Schizophrenic Patients' Attitudes to Therapists Using Behavioral and Holistic-Humanistic Techniques

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In a preliminary study of patients' perceptions of therapists' styles, 18 subjects with diagnoses of schizophrenia were randomly assigned either to social skills training or holistic health therapy. Four therapists conducted each treatment session in pairs, rotating between treatment conditions daily. At the end of 10 weeks of treatment, patients were able to discriminate among therapists on three interactive styles—"understanding," "independence-encouraging," and "critical-hostile"—and were able to differentiate between behavioral and holistic health treatments on "authoritarian" attitudes.

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Psychosocial treatments of schizophrenia have been shown to provide protection against stress-induced relapse beyond the benefits afforded by neuroleptic drugs. Elements common to empirically validated psychosocial treatments have been identified as practical, behavioral, and psychoeducational techniques. Chronically mentally ill adults who have participated in holistic-humanistic programs have also experienced significant reductions in their psychiatric symptoms. Holistic-humanistic treatment programs include training in stress reduction through exercise and meditation, and they also encourage patients’ exploration of the growth potential of their psychotic experiences.

While a warm, engaging therapeutic alliance is presumed to be a necessary ingredient for the successful psychiatric treatment of this population, scant research has focused on the qualities of the patient-therapist relationship in schizophrenia.

Frank and her colleagues showed that psychodynamic psychotherapists who were perceived by their patients as open and non-aggressive were able to keep schizophrenic patients in treatment longer. Frank and Gunderson also showed that patients who built a close working alliance with their therapists were likely to remain in therapy longer, and these patients showed greater improvement on tests measuring symptoms and social functioning than patients who dropped out of treatment prematurely.

A study by Paul and Lentz showed differences in the quality of staff-patient exchanges between milieu and behavioral inpatient programs for schizophrenics. Using data from the Staff Resident Interaction Chronograph collected at random times each day, these investigators described staff-patient interactions on the behavior therapy unit as more “proactive” and “here-and-now” oriented, whereas staff-patient interactions on the milieu therapy unit were more “formal” and “reactive.”

Although past studies have investigated schizophrenic patients’ perceptions of the therapeutic style for clinicians who practice behavior therapy or psychodynamic therapy, we were not able to find a study in the literature that investigated attitudes about practitioners of holistic-humanistic therapies. Although the study by Carl Rogers and others addressed the client-centered treatment of patients with schizophrenia, subjects in that study were not interviewed regarding their perceptions of therapists’ styles.

In the current preliminary study, schizophrenic inpatients participating in a three-month comparison of behavior therapy and holistic-humanistic therapy were surveyed for perceptions of their therapists. Two questions were addressed with these data:

1. Can schizophrenic patients accurately describe their perceptions of therapists’ characteristics, given their psychotic symptoms? Previous research has shown that patients with major mental disorders are able to describe reliably the quality of their therapeutic relationships in supportive therapies as well as their relationships with significant others. Hence, we hypothesized that schizophrenics whose positive symptoms were stabilized with antipsychotic medication would be able to report their perceptions reliably.

2. Do schizophrenic patients discriminate between the interactional styles of therapists conducting behavioral therapy and those conducting holistic-humanistic therapy? We predicted that, given the warm and empathic manner in which behavioral interventions are currently administered, patients would not differentiate between the interactional styles of behavioral and humanistic clinicians. Regarding favorable or unfavorable perceptions of the therapists, on the other hand, we predicted that behavior therapy’s abundant positive reinforcement and highly specified and achievable goals would create more favorable patient perceptions of behavior.
therapists than of holistic-humanistic therapists.

**Methods**

Eighteen patients with schizophrenia participated in a three-month evaluation of social skills training (SST) and holistic health therapy (HHT) conducted at the Clinical Research Unit of Camarillo State Hospital. The patients were diagnosed using the Catego criteria elicited by the Present State Examination; moreover, all patients satisfied DSM-III-R criteria for schizophrenia. Patients were on low to moderate doses of antipsychotic medications for at least one month prior to their entry into the study and remained on maintenance pharmacotherapy throughout their hospital stay. They ranged in age from 19 to 35 years, and they had generally poor work and social adjustments as well as two or more previous hospitalizations. Before the current hospitalization, all patients were living with families rated high on "expressed emotion." Subjects were admitted into the study in cohorts of six and randomly assigned to either SST or HHT.

Active therapy for these subjects began after two to three weeks of orientation, baseline testing, and medication stabilization. Subjects in the SST condition learned problem-solving techniques by role-playing solutions to interpersonal difficulties that might occur in hospital, family, and community situations. Structured questions then helped patients to improve the accuracy of their social perceptions and to remember what they had learned. The HHT condition included stress reduction techniques such as yoga training, aerobic exercises, and mantra meditation. In addition, therapists in the HHT condition attempted to help patients view their psychotic experiences more optimistically through lectures, discussions, readings, and art therapy. Sessions for both therapies were run in groups of 5 patients for 3 hours per day, 5 days a week, for 10 weeks. In addition to these interventions, patients in both conditions received weekly medication reviews, aftercare planning, and family therapy.

Four therapists received training in the SST and HHT methods prior to the start of the study. Explicit manuals for each condition prescribed intervention procedures by which individual sessions were conducted. To control for the effect of therapists' personalities on patients' perceptions of interactional style, therapists rotated on a daily basis between the two treatment conditions. Therapists conducted treatments in pairs. Independent fidelity judgments showed that all therapists were conducting both treatments in accordance with manual prescriptions. Experience, age, sex, and theoretical orientations of the four therapists are summarized in Table 1; some differences existed among therapists on these variables.

During the last week of participation in the program, subjects rated the four therapists on the 35-item Client Perception of Therapists Questionnaire, which includes such items as "Is easy to talk to" and "Seems to know exactly what I feel." Subjects rated the frequency with which individual clini-

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cians exhibited the various therapeutic behaviors on a 4-point Likert scale: almost never, sometimes, usually, nearly always. Lorr's early research showed that the items on this questionnaire could be clustered into five factors:

1. Understanding (the therapist understands what the patient is communicating and feeling).
2. Accepting (the therapist is perceived as nurturing and interested).
3. Authoritarian (the therapist wields great control over the sessions).
4. Independence-encouraging (the therapist helps the client to be independent).
5. Critical-hostile (the therapist is perceived as cold, critical, and impatient).

In addition, weekly assessments of psychopathology using the Brief Psychiatric Rating Scale (BPRS) were made throughout the 10-week program. This weekly assessment permitted determination of patients' symptomatology at the time they reported their attitudes regarding the therapists.

RESULTS

The symptoms of patients as measured on the BPRS improved significantly in both treatment conditions between the start and the completion of the 10-week inpatient period. Hence, patients' judgments of therapists were made at a time of substantial remission of psychotic symptoms and should not have been seriously skewed by cognitive misperceptions.

Differences in the five attitudinal scales of the Client Perception of Therapists Questionnaire were tested in a 4x2 factorial ANOVA across the four therapists and the two treatment orientations. A main effect was found across the therapist factor, differing in patients' descriptions of individual therapists for "understanding" ($P < 0.05$), "independence-encouraging" ($P < 0.01$), and "critical-hostile" ($P < 0.05$). As shown in Figure 1, post hoc analyses found that patients rated therapists 1 as less "understanding" than therapists 3 and 4. Comparisons for "independence-encouraging" and "critical-hostile" did not yield significant differences.

There was also a main effect across the treatment orientation factor for "authoritarian" attitudes ($P < 0.05$). Patients in SST groups rated their therapists lower on "authoritarian" style than patients receiving HHT. No differences existed across treatment orientations for the other four attitudes. A treatment orientation by therapist interaction was found for the "critical-hostile" scale ($P < 0.05$). Individual comparisons showed that SST patients rated therapist 4 as less "critical-hostile" ($P < 0.05$) than did HHT patients.

DISCUSSION

Schizophrenic subjects in reasonable remission from their psychotic symptoms were able to discriminate the interactional styles of individual therapists on 3 of 5 attitudinal measures. Moreover, subjects rated the same therapists differently when the latter were conducting treatment according to behavioral as opposed to holistic-humanistic orientations. These findings reflect the sensitivity

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of patients with schizophrenia to their therapists' treatment orientations as well as their therapists' interactional styles. Schizophrenic patients in this study perceived therapists as less "authoritarian" and less "critical-hostile" when conducting behavior therapy than when providing holistic-humanistic therapy. While these findings replicate the results of other studies, they are still remarkable, considering that behavior therapists have been customarily characterized as aloof and impersonal. Differences in perceptions of interactional styles across orientations may be attributable to the kinds of therapeutic interactions emphasized in each condition. The SST program consisted of a variety of role-playing situations during which patients were praised extensively for making an effort, giving correct responses, and mastering small steps toward improvement. HHT patients, on the other hand, were prompted to complete yoga, meditation, and art therapy exercises that involved longer latencies between response and praise. In addition, considerable prompting was necessary to gain patients' active participation in HHT activities. Therefore, the SST program, with its denser schedules of reinforcement, may have influenced patients' perceptions of therapists conducting SST as less "authoritarian" and less "critical-hostile."

Future research needs to determine the relationship between patients' ratings of therapists' styles and the outcome of treatment. In this study, while symptomatic improvements during the 10-week intervention were substantial and were equal for patients in both treatments, differences in long-term remissions and improved social competencies were significantly greater for the SST group. Two recent studies have documented the importance of therapists' styles and the therapeutic alliance on clinical outcomes in schizophrenia and agoraphobia. The contributions that therapists' interactional styles make to clinical outcomes need to be studied more fully.

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