Psychosocial Treatment: Individual, Group, Family, and Community Support Approaches

by Loren R. Mosher and Samuel J. Keith

Abstract

The authors present an overview of research on psychosocial treatments for schizophrenia. Findings from studies of four therapeutic approaches—individual psychotherapy, group psychotherapy, family therapy, and community support systems—are discussed in detail. The usefulness of each type of therapy is critically assessed on the basis of available data from controlled outcome studies. The authors make recommendations regarding high-priority areas to be addressed in future studies of psychosocial treatment.

The tendency for mental health workers, family members, and society to withdraw from personal involvement with schizophrenic patients is regrettable but understandable. Indeed, this withdrawal often mirrors, and is reinforced by, the schizophrenic patients’ own behavior and the alienating social context in which these patients find themselves. However schizophrenia is defined, most persons who receive this diagnosis have extraordinary difficulty in establishing and maintaining human relationships. It is in the attempt to modify this aspect of schizophrenia that psychosocial treatments appear to hold special promise.

Unfortunately, there is as yet relatively little research evidence documenting the efficacy of specific psychosocial treatments with schizophrenic patients. Perhaps because of the lack of positive findings, there has been a tendency for mental health workers to take the position, “Why bother, if it can’t be shown to do any good?” The withdrawal of interest on the part of “helping” persons reinforces the maladaptive behavior patterns of clients in whom withdrawal is already a defining characteristic. When the mutual withdrawal is sufficiently great and fixed in nature, we are apt to label the patient a “chronic, unremitting, back ward schizophrenic.” Continued human involvement is the only known means of preventing this wasteful denouement.

Scope of This Review

The psychosocial treatment of schizophrenia is a book-length topic, and space limitations inevitably preclude our addressing a number of important issues in detail.

Heterogeneity of Persons Diagnosed as Schizophrenic. We recognize that a person who receives this diagnosis at age 17 after spending 4 years as a recluse at home is very different from one so labeled at age 35 who has been working productively and rearing a family. Although we


Reprint requests should be sent to Dr. Mosher at Center for Studies of Schizophrenia, NIMH, Rm. 10–95, 5600 Fishers Lane, Rockville, MD 20857.
believe, based on clinical experience, that the most effective types of psychosocial treatments are likely to be quite different for these two individuals, we do not propose to describe a series of prototypical patients and prototypical appropriate psychosocial treatments. Our restraint is dictated not only by space limitations but also by the limitations of the research evidence on which our recommendations would be based. We will attempt, however, to indicate whether the patient groups studied are acute or chronic and whether the study was conducted in an inpatient or outpatient setting.

Heterogeneity of Psychosocial Treatments. This will not be an encyclopedic review of all types of psychosocial treatments given schizophrenic patients. We will focus on four broad categories: individual, group, and family psychotherapy and community support systems. Milieu and social skills training approaches are addressed elsewhere in the issue (see Gunderson 1980; Wallace et al. 1980). We recognize that within each category of psychosocial treatment, there are numerous major variations in theory and practice. Our attempt will be to take an intermediate position; we will discuss, for example, what we consider a modal type of group therapy offered schizophrenic patients. Again, as is the case with patient heterogeneity, there is very little other than personal bias on which to base a preference for one theory or practice of psychotherapy over another.

We subscribe to Frank’s (1961) view that all psychosocial treatments—regardless of whether they are clearly defined entities like individual psychotherapy—share common nonspecific elements:

- An emotionally charged relationship with a helping person.
- A plausible explanation of the causes of distress.
- The provision of some experiences of success.
- The use of the therapist’s personal qualities to strengthen the client’s expectation of help.

A nontraditional form of psychosocial treatment is exemplified by the movement to develop community support systems for schizophrenic patients (Turner and Tenhoor 1978). Broad-scaled social interventions of this kind have not generally been defined as a specific form of therapy. Rather, they have been viewed as background conditions onto which the real treatments (e.g., neuroleptics, individual therapy) are overlaid. We disagree with this assessment, and there are some data to support our position (Ellsworth, in press; Hammer, Makiesky-Barrow, and Gutwirth 1978; Vaughn and Leff 1976). It is becoming increasingly clear that attempts to modify the patient’s social context—as by creating community support systems—can have powerful positive or negative effects on his eventual outcome. For this reason, we are including community support system approaches in our review. By highlighting them, we hope to direct more attention to what appear to be undervalued aspects of psychosocial treatment.

Interactive Effects of Neuroleptic Drugs. Neuroleptic drugs are now an almost universal element in the treatment of schizophrenia. Some patients are treated with these agents only briefly, while others are maintained on them for years; but schizophrenics never exposed to neuroleptic drugs are very scarce in the current mental health treatment system. For purposes of our review, we will assume that patients in those studies in which neuroleptic drugs are not an independent variable have been or are currently on neuroleptic medication. We will also assume that the drugs are being prescribed in a thoughtful, responsive manner (although in our experience this assumption does not always coincide with reality). It seems obvious that both over- and undermedication could undermine the effectiveness of psychosocial interventions. But although combined pharmacologic/psychosocial treatment approaches are in widespread clinical use, the facilitative, neutral, or interfering interactions of the two forms of therapy are largely unknown (Group for the Advancement of Psychiatry 1975).

Varying Characteristics of Therapist and Setting. Clinicians generally agree that there are competent and incompetent therapists, but—not surprisingly—the defining qualities of each type are controversial. Although much has been written about therapist characteristics (Kiesler 1973; Razin 1971; Rogers et al. 1967; Rosen 1969), space does not allow us to consider these characteristics in detail. We will assume that the therapists giving the treatments to be described are at least of average competence—neither specially gifted and charismatic nor grossly inexperienced and uninterested. Because the effectiveness of psychosocial treatments depends upon the mutual commitment of patient and therapist, it is important that the therapist believe in what he is doing. Belief does not mean overwhelming, uncritical zealotry—rather sufficient...
interest, investment, and involvement to continue what may often be a draining, unrewarding effort. Such belief is difficult to sustain over long periods without some type of reinforcement. If the therapist is not to become excessively dependent on patients for reinforcement, the social context within which he does his work must share and support his commitment. For the purposes of this review, we will assume that psychotherapy is not being conducted in a setting in which it is dismissed as a waste of time, and medication is held to be the only effective treatment for schizophrenia.

The foregoing recitation of caveats may seem excessive or unimportant to some readers. It is our conviction, however, that each factor alluded to has importance to, and relevance for, the extraordinary complexities of psychosocial treatments. As such, they should all be considered when psychosocial treatments are studied.

Studies Reviewed—Criteria for Inclusion

Each section that follows will have a common format: historical background, definition of the treatment, and current status of research.

In reviewing the last decade of research, we have been selective. Studies without comparison groups have not been included. Further, we have selected studies that make some attempt to address most of six widely accepted requirements in the design of psychotherapeutic research (Fiske et al. 1970; Mosher 1972).

Theory and Technique. The nature of the treatment to be delivered must be adequately defined. Moreover, definition should coincide with reality; that is, the treatment should relate in a coherent and meaningful way to the theory underlying it. As is well known, what we say (and believe) we are doing may be very different from what we are doing.

Patient Characteristics. The patient group should be adequately defined. Since diagnostic difficulties with schizophrenia are notorious, each researcher’s criteria must be explicit (i.e., based on behavioral items that can be rated reliably) to permit replication and comparison across studies. Our recommendation of explicit criteria does not imply that we believe investigators should all use the same diagnostic system—for example, the Research Diagnostic Criteria (Spitzer, Endicott, and Robins 1978) or the Feighner Criteria (Feighner et al. 1972). These systems are all useful, but there is no scientific basis for choosing one as defining “true” schizophrenia (Fenton, Matthews, and Mosher 1980).

Therapist Characteristics. In studies of psychological intervention, the therapist, as well as his patients, must be the object of study. At a minimum, he should be categorized according to level of experience, theoretical orientation, enthusiasm, and type of patient-therapist relationship that evolves. In studies of group therapy, the therapist’s role as a leader should obviously be assessed.

Process Characteristics. Research addressing primarily the result of interpersonal interactions cannot ignore these processes themselves. Unfortunately, our tools for evaluating a transacting dyad are inadequate. While the individual roles of both patient and therapist have been studied extensively (e.g., Rogers et al. 1967), the transactional flow between them has received little attention. This area is vitally in need of new methods.

Setting Characteristics. Psychological interventions are very sensitive to the context within which they are delivered. It is therefore crucial to understand the attitudes, belief systems, and demand characteristics of the settings in which treatment is carried out.

Outcome. Criteria measuring outcome should be carefully defined and do justice to the treatment being tested. In assessing individual psychotherapy, for example, measures of personality change and insight may be more relevant than symptom reduction. These criteria should also allow for a long-range view.

Flaws of Psychosocial Research

Although we have learned a great deal about the design of research on psychosocial treatment, the data now available are sufficiently flawed to lead us to eschew categorical “yes, it works” or “no, it does not work” statements about a given therapeutic approach. The most common failings of the currently available studies are summarized below.

Insufficient Exposure to the Intervention. The treatment is not given a reasonable chance to demonstrate its ability to produce change. By their very nature, psychosocial treatments cannot be expected to produce rapid, dramatic changes. For example, Hogarty et al. (1974a, 1974b) did not see significant beneficial effects from major role therapy until patients had completed 18 months of treatment, and these effects were even more pronounced at 24 months.
Inadequate Characterization of Treatment, Therapists, and Patients. Some studies report results from undefined individual therapy delivered by inexperienced therapists, fail to assess the fit between patient and therapist, and make no attempt to study whether therapy was in fact taking place. The mere juxtaposition of patients and therapists in a room for an hour does not ensure that therapy is being given.

Inappropriate Outcome Measures. Unfortunately, rehospitalization has retained its preeminent position in the most widely cited outcome variable, despite the fact that myriad non-patient-related factors are known to affect rehospitalization (e.g., administrative policies, availability of nonhospital resources for care, type of living arrangements, family emotional climate). In addition, psychosocial treatments address their major efforts to enhancing social adjustment, which has only a modest relationship to recidivism. Despite this, many psychosocial treatment studies have not assessed systematically the variables that are particularly relevant to this type of treatment, e.g., ability to work and social and interpersonal skills.

Individual Psychotherapy
The use of individual therapy with schizophrenic patients grew out of the psychoanalytic movement. Although psychoanalysis had European origins, the work of Meyer (1948-1952) and Sullivan (1962) in this country provided a fertile ground for its transfer and use with schizophrenic patients here. Interest in individual psychoanalytic therapy with schizophrenics grew dramatically in the 1950s and early 1960s. This burgeoning interest was in part responsible for research conducted to assess the efficacy of such therapy during those years. It should be noted that most of the patients who received this treatment did so in a very small number of private treatment facilities (e.g., Chestnut Lodge and the Menninger Clinic). However, because of the influence of psychoanalysis in university departments of psychiatry and the prolific writings of some analysts (e.g., Arieti and Searles), the impact of the treatment of these relatively few patients was far greater than their numbers.

Controlled Research. Current doubts about the usefulness of individual psychotherapy as a treatment for schizophrenic patients stem from the negative results of controlled outcome studies in the 1960s, the development of clearly effective drug treatment, and the waning influence of psychoanalysis in departments of psychiatry. In the 1960s, there were four major studies in which schizophrenic inpatients treated with psychotherapy were compared to those who received other forms of treatment (see table 1). The sample selection and individual psychotherapy techniques are summarized below:

1. Grinspoon, Ewalt, and Shader (1972) studied single, male, chronic schizophrenics who had been hospitalized for more than 3 years in a large state hospital and treated with an analytically oriented approach by experienced therapists.

2. May (1968) reported on first admission “middle prognosis” schizophrenics treated with an egosupportive approach, primarily by state hospital residents.

3. Karon and Vandenbos (1972) studied acute, lower class, inner city, first admission schizophrenics who were given either direct analysis or ego analysis by both experienced and inexperienced psychologists.

4. Rogers et al. (1967) studied a mixed group of acute and chronic state hospital schizophrenics treated with client-centered therapy, primarily by experienced psychologists.

Several extensive critical reviews of these studies are available (Feinsilver and Gunderson 1972; Gunderson 1979; May 1974). The fall from favor of individual psychotherapy as a treatment for schizophrenia is dramatically illustrated by the following: When one of the four studies was being designed in 1960, it was regarded as unethical for a control group not to receive psychotherapy, but by 1968 it was considered unethical to give a control group in another study psychotherapy alone.

Of the four controlled psychotherapy studies conducted during this period, those by Grinspoon, Ewalt, and Shader (1972) and May (1968), both of which had largely negative results, became the most widely known and influential. The two other studies (Karon and Vandenbos 1972; Rogers et al. 1967) had more positive results. Each of the four studies, viewed in retrospect, had critical design problems that led many scientists to warn against the premature conclusion that individual psychotherapy is of no value with schizophrenics. For example, Grinspoon, Ewalt, and Shader focused on a small group of very chronic “back ward” patients who were transferred from a large state hospital into a highly staffed, nurturing, but undemanding milieu. We now know that for the chronic patient the dependency-reinforcing effects of such a milieu are likely to outweigh any possible benefit derived from 4 or 5 hours of individual
Table 1. Individual psychotherapy studies

<table>
<thead>
<tr>
<th>Study</th>
<th>Comparison groups</th>
<th>Subject characteristics and n</th>
<th>Diagnosis</th>
<th>Assignment</th>
<th>Type of treatment</th>
<th>Length of treatment</th>
<th>Drug usage</th>
<th>Measures</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>May (1968)</td>
<td>1. Individual psychotherapy, alone</td>
<td>N = 22.8; average age = 28; IQ = 107; 68% white, 21% black; 9% hispanic; 60% had been married at some time; 40% currently married</td>
<td>Schizophrenia with &quot;average&quot; prognosis as clinically determined</td>
<td>Stratified</td>
<td>1. Ego supportive</td>
<td>Until successful; or for 1 year without prospect of release; or minimum or 6 months of &quot;good&quot; trial</td>
<td>2. 10-120 mg STZ q.d.</td>
<td>Clinical, psychiatric movement, and cost</td>
<td>2 + 3 most effective; 1 + 5 least effective; 4 in middle</td>
</tr>
<tr>
<td>Grinspoon, Ewalt, and Shader (1972)</td>
<td>Study groups: 1. Psychotherapy+ drugs</td>
<td>N = 41; all male; age 18-35; unmarried; hospitalized for 3 or more years</td>
<td>Chronic schizophrenia</td>
<td>Self-selection</td>
<td>Analytically oriented by senior analysts</td>
<td>2 hours/week for 2 years</td>
<td>Study group—10 drug free, 10 on drugs</td>
<td>Extensive battery of behavioral and symptomatic assessments</td>
<td>Psychotherapy + drugs much more effective than psychotherapy alone</td>
</tr>
<tr>
<td>Rogers et al. (1967)</td>
<td>1. &quot;More chronic schizophrenics&quot;</td>
<td>N = 48; 24 males; 24 females; average age 35</td>
<td>Clinical diagnosis of schizophrenia</td>
<td>Stratified</td>
<td>Client-centered</td>
<td>2 hrs/week for design for therapy cases but some research on it anyway</td>
<td>No drugs in design for therapy cases but some research on it anyway</td>
<td>Extensive battery to measure patient and relationship variables</td>
<td>Psychotherapy + hospital equivocally better than usual hospital treatment</td>
</tr>
<tr>
<td>Hogarty et al. (1973, 1974, 1976)</td>
<td>MRT/drug; MRT/placebo; No MRT/drug; No MRT/placebo</td>
<td>N = 374; age 18-55; IQ &gt; 70; no organic brain syndrome, drug or alcohol abuse, or serious suicidal or homicidal behavior</td>
<td>Hospital diagnosis of schizophrenia confirmed by research psychiatrists</td>
<td>Random, stratified by sex</td>
<td>MRT-social case work, vocational rehabilitation by experienced MSW at least once a month; Average of 2.04 hrs/month</td>
<td>2 years</td>
<td>For drug group 270 ± 140 mg CPZ</td>
<td>Relapse + 14 rating scales</td>
<td>Relapse—80% of placebo, 48% of drug treated, 37% of MRT + drug at 24 months; MRT + drug group had better social adjustment at 18 to 24 months</td>
</tr>
</tbody>
</table>
Karon and Van den bos (1972) Group A—psychoanalytic psychotherapy, active, without drugs; Group B—psychoanalytic psychotherapy, ego analytic with CPZ; Group C—hospital control, CPZ in "good public hospital"

<table>
<thead>
<tr>
<th>Group</th>
<th>Description</th>
<th>N</th>
<th>Treatment Schedule</th>
<th>Intellectual tests, Rorschach, TAT, and clinical status interim at</th>
<th>A + B—significantly less hospital days than C; A + B—significantly better on overall clinical evaluation and thought disorder scale than C; no difference on projective tests</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>active, direct interpretation;</td>
<td>12</td>
<td>A—5 times a week until discharge (in 2-8 weeks), then once a week;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>&quot;ego analytic&quot;</td>
<td>12</td>
<td>B—3 times a week for 20 sessions, then once a week;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>drug treatment</td>
<td>12</td>
<td>C—interviews to adjust dosage as needed</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Each "set" of three randomly assigned to treatment groups:

A
B
C

Schizophrenics, 2/3 without prior hospitalization

80-100

300-1,600 mg q.d.

5 times a week until discharge (in 2-8 weeks), then once a week;

3 times a week for 20 sessions, then once a week;

Interviews to adjust dosage as needed
therapy, even when it is provided by highly experienced therapists such as those in the study by Grinspoon, Ewalt, and Shader. The influential study by May (1968) had two major flaws as a test of individual therapy: Inexperienced state hospital residents served as therapists, and the subjects (middle prognosis, first admission schizophrenic patients) received relatively few hours of therapy (an average of 46). It should be remembered that despite the prevailing negative zeitgeist about individual psychotherapy for inpatient schizophrenics, Karon and Vandenbos (1972) reported positive results from their controlled study, and Rogers et al. (1967) obtained equivocally positive results. However, the more positive studies also had enough design problems to make it unwise to draw firm conclusions about the value of individual psychotherapy for inpatient schizophrenics.

Fortunately, there is now a collaborative study under way at McLean Hospital and Boston University, under the direction of Drs. Alfred Stanton and Peter Knapp, that addresses many of the problems of previous research on inpatients treated by intensive psychotherapy. The patients are relatively acute, neuroleptic drug treatment is controlled, the therapists are experienced, the treatment will continue over a prolonged period and into the outpatient phase (a year or more), the outcome measures are appropriate to this treatment, whether therapy is in fact going on will be assessed, and the therapists and their fit with the patients will be studied.

Since the publication of the four inpatient studies in the 1960s, four posthospitalization comparisons of group and individual therapy with heterogeneous populations of schizophrenic patients have been published (Herz et al. 1974; Levene et al. 1970; O’Brien et al. 1972; Purvis and Miskimins 1970). Using readmission as a measure of outcome, three showed individual therapy and group therapy to be similar, and one (Purvis and Miskimins 1970) found an advantage for group therapy. Two studies also measured social adjustment but found opposite results—one in favor of group therapy (O’Brien et al. 1972) and the other in favor of individual therapy (Levene et al. 1970). They will be discussed in greater detail in the next section.

In general these studies also suffer from design problems, especially in control of neuroleptic drugs, assessments of whether therapy was actually taking place, and use of appropriate outcome measures. However, the data seem to indicate that group therapy has some advantages, based on patient and therapist satisfaction, over individual therapy for the more chronic outpatients. There are no data on strictly acute patients treated with individual therapy after discharge. Nor are there data on whether group and individual therapy might be synergistic for some patients. Both of these deficiencies should be remedied by a new generation of studies.

A recent outpatient study of major importance was conducted by Hogarty, Schoeller, Goldberg and their associates (Goldberg et al. 1977; Hogarty et al. 1973, 1974a, 1974b, 1976; Hogarty and Ulrich 1977). Their elegant study is difficult to categorize because the psychosocial intervention was specifically defined not to be traditional individual psychotherapy, either supportive or insight oriented. Rather, the treatment was called major role therapy (MRT) which, as indicated by its name, focused principally on helping posthospitalization schizophrenics to resume and maintain their roles in the community. Although originally conceived as a combination of social work and vocational rehabilitation, it actually evolved into a treatment focused on developing community survival skills. Treatment was carried out by experienced social workers who did whatever they felt necessary to enable their clients to adjust and survive outside the hospital. Hogarty et al. (1974) have described the program as follows:

The MRT was administered by social workers with MSW degrees, with an average of nearly seven years’ experience (range five to ten years), most of whom were graduates of more functional (Rankian) schools of social work. The MRT was viewed as a psychosocial, problem-solving method designed to respond to the interpersonal, personal, social, and rehabilitative needs of study patients and their families. An effort was made merely to evaluate the needs of non-MRT patients. . . . The MRT attempted an approximate solution of practical problems, which frequently included situational crises. The primary goal toward which social workers were directed was the resolution of personal or environmental problems, or both, that directly affected the patient’s performance as a home maker or as a real or potential wage earner. Otherwise, therapeutic objectives ranged from improving the quality of interpersonal relationships and ameliorating social isolation, to the rudiments of self-care, financial assistance, and medication maintenance. Principles of practice included acceptance, clarification, material and emotional support, and appropriate assurance. (p. 604)

Although therapy was relatively nonintensive (average of 2.04 face-to-face contacts per month in the MRT groups), the therapists spent considerably more time in telephone
contact with and about their clients. We have included this study as “individual psychotherapy” because the basic paradigm is 1:1 contact between therapist and client. In fact, the amount of contact in this study is not very different from that given in most outpatient studies comparing group and individual psychotherapy treatment (see next section).

The reports of Hogarty et al. should be read by everyone interested in the design of psychosocial treatment research. The study’s only flaws were insufficient attention to the therapists and the therapeutic process variables.

Patients were randomly assigned to four groups: drugs alone, drugs plus MRT, placebo alone, and placebo plus MRT. The major finding was that by 24 months, 80 percent of the placebo-treated patients had relapsed as compared with only 48 percent of the drug-treated patients. Interestingly, drug-treated females had much lower relapse rates (37 percent) than drug-treated males (63 percent). The relapse rate for patients receiving MRT and drugs was lowered to 37 percent at 2 years. MRT had a complex effect but, by itself, did not decrease relapse rates significantly. In patients who did not relapse within the first 6 months, however, MRT showed a significant effect in reducing relapse between 7 and 24 months; that is, during this 18-month period, 44 percent of all MRT patients relapsed as compared with 58 percent of non-MRT patients. In addition, patients who received MRT plus drugs showed significantly better social adjustments than patients treated with drugs alone. This effect first appeared at 18 months and was somewhat greater by 24 months. One possible explanation for the beneficial effect of MRT—that its principal contribution was in encouraging patients to take their drugs more reliably—has been tested but did not find support (Hogarty et al. 1976). On close examination, it appeared that MRT was most effective in patients who were relatively asymptomatic at intake, but actually hastened relapse in symptomatic patients.

The same group of investigators (Hogarty et al. 1979) have conducted a study in which medication compliance was guaranteed by the use of depot fluphenazine decanoate. The design included four treatment groups: depot fluphenazine/high social therapy; depot fluphenazine/low social therapy; oral fluphenazine/high social therapy; oral fluphenazine/low social therapy. High social therapy is essentially similar to MRT, with the addition of a “social-recreational program of a patient club.” Low social therapy was an evaluation and referral process without any planned follow-through. Using the life table method to provide data on the ultimate relapse or survivorship, they found no difference in survivorship during the first year between the oral or depot fluphenazine group. Striking in their findings, however, was that after 8 months, there were no relapses in the depot fluphenazine/high social therapy group. Over the 2-year study, a clear trend favoring this group was established, but did not reach statistical significance, probably because of insufficient sample size. By either the likelihood ratio test or analysis of variance, no statistically significant differences were found over 2 years between the oral or depot fluphenazine group or between the high and low social therapy groups.

As expected, the studies of Hogarty, Schoeler, Goldberg, and their associates found neuroleptics to be powerful agents in the prevention of relapse. The effects of social therapy were seemingly additive to those of the neuroleptics—but in a complex way. Relatively asymptomatic females seemed to benefit most. The series of reports from this investigation have several important implications for future research:

(1) Oral and depot neuroleptics are equally effective; ergo, oral medication is preferable because it is cheaper and has fewer side effects.

(2) The effects of non-intensive social therapy (if any) will appear relatively late.

(3) Simple group comparisons may obscure important positive or negative effects (or interactions) in subgroups of patients.

Thus, studies of individual and group treatments conducted with relatively large samples of patients—perhaps only possible in collaborative work—should be given high priority in plans for future research.

Group Psychotherapy

Group psychotherapy grew out of the observation that patients with similar medical or psychological problems could benefit from one another as well as from their doctors. Gomes (1975) has described group therapy for hospitalized patients as originally consisting of lectures for “mental reeducation” (Lazell 1921; Marsh 1933). Since its introduction, group treatment of schizophrenia has diversified into many forms—for example, supportive therapy, psychodynamic therapy, and activity groups. Neither the early didactic techniques, which instilled understanding of the psychological mechanisms underlying behavior through classroom presentations and lectures (Alshuler 1940; Boisen 1954;
Klapman 1946), nor the strictly psychoanalytic approaches introduced during the same period (Abrahams 1948; Beukenkamp 1958; Schilder 1936; Wender 1936) remain in wide use with schizophrenic patients.

Group treatment achieved its greatest popularity after World War II, when it offered the most expedient means of dealing with the large numbers of returning veterans with psychological problems. In fact, the Veterans Administration sponsored one of the earliest studies of group therapy’s efficacy with schizophrenics, resulting in the widely influential book by Powedermaker and Frank (1953).

While the primary aim in most traditional group therapies is facilitation of insight into personal and interpersonal problems, much group work with schizophrenics is oriented toward providing support, an environment in which patients can develop social skills, or a format that allows friendships to begin and be sustained. Therapy is not always limited to verbal interaction. Hypnosis (Illovsky 1962), play therapy (Freedman et al. 1959), and Gestalt games (Bowers, Banquer, and Bloomfield 1974) have been attempted. Occasionally, treatments conducted in a group context involve individual body awareness (Goertzel et al. 1965) or play with symbol-laden infantile objects (Azima, Wittkower, and Latendresse 1958) rather than interaction between group members.

Early enthusiasts saw group therapy as more economical, more widely applicable, simpler, and perhaps more effective than individual treatment. But this optimistic assessment has been considerably modified in the light of clinical and research experience. Group therapy is no longer viewed as a replacement for individual psychotherapy, but rather as another approach which offers alternative techniques for the more effective treatment of some patients and particular problems.

Group therapy has been defined as anything ranging from a casual Kaffee-Klatsch to psychoanalysis-in-groups. Part of the confusion stems from the failure to distinguish between psychotherapy groups and groups that are therapeutic (including self-help groups such as Alcoholics Anonymous, Synanon, and Recovery, Inc.; activity groups such as Great Books, P.T.A., and Boy Scouts; and training groups such as T-Groups and group institutes). There are basic dynamic differences between these two types of groups. Although both types may be therapeutic, they achieve similar goals through quite dissimilar means. Powles (1964) suggests three useful criteria for defining group psychotherapy: (1) that there be a group of troubled people gathered for some therapeutic goal; (2) that there be a professional or expert leader present to assist the group; and (3) that the relationships and interactions between group members be exploited as a tool for clarification, motivation, or behavior change. Clearly, self-help, social, and training groups may be therapeutic, even if not purposefully psychotherapy. Other group activities such as social groups, occupational-recreational therapy groups, and diagnostic intake groups may have both educational and therapeutic elements. Thus, the distinction between types of group activities is sometimes arbitrary. Group psychotherapy is not one technique but many, although almost all forms of group therapy have the common goal of enhancing social interaction.

A convenient method for categorizing the type of therapy group is derived from Levine's (1961) four categories of therapeutic interaction: suppressive, supportive, relationship, and expressive insight. Each type of interaction may occur within the same group over time, but one type of interaction will probably be typical of a given group. There are a multiplicity of reviews of the group therapy outcome literature extending to 1968 (e.g., Bednar and Lawlis 1971; Meltzoff and Kornreic 1970; Pattison 1965; Stotsky and Zolik 1965). It is fair to say that based on the data available to them, these reviewers generally concluded that most controlled evaluations of group therapy with schizophrenics (especially long-term inpatients) showed meager, if any, therapeutic benefit from groups. There were individual instances of special benefits from group treatment, but design problems such as lack of followup, inappropriate control groups, and insufficient duration of treatment made it difficult to draw firm conclusions—whether pro or con. Our focus will be the 1966–76 decade of research. This review is adapted, with modification, from Parloff and Dies (1977).

Studies With Hospitalized Patients. Hospital settings almost always provide a wide range of treatment modalities: for example, recreational therapy, occupational therapy, art therapy, music therapy, and medication. Therefore, group psychotherapy offered in inpatient settings is an “add-on” rather than an exclusive treatment form. In each of the six studies reviewed below, patients selected as suitable for group therapy were assigned to either group therapy or no group therapy (i.e., usual hospital treatment). Unfortunately, as is so often the case, diverse measures of out-
come were used, so that comparison of results is difficult.

Group therapy vs. no group therapy. (See table 2.) Boe, Gocka, and Kogan (1966) compared two groups of 19 male patients with diagnoses of schizophrenia (mild to moderate), depressive reaction, or character disorder (severe). The control group received the usual hospital services, and the experimental group received, in addition, 6 weeks of nondirective group psychotherapy. Changes in interpersonal perceptions were assessed at 6 weeks. The dropout rate was high (32 percent), but was equal for both experimental and control conditions. Boe, Gocka, and Kogan reported that control patients described themselves as gaining in social dominance, whereas group-treated patients tended to see themselves as having become less assertive and more tolerant of others. Unfortunately, it is unclear whether the reported changes represented realistic self-appraisals (i.e., reflected changed levels of social interaction). In addition, it is difficult to decide whether the changes in the control or experimental groups were more positive.

The study of Pattison, Brissenden, and Wohl (1967) examined the effectiveness of 10 to 12 weeks of analytically oriented group therapy for 24 male patients, most of whom received diagnoses of chronic character disorder or chronic schizophrenia. Of the 12 patients randomly assigned to group therapy, three concurrently received individual therapy; six of the 12 patients in the no group therapy condition received individual therapy. Both experimental and control patients improved to about the same degree, but patients in group therapy tended to improve less than controls on self-acceptance and to show less positive personality change. All patients were receiving unspecified drugs in unknown doses.

An analysis of the trends in the subsample who had been exposed to various combinations of group and individual therapy suggested that patients in individual therapy improved more than patients in group therapy alone. It should be noted, however, that although patients were randomly assigned to group or no group therapy, patients receiving individual therapy were "usually those considered to have the best therapeutic potential" (p. 293). Pattison, Brissenden, and Wohl conclude that psychoanalytically oriented group therapy is probably inappropriate for relatively short-term hospital inpatients when the goal of treatment is immediate reconstitution and return to the community. Only one therapist conducted the analytic group psychotherapy, however, so it is impossible to determine whether the effects observed are attributable to group therapy or to the particular therapist.

Lipton, Fields, and Scott (1968) studied male VA hospital patients who were given twice-a-week group therapy focused on increasing "general insight and socialization." Patients on two control wards participated in once-a-week "gripe sessions"; discussion of personal problems in these sessions was discouraged. Although the 180 control and experimental subjects were demographically similar, one control ward contained more patients judged to be sicker by the psychiatrist. No information on diagnosis or drug use was provided, and group assignment was nonrandom. Over the 9-month treatment period, Lipton, Fields, and Scott (1968) showed an advantage for group psychotherapy on measures of admission to closed wards as compared to one of the two nongroup therapy control wards—oddly enough, the one containing the "less sick" patients. There were no other significant differences. "Insight" and "socialization" were not assessed directly, so outcome for the experimental and control groups cannot be compared on those relevant dimensions.

Haven and Wood (1970) compared recidivism among 68 patients of various psychiatric diagnoses, half of whom received group therapy and half of whom received usual hospital treatment. The group therapy, conducted in twice weekly, 1-hour sessions, was described as eclectic but directive and reality oriented. Duration of treatment was determined by the "patient's readiness for release." The median number of sessions for the 36 patients assigned to group therapy was 16 (range 8 to 22 sessions). At the end of a 12-month follow-up period, there were no differences between group- and nongroup-treated schizophrenic patients on hospital discharge rates, readmissions, community tenure, and continued hospitalization. However, experimental subjects diagnosed as anxiety reaction did show lower recidivism rates at 12 months than comparable control subjects.

Vitalo (1971) compared the relative impact of three treatments: (1) Group psychotherapy, type unspecified. (2) Hospital milieu therapy (control condition). (3) A special training program emphasizing Rogerian dimensions of interpersonal relationships—empathy, positive regard, and genuineness. Twenty-nine patients, who averaged 5 years of previous hospitalization, were randomly assigned to one of the three treatments. The diagnostic breakdown was as follows: 75 percent
Table 2. Inpatient studies: Group therapy vs. no group therapy

<table>
<thead>
<tr>
<th>Study</th>
<th>Comparison groups</th>
<th>Subject characteristics and n</th>
<th>Diagnosis</th>
<th>Assignment</th>
<th>Type of treatment</th>
<th>Length of treatment</th>
<th>Drug usage</th>
<th>Measures</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boe et al. (1966)</td>
<td>Small group therapy vs. no small group therapy</td>
<td>N = 38, all male VAH, aged 23-68</td>
<td>Schizophrenic, depressed character disorder</td>
<td>Matched, random</td>
<td>Nondirective, patient centered</td>
<td>60 minutes 3 times/week for 6 weeks</td>
<td>Meds received, noncontrolled</td>
<td>Revised interpersonal checklist at 0, 3, and 6 weeks</td>
<td>Group therapy patients see selves and others as less assertive and pompous</td>
</tr>
<tr>
<td>Haven and Wood (1970)</td>
<td>Group vs. no group therapy</td>
<td>N = 68, male VAH, aged 20-58 (median 42)</td>
<td>All subjects had psychiatric diagnoses</td>
<td>Subject placed alternately in experimental and control group</td>
<td>Eclectic, directive oriented toward total reality testing</td>
<td>Group me: 60 minutes, 2 times/week for 6-22 sessions (median = 16)</td>
<td>Not described</td>
<td>Recidivism out to 12 months postdischarge</td>
<td>$\chi^2$ at 12 months showed no difference in recidivism</td>
</tr>
<tr>
<td>Lipton et al. (1968)</td>
<td>Group psychotherapy vs. no group (ward meeting &quot;gripe sessions&quot;)</td>
<td>N = 180, male VAH, aged 20-65</td>
<td>Not described</td>
<td>Matched wards (but patients on one control ward sicker)</td>
<td>Determined by therapist (generally insight oriented plus aimed at increasing socialization)</td>
<td>Not described</td>
<td>Discharge rates, admission to closed wards, ward readmission rates</td>
<td>Experimental ward had significantly lower rates of admission to closed wards than one control ward (the one containing &quot;less sick&quot; patients) but did not differ from the other control ward; no other significant differences</td>
<td></td>
</tr>
<tr>
<td>Olson and Greenberg (1972)</td>
<td>Group vs incentive vs milieu</td>
<td>N = 74, male VAH, aged 29-74 (X = 48). 1-60 months hospitalization (X = 42) over past 5 years</td>
<td>52 schizophrenic, 14 organic, 8 other</td>
<td>Matched wards (1) Current problem mutual help (2) Minue and behavioral treatment (3) Ordinary milieu</td>
<td>All had weekly group therapy, group anc incentive received additional small group meeting. 60 minutes 2 times week for 4 months Incentive behavior on ward subject to re-</td>
<td>8-week pretest period and throughout 4-month treatment period. Intra- and extra-hospital adjustment: (1) Attendance at activities (2) Social Adjustment Behavior Rating Scale (nurse ratings) (3) Patient Activity Checklist (social interaction levels rated by psychological interns)</td>
<td>Meds received, noncontrolled</td>
<td></td>
<td>Group—better social adjustment; incentive—more passes and more attendance at details</td>
</tr>
</tbody>
</table>
Note.—Abbreviations used in tables 2-6: BPRS = Brief Psychiatric Rating Scale; ICL = Interpersonal Checklist; IMPS = Inpatient Multidimensional Psychiatric Scale; KAS = Katz Adjustment Scale; MMPI = Minnesota Multiphasic Personality Inventory; Menninger HSR = Menninger Health-Sickness Rating Scale; MSRPP = Multidimensional Scale for Rating Psychiatric Patients; NHSI = New Haven Schizophrenia Index; PAS = Problem Appraisal Scales; SDCL = Symptom Distress Checklist; TAT = Thematic Apperception Test; VAH = Veterans Administration Hospital; WAIS = Wechsler Adult Intelligence Scale.
psychotic, 21 percent neurotic, and 4 percent other. No mention was made of medication use. Following treatment, patients in group therapy showed less clinical pathology than patients in either the training or the milieu control group. As predicted, the group that received special training in recognizing and expressing empathy, positive regard, and genuineness scored higher on instruments presumed to measure these skills. However, these training effects, which were achieved after as few as 15 hours of program participation, did not appear to be translated into personality changes. The nature and degree of socialization were similar for patients in the group therapy and the special training conditions and were superior to the ward milieu control group.

Olson and Greenberg (1972) studied 74 patients, who were mostly diagnosed schizophrenic (70 percent) and had averaged 42 months of hospitalization over the past 5 years. Twenty-eight patients were assigned to the experimental treatment, incentive group therapy, which rewarded them for developing mutual responsibility for specific tasks. The remaining patients were assigned to two control groups. Eighteen patients participated in interaction (problem-focused) groups, while 28 patients received only “usual” hospital treatment, which included weekly nurse-led group therapy. The matched interaction and incentive groups received 1 hour of additional therapy twice a week over a 4-month period. The ward behavior of incentive group patients was subject to response-contingent management, with access to personal funds, coupons, and vacation from work assignment used as reinforcers. Patients in incentive group therapy were not permitted to see the professional staff (e.g., psychiatrists, psychologists, or social workers) individually. In-hospital adjustment, activity levels, and extra-hospital adjustment were measured before, during, and for 4 months after termination of the treatment program. No differences were found between treatment groups on interactional levels as measured on an activity checklist. On the dimension of in-hospital social adjustment, however, the nurses described patients in the two control groups as being better adjusted than patients treated with incentive therapy; the latter patients, in fact, were rated by nurses as having “gotten worse.” Yet, patients receiving incentive therapy attended more scheduled activities, spent more time away from the hospital, and obtained more town passes during the 4-month followup period than control patients.

The studies by Vitalo (1971) and Olson and Greenberg (1972) suggest that focused interventions aimed at producing specific effects (e.g., Rogerian interpersonal training and incentive therapy) can achieve very clearly defined goals. In summary, of the six comparisons of group therapy of schizophrenics against a no group therapy/usual hospital condition, four failed to reveal any unique or impressive contribution assignable to group psychotherapy. It should be noted, however, that the studies with positive results (Olson and Greenberg 1972; Vitalo 1971) were better designed in terms of length of treatment and outcome measures that addressed the investigators’ hypotheses directly.

Group psychotherapy combined with other psychosocial interventions. (See table 3.) Corder, Corder, and Hendricks (1971) compared the effects of group therapy alone and group therapy combined with a dyadic social interaction in a group of female inpatients, mostly first admissions, who had a “variety of diagnoses.” The experimental condition required each patient to spend a minimum of 30 minutes daily discussing personal problems with an assigned patient-partner, in addition to participating in group therapy twice a week. The tapes of the group therapy sessions of patients who also took part in the experimental dyadic sessions were compared with the tapes of group therapy sessions conducted by the same experimenter with matched control patients who received only group therapy. Results showed that patients in the experimental group manifested more reality contact, greater intimacy, a deeper level of emotional material, and more verbal interaction with fellow patients than did control patients.

Coons and Peacock (1970) also studied whether prescribed social interaction among patients usefully augments group therapy. Four male and four female groups of seven inpatients (38 of the 56 patients were schizophrenic) were assigned to one of four treatment conditions: group therapy plus random ward interaction; group therapy plus organized ward interaction; random ward interaction alone; and organized ward interaction alone. Thirty hours of group therapy were given over a 6-week period. Patients on drugs (number not given) were off medication for at least 48 hours before and throughout the assessment periods.

Group therapy was aimed at fostering intragroup transactions in a warm, accepting, and permissive atmosphere. In the organized ward interaction condition, patients were assigned to seven-member groups that maintained their identity
Table 3. Inpatient studies: Group therapy alone vs. group therapy combined with other psychosocial treatments

<table>
<thead>
<tr>
<th>Study</th>
<th>Comparison groups</th>
<th>Subject characteristics and n</th>
<th>Diagnosis</th>
<th>Assignment</th>
<th>Type of treatment</th>
<th>Length of treatment</th>
<th>Drug usage</th>
<th>Measures</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coons and Peacock (1970)</td>
<td>(1) Group plus random ward interaction; (2) Group plus organized ward interaction; (3) Random ward (no group); (4) Organized ward (no group)</td>
<td>N = 56; both sexes; aged 15-51 (X = 29); 1-169 weeks hospitalization (X = 45); IQ = 100 for males, 89 for females</td>
<td>Most schizophrenic (n = 38)</td>
<td>Random</td>
<td>Nondirective intragroup interaction</td>
<td>30 hours over 6 weeks (group therapy)</td>
<td>Meds. available but patients drug free for assessments</td>
<td>Pre-post: WAIS, Hospital Adjustment Scale, Rorschach</td>
<td>Group therapy produced higher intellectual functioning; group and organized ward interaction produced greater improvement in hospital adjustment. Group and random ward interaction resulted in improved Rorschach</td>
</tr>
<tr>
<td>Corder et al. (1971)</td>
<td>Group vs. group plus patient-paired meetings</td>
<td>N = between 5 and 15 female patients at any time; X age = 28; X education = 9th grade; mostly first admissions, X hospital stay = 2 months</td>
<td>Variety of diagnoses Nonrandom, but randomly assigned to partner. Group participation voluntary but all urged to attend.</td>
<td>Group therapy, nonspecific; paired meetings (self-help, discuss problem areas with one another)</td>
<td>2 times/week therapy plus 30 minutes of daily patient-paired meetings for a 3-month period</td>
<td>Meds. received, nonspecific, noncontrolled</td>
<td>7 judges made ratings of content, intimacy, emotional tone, interaction, reality content</td>
<td>Group plus patient-paired showed higher degree of intimacy, more reality contact, deeper emotional level, and greater increase in verbal interaction</td>
<td></td>
</tr>
<tr>
<td>Roback (1972)</td>
<td>(1) Insight plus interaction</td>
<td>N = 24; male; aged 21-55 (X = 36); X = 11 years</td>
<td>20 schizophrenic</td>
<td>Random</td>
<td>Stress interpretive procedures to bring about</td>
<td>60 minutes 3 times/week for at least 16 but no more</td>
<td>Meds. received but patients taken off medication</td>
<td>Pre-post therapy: Hospital Adjustment Scale, Wittenborn Psychiatric Rating Scale, MMPI</td>
<td>Insight and interaction group showed greatest overall improvement on 21 measures assumed to assess &quot;personal functioning&quot;</td>
</tr>
<tr>
<td>Study</td>
<td>Comparison groups</td>
<td>Subject characteristics and n</td>
<td>Assignment</td>
<td>Type of treatment</td>
<td>Length of treatment</td>
<td>Drug usage</td>
<td>Measures</td>
<td>Outcome</td>
<td></td>
</tr>
<tr>
<td>-----------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
<td>-----------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>---------------------</td>
<td>------------</td>
<td>--------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Roback (1972)—continued</td>
<td>(2) Interaction (3) Insight (4) Audio-visual therapy (control)</td>
<td>education; spent average of 10 years hospitalized, with current hospitalization averaging 8 years (range: 2 months-36 years)</td>
<td>Insight, or encourage client-to-client interaction, or both, as defined by group assignment</td>
<td>than 30 sessions for the 3 experimental groups. Control group audio-visual therapy approximately 60 minutes per week</td>
<td>for 48 hours, before and during the 2 assessment periods</td>
<td>Symptom Disability Checklist, Adjective Checklist, WAIS, days out of hospital during 4½ months post-therapy</td>
<td>Pre-post: Q-sort (real-ideal)</td>
<td>More positive change for group and alternate sessions showed negative change in self-concept</td>
<td></td>
</tr>
<tr>
<td>Robinson (1970)</td>
<td>Group vs. group with video tape feedback</td>
<td>N = 119; both sexes; aged 20-49 (X = 32); at least 9 years’ education (X = 11.5); hospitalization no longer than 18 months (X = 16)</td>
<td>Not described</td>
<td>Directive patient-centered, promoting self-awareness</td>
<td>2 successive weeks in tr-weekly 1-hour video-taped sessions</td>
<td>Not described</td>
<td>Behavioral Change Index (subtract maladaptive from adaptive responses) following each session</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Truax et al (1966)</td>
<td>Group vs. group plus alternate sessions</td>
<td>N = 80 (40 mental patients, 40 male juvenile delinquents); 40 mental patients: both sexes, aged 22-65, X = 43.5, length of hospitalization = 2 years</td>
<td>Random</td>
<td>2 times/ week for 3 months; 24 sessions for group and 14 &quot;extra&quot; sessions for alternate group</td>
<td>No heavy meds.</td>
<td>Pre-post: Q-sort (real-ideal)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
throughout most of the daily hospital activities. Hospital staff members were involved in planning, conducting, and supervising the organized ward interactions but not the random ward activities.

It was found that increments in intelligence, as measured by the Wechsler Adult Intelligence Scale (WAIS), were associated with participation in group therapy independent of the form of ward activity. However, patients in the group psychotherapy/organized ward interaction condition were rated by the ward staff on the Hospital Adjustment Scale (HAS) as having improved significantly more than patients in the group therapy/random ward interaction condition. Positive change on the Rorschach Test was associated with the combination of group therapy and random ward interaction. The data suggested that on all three criterion measures used (i.e., the WAIS, the HAS, and the Rorschach) the combination of group psychotherapy with organized or random ward activity produced significantly greater positive change than did either ward condition alone.

Coons and Peacock speculate that the findings on hospital adjustment, which were based on ratings by the ward staff, may reflect a bias in favor of those programs in which the ward staff was actively involved. Thus, organized ward activities directed by the staff were judged by them to be more useful than unorganized ward activities in which they were not involved. Patient change on independent measures of intelligence and personality did not appear consistent with staff ratings of institutional adjustment. Taken in conjunction with apparently similar rater-based discrepancies found by Olson and Greenberg (1972), these findings point to an important methodological question; i.e., that therapy outcome depends upon who evaluates improvement.

Roback (1972) compared group therapy focused on patient-to-patient interactions with both a more insight-oriented group therapy and a no group therapy control condition. In addition, a treatment group that combined both interactional and insight-oriented approaches was studied. The subjects were 24 male patients (20 of 24 diagnosed schizophrenic), who had spent an average of 8 years in their current hospitalization. Each treatment group met three times a week for a minimum of 16 and a maximum of 30 one-hour sessions. The interactional and insight-oriented approaches did not differ significantly on a wide range of behavioral and psychometric measures. However, measures of personal functioning within the institution showed the combined treatment form to be consistently superior to either treatment alone, or to the no group therapy control condition. No differences on days spent out of the hospital were found among any of the treatments tested.

Truax et al. (1966) compared the effects of group therapy alone versus group therapy supplemented by "alternate" group meetings not supervised by the therapist. Subjects were 40 male juvenile delinquents and 40 mental hospital patients (mostly chronic schizophrenics), who had spent an average of 2 years in the hospital when therapy began. All groups met twice weekly over a 3-month period for a total of 24 sessions. There were a total of 12 "alternate" group meetings. No patient on "heavy" medication was included. The investigators found that patients who participated in the alternate sessions had developed significantly less adequate self- and ideal self-descriptions and tended to describe themselves as deflecting more from experts' depictions of positive mental health than they had before group therapy began. This shift was not found in patients treated in the group therapy only condition. Changes on the Minnesota Multiphasic Personality Inventory (MMPI) were compatible with these findings in that patients having alternate sessions showed less improvement on the Paranoia and Schizophrenia scales than patients taking part only in the regular group sessions. It was concluded that alternate sessions may have a disruptive rather than a facilitative effect on chronic schizophrenic patients.

Robinson (1970) attempted to determine whether group psychotherapy combined with videotape feedback was more useful to seriously disordered inpatients than group therapy alone. From the initial sample of 119 subjects, 40 patients, selected by hospital staff members as being in good contact with reality, having adequate verbal facility, and not having been hospitalized for longer than 18 months before the study, were divided into six groups (i.e., both the experimental and control sets were composed of three groups of six or seven patients). All patients received group psychotherapy, which was videotaped during the experimental period. The three experimental groups were offered 1 hour of videotape feedback immediately after each session, whereas the three control groups were offered 1 hour of postgroup discussion but did not see the videotapes. The entire experimental period was limited to 6 hours over 2 weeks.

Two criteria of change were used: judges' ratings of the frequency of adaptive and maladaptive behaviors...
manifested in the first and fifth video-taped therapy sessions, and patients’ own ratings of their adaptive behavior. The judges reported that the patients in the focused feedback condition showed a significantly greater increase in behaviors that had been sanctioned by the therapist than did patients in the control group. There was no significant difference, however, between treatment forms in decreasing behaviors cited by the therapist as “maladaptive.” Patients’ self-reports failed to reveal any differences attributable to either treatment approach.

In brief, four of the five studies that tested group therapy in combination with another treatment approach reported that the combination—be it drug, videotape feedback, ward activity, or dyadic social interaction—was superior to group treatment alone.

Integrating the results of these two types of in-hospital studies is difficult for a number of reasons: The patient groups are often noncomparable, many of the studies involve extremely short treatment periods, and the outcome measures not only vary widely but frequently are not addressed to the specific effects sought by the treatment. Nevertheless, positive results were found in those studies that carefully defined the behaviors or attitudes they wished to change and used outcome measures that tapped them. In addition, it appears that the more clearly defined and structured the activity (i.e., Olson and Greenberg’s incentive therapy, Corder and associates’ required dyadic interaction, and Robinson’s videotape feedback), the more likely a positive result. Although somewhat speculative, this interpretation is consistent with the types of milieu therapy found to be most useful for chronic patients (see Mosher and Gunderson, in press; Mosher and Keith 1979). Most of the patient samples in the studies reviewed above are probably best characterized as chronic.

**Aftercare Treatment Studies.** The emphasis during the last 15 years on community treatment has highlighted the need for psychosocial interventions to aid patients in maintaining community adjustment. Although useful for reducing symptoms and hospital stays, drugs do not promote individual work, social, and interpersonal skills. Group psychotherapy is now used frequently as a means of developing, maintaining, and enhancing these skills in discharged patients in the community.

**Group vs. individual therapy.** (See table 4.) Levene et al. (1970) studied 31 chronically ill schizophrenics on maintenance phenothiazines who were on indefinite home leave from a state hospital. All subjects were seen monthly, either in brief individual sessions (15–30 minutes) or in 1-hour group sessions with five to seven patients. The investigators found no differences in rehospitalization rates or social adjustment between group and individually treated patients.

O’Brien et al. (1972) randomly assigned 100 schizophrenic patients, all of whom were on maintenance medication, to group or individual treatment. Most of the patients had a relatively poor prognosis, with a mean number of 2.85 psychiatric hospitalizations. Patients were evaluated 12 and 24 months after beginning outpatient treatment. They remained in treatment for an average of 13 months, with more group-treated patients in treatment at both 1 and 2 years. There were no significant differences in rates of rehospitalization at either 12 or 24 months, although the trend favored group treatment. The 24-month overall outcome rating revealed that the group-treated patients had improved significantly more on the Brief Psychiatric Rating Scale and a social effectiveness scale. Individually treated patients improved significantly only on the social effectiveness scale, and their improvement was significantly smaller than the improvement of group-treated patients.

In contrast to O’Brien and his associates, Levene et al. observed that relatives’ ratings of patient behavior showed significantly more improvement for patients treated individually than for those treated in group therapy. Four other measures of social adjustment in the Levene et al. study failed to discriminate between the patients treated individually and those treated in groups; neither treatment gave impressive results.

Herz et al. (1974) studied 144 aftercare patients—76 randomly assigned to group therapy and 68 to individual therapy. Both treatment modalities were supportive and reality-oriented, and all but nine patients were on psychotropic medication. First-year residents, randomly assigned to conduct either group or individual therapy, were each responsible for 12 patients and were instructed to limit therapy to 1½-hour weekly clinics. Group therapy sessions were held weekly, and two-thirds of the patients attended either weekly or biweekly. Therapists were available to individual patients, according to their needs, during a 1½-hour time period each week; 75 percent of individual patients were seen once or twice a month in 15- to 30-minute sessions. Of the initial study sample of 144 patients, 36 patients never met with their assigned therapists. The remaining 108 patients (66 percent
<table>
<thead>
<tr>
<th>Study</th>
<th>Comparison groups</th>
<th>Subject characteristics and n</th>
<th>Diagnosis</th>
<th>Assignment</th>
<th>Type of treatment</th>
<th>Length of treatment</th>
<th>Drug usage</th>
<th>Measures</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Donlon et al. (1973)</td>
<td>Individual vs. group</td>
<td>N = 24; aged 19–31 (X = 33); both sexes; lower social classes; previous hospitalization ranged from 2 months to 18 years (X = 3.2 years)</td>
<td>Refractory chronic schizophrenics</td>
<td>Random</td>
<td>Provide nurturance and alleviate interpersonal anxieties</td>
<td>9 biweekly clinic visits for 1½ hours each</td>
<td>All maintained on fluphenazine enanthate</td>
<td>Attendance at appointments, socialization, cost efficiency for therapist's hours</td>
<td>Group arrived on time and kept more appointments, showed more socialization, and therapy was more cost effective</td>
</tr>
<tr>
<td>Herz et al. (1974)</td>
<td>Individual vs. group</td>
<td>Initial n = 144; final n = 108; aged 18–65 (X = 32); both sexes; predominately white, single, with 1 previous hospitalization</td>
<td>66% schizophrenic, 15% affective, 19% other</td>
<td>Random</td>
<td>Supportive, reality-oriented with little emphasis on insight; promotes socialization and deals with interpersonal issues</td>
<td>1½ hour weekly clinic for group and individual 67% group therapy seen weekly or biweekly, 75% individual seen biweekly or bimonthly for 15–30 minutes</td>
<td>92% received phenothiazines</td>
<td>PAS, Menninger HSR, SOCL at initial session 4, 7, and 11 months</td>
<td>No difference in readmissions, no psychopathology difference at 11 months. No vocational adjustment differences. No self-report differences. However, both therapists and patients seemed to favor the group method</td>
</tr>
<tr>
<td>Levene et al. (1970)</td>
<td>Individual vs. group</td>
<td>N = 31; age = 35; 49% married, 31% single; most high school education or better; most had ≥ 3 previous hospitalizations</td>
<td>Schizophrenic</td>
<td>Not described</td>
<td>A review of current status and adjustment and a renewal of medications</td>
<td>Individual 15–30 minutes/monthly, group = 1 hour/monthly</td>
<td>Required use for inclusion in study</td>
<td>KAS (both subject and relative), BPRS at pre-treatment and 1 year</td>
<td>No difference in rehospitalization between groups. Individual tended to improve more on KAS but not significantly. Neither method of aftercare gave impressive results</td>
</tr>
</tbody>
</table>
Table 4. Outpatient studies: Group therapy vs. individual therapy—continued

<table>
<thead>
<tr>
<th>Study</th>
<th>Comparison groups</th>
<th>Subject characteristics and n</th>
<th>Diagnosis</th>
<th>Assignment</th>
<th>Type of treatment</th>
<th>Length of treatment</th>
<th>Drug usage</th>
<th>Measures</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>O'Brien et al. (1972)</td>
<td>Individual vs. group</td>
<td>N = 100; both sexes; X age = 27; X hospitalization = 2.8; X years education = 10</td>
<td>Schizophrenic</td>
<td>Random</td>
<td>Supportive</td>
<td>Up to 24 months</td>
<td>All patients on therapeutic doses of phenothiazines at beginning of study</td>
<td>BPRS, Social effectiveness, Zung Depression scale, Mental Status Scale used at MH Clinic pretreatment and at 12 and 24 months</td>
<td>No significant difference in rehospitalization rates. Group treatment most likely to continue active treatment. Group improved significantly on both BPRS and Social Effectiveness Scales; individuals improved significantly only on social effectiveness. The 24-month overall outcome rating significantly favored group-treated patients</td>
</tr>
<tr>
<td>Purvis and Miskimins (1970)</td>
<td>Group vs. individual vs. control (no therapy); 3 degrees of participation: active, moderate, or none</td>
<td>N = 152; Discharged state hospital patients</td>
<td>Not described</td>
<td>Random</td>
<td>Support, crisis intervention, vocational counseling, and counseling for community and personal adjustment</td>
<td>Group met weekly, individual involved contact on a &quot;regular basis&quot;</td>
<td>Not described</td>
<td>Vocational success, vocational satisfaction, rehospitalization</td>
<td>Followup which offers moderate support fosters most independence and adjustment. Active group had lowest hospital contact rate and less recidivism, whereas active individual had highest hospital contact rate and recidivism. Group and individual showed greater vocational success than control; group reported greater work satisfaction</td>
</tr>
</tbody>
</table>

Note.—See footnote under table 2 for explanation of abbreviations.
chronic schizophrenic) were equally divided between group and individual therapy. Each subject was evaluated after the first session and at 4, 7, and 11 months. As was the case in the previous two studies, group and individually treated patients had similar readmission rates. In terms of reduction of psychopathology, Herz et al. found no differences in the relative effectiveness of group and individual therapy as judged either by mental health experts or by the patients themselves, although both tended to prefer the group method.

Purvis and Miskimins (1970) conducted a followup study of 152 discharged state hospital patients. Patients were assigned to three different followup conditions: (1) Weekly group meetings conducted by two vocational rehabilitation counselors. (2) Individual counseling contacts made on a regular basis by a vocational rehabilitation counselor. (3) A control condition, which consisted of the issuance of periodic research forms. No information concerning the patients' diagnoses or medication was provided. Patients in the three followup conditions differed significantly in the extent of their contact with the hospital. Group patients had the least hospital contact, 35 percent, whereas the corresponding figures for individual and control patients were 56 percent and 54 percent, respectively. In contrast to the findings of the other three studies, patients rated by their counselors as having been active participants in individual sessions were significantly more often readmitted than active group participants (those who had attended at least five meetings). Recidivism rates were 58 percent for active individual patients, 16 percent for active group patients, and 34 percent for controls. Vocational success or failure was unaffected by treatment, but group therapy patients did report greater work satisfaction.

Donlon, Rada, and Knight (1973), in a very clinically relevant study, examined the results achieved with 24 treatment-refractory schizophrenic outpatients who were randomly assigned to receive either group or individual therapy. All patients were being treated with fluphenazine enanthate. Both group and individual therapy were given by the same primary therapist, a psychiatric nurse, during the course of nine biweekly 1½-hour clinic visits. Group patients participated in a 30-minute group meeting, after which they were seen individually by the therapist for about 5 minutes. Individual patients were seen by the therapist for 10 to 20 minutes. Pre- and posttreatment measures of attendance, socialization, and cost of treatment revealed some advantages for group therapy: Group-treated patients more often kept appointments; socialized more; their treatment cost less; and the primary therapist came to prefer group treatment. There are two major problems in interpreting the study's findings: (1) The two forms of treatment were not "pure" since group patients had some individual contact, and individual patients had some informal group contact during their clinic visits. (2) The advantages found for group therapy cannot be disentangled from the primary therapist's preference for it as a form of treatment.

Group vs. no group therapy. (See table 5.) Shattan et al. (1966) studied a total of 90 "conditionally discharged" state hospital patients, who were primarily diagnosed as having schizophrenic reactions. Half of the patients received monthly group therapy, and half received no group therapy. Eighty-seven percent of the patients were on medication, and experimental and control subjects were matched for age, sex, race, marital status, and diagnosis. Control subjects had approximately half as many clinic contacts following hospital discharge as experimental subjects. Group-treated patients had fewer readmissions and a greater number of absolute discharges after 1 year of conditional discharge, but did not differ from the control group on the number of months out of the hospital during the trial discharge period or in employment after the 12-month probability period. The findings on employment are reminiscent of those of Purvis and Miskimins (1970), who also failed to find any significant advantage for group-treated patients on this variable—even though their study was specifically directed at enhancing vocational adjustment.

Claghorn et al. (1974) tested the effects of thiothixene and chlorpromazine alone or in combination with 6 months of weekly, structured, practical-problem-oriented group psychotherapy in the treatment of 49 outpatient schizophrenics (27 chronic undifferentiated, 19 paranoid, and 3 others) seeking outpatient care following their first admission to a state hospital. Both medications affected positive symptom change to an approximately equal degree, but group therapy did not appear to contribute significantly to the effects of the drugs in reducing symptomatology. There was evidence, however, that the group therapy patients achieved a greater appreciation of their own disability, in that they perceived others as "healthier" in terms of their being more dominant and affiliative. Group-treated patients also reported their own basic intentionality (as measured by the MMPI Pd and Mf scales) as having shifted to a much
### Table 5. Outpatient studies: Group therapy vs. no group therapy

<table>
<thead>
<tr>
<th>Study</th>
<th>Comparison groups</th>
<th>Subject characteristics and n</th>
<th>Diagnosis</th>
<th>Assignment</th>
<th>Type of treatment</th>
<th>Length of treatment</th>
<th>Drug usage</th>
<th>Measures</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Borowski and Tolwinski (1969)</td>
<td>Group vs group plus chlorpromazine</td>
<td>$N = 80; 65$ males, 15 females; aged 25–50; duration of illness 5 years</td>
<td>Paranoid schizophrenia</td>
<td>Not described</td>
<td>Reassurance, persuasion, discussion, clarification</td>
<td>60 minutes, 2 times/week for 2 months</td>
<td>300–600 mg chlorpromazine daily</td>
<td>Weekly evaluation of symptoms, interest in own problems, attitude toward environment and work performance</td>
<td>Group plus drugs better overall and more rapid decrease in symptoms</td>
</tr>
<tr>
<td>Claghorn et al. (1974)</td>
<td>Two drug groupings subdivided into group therapy or no psychotherapy</td>
<td>$N = 49$, aged 17–59 ($X = 39$); 29 males, 20 females; post-first admission to state hospital</td>
<td>Schizophrenic</td>
<td>Random</td>
<td>Structured with emphasis on tasks of daily living</td>
<td>Once a week for 6 months</td>
<td>One-two capsules 50 mg chlorpromazine or 5 mg thiothixene 3 times/daily</td>
<td>Before treatment and monthly; BPRS, Interpersonal Diagnosis of Personality, MMPI, ILC, TAT</td>
<td>Both drug groups improved on BPRS. Both groups shifted from oppositional to affiliative behavior. The drug plus group's self-perception showed less dominance and less affiliation, showed more dominance in relationships</td>
</tr>
<tr>
<td>Shattan et al. (1966)</td>
<td>Group vs no treatment</td>
<td>45 experimental and 45 controls matched for age, sex, race, marital status, and diagnosis</td>
<td>86% schizophrenic reaction, 14% other</td>
<td>Random</td>
<td>Not described</td>
<td>60 minutes monthly group therapy meetings</td>
<td>41 experimental and 37 controls received medication</td>
<td>Recidivism, receipt of absolute discharge, X number of months out of hospital, employment</td>
<td>Experimental patients had significantly less rehospitalization. More absolute discharges after 1 year of conditional discharge, and more clinic contacts. No significant difference in use of medications or number of months out of hospital although the latter favored the experimental group</td>
</tr>
</tbody>
</table>

Note.—See footnote under Table 2 for explanation of abbreviations.
more dominant position, although their affiliation scores on this measure did not change significantly over the treatment period.

Borowski and Tolwinski (1969) compared the effects of chlorpromazine alone and chlorpromazine in combination with twice weekly 1-hour group psychotherapy for a period of 2 months. Subjects were two groups of 40 paranoid schizophrenic outpatients with an average of four previous hospitalizations and an average duration of illness of 5 years. The method of assignment to treatment was not described. All patients received between 300 and 600 mg chlorpromazine (Thorazine) per day. Treatment included reassurance, persuasion, discussion, clarification, and in some cases manipulation of family situations.

The patients treated by a combination of chlorpromazine and group therapy showed greater symptomatic improvement than patients treated by chlorpromazine alone. Equally important was the finding that patients in the combined treatment condition showed more rapid reduction of clinical pathology. Delusional thinking, for example, lessened in 61 percent of the patients in the combined treatment group by the third or fourth week, while in the same period only 14 percent of the patients in the chlorpromazine alone condition were free of delusional thinking.

In summary, recent studies of "group psychotherapy," primarily as an undefined treatment given in various amounts to heterogeneous (especially in terms of concurrent drug treatment) groups of outpatient schizophrenics, have not yielded strong or consistent evidence that this form of treatment differentially reduced rates of rehospitalization, improved vocational adjustment, or diminished psychopathology. However, a treatment whose principal aim is to promote socialization and enhance interpersonal skills should probably not be expected to have a striking effect on rehospitalization rates or vocational adjustment. Three of the four studies that addressed the relevant outcome variables (Clagham et al. 1974; Donlon, Rada, and Knight 1973; Levene et al. 1970; O'Brien et al. 1972) did demonstrate positive effects of group treatment. The negative findings of Levene et al. were based on relatives' ratings, whereas the positive findings of the other studies came from research ratings and patients' self-ratings. Thus, the same methodological issue that complicated the interpretation of studies of group therapy with patients encountered here: the influence of who does the ratings that form the basis for assessments of outcome. It should also be noted that O'Brien et al. (1972), Herz et al. (1974), and Donlon, Rada, and Knight (1973) found that both group patients and therapists retrospectively reported more favorable feelings about the treatment experience than did the individually treated patients and their therapists. These morale-enhancing, affiliative effects are likely to be very important with long-term, community-based patients, and they certainly need further research.

A striking aspect of the treatment studies included in this review is what is being touted as "therapy." Individual treatment, given on a 15- to 30-minute weekly or biweekly basis, would unquestionably be considered inadequate by practitioners of individual psychotherapy. Yet, this is the principal form of "individual therapy" given in the outpatient studies reviewed here.

Likewise, group meetings focused on medication and compliance would not be recognized by most clinicians as "group therapy." In addition, the therapies are generally very vaguely described, with little information provided concerning their focus and formats. Finally, the treatment is frequently delivered by therapists of uncited characteristics and qualifications. No wonder psychosocial treatment for schizophrenia is in disrepute!

What is badly needed now are comparative studies in which group or individual therapy is used to treat relatively acute patients; treatment should be started after the patients' psychoses have subsided but while they are still in residential care, and it should be continued into their posthospital period. The design should include patients maintained on and patients withdrawn from neuroleptic drugs. In addition, the therapy should be of a prolonged period (at least 6 months), the outcome measures should be focused primarily on social and interpersonal variables rather than rehospitalization rates, and a 2-year followup assessment period should be required. Finally, the samples should be sufficiently large to allow subgroup analysis in order to distinguish the types of patients who respond especially well, or poorly, to each form of treatment.

**Family Therapy**

The family did not come under the scrutiny of psychiatrists until the late 1940s and early 1950s, some 40 years after social workers and child guidance clinics had begun to deal with it as an important aspect of the treatment of individual patients. Frieda Fromm-Reichmann's (1948) article on the schizophrenogenic mother—a conceptual parent to the later hypothesized schizophrenogenic mother—
family—was the first in this vein to receive widespread attention in the psychiatric literature. Since that time, research work on and with families has been carried out at a number of American centers, principally Palo Alto, Bethesda, Philadelphia, New York, New Haven, Boston, Denver, and Galveston; important contributions have also been made by a London-based group.

The major influence of this research on contemporary psychiatry has been in broadening the field's conceptual "sights." Once focused almost exclusively on the intrapsychic pathology of the individual patient, psychiatrists are increasingly coming to view the family context as relevant to the problems of afflicted individuals. The contention that the patient can be treated in isolation from major parts of his social environment, especially the family, grows daily less tenable. Indeed, some theorists no longer conceptualize the problem of schizophrenia as residing in the designated patient, but rather see it as being inexorably intertwined with his family and the wider social context. As an outgrowth of this position, the important unit in therapy is not the single patient, or the transacting psychotherapeutic dyad, but the patient's family and perhaps also the relevant social network. In network therapy (Speck and Atteave 1973), for example, 30 or more persons may be seen simultaneously. Thus, the family has, to a greater and lesser extent, penetrated the psychiatric consciousness of practitioners, who variously hold that the family cannot be disregarded in treatment or that it should be the principal object of treatment. But whether seen as a contributing or preeminent factor, the family has undeniably emerged as an element to be contended with in the treatment of schizophrenic patients.

One baffling aspect of the new focus of attention on the family in psychiatric research and practice is the remarkable gap between research on families, on the one hand, and the translation of these research findings into treatment principles. It is not unreasonable to expect that two decades of research on families might have identified principles important in the day-to-day practice of treating schizophrenic patients. Yet, the findings of this research have not, in fact, been systematically translated into the treatment of schizophrenia—until carried out by family therapists. Mosher (1969) hypothesized that the lack of communication between fields of family therapy and family research exists because the former grew out of the individual and group therapy tradition, while the latter has its roots in sociology and experimental psychology.

Family therapy is defined in myriad ways; in practice, it ranges from individual psychoanalysis focused on the family relations of individual patients to group meetings involving large 30–40 person social networks. Family therapy is defined here as therapist(s) meeting with two or more family members with an explicit focus on family problems. Meetings with various family members that may have incidental therapeutic value (e.g., social work intake interviews) are excluded from our review.

**Research on Family Therapy.** Family therapy is now two decades old. Does it work? If so, with what types of patients (or families), and in conjunction with which other treatment modalities? These questions are easy to pose but notoriously difficult to answer. Indeed, questions about efficacy may be premature. Until family therapy is itself better defined, we cannot hope to know whether "it" works. Diagnosis is also a troubling problem in dealing with families. With a few exceptions (e.g., Reiss 1971), family studies have used traditional diagnostic terminology derived from studies of individual patients. However, if the family is indeed more than the sum of its parts, a typology of individuals will inevitably prove inadequate. The field is in need of a family typology.

There are only three controlled studies of the outcome of family therapy that include a substantial proportion of schizophrenics (see table 6). Wynne (1974) has pessimistically suggested that such research may not be possible because of the tremendous variety of influences, in addition to family therapy, to which the hospitalized patient is subject. This criticism is, of course, applicable to all treatment studies. Evaluations of the outcome of family therapy with schizophrenic patients have been generally limited to anecdotal accounts of a therapist's experiences with a single case or global comparisons of the progress made by various families treated with the same techniques. The first controlled investigation of outpatient family therapy with patients who otherwise would have been hospitalized was conducted by Langsley and his collaborators (Langsley et al. 1968; Langsley, Flomenhaft, and Machotka 1969; Langsley, Machotka, and Flomenhaft 1968, 1971). In this study, the relative merits of outpatient family intervention were compared with those of hospitalization for the member experiencing an acute psychiatric crisis. From a group of 300 families requesting emergency treatment for a family member in acute distress, half of the disturbed
<table>
<thead>
<tr>
<th>Study</th>
<th>Comparison groups</th>
<th>Subject characteristics and n</th>
<th>Diagnosis</th>
<th>Assignment</th>
<th>Type of treatment</th>
<th>Length of treatment</th>
<th>Drug usage</th>
<th>Measures</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goldstein et al. (1978)</td>
<td>2 x 2 factorial high and low dose fluphenazine enanthate plus family therapy or no therapy</td>
<td>N = 104, 69% first admissions; mean age 23.4, SD 4.21; 79% white; 14% hispanic; 7% black; 40% had not graduated from high school; 62% single</td>
<td>NHSI score of 4 or more</td>
<td>Stratified by good or poor premorbid for each sex, then random</td>
<td>High and low dose drugs plus crisis-oriented family therapy or its absence</td>
<td>2 hrs/week for 6 weeks</td>
<td>1 ml = high 0.25 = low every 14 days</td>
<td>BPRS at 6 weeks and 6 months</td>
<td>Relapse at 6-month followup: 0% for high dose therapy; 48% for low dose, no therapy. BPRS showed family therapy effect at 6 weeks; sustained only in high dose group at 6 months</td>
</tr>
<tr>
<td>Langsley et al. (1968)</td>
<td>Outpatient family crisis therapy vs. inpatient university psychiatric hospital</td>
<td>N = 300; no significant intergroup differences on 15 demographic variables (Schiz. subgroup)</td>
<td>Acutely disturbed schizophrenics, suicidal depressions and other dramatic behavioral disturbances</td>
<td>Random</td>
<td>Family crisis therapy</td>
<td>FCT: 4.2 office visits, 1.3 home, 5.4 phone, 1.2 collat. 24.2 days; Inpatient: 28.6 days</td>
<td>Meds. used as needed in both groups</td>
<td>Rehospitalization Social Adjustment Inventory (SAI) Personal Functioning Scale (PFS)</td>
<td>Rehospitalization: FCT significantly better in number rehospitalized and cumulative days in hospital at 6 months and significantly better in cumulative days at 18 months. Both groups improved on SAI and PFS; no significant intergroup differences</td>
</tr>
<tr>
<td>Ro-Trock, Wellisch, and Schoolar (1977)</td>
<td>Family therapy (FT) vs. individual therapy (IT)</td>
<td>Hospitalized adolescents; n = 28; 14 in each group; 18 male; 10 female; 25 white, 3 nonwhite; age 16.5 in FT, 18.4 in IT</td>
<td>Schizophrenic reaction, adolescent adjustment reaction drug problem</td>
<td>Random</td>
<td>Family therapy focus on communication; individual therapy focus on problem schizophrenics</td>
<td>10 sessions of family or individual therapy</td>
<td>Not stated</td>
<td>Rehospitalization at 3 months, Family Problem Solving, Community Adjustment Self-Report Form</td>
<td>Rehospitalization: Significantly favored FT over IT, p &lt; .025. FT required significantly fewer days to return to community functioning. No consistent effects on family interaction or self-report</td>
</tr>
</tbody>
</table>

Note.—See footnote under table 2 for explanation of abbreviations.
family members were randomly assigned to inpatient hospital care including individual and group therapy, milieu treatment, and ataractic drugs, and half to family therapy aimed at quickly reducing the level of tension so that family resources could be garnered to cope more effectively with the crisis situation. Crisis intervention included approximately five office visits, one home visit, and several telephone conversations during the course of 2½ to 3 weeks. If long-term therapy seemed necessary after the immediate crisis had been resolved, referrals to other facilities were made.

Followup family interviews by an independent psychiatric social worker 6, 12, and 18 months after treatment revealed that patients who received family crisis therapy were less likely to be hospitalized later and spent fewer days in the hospital than control patients. Although these differences between therapy and control patients were smaller at each successive evaluation, it appeared that outpatient family therapy prevented rather than postponed hospitalization. Although patients who received family therapy demonstrated greater capacity to manage crisis than control patients (particularly at the 6-month evaluation), the two groups of patients improved similarly in both social adjustment and personal functioning (adequacy of role performance, general health, and absence of psychiatric symptoms). A subanalysis contrasting the crisis management skills of 50 schizophrenic and 50 nonschizophrenic patients (Langsley, Pittman, and Swank 1969) revealed that only the nonschizophrenics who had received family therapy improved in their ability to deal with stressful events. The results of this study indicate that schizophrenics can be handled successfully on an outpatient basis but reveal no advantage over hospitalization for schizophrenics per se. Ro-Trock, Wellisch, and Schoolar (1977) compared family therapy with individual therapy in two small groups (n = 14 in each) of randomly assigned hospitalized adolescents. Sixteen of the 28 adolescents (mean age about 17) were diagnosed as schizophrenic; 10 were in the family therapy condition and 6 in individual therapy. Two experienced co-therapist teams each treated seven families; two experienced individual therapists treated seven adolescents each. Both groups received 10 therapy sessions. The family therapy was intended to promote clear communication and to shift the balance of maladaptive relationships within the family so that new, more adaptive forms of relating would be possible. The individual therapy was focused on helping the patient develop solutions and problem solving skills in dealing with life conflicts. Outcome measures included a self-report form and assessed family problem solving (Strodtbeck’s Revealed Differences), community adjustment, and rehospitalization.

There were a number of complex pre-posttreatment changes on variables derived from the family interaction measure, but few on the self-reports. Although both family and individual therapy (and the different therapists) appeared to exert some influence, the patterns were difficult to interpret. On followup 3 months postdischarge, no family-therapy-treated subjects had been rehospitalized, whereas 6 of 14 individually treated subjects had been (p < .025). In addition, family therapy subjects required significantly fewer days to return to functioning in the community. The study is noteworthy in its attention to methodologic details (such as including the therapists as an independent variable in the design) and sophisticated data analytic techniques. As the authors themselves note, the lack of strong, consistent effects on their family interaction and self-report measures could reflect their having been repeated only at the end of treatment and not at the 3-month followup period when the most impressive outcome differences were found. Other problems with the study are the small number of subjects in the samples, the limited number of sessions (10), and the lack of information on psychotropic drug use in the two groups. Finally, it would have been desirable to have had the data from the two groups of schizophrenics analyzed separately from those for the nonschizophrenic adolescents.

The most recent comparative outcome study of family therapy was conducted by Goldstein et al. (1975, 1978). In this study, 104 consecutive first admission schizophrenic patients discharged from brief inpatient stays (mean = 12 days) were randomly assigned to one of four treatment conditions: (1) Low dose (.25 cc every other week) injectable neuroleptic plus family therapy; (2) low dose injectable neuroleptic without family therapy; (3) moderate dose (1.5 cc every other week) injectable neuroleptic plus family therapy; and (4) moderate dose injectable neuroleptic without family therapy. The family therapy consisted of six weekly 2-hour sessions, beginning in the first week after discharge. The therapy is described as "crisis oriented" with four major goals: (1) Accepting the occurrence of the psychosis; (2) identifying precipitating stresses; (3) looking at possible future similar stressful events; (4) developing strategies for avoiding,
minimizing, and coping with these stresses. Pre-posttreatment and 6-month followup data on symptomatology and community adjustment were collected. Significant family therapy effects were identified at 6 weeks (end of family treatment). By 6 months, however, the positive effects of family therapy on community adjustment and relapse rates had endured only in the portion of the sample characterized as having good premorbid adjustment—an effect that was seemingly independent of drug dosage level. Poor premorbid patients, on the other hand, showed a significant drug effect at 6 months; relapse rates in the high dose group were significantly lower, independent of the presence or absence of family therapy. A further analysis of relapsing patients showed that with one exception, they were all in one of two groups: good premorbid females (four) and poor premorbid males (five). None of the four good premorbid females who relapsed received family therapy. At 6-week followup, results on the Brief Psychiatric Rating Scale (BPRS) showed a trend toward less psychopathology in the family therapy samples. A significant therapy effect was found for all those completing the 6-week period on measures of withdrawal and anxiety. At 6-month followup, the therapy advantage on the measure of withdrawal was significant only in the high dosage group.

Given the lack of clearly negative results from family therapy, it is difficult to understand why so few studies of this type of treatment are available. Because family therapy is in widespread use in both inpatient and outpatient settings, research on its efficacy should be stimulated and supported. In particular, this research should compare longer-term family therapy (6–12 months) with another psychosocial treatment; the sophisticated approach of Goldstein et al. (1975, 1978) to the neuroleptic drug variable and subgroup analysis should be combined with the family interaction methodology of Ro-Trock, Wellisch, and Schoolar (1977).

In addition, the design should include 1- to 2-year posttreatment assessment of community adjustment and family interaction. Because of the origins and theoretical underpinnings of the family approach, this research might best be focused primarily on late adolescent and early adult schizophrenics living with their families of origin.

Community Support Systems

The past decade has seen a gradual emergence of interest in a variety of community-based resources that, taken together, provide important support to schizophrenic patients. At least 10 different potential elements of community support programs have been identified (Turner and TenHoor 1978). These resources include cooperative apartments, halfway houses, and psychosocial rehabilitation centers such as Fountain House and Thresholds (Glasscote et al. 1971). Such community support systems are in part a response to the progressive nuclearization of the family and are intended to provide the support that has been lost because of the dissolution of extended kinship networks or discharge from the hospital.

Unfortunately, community resources are still relatively scarce, they can accommodate only a small portion of potential clients, and they remain largely isolated and little known because most result from the efforts of one or two concerned, enthusiastic persons. Generally, they are a response of the private sector to failures of the medical and social welfare systems to provide adequately for the needs of patients. However, NIMH has recently funded 18 pilot demonstration community support programs.

There are data that suggest community support systems are effective and will therefore receive even greater emphasis in the next decade. Findings from the International Pilot Study of Schizophrenia (Sartorius, Jablensky, and Shapiro 1978) are relevant to the issue of community support. This careful longitudinal research involved more than 1,000 patients in eight countries on admission to a hospital and 2 and 5 years later.

A surprizing finding was that the outcomes of schizophrenic patients in developing countries (Nigeria, India, Colombia) were significantly better than those of patients in developed countries (United States, Russia, England, Denmark, Czechoslovakia). Although this finding is open to a variety of interpretations, an explanation positing the presence of supportive extended kinship networks is consistent with the family organizational structures in these developing countries. A related explanation—that these relatively uncomplicated societies are less stressful to individuals—also fits the community support model. It has been shown for medical illness (Cobb 1976; Kaplan, Cassel, and Gore 1977) that social support protects against the development of illness and aids recovery when illness is related to life stress. Thus, one parsimonious explanation is that in developing countries, for whatever levels of stress occur, there is greater protection available to individuals from their naturally occurring social support systems. This case is even more persuasive when taken in conjunction with two bodies of data from the United Kingdom which indicate that (1)
schizophrenics experience greater life stress than others in the 3-week period before the onset of overt symptomatology (Brown and Birley 1968), and (2) having more than 35 hours a week of face-to-face contact with hostile, critical, overinvolved parents or spouses is highly predictive of relapse among discharged schizophrenics, even when they are maintained on neuroleptic drugs (Vaughn and Leff 1976).

Psychosocial rehabilitation services, which began when a group of former state mental hospital patients banded together in New York in the late 1940s, have come to represent a major force in responding to the needs of the chronic schizophrenic population. The active collaboration of patients in the programs has been maintained, and the services have developed with professional leadership. The general goal is reintegration of the psychiatrically disabled into the community by maintaining and augmenting whatever level of functional independence a patient has been able to achieve. In general, rehabilitation has focused on programs to develop social support and independent living capabilities, emphasizing vocational components.

Results of research on the chronic patient population have underlined the importance of rehabilitation programs for this high-recidivism and low-employment group. An extensive review of research findings by Anthony, Cohen, and Vitalo (1978) showed baseline readmission figures of 30–40 percent after 6 months, 35–50 percent after 1 year, and 60–75 percent after 3–5 years. In terms of employment, most studies indicate a 10–30 percent rate of independent employment at followup, regardless of the time period studied. Unfortunately, little controlled comparative research has been carried out on the impact of comprehensive psychosocial rehabilitation centers on recidivism and employment.

Beard, Malamud, and Rossmann (1978) have recently reported on a 5-year followup study, which showed that with an active outreach program for the initial 2 years of participation, Fountain House clients had significantly lower rehospitalization rates at 1, 2, and 5 years than control subjects. Those who were rehospitalized spent 40 percent fewer days in the hospital than rehospitalized control subjects. Their data also indicate that the more contact patients had with the program, the less likely they were to be rehospitalized.

Other aspects of comprehensive rehabilitation programs that have received research attention are aftercare clinics and transitional living arrangements. Aftercare clinics, which usually include some form of therapeutic or casework contact in addition to medication, have been shown to reduce readmission rates (Anthony et al. 1972). Evidence indicates that this effect results from a combination of factors—drugs, additional services, and the type of patients who attend. Hogarty et al. (1973, 1974a, 1974b) reported that patients who received major role therapy (casework with an experienced social worker) plus drugs had significantly better social adjustment than those who received drugs alone. This effect first appeared at 18 months and was somewhat stronger at 24 months. Kirk (1976) reported that chronicity (a composite rating based on the number of previous hospitalizations, length of last hospitalization, psychotic versus nonpsychotic diagnoses, and previous employment status) is predictive of rehabilitation outcome. Kirk found that the recidivism rate of aftercare clinic attenders who had a high level of chronicity decreased as the number of visits increased to above six. In contrast, the recidivism rate of aftercare clinic attenders who had a low level of chronicity was not affected by an increased number of visits. Based on the results of this and another recent study (McCranie and Mizell 1978), as well as the Fountain House results, it is tempting to conclude that aftercare treatment is most effective with those chronic patients who maintain a continuing relationship with the program.

Transitional facilities (halfway houses, day centers) are a major component of psychosocial rehabilitation and have been shown to be effective in reducing recidivism as long as the patients remain in contact with the facility (Anthony et al. 1972). In their review, Rog and Raush (1975) found data to suggest lower recidivism rates for residents of halfway houses, although they noted the almost complete absence of controlled studies. Successful programs have also been developed using a transitional person rather than a transitional facility to reduce readmission (Katkin et al. 1971, 1975; Weinman 1975).

The field of psychosocial rehabilitation is experiencing a rapid expansion of its activities, as indicated by the establishment of the International Association of Psychosocial Rehabilitative Services and NIMH's new Community Support Program (a major component of which is psychosocial rehabilitative services). High priority should be given in this field to studies obtaining basic recidivism and employment data from several centers in an attempt to replicate the Fountain House results. Following this initial research effort, more complex studies of patients' skill gains, quality of life, and satisfaction with
services, as well as patient/program “fit” and patient/society benefits, should be implemented.

In sum, there is a substantial body of data derived from several different perspectives indicating that social support systems, especially relationships outside the nuclear family unit, can serve as protective buffers for individuals exposed to stresses that can result in the development or exacerbation of schizophrenia.

Although they have not generally been conceptualized as community support systems, a variety of alternatives to hospitalization have been studied; these can be seen as providing support systems for individuals undergoing the severe personal distress and crisis that comes to be labeled schizophrenia. Diverse examples of the intentional provision of a support program in lieu of the support inherent in hospital care can be found in the following studies: training in community living (Stein and Test 1976), family crisis intervention (Langsley, Pittman, and Swank 1969), visiting nurse program (Pasamanick, Scarpitti, and Dinitz 1967), “enablers” program (Sanders et al. 1976), family foster care (Polak and Kirby 1976), community lodges (Fairweather et al. 1969), Soteria House (Mosher and Menn 1978), and day care centers (Herz et al. 1971; Linn et al. 1979; Wilder, Levin, and Zwerling 1966). The results of these programs, tried with a wide variety of patients, have been similar. Each study found that the vast majority of acutely disturbed schizophrenics, who would otherwise have been hospitalized, can be treated effectively and at lower cost in nonhospital settings if sufficient interpersonal support and protection are made available to them and to their caretakers.

What remains to be learned from these studies is a more refined definition of the specific and nonspecific ingredients in each program that result in optimal recovery. However, the uniformity of available results seems to warrant the more widespread implementation of such programs—especially in view of rapidly escalating hospital costs. Yet, with the exception of the community lodges of Fairweather et al. (1969), this has not happened. The barriers to wider use are both conceptual, in that treating severely disturbed persons outside of hospitals is contrary to longstanding practice, and fiscal, in that third-party payers, including Medicaid, as a rule will not reimburse for nonhospital residential care. Thus, in addition to the further research needed, there is also a need for incentives to provide cost-effective alternatives to hospitalization and fiscal mechanisms that will support such alternatives adequately.

Conclusions

Perhaps the most important statement that can be made on the basis of this review of recent research on psychosocial treatments for schizophrenia is that we know more about their effectiveness than is generally acknowledged. Although critical, experimentally oriented researchers might disagree with this conclusion on methodological grounds, we believe the consistency of the data about the effectiveness of psychosocial treatments supports this interpretation. It is noteworthy that the positive findings from controlled studies are most consistent for those treatments that involve extensive attention to the individual patient’s social environment (i.e., nonhospital-based family therapy and various residential milieu therapies, including alternatives to hospitalization).

If these findings are considered in conjunction with the less methodologically rigorous evidence for the positive effects of support systems on outcome, it is tempting to conclude that the most effective types of psychosocial treatments for schizophrenia are those that provide the most comprehensive, corrective, and sustaining social support systems.

References

Altshuler, J.M. One year’s experience with group psychotherapy. Mental Hygiene, 24:190–196, 1940.


Levine, M. Principles of psychiatric...


Ro-Trock, G.K.; Wellisch, D.K.; and Schoolar, J.C. A family therapy outcome study in an inpatient setting.

Sanders, S.H.; Williamson, D.; Akey, R.; and Hollis, P. Advance-
ment to independent living: A model behavioral program for the in-
termediate care of adults with beh-
avioral and emotional problems. Journal of Community Psychology,

Sartorius, N.; Jablensky, A.; and
Shapiro, R. Cross-cultural differ-
ences in the short-term prognosis of schizophre-
nic psychoses. Schizop-

Schilder, P. The analysis of ideolo-
gies as a psychotherapeutic method, especially in group treat-

Shattan, S.P.; Dcamp, L.; Fujii, E.;
Fross, G.G.; and Wolff, R.J. Group treat-
ments of conditionally dis-


Spitzer, R.L.; Endicott, J.; and Rob-


Truax, S.B.; Wargo, D.G.; Carkhuff,
R.R.; Kodman, R.; and Moles, E.A. Changes in self-concepts during group psychotherapy as a function of alternate sessions and vicarious therapy pretraining in institutional mental patients and juvenile delin-


Vaughn, C.E., and Leff, J.P. The influ-

Vitalo, R.L. Teaching improved inter-
personal functioning as a pre-

Wallace, C.J.; Nelson, C.J.; Liber-
man, R.P.; Aitchison, R.A.; Lukoff,
D.; Elder, J.P.; and Ferris, C. A re-
view and critique of social skills train-
ing with schizophrenic patients. Schizophrenia Bulletin, 6(1):42–63,
1980.


Wender, L. Dynamics of group therapy and its application. Journal of Nervous and Mental Disease, 84:54–60, 1936.

Wildcr, J.F.; Levin, G.; and Zwer-
ling, I. A two-year followup evalua-

Wynne, L.C. Family and group treatment of schizophrenia: An interim view. In: Cancro, R.; Fox, N.; and Shapiro, L., eds. Strategic Inter-

The Authors

Loren R. Mosher, M.D., is Chief, and Samuel J. Keith, M.D., is Assistant Chief, Center for Studies of Schizophrenia, Clinical Research Branch, Division of Extramural Research Pro-
grams, National Institute of Mental Health, Rockville, Md.