group therapy for schizophrenia: a practical approach*

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Schizophrenics have been treated in groups since the method was introduced early in the century. Lazell (1921) was the first to report a special therapeutic advantage in group therapy for schizophrenic patients, and over the years, other authors have reported success with the group method, with some claiming that this is the preferable way to treat schizophrenia.

Various advantages for group therapy have been cited. Payn (1965 and 1974), for example, noted that providing socializing experiences for patients tends to diminish anxiety, improve reality testing, increase self-esteem, and reduce necessity for hospitalization. Others have suggested that group-treated patients take neuroleptic drugs more consistently (O'Brien et al. 1972), but this has not been verified in controlled studies with urine or blood level determinations. Striking improvement in social functioning of schizophrenics has been reported by several authors (Masnik et al. 1971, Schultz and Ross 1955, and Donlon, Rada, and Knight 1973), and increased staff enthusiasm also seems to be a consistent finding (Masnik et al. 1971, O'Brien et al. 1972, and Herz et al. 1974).

Enhanced staff efficiency is a logical expectation when the group technique is introduced. If 10 or 12 patients can be seen simultaneously, a therapist can manage a larger caseload or have more contact with the same caseload.

Recently there have been reports of comparisons of the efficacy of group and individual treatments. Actually, the concept of group *versus* individual treatment implies a conflict, whereas in fact the two approaches are complementary, as we will show further on. To demonstrate that group therapy is indeed an effective approach, however, a comparison with standard individual therapy is unavoidable.

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Most of the comparisons have been in outpatient settings where long-term followup is feasible. Medication is continued, but the type of psychotherapy—group or individual—is experimentally manipulated. Shatton et al. (1966) compared outcome in 45 schizophrenic patients randomly assigned to an experimental team using group therapy with outcome of 45 matched controls who received only individual therapy; both groups received neuroleptic medication. After 1 year, the group patients had a significantly lower rehospitalization rate and a higher rate of absolute discharge from the clinic. While one might attribute this finding to the increased attention and clinic contact coincident with being the "experimental group," this does not explain the results of our own study (O'Brien et al. 1972).

In this study of schizophrenic patients recently discharged from a State mental hospital, 100 consecutive patients were rated by an independent research team and then *randomly* assigned to either group or individual treatment. No special groups were formed, and no special attention was given. At 1- and 2-year followups, the group patients had fewer rehospitalizations (12 percent group vs. 24 percent individual at 1 year), but the difference was not statistically significant. On social-function rating scales, however, there was a significant advantage for group patients at both 1- and 2-year assessments. Subsequently Prince, Ackerman, and Barksdale (1973), in a similar study, did find a significant reduction in rehospitalization rates for group-treated chronic schizophrenics. Claghorn et al. (1974), in still another controlled study, noted significant improvement for group patients on an interpersonal test battery, suggesting a "healthier orientation toward relationships with others." The controls for Claghorn's study consisted of patients seen by a psychiatrist for medication checks only. Herz et al. (1974) compared group and individual aftercare for 108 patients, 66 percent of them with a diagnosis of schizophrenia. In this mixed but predominantly schizophrenic population,

the patients assigned to group therapy had a lower rehospitalization rate (16 percent vs. 24 percent), but this difference disappeared when early dropouts were excluded. Herz and his associates did note a dramatic shift in therapists' attitudes in favor of group therapy, and they observed that group patients seemed "more lively and enthusiastic."

In contrast, Levene et al. (1970) found no significant differences in the results of group and individual therapy after 1 year of treatment. The Levene study, although well controlled, suffers from a small initial population (N=31), so that at the 1-year followup only eight group and seven individual patients remained in therapy.

In summary, the reports from personal experiences and the controlled comparisons seem to converge on certain points: therapists and patients, after some resistance, become increasingly enthusiastic about group therapy, and communication and socialization tend to increase. Perhaps these are nonspecific effects of enthusiasm; perhaps they are related to the interpersonal experience of being in a group; or perhaps the group patients simply take neuroleptic medication more consistently. Whatever the reason, group therapy appears to have found a place in the treatment of schizophrenia.

The Place of Group Therapy in a Comprehensive Treatment Program

Inpatient Treatment

In the acute phase of schizophrenia, treatment is usually conducted in a hospital, and neuroleptic medication is generally considered to be the mainstay of treatment. Group therapy has been advocated for inpatient schizophrenics, but this has usually been in long-stay institutions (Schultz and Ross 1955). Now that inpatient care for acute schizophrenics is relatively brief, there is insufficient time for the group process to fully develop. Moreover, some therapists have the impression that acute psychotics may become further fragmented in a therapy group. Prince, Ackerman, and Barksdale (1973) collected data showing that schizophrenics benefit from outpatient but not from inpatient group therapy. This does not mean that acute schizophrenics should not take part in large ward meetings. In the broad sense, a group always exists on an inpatient ward, and the staff should try to give it some structure by holding ward meetings attended by all the patients and staff of a given unit. Practical problems of living on the ward can be the focus of such meetings.

During the inpatient phase, the patient can also be involved in family therapy—a special form of group therapy that is important for diagnosis, disposition, and treatment. These sessions can be used to elucidate the dynamics of the patient's family situation. Excessive dependency is a common problem that can be worked on in family sessions during the inpatient phase. Extricating the patient from his family may be a useful (although often unrealistic) goal, and to this end, discharge to a halfway house or independent living is desirable when possible. During outpatient treatment, the frequency of family sessions depends on whether or not the patient is living with the family and how well he transfers dependency from his family to the group. Periodic outpatient family sessions are almost always helpful.

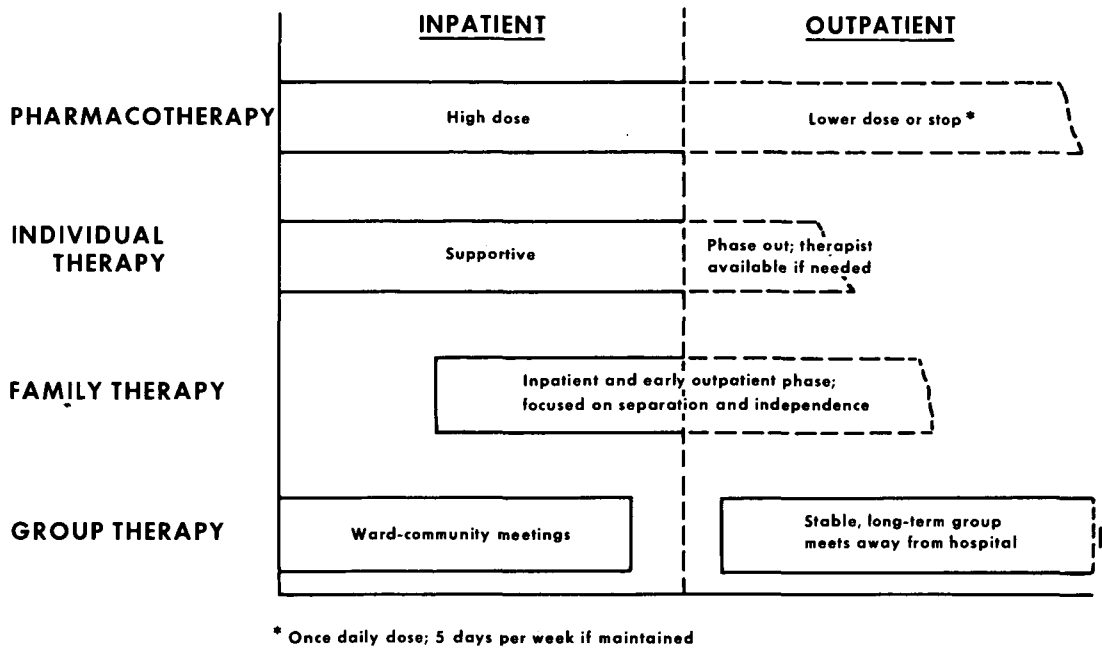
Outpatient Treatment

In the outpatient phase of treatment, group therapy can be the primary modality. Medication should, of course, be continued as long as necessary. Maintenance neuroleptic medication does not interfere with group therapy, and in fact the two treatments may facilitate each other. There are no published studies to support this impression, but patients doing well in a group seem able to be maintained on less medication, possibly because of the effects of group support. Certainly each group session enables the therapist to see the patient express a greater variety of behaviors over a longer period of time than in individual sessions, and he may therefore feel more comfortable about trials of reduced medication or no medication. If group behavior shows beginning symptoms of deterioration, medication can be reinstituted or increased at the therapist's discretion. The risk of long-term neuroleptic side effects such as tardive dyskinesia is, therefore, kept at a minimum. Figure 1 shows diagrammatically how group therapy may fit into an overall therapeutic program for schizophrenia.

Techniques of Group Psychotherapy

Most of the published work on group technique is focused on nonschizophrenic populations. The specific methods described are almost invariably based on the

Figure 1. How group therapy fits into an overall therapeutic program for schizophrenia.



author's clinical experience and not on controlled outcome studies. The studies cited above provide little information on specific group therapy techniques. At this stage it is a difficult enough task to randomly separate therapy into gross categories, i.e., group, individual, and family.

By necessity, therefore, the technical recommendations in this paper derive from my own clinical experiences, from discussions with colleagues, and from reviews of articles published by other authors on group technique. There are differences of opinion as to what "works" with schizophrenics, but little data to support these opinions. For internal consistency, it seems reasonable to present the methods that I know and that my colleagues and I used to a great extent in conducting one of the earliest controlled studies of group techniques (O'Brien et al. 1972). These methods are not held up as an ideal, but they represent practical guidelines for a busy practice or an active aftercare clinic.

Selecting Patients for Groups

Plans for aftercare should begin before the patient's discharge from the hospital. Continuity of care is very important. Since it is usually not possible for a patient to have the same therapist during both inpatient and outpatient care, his hospital therapist should acquaint him with what to expect after discharge. The patient should be given a specific appointment within 2 weeks of his release from the hospital.

In the controlled studies referred to above, patients were assigned to outpatient groups at random. This was simply a method to determine what the results would be in the extreme case: putting unselected patients into group therapy. It resulted in a high initial dropout rate because not all patients are ready for groups at the time of hospital discharge.

Patients who have had no previous group experience and patients who have had a prior upsetting experience,

perhaps with an inpatient group, require a thorough explanation of outpatient groups. This explanation may entail several visits and should be presented by a therapist who is himself fully acquainted with the value of the group approach. If the patient or his family is resistant, the group should not be forced on them. Too often, in a busy clinic with a low staff/patient ratio, the patient and his family gain the impression that group therapy is stressed because there are not enough therapists to go around. The fact that group treatment is a unique experience—one that seems to provide some things that individual therapy does not—is the aspect that should be stressed.

For purposes of this discussion, let us divide ambulatory schizophrenic patients into two categories: withdrawn and activated. Acutely ill patients will not be considered here because they are usually hospitalized.

Withdrawn Patients

This category includes the familiar chronic, poor prognosis, or "process" patients who never fully recover between hospitalizations. Affect remains blunted, and spontaneous speech is limited. Delusions may still be present, but the patient has "learned" not to talk about them so that he can be released from the hospital. This type of patient usually requires maintenance neuroleptic medication.

Activated Patients

Patients in this category speak spontaneously and show affect; they may have had repeated psychotic episodes, but these are likely to have been "reactive" or associated with a precipitating event. Activated patients are less likely than withdrawn patients to require maintenance neuroleptics, but they may do well if neuroleptics are resumed at times of stress. The term activated would also include the borderline, pseudo-neurotic, or latent schizophrenic.

Organizing Schizophrenic Groups

In a community mental health center we can usually organize separate groups for withdrawn and activated schizophrenics, although mixing is occasionally necessary because of scheduling problems. Mixing is more often done in private practice because the population from which groups are drawn is more limited. We have found that one or two withdrawn patients may do well in a group of activated patients, but that one or two activated patients will fit poorly into a predominantly withdrawn group. Similarly, a few activated schizophrenics may do nicely in a group of patients with psychoneurotic or personality disorders. At least one author (Astrup 1961) feels that neurotic patients themselves may benefit in groups composed mainly of schizophrenics.

The distinction between withdrawn and activated patients is made on the basis of ability to function in a group rather than on a diagnosis. As with most psychiatric labeling, it is arbitrary and somewhat artificial. Again, it is done here for the purpose of discussion. A withdrawn patient will often become activated during the course of group therapy. This, of course, is one of the treatment goals. He could then be transferred to another group, but in most instances it is best to leave him with his original group, where he can exert a positive effect on the other patients. On the other hand, putting an already-activated patient into a predominantly withdrawn group can lead to difficulties. The activated patient may become bored or impatient with the slow pace and meager participation of the withdrawn members.

Another issue to be considered in the selection of patients is that of group balance. This is achieved by considering age, sex, race, education, assertiveness, expressiveness, and overt symptoms. A blend of different qualities among the group members is desirable. Good results can be achieved with an age spread of 15 to 20 years; however, adolescents should be considered in a separate category. Balance is easier to achieve in a group of activated patients or in a mixed neurotic-schizophrenic group. A withdrawn group, by its very nature, may be out of balance because most of the patients begin as passive, nonspontaneous people. This makes the therapist's job more difficult, especially when a group is beginning. After a group is doing well, it can absorb a quiet, withdrawn patient more successfully. Symptom considerations are also important. A group can usually deal with one or two paranoid individuals, but including more of them creates a very difficult situation.

The Therapists

A group composed mainly of patients on medication (usually a predominantly withdrawn group) may function

well at the beginning with the subject of medication as the major focus (Payn 1965). In such a group, it is convenient to have a physician as co-therapist. If a psychiatrist or other physician is not a co-therapist, then the patients receiving neuroleptic medication will have to be seen separately by the responsible physician at least once every 3 months.

In groups of activated schizophrenics or mixed groups of neurotics and activated schizophrenics, the focus on medication is much less common and the need for physician involvement is less. An activated schizophrenic group may function much as a neurotic group does. Effective treatment teams for activated groups can come from a variety of disciplines; they can be psychologists, social workers, nurses, students, and other professionals or apprentices.

It is always important that supervision or consultation be available for treatment teams. Subtle aspects of group dynamics may not become apparent until the sessions are discussed with a supervisor or consultant. The supervisor should be an experienced group therapist from any of several disciplines. If a majority of the patients are on medication, it is convenient to have a psychiatrist.

The co-therapy team approach has several advantages. The therapists may interact with one another and thus provide a model of interpersonal relations for the patients. They provide useful support for one another during discouraging phases of the group's development; this is especially true when groups are just getting started. The team approach also provides a valuable opportunity for an inexperienced therapist to work with a more experienced one. But the therapists may, of course, be equals in experience.

A male-female team has the unique advantage of recreating aspects of the parental roles in the group. Patients may exhibit patterns of relating to each therapist that can be interpreted or used as information during therapy.

There are no published studies comparing the effectiveness of single group therapist vs. co-therapy teams, but good results can certainly be obtained by either approach. We generally recommend teams if staffing permits, however, because of the advantages already cited.

The best training for group therapy with schizophrenics is supervised experience with individual schizophrenic patients and a period of apprenticeship as a co-therapist. Of course, the therapist or apprentice should be a mature, stable individual who can tolerate the stress of having to deal with chaotic thinking from all directions. We have found that even relatively inexperienced therapists can get good results with schizophrenic patients in group therapy. What they lack in experience they may make up in enthusiasm and optimism. The period of apprenticeship with an experienced group therapist and the availability of regular supervisory sessions are important, however. We found in evaluating the results of group therapy with predominantly withdrawn schizophrenics that supervised medical students (doing a prolonged elective in psychiatry) obtained results—i.e., improvement on ratings of their patients by independent observers—not significantly different from those of psychiatrists and psychiatric social workers (O'Brien et al. 1972).

An opposite finding regarding experience, however, was observed by Karon (1972). He found that experienced therapists generally used less medication and obtained better results. In Karon's study comparing three different individual treatment approaches, there seemed to be a correlation between therapist experience and use of medication. When inexperienced trainees did not use medication, they obtained better results than their supervisors on some measures. Overall, the supervisors tended to produce more balanced improvement. Thus the relationship between outcome of treatment and the length of therapist experience is unclear.

Practical Issues

Size of Group

Various recommendations have been made regarding group size (Battegay 1965 and Herschelman and Freundlich 1970). We have found that withdrawn schizophrenics do well in groups of 8 to 12 persons. Activated patients seem to tolerate the stress of smaller groups, but this is more difficult for the withdrawn patients. Individual group members feel more pressure to speak up in smaller groups, and thus a withdrawn patient who cannot respond may simply drop out. Giant groups consisting of 20-40 patients and multiple therapists have been described (Herschelman and Freundlich 1970), but these have generally been sessions with ward-meeting formats and with little evidence of group process.

Frequency of Sessions

Group sessions are usually held once a week, but good results with withdrawn patients have been obtained with

sessions as infrequent as once a month. More frequent sessions are desirable but not always possible, due to staffing limitations. The less frequent the sessions, the more likely the sessions are to be focused around drugs and side effects. For withdrawn patients this may be useful (Payn 1965 and 1972 and Isenberg, Mahnke, and Shields 1974) but with activated groups the time is better spent on nonmedication issues.

Length of Sessions

The duration of sessions is usually 60 minutes for withdrawn groups and 60-90 minutes for activated ones. It may be very difficult at first for therapists to spend a full 60 minutes with a withdrawn group. Having a co-therapist helps, and having structured activities, such as coffee making and cake baking, provides the patients with concrete topics of conversation (Masnik et al. 1971).

Open and Closed Groups

It is usually convenient to have groups open ended. New members can be admitted as openings occur. The admitting process can be structured to meet the requirements of both mental health clinics and private practice situations. New patients can be interviewed at the time of referral and a determination made as to whether they are appropriate candidates for group therapy. It is also important to decide whether any of the existing groups have an opening suitable for a particular patient.

Openings may occur because of termination due to graduation or dropout. In either case, the group should have time to deal with its feelings of separation from the former members before the new member is introduced. When a termination is expected in advance, the group should have several sessions to discuss it with the departing member. The process of termination and of accepting new members is a vital one. It often evokes feelings from individuals previously thought to be "flat."

An alternative system would be closed groups in which members start and terminate together. This enables the patients to experience termination simultaneously and to share their feelings. A problem in using this system for schizophrenics is the chronicity of the illness. It is likely that at least some of the group members will need continuing care after the group's termination. Even if the group disbands, therefore, some of the patients tend to remain attached to the therapist or clinic.

Therapeutic Goals and Stages

The specific techniques employed in group therapy with schizophrenics depend in large measure on the background of the therapist, the setting, and the level of functioning of the group at that moment. Many of the techniques are identical to those employed in neurotic groups. Group process develops in stages (Fidler 1965 and Forer 1961), but there seems to be no generally agreed upon sequence of group development. The common elements in the various schemes proposed seem to be: the development of communication; the development of trust; behavior changes within the group; and finally, changes in the members' behavior outside the group.

Promoting Interaction

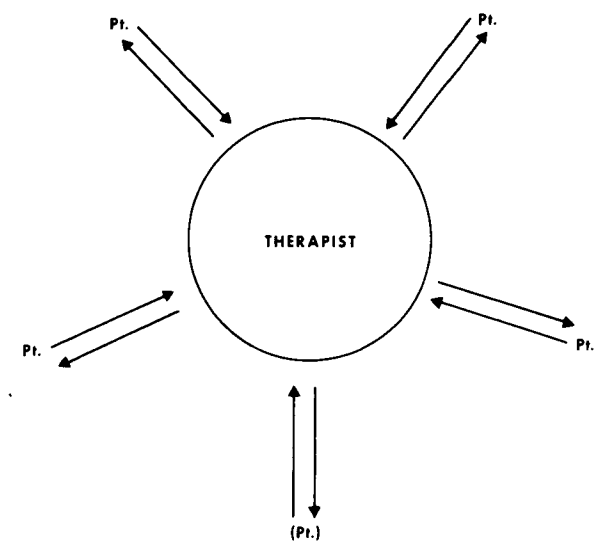
In general, the job of the therapist is to promote interaction among patients, who look to him for wisdom, guidance, and medication. The communication diagram for a new schizophrenic group is shown in figure 2. One of the objectives of the therapist is to transform the situation to something similar to that shown in figure 3, in which the patients are less oriented toward the therapist; they freely interact with one another and do not wait for permission from the therapist to speak.

Nonverbal interaction. Although various techniques may be used to encourage interaction, sensitivity techniques featuring touching and confrontation are generally not recommended; they may be too frightening for the average schizophrenic outpatient.

Bowers, Banquer, and Bloomfield (1974), however, have described the use of some nonverbal exercises that are not excessively provocative when used in a group whose members have begun to develop some trust in the therapist and in each other. Exercises that are focused on a here-and-now situation are selected. They are frequently designed to help a group member who is having difficulty in becoming aware of his feelings even though they seem apparent to other members and therapists.

An example of nonverbal techniques for promoting interaction would be the rearrangement of chairs so that

Figure 2. Communication diagram for a new schizophrenic group.[1]



[1]Patient (Pt.)

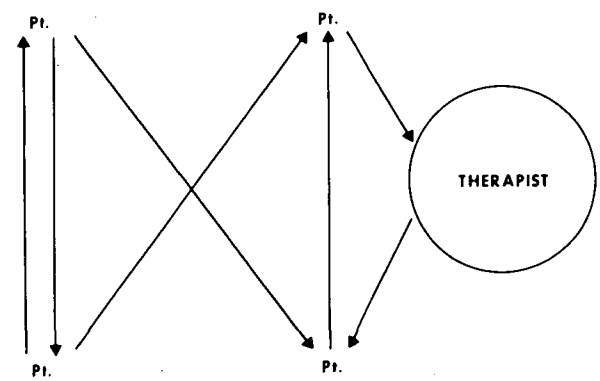
the members do not sit in the same pattern each week; a break in the pattern often causes a shift in communication and helps to get the group out of a rut. When two members are angry with one another but are not expressing their hostility, the following exercise may be employed (Bowers, Banquer, and Bloomfield 1974): the two members are instructed to face each other and clasp both hands palm to palm. At a signal from the therapist, both begin pushing. This often facilitates the verbal expression of anger in individuals who have had great trouble in even becoming aware of emotion.

Food is often an excellent means of stimulating interaction among withdrawn patients. Masnik et al. (1971) have described a technique called "Coffee and . . . " that uses coffee and cookies to promote conversation. The clinic may supply the coffee, but the patients should be encouraged to bring in their own cakes and cookies. Something very similar was independently described by Parras (1974). The "Coffee and . . . " technique can be enlarged upon to provide an experience of sharing and pride. One of our groups composed of very withdrawn members who could not interact verbally was prompted to begin sharing a communal meal at the clinic. Each member was given responsibility for a different part of the meal: punch, fried chicken, salad, bread, dessert, coffee. At first the therapist had to organize the patients, but later they did this themselves. They rotated the responsibilities, took pride in their own contribution of food, and began to show feeling for one another. Eventually they were able to contribute verbally and discuss problems instead of just food.

One can speculate theoretically about the need to gratify exaggerated oral-dependent strivings in regressed schizophrenics. But from a practical point of view, our concern is with a healthy social experience. When people interact in a group, whether verbally or through the sharing of food, they find the process easier the next time. One social interaction leads to another in a progressive fashion.

Medication can be another important focus for withdrawn patients. If one of the therapists is a physician, prescription writing may be an important part of a withdrawn group session (Payn 1974). The medication ritual, including the discussion of side effects, may

Figure 3. Communication diagram for an intermediate schizophrenic group.[1]



[1]Patient (Pt.)

actually facilitate group interaction. Medication is something the patients share in common. It is a concrete, here-and-now subject. In turn, the group process may facilitate the taking of medication by exerting pressure on a reluctant member to take his medicine regularly. Occasionally several patients at once will rebel against medication. Usually however, in a group of chronic withdrawn patients one of the members will point out what happened when he abruptly stopped medication in the past; the patients seem to develop a feeling of responsibility for one another. In most instances, the reluctant patient will be convinced that he should continue with the treatment.

In groups that have been functioning for 6 months or more, there may be patients who have had their medication decreased or stopped because of clinical improvement. This may cause a problem because of competition among group members who think they, too, should be able to discontinue medication. Such issues should be dealt with openly in the group. The therapist may be tempted to give an intellectual explanation about such things as different rates of progress, but this approach would avert the opportunity to deal with the member's *feelings* about having to remain on daily medication. Discussion of feelings in this area is of dual importance. It provides the experience of appropriate emotional expression, something badly needed by schizophrenics, and by providing a forum for ventilation it also lessens the likelihood that the patient will abruptly discontinue his medication.

It should be emphasized that groups are not designed simply as a convenient mechanism to keep patients medicated. Actually, it is our impression that group therapy permits a lower dose of medication and perhaps a shorter period of treatment. This is a readily testable observation, and should be the object of further research.

Medication is not often the main focus of activated schizophrenic groups, because fewer activated patients require maintenance medication and because they are not restricted to such concrete items of discussion. Activated patients are capable of expressing emotion and gaining "insight." Still, the therapist should not, as a rule, deliberately provoke anxiety. A therapist who is totally nondirective or almost completely silent during a session may create unnecessary tension and may lose the opportunity to actively direct the group in important areas. The manner of ending a session is also important. In a strict analytic group, the therapist may wish to stop at precisely the contracted minute. In a schizophrenic or mixed neurotic-schizophrenic group, however, he should be aware of the momentum of the session and not cut the members off abruptly. Going a few minutes overtime may be a good idea if it permits an important interaction to develop.

Verbal interaction. The importance of patient-to-patient interaction cannot be overemphasized; it is the immediate objective of group treatment. While nonverbal techniques, as described above, have their place, most of the therapist's efforts center upon verbal methods.

The *"go around"* is a simple but time-tested method to get people to talk. The therapist asks each member to give his opinion on a particular subject. The subject may be something that has just occurred in the session or it may relate to something in the members' personal lives. Schizophrenic patients and even some nonschizophrenics feel excessive pressure when their turn comes around. When a group is just beginning or when a new member enters an established group, the therapist must be aware of this pressure and try steering the "go arounds" to noncontroversial matters. The easiest subjects are the most concrete: "How does this brand of coffee compare with the one we had last week?" More difficult are issues dealing with emotional or abstract matters: "How would you feel if you had just been disappointed the way John was?"

Often the *go around* stimulates interaction among group members, who comment on each other's comments. Withdrawn patients, however, may refuse to respond at all or may simply say, "I don't know." Pressuring a withdrawn patient to commit himself usually fails. The therapist should move on to the next member without calling undue attention to the fact that the previous patient failed to contribute anything.

Not all therapists would approach withdrawn patients as actively as I am suggesting here. Ward (1974), for example, tells of letting a group sit in total silence for 50 minutes in order for the members to feel responsibility to be active on their own. Although this was described as a successful technique, most therapists would probably consider it extreme. On the other hand when the therapist is too active, the responsibility to interact may be taken from the group members. All this touches on one of the differences of opinion alluded to previously in this paper. Actual outcome studies comparing very active therapists with very passive ones are not available. Presumably extremes in either direction are counterproductive.

Another technique to stimulate expression in schizophrenic groups is to organize a simplified form of psychodrama, a *structured dialogue*. This method has been successfully used at the Bechterev Institute in Leningrad by Dr. V. M. Volovik (personal communication, 1974). The patients are first given a story in the form of a dialogue that they act out under the direction of the co-therapists. Later they are given themes and asked to make up their own dialogue. The structured dialogue takes up only the first 15 minutes or so of the session. The group can then discuss the dialogue and the feelings expressed by the "actors." Once warmed up, the group finds it easier to start discussing problems.

Role playing is another technique that can be borrowed from psychodrama. A patient may be asked to rehearse a difficult task such as a job interview during a group session. Another member will play the role of interviewer. The interview may be repeated with a third member playing the role of applicant, so the first patient can see how someone else might handle the situation. Similarly, other members can be asked to play the role of parents, siblings, spouse, or landlord—to name a few—and to aid in working out other problems. Role reversal, in which group members play one another, is usually difficult in predominantly withdrawn groups. It may be possible, however, if the therapist is sufficiently enthusiastic. This technique may help greatly in working out angry conflicts within the group by enabling patients to see things from each other's points of view.

The above techniques require no special equipment or meeting room. Rearranging chairs may be helpful, not only during role playing but at any time the group seems to be stuck in a set pattern. If special equipment such as a tape recorder or a videotape system is available, it can be quite useful in loosening up withdrawn members in a gentle way. Playing back segments of a meeting is a great stimulus for expression.

Group activities. Usually a predominantly activated schizophrenic group or a mixed group will acquire some group cohesion within three to five sessions and begin sharing feelings and dealing effectively with problems. In contrast, a withdrawn group may require much more of the therapist's efforts at promoting interaction. The use of a communal meal has been mentioned. Sometimes the group can be formed as part of a day hospital program, with interaction initially centering around games, workshops, parties, etc. Activities such as writing a card to a sick member or a constructive letter to the editor of a newspaper may help develop a sense of working together. Members may offer each other rides to group meetings and exchange telephone numbers for the purposes of supportive phone calls. True, there are potential problems with such out-of-group contact, but these can be dealt with if members do not keep secrets from the rest of the group. Therapists also must be on guard against the development of subgroups within the main group.

Promoting and Maintaining Behavioral Changes

In a sense, much of what has already been presented in this paper constitutes "behavior therapy." It has been predicated on the behaviorist notion that the experience of interaction can be reinforced in a protected group setting and that this will generalize to the "outside world," facilitating social functioning.

Formal behavior therapy utilizing token economies and food reinforcement has been shown to be useful for hospitalized patients (Ayllon 1963). Little has been written about the use of behavioral methods for outpatient schizophrenics, however.

Role-playing techniques can be a form of behavioral training. Bloomfield (1974), for example, has described their use in assertive training for schizophrenic outpatients. He notes that such patients, who tend to be excessively compliant, submissive, and socially inhibited, can be taught socially appropriate assertiveness in a group setting with the consequent release of pent-up hostility. Bloomfield finds chronic schizophrenic patients fully capable of behavior rehearsal, role playing, and role reversal with no negative effects. His experience coincides with our own in this regard.

Other behavior therapy principles may be used in group therapy. The therapist should always keep in mind the power of reinforcement and make a conscious effort to reward desirable behavior. Any show of emotion from a previously "flat" patient should be given much positive attention. When a patient begins to interact with other members for the first time, the therapist should always give reinforcement. This need not be a direct comment to the patient praising him for the interaction. Rather, it can ostensibly be directed to another patient: "Ellen, John's comment to you really makes sense; have you ever looked at it that way before?" Such a response makes it more likely that John will repeat the behavior soon.

Reward is only one of the therapist's techniques for

altering behavior. He can selectively ignore behavior that is regressive—e.g., inappropriate laughter, grossly loose associations, or obvious hallucinations. When the patient makes an appropriate comment, it should be promptly reinforced.

An exception to the nonreinforcement of inappropriate behavior would be the case of a patient who has been a rational member of the group for a number of sessions and whose behavior is suddenly and severely out of context. The therapist should try to determine the factors that might be responsible for the regression. Are there stresses at home, on the job, in the group? Or is it a need for resumption or increase of medication?

Psychotic Deterioration

As everyone knows, the relapse rate for outpatient schizophrenics is quite high. Even with the best of aftercare, some patients will have repeated psychotic episodes. If the deterioration is a gradual process, it can be dealt with by group support, supplementary individual sessions, and increased medication. Sometimes a member who is doing poorly will simply drop out and turn up later in the hospital. If a member misses a few sessions and then comes to a group meeting in a grossly psychotic state, it requires real effort on the part of the therapist to deal with the situation.

Psychotic behavior is a threat to the other members because of the frightening recollections it raises in them. It is also quite threatening to therapists, who worry that their entire group may suddenly become uncontrollably psychotic. Relax! It doesn't happen. It upsets the group, of course, and it may have to be discussed for several sessions thereafter. A therapist may feel guilty because of his own sense of failure in the treatment. The group members may share this guilty feeling at having failed to help the individual. If the therapist first recognizes his own feelings in the situation, he will be more successful in reassuring the disturbed patients.

Theoretical Considerations

This paper, as the title indicates, is designed to deal with practical rather than theoretical matters. The underlying concepts are that neuroleptic medication is effective in ameliorating the symptoms of schizophrenia and that the quality of the treatment can be improved, at least in some patients, by psychosocial intervention (Hogarty et al. 1974 and O'Brien et al. 1972). If group psychotherapy does nothing more than permit a greater proportion of schizophrenic patients to remain drug-free or on a low dosage, this achievement is worthwhile. The hypothesis of a group-neuroleptic drug synergism, however, is as yet unsupported by evidence from controlled studies.

Several theoretical reports have dealt with the psychodynamic theory of schizophrenic groups. The reader is referred to Wolman (1960), Slavson (1961), and Alikakos (1965) for a discussion of multiple transference, in which the group members spread the transference, so to speak, among therapists and the other members of the group. Slavson further emphasizes the importance of confrontation rather than exploration. One need not try to uncover unconscious drives in treating schizophrenics. The therapy should be oriented to the present reality. When we give schizophrenic patients a healthy group social experience, we are fulfilling this goal.

Therapists with different backgrounds in psychodynamic theory may interpret group behavior in different ways. Thus some of them emphasize the manifestations of ego weakness, some stress the transactions, and some are strict behaviorists. Good results have been obtained by therapists using vastly different theoretical rationales and even by therapists with little theoretical training beyond their supervised experience. In using group therapy with schizophrenics, one should remember that the *process* of interaction is more important than the *content*, however rich the content may seem in material for analysis.

Summary

Salient points presented in this article are that:

- Several recent controlled studies suggest that group therapy may have therapeutic advantages for outpatient schizophrenics.
- Group patients show improved social functioning, and they are more pleasant for therapists to work with.
- Groups have not been shown to be effective for acute psychotics, and there is some evidence that they may have a negative effect on newly admitted inpatients.
- Long-term outpatient group therapy is acceptable to most schizophrenic patients. It should be introduced to

the patient by a therapist experienced in the field so that the advantages can be presented.

- Groups should be balanced according to function rather than diagnosis. Activated schizophrenic patients may do well in predominantly nonschizophrenic groups.
- In treating withdrawn patients, the therapist's immediate task is to promote social interaction among the group members. Various techniques are mentioned that aid in this process.
- Group therapy blends well in an overall rehabilitation program with pharmacotherapy, individual psychotherapy, family therapy, and a day hospital program.
- Both community mental health clinics and private practice settings are appropriate for this type of group therapy.

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