves the social worker's encouraging and supporting the client's elaboration of activities, meanings, and life goals. If the client perceives the social worker as a concerned listener, "reality tester", and trusted assessor of the client's position in the social world, he or she will feel more grounded about making future plans (Walsh 2000). The client can develop a new understanding of himself and develop a new life story based on an integration of his past and present concerns (Rhodes and Jakes 2009).

Elliot had a delusional belief that he was destined to be a great Olympic athlete, specializing in cycling events. Since his initial psychotic break in late adolescence, after he had become socially isolated from others, he found solace in taking his bicycle into the countryside for long rides. He was very much an amateur in this sense, but the activity fed a delusion that he was preparing for the Olympic games. He claimed to have a half-dozen sponsors (the manufacturers of the equipment he used) and believed that he would be accepted onto several European racing teams after the upcoming games. While this goal had been a theme throughout their work together, the social worker never argued against it. Rather, he encouraged the client to share his training regimens and other preparations, and only gradually suggested that he explore alternative plans for his current and future life. The social worker emphasized that it was a good idea for anyone to have "back-up" career plans in case his primary goal didn't work out. What follows are Elliot's thoughts about changing his career goal. It is apparent that he is considering a more social life for himself.

I can always be a cyclist, no matter what. I can practice around here if I get my own apartment, and enter the local and regional events like I already do. It might be less expensive if I don't turn professional, and I could spend time doing other things. I've worked in restaurants, you know, and I like cooking, so maybe I'll become a professional cook. I've cooked at home a lot. It makes me feel less guilty about still living at home. Cooking can be a career, and it can also be something you do for friends. I'm no good with girls, they seem to be put off by me, I don't know why, but maybe if I cooked for them, I'd have a chance. I could ask them out, and when they say, "What will we do?" I'll say I can cook for them. And then we can have something to talk about, which is my cooking the meal.

Whether Elliot had the talent and focus to get through chef's school, which became his new career goal, remained to be seen. But it was certainly a more realistic goal than

professional athletics, and soon after making this decision, he found a job in a sandwich shop.

Summary

> Elliot: Who you are as a person is more important that what psychological organization you are born with.

The emergence of evidence-based practice standards has obscured for some practitioners the significance of the social worker–client relationship, the quality of which is critical in working with persons who have psychotic disorders. Only by developing a greater appreciation for the lived experience of clients can social workers maximize their potential to effectively implement the non-specific intervention guidelines of sustainment, expanding the client's perspectives, processing distress, facilitating new understandings, and introducing new possibilities for action in the social world. These interventions can be useful for ameliorating the psychotic client's symptoms and facilitating long-term intervention toward improved social functioning.

The successful use of these relationship-based interventions is not easy, as many psychotic clients maintain strong schizoid defenses (Marcus 2003). Many clients tend to be mistrusting and have little faith in relationships. They may feel anger toward others due to feeling discounted over a long period of time. The client has needs for interpersonal relatedness, but at the same time fears putting trust in others. In another sense, the social worker may be experienced as threatening to rob the client of his or her individuality. That is, getting "well" may mean returning to an anxiety-ridden state. Relevant skills for social workers to develop, so that their potential for connection with clients might be maximized, include the ability to assess for the effects of cognitive deficits related to psychosis, and the psychodynamic principles of client engagement. That is, most schools of social work emphasize the importance of client engagement but do not always help practitioners develop an appreciation for both the conscious and unconscious sources of client motivation.

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