Abstract

Some form of individual psychotherapy, in combination with the prescription of antipsychotic medications, is likely the most common treatment for patients with schizophrenia. In the absence of empirical data supporting the efficacy of a particular approach, psychotherapy has often been guided by ideology and deference to authority. In recent years, a reformulation of schizophrenia as a disorder requiring individualized, comprehensive treatment has allowed the development and empirical testing of new targeted and illness-phase-specific individual psychotherapies. This report reviews randomized clinical trials that have evaluated individual psychotherapy of schizophrenia in the context of changing contemporaneous beliefs about the disorder’s etiology and treatment. A general approach to individual treatment, termed “flexible psychotherapy,” derived from historical approaches but consistent with available clinical and research perspectives, is outlined.

Keywords: Schizophrenia, psychotherapy, randomized clinical trials, psychosocial treatment, evidence-based medicine, treatment outcome.


With virtually no data to support its efficacy, individual psychotherapy has been the cornerstone of treatment for schizophrenia for decades. Even in today’s era of evidence-based medicine, some form of individual psychotherapy in combination with antipsychotic medications is likely the most common treatment offered to patients with schizophrenia (Dixon et al. 1999). Furthermore, surveys of patients and their families consistently rank individual psychotherapy among the most highly valued services provided by mental health practitioners (Coursey et al. 1991, 1995; Hatfield et al. 1996; Perreault et al. 1996).

What is psychotherapy? Who is qualified to provide it? How does psychotherapy differ from case management? From adequate clinical care? What is the difference between psychotherapy and the monitoring necessary for good pharmacotherapy? Who needs psychotherapy? For what problems, and when?

In their 1995 evidence-based review of treatment efficacy, the Schizophrenia Patient Outcomes Research Team (PORT) defined individual psychotherapy structurally, as interventions with one-to-one contact between a patient and a therapist (Scott and Dixon 1995). Assuming patients were receiving adequate clinical care, individual psychological interventions were found to lack an adequate base of demonstrated efficacy (Lehman et al. 1995). With ample conflicting opinions but no real data, the practicing clinician was left to define exactly what was “adequate clinical care” on a case-by-case basis.

Hundreds of studies have evaluated pharmacological agents in schizophrenia, but very few controlled clinical trials of individual psychotherapy have been conducted. Often initiated in the context of factionalism between psychologically and biologically oriented psychiatry, these trials have generally been of greater value in dislodging passionately held beliefs about the effectiveness of specific types of individual psychotherapy than in pinpointing to what does work.

Over the past 5 years, however, researchers in the United States and United Kingdom have made significant steps in alleviating some of the intractable problems of defining and studying individual psychotherapy for schizophrenia. This progress had to await a shift away from ideological disputes about what was the best treatment for schizophrenia to a consensus that no single treatment can ameliorate the myriad symptoms and disabilities associated with the disorder. As articulated in the American

Reprint requests should be sent to Dr. W.S. Fenton, National Institute of Mental Health, Neuroscience Center, 6001 Executive Blvd., Room 6216, MSC 9621, Bethesda, MD 20892-9621.
Psychiatric Association’s “Practice Guidelines for the Treatment of Patients with Schizophrenia” (1997), therapeutic efforts must be comprehensive, multimodal, and empirically titrated to the individual patient’s response and progress. In a context that presupposes the need for comprehensive treatment, recent trials of one-to-one interventions have begun to generate rigorous empirical support for disorder-specific, targeted individual psychotherapeutic approaches that can help inform clinical practice.

The purpose of this article is (1) to provide an overview of major historical trends in the psychotherapy of schizophrenia and (2) to review randomized clinical trials that have evaluated individual psychotherapy for schizophrenia. Studies are described and evaluated in the context of changing contemporaneous beliefs about the disorder’s etiology and treatment. While data generated to date do not unambiguously endorse any single approach to psychotherapy for schizophrenia, a general strategy, termed flexible psychotherapy, derived from historical approaches but consistent with available clinical and research perspectives, is outlined.

Methods

The clinical and theoretical literature on the psychotherapy of schizophrenia is vast. Because clinical trials of individual psychotherapy for schizophrenia are best understood in historical context, a brief overview of the traditions of investigative and supportive psychotherapy is provided. Individual psychotherapy is defined as a one-to-one psychosocial intervention, delivered alone or in combination with other treatments, designed to improve symptoms, functioning, and quality of life or to forestall or prevent relapse. Primary randomized clinical trials (RCTs) of individual psychotherapy predating 1990 were selected based on their inclusion in one or more reviews assessed by the Schizophrenia PORT (Mosher and Keith 1980; Heinrichs and Carpenter 1981; Gomez-Schwartz 1984; Mueser and Berenbaum 1990). More recent RCTs that evaluate individual psychotherapy were identified from the English language psychiatric and psychological literature with the aid of computer searches, using keywords such as individual psychotherapy, psychological treatment, and schizophrenia. Studies comparing models of case management, social skills training, and cognitive retraining methods, and studies designed primarily to evaluate other psychosocial treatments (e.g., group therapy) that use individual psychotherapy as a treatment as usual comparison were not included for review. Methodological aspects of psychotherapy research have been extensively considered by others (Heinrichs and Carpenter 1981; Aveline and Shapiro 1995). This review aims to emphasize the clinical implications of available data and to describe the evolution and current status of this treatment modality.

Background

Investigative and Supportive Psychotherapy. In the early decades of the 20th century schizophrenia was viewed as untreatable. “Organic” psychiatry as represented by Emil Kraepelin saw schizophrenic personality disintegration as an inevitable product of neurological deterioration. Following Freud, most psychoanalysts considered dementia praecox to be a “narcissistic neurosis,” where transference and analytic treatment were impossible. The diagnosis of dementia praecox most often led to therapeutic nihilism and recommendation of lifelong institutional care (Rothman 1971).

Despite the misgivings of Freud, early psychoanalysts such as Brill advocated an active effort to promote “rapport” and arouse the patient’s interest in his or her own malady. In time, Brill observed, confidence in and a “passive attachment” to the physician could develop so that the doctor could become a bridge between the patient and reality (Brill 1929).

Between 1922 and 1930, Harry Stack Sullivan organized a small treatment unit for male patients with schizophrenia at Sheppard and Enoch Pratt Hospital in Towson, Maryland. Sullivan staffed his unit with introverted male attendants and, stressing that patients’ difficulties were similar to those of so-called normals, promoted development of benevolent intimacy in this milieu. He observed that providing an experience of reciprocal trust—which he hypothesized many patients missed during important periods of development—could be beneficial, by allowing a “validation of all components of personal worth” (Sullivan 1931, 1970; Perry 1982).

Observing the difficulties patients had in maintaining relationships led Sullivan to formulate the paradigm of “interpersonal psychiatry.” Psychopathology was viewed as difficulties in living arising largely from personal and social relations, and as personality warps thought to be the lasting residue of earlier unsatisfactory interpersonal experiences. Sullivan elaborated these ideas in a series of seminars at Chestnut Lodge Hospital, in Rockville, Maryland, where a group of psychoanalysts and social scientists interested in the intensive study of schizophrenia assembled during the 1940s (Rioch et al. 1984). Here, it was observed that covert staff tension and disagreements often appeared to be associated with worsening of patients’ psychotic symptoms; likewise, improvement followed when those tensions were resolved (Stanton and Schwartz 1954). These observations suggested that the ill-
ness itself might be caused and cured by psychosocial means. Frieda Fromm-Reichmann's *Principles of Intensive Psychotherapy* (1950) was the first systematic elaboration of what became known as intensive psychodynamic psychotherapy. The predecessors of ego and self psychology (Greenberg and Mitchell 1983), "interpersonal psychiatry" and "psychodynamic psychotherapy," became dominant paradigms in American psychiatry in the 1940s, 1950s, and 1960s (Klerman 1984).

**Investigative Psychotherapy: Theory and Practice.** The goal of intensive, or investigative, psychotherapy is alleviation of the patient’s emotional difficulties and elimination of symptoms. This is accomplished by undertaking a thorough scrutiny of the patient’s life history, reviewing in close detail the realities of the patient’s current relationships and life situation and understanding the historical roots and current ramifications of maladaptive interpersonal patterns as reflected in the doctor-patient relationship and in daily life. This process is expected to result in modification of maladaptive interpersonal patterns and personality growth.

The literature on intensive psychotherapy emphasizes the influence of the environment in the etiology of schizophrenia. Characteristic difficulties among patients with schizophrenia are said to include (1) a basic mistrust and expectation of harm from others; (2) a marked ambivalence in relationships, with oscillations between longing for merger based on intolerance of loneliness and withdrawal and isolation based on terror of closeness; and (3) weak or absent ego boundaries with resulting difficulty differentiating one’s own thoughts and impulses from those of others (McGlashan 1983). The central conflict of schizophrenia patients was described as “that of a small child dependent on a person by whom he feels persecuted and who is, in his opinion, unstable and uncertain” (Hill 1955). This position was thought to represent the patient’s conviction concerning the nature of human relationships.

“Process” refers to expected developments in the doctor-patient relationship as it evolves over time. “Transference” is the manner in which the perception of others in the present is shaded or distorted by important past relationships. It is thought of as a natural, but often unconscious, aspect of all human relationships. Examining transference in the doctor-patient relationship is a major task in investigative (as opposed to supportive) psychotherapy—this examination is expected to be useful in allowing the patient to better understand his or her current difficulties and respond more realistically to people in his or her current life.

“Countertransference” refers to all of the therapist’s thoughts and feelings about the patient. Some of these are distortions arising from the therapist’s past, but others derive from current interaction with the patient. Feelings that arise in work with schizophrenia patients can be particularly intense and may include discouragement, fear, worthlessness, guilt, rage, envy, or lust. In view of this, awareness of countertransference and the ability through introspection to understand its sources are crucial functions for the psychotherapist. In the tradition of investigative psychotherapy, countertransference also serves as a source of information about the patient’s state of mind, and as an indicator for understanding how others typically react and respond to the patient (Searles 1965, 1979). Successful management of countertransference allows the therapist to create a “holding” or “containing” relationship with the patient that is postulated to be central to the action of psychotherapy (Pao 1979; Levine and Wilson 1985).

The literature on intensive psychotherapy describes interventions that correspond to different phases of therapy: (1) establishing a relationship with the patient, (2) elucidating the patient’s experience, (3) tolerating mobilized transference and countertransference, (4) integrating the patient’s experiences into an expanded perspective of the self, and (5) working through. The accomplishment of earlier tasks allows greater attention to be paid to subsequent ones (McGlashan 1983; McGlashan and Keats 1989).

Establishing a relationship with a schizophrenia patient can be challenging. Therapist attributes seen as important are an interest in and capacity to tolerate intense affect, dependency, and ambiguous communication. Basic respect for the patient is a prerequisite. Aloofness, rigidity, and critical pomposity are especially discouraged. The psychotherapist should be flexible, creative, and willing to admit when he or she is wrong. Frequency of visits can range from one to five per week, and free association is discouraged as aggravating disorganization and thought disorder. Within bounds, a reasonable degree of self-disclosure on the therapist’s part can help counter distortions by allowing the patient to gain a fix on the therapist as a person. A relationship should be sought on the patient’s terms. If the initial encounters are traversed successfully, a background feeling of security and predictability will increasingly characterize the therapy.

Semrad viewed the three core tasks of psychotherapy as helping the patient acknowledge, bear, and put into perspective his feelings and painful life experiences (Rako and Mazer 1980). Acknowledging the patient’s feelings and painful experiences becomes pertinent once a relationship has been established. Acknowledging requires elucidating affects, employing strategies such as listening, narrowing the focus, seeking concrete detail, acknowledging feelings (especially loss, anger, and sadness), and naming or labeling affects. The therapist conveys to the patient that experiencing emotions will neither overwhelm the patient nor hurt others. Psychotic
model implies essential elements of expected behavior for the patient is seen as suffering from an organically based and technically it is grounded in the medical model where medically and pharmacologically oriented clinicians. In theory his or her functions and eventually becomes capable of the patient becomes better able to help the therapist perform functions independently.

Supportive Psychotherapy: Theory and Practice. Supportive psychotherapy has been favored by biologically and pharmacologically oriented clinicians. In theory and technique it is grounded in the medical model where the patient is seen as suffering from an organically based illness requiring treatment from a physician.

As described by Talcot Parsons (1951), the medical model implies essential elements of expected behavior for both the physician and patient. These elements define the physician’s and patient’s roles, relationship, and responsibilities.

The physician’s role is characterized by four key qualities: (1) universalistic, (2) functionally specific, (3) affectively neutral, and (4) collectivity oriented. The universalistic norm requires the physician to treat all patients alike according to scientific and medical standards. The role is functionally specific in that the physician is seen as a specialist in health and disease and is expected to limit attention to circumscribed medical matters. Affective neutrality prevents the doctor from entering too sympathetically into the patient’s situation; this allows for steadfastness of judgment and the exercise of emotional control. Finally, collectivity orientation, as opposed to self-orientation, demands that the doctor treat the patient according to the patient’s needs and the health standards of the community.

The role of the patient, like the role of the physician, is defined by expected behavior that involves both rights and obligations. First, the person who is ill is exempt from normal social responsibilities and excused from customary obligations so he or she may attend to the process of getting well. A second right is exemption from responsibility for illness—the illness is not considered the patient’s fault, and the patient has the right to receive care. At the same time, the patient has the obligation to want to get well, to obtain technically competent help, and to cooperate with treatment.

In contrast to the ambitious aim of personality change associated with the intensive therapy tradition, the short- and long-term goals of supportive psychotherapy are comparatively modest. They include the following: (1) relief from the immediate crisis or direct reduction of acute disequilibrium, (2) removal of symptoms to premorbid levels, (3) reestablishment of psychic homeostasis through a strengthening of defenses, (4) sealing over psychotic experiences and conflicts, (5) the circumscribed fostering of adaptation, and (6) mobilization and preservation of healthy aspects of the patient to enable optimal functioning and minimize the impact of persistent deficits (Mclachlan 1982; Gilbert and Ugelstad 1994). Supportive therapy uses the physician-patient relationship to create a background of adequate clinical care to support the prescription of effective pharmacological interventions. Functional or social recovery, rather than personality change, is the primary aim of treatment.

The overall technical approach of supportive psychotherapy is one of pragmatism in which the physician, based on medical and psychiatric expertise, helps the patient interpret and adapt to reality (Winston et al. 1986). As such, the therapist employs techniques that include defining reality, offering direct reassurance, giving advice on current problems of living, urging modification of expectations, and actively organizing the environment for
patients who cannot do so themselves (Zahniser et al. 1991). To help stabilize the patient’s environment, the therapist often maintains close contact with the patient’s family or others providing treatment and may intervene on the patient’s behalf with family, employers, and social agencies.

Eliciting and tracking symptomatology and targeting symptoms for psychopharmacological intervention is a major focus for the supportive psychotherapist. Psychopathology is interpreted in a medical context as the unwanted emergence of signs of illness. The basic content of psychotherapy focuses on teaching and relearning—the patient is educated regarding the nature of the illness, taught to monitor symptoms, and act promptly to suppress his or her exacerbation. The therapist fosters positive transference as a benign authority; positive feelings are regarded as real. Negative transference is avoided. The therapist may become active in helping the patient learn new ways of adapting and may use or prescribe cognitive, behavioral, or social skill training techniques.

Empirical Studies

Efficacy of Individual Psychotherapy: Trials in the Drugs Versus Psychotherapy Paradigm (1960–1975). Following the introduction of phenothiazines, psychiatry became increasingly divided into adherents of the “psychodynamic” or “biological” approaches. Disagreement concerning the value of intensive psychotherapy and medications was a focal point of acrimonious ideological and scientific debates. Randomized clinical trial methodology demonstrated the value of pharmacological interventions in schizophrenia and was recognized as the optimal standard for evaluating all treatments (Klerman 1984). In this context, six controlled trials conducted during the 1960s and 1970s attempted to assess the efficacy of various forms of individual psychotherapy compared with treatment programs not specifically featuring psychotherapy (May and Tuma 1964; Rogers et al. 1967; Grinspoon et al. 1968; Messier 1969; Karon and Vandenbos 1972, 1982; Hogarty et al. 1973, 1974a, 1974b; May et al. 1976a, 1976b, 1981). Reflecting the then-salient drugs versus psychotherapy debate, most include a no-medication cell.

As indicated in table 1, each study conducted during this period had unique methodological strengths and weaknesses. The Karon and Vandenbos (1972) and Grinspoon et al. (1968) studies of psychoanalytic treatment are particularly difficult to interpret because psychotherapy was provided in special research units while nonpsychotherapy comparison group patients were transferred to or treated in different wards of State hospitals (May and Tuma 1972). Although all studies were criticized by proponents of investigative psychotherapy on a number of methodological grounds (Dyrud and Holzman 1973; Feinsilver and Gunderson 1975; Wexler 1975), together the results of these trials suggested the following conclusions:

1. No study provided evidence to support the efficacy of any type of individual psychotherapy as a sole treatment for schizophrenia: When pharmacological treatment was controlled, medication-treated groups always demonstrated superior outcome, whether or not psychotherapy was offered to non-medication-treated comparison groups.

2. Studies of psychoanalytic psychotherapy that included a followup component (May and Tuma 1964; Grinspoon et al. 1968; Karon and Vandenbos 1972) indicated no clear advantage for psychoanalytic therapy plus drugs versus drugs alone, with the possible exception of the one finding of a better outcome among patients of two very experienced therapists (Karon and Vandenbos 1982).

3. Two methodologically sophisticated and carefully conducted investigations suggested an additive effect on both relapse and functioning for a pragmatic problem-oriented therapy termed Major Role Therapy (Hogarty et al. 1973, 1974a, 1974b, 1979). This was described as an individual problem-solving method focused on the resolution of personal or environmental problems or both that directly affected the patient’s functioning (Hogarty et al. 1974b).

These conclusions were further supported by the results of long-term followup studies of patients treated with intensive psychodynamic psychotherapy at Chestnut Lodge and the Columbia New York State Psychiatric Institute. The majority of patients in both followup cohorts remained seriously disabled by chronic schizophrenia (McGlashan 1984, 1988), and both groups experienced significant rates of death from suicide (Fenton et al. 1997; Stone 1986).
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>228 first-admission inpatients, mid-range prognosis</td>
<td>32 inpatients</td>
<td>20 inpatients with chronic schizophrenia</td>
<td>32 patients, two-thirds first admission</td>
<td>374 discharged patients</td>
<td>105 discharged patients</td>
</tr>
<tr>
<td>Design</td>
<td>Random assignment, assessed after treatment and naturalistic followup</td>
<td>Random, stratified by duration of hospitalization and sex, with 1-yr followup</td>
<td>Selected patients compared with controls (n = 20) in different hospital</td>
<td>Random, but usual treatment group in different facility, with 2-yr followup</td>
<td>Random, stratified</td>
<td>Random</td>
</tr>
<tr>
<td>Therapists</td>
<td>Residents with 6 mos–6 yrs’ experience, supervised one-half hr per wk</td>
<td>1 to 25 yrs’ experience, not supervised</td>
<td>Senior analysts</td>
<td>2 experienced analysts and 10 trainees</td>
<td>Social workers</td>
<td>Social workers with more than 0 yrs’ experience</td>
</tr>
<tr>
<td>Therapy duration / Intensity</td>
<td>2 hrs/wk for 1 yr (mean of 46 sessions)</td>
<td>2 hrs/wk for 2 to 30 mos</td>
<td>2 times/wk 2 yrs controlled 3-yr followup</td>
<td>1. 5 times/wk until discharge 2. 3 times/wk until discharge After discharge, 1 time/wk for 20 mos</td>
<td>At least monthly, varied by need 2-yr duration</td>
<td>Varied by need 2-yr duration</td>
</tr>
<tr>
<td>Medications</td>
<td>Outcome domains</td>
<td>Results</td>
<td>Methodological strengths</td>
<td>Methodological weaknesses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-----------------</td>
<td>------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Stelazine 10–120 mg</td>
<td>BEH, PSY, SX</td>
<td>End of treatment: drugs alone or drugs + ECT &gt; therapy alone &gt; milieu</td>
<td>Focus on patient’s perception of helpfulness</td>
<td>Inexperienced therapists; Treatment uncontrolled during followup Results limited to inpatient psychotherapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Stelazine 4–120 mg, controlled during inpatient phase</td>
<td>LOS, SOC, VOC, PSY, BEH, SX</td>
<td>At 3–5-yr followup: drugs alone or ECT = best; psychotherapy alone = worst</td>
<td>Senior therapists; Long duration of treatment</td>
<td>Mainly concerned with process Medication uncontrolled and confound results</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Thoridazine 300–1000 mg daily</td>
<td>SX, BEH, LOS, REHOSP</td>
<td>No significant differences between therapy and controls, but trend favors therapy</td>
<td>Large sample; Sophisticated design; Multiple outcome measures</td>
<td>Nonrandom patient selection Control patients in different hospital Small n</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Chlorpromazine 150–600 mg</td>
<td>LOS, SX, PSY, REHOSP</td>
<td>End of treatment: drugs + psychotherapy &gt; psychotherapy alone; no value for psychotherapy alone</td>
<td>Large sample; Multiple outcome measures; Adequate treatment duration</td>
<td>Inconsistent medication across groups Usual treatment group transferred to State hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Chlorpromazine 300–1600 mg</td>
<td>REHOSP, SX, PSYCH, VOC, SOC</td>
<td>At 2-year followup: psychotherapy + drugs same as usual care; psychotherapy &gt; usual care, experienced therapists only</td>
<td>Adequate duration of treatment</td>
<td>Treatment vaguely specified; overlap in psychosocial treatment groups Vaguely specified</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. chlorpromazine at least 100 mg daily</td>
<td>REHOSP, SX, VOC, SOC</td>
<td>Relapse: Placebo 80%, drug 48%, MRT + drug 37%; MRT + drug, better adjustment at 24 mos</td>
<td>Adequate power to test interactions Social treatment vaguely specified</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3: 12.5 mg to 125 mg biweekly</td>
<td></td>
<td>No significant difference in group relapse rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.4: mean 10 mg daily</td>
<td></td>
<td>Near significant interaction: decanoate + social therapy has lowest relapse rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note.—BEH = ward behavior; ECT = electroconvulsive therapy; LOS = length of stay; MRT = major role therapy; PSY = psychological testing; REHOSP = rehospitalization rate; SOC = social functioning; SX = symptom measures; VOC = vocational functioning.
Efficacy of Individual Psychotherapy Combined With Medication Versus Supportive Versus Investigative Psychotherapy (circa 1980). The Boston Psychotherapy Study (Gunderson et al. 1984; Stanton et al. 1984) aimed to compare the effectiveness of expressive insight-oriented (EIO) individual psychotherapy and reality-adaptive supportive (RAS) psychotherapy against a backdrop of high-quality inpatient, outpatient, and pharmacological treatment provided to both patient groups. Designed to remedy methodological deficiencies identified in the first generation RCTs in schizophrenia, advances incorporated into this investigation included (1) well-defined treatments; (2) experienced and ideologically committed therapists; (3) process and treatment adherence measures; (4) reliable diagnostic, prognostic, and outcome measures; (5) adequate pharmacological treatment for both patient groups; and (6) sufficiently large sample and duration of treatment to detect effects. The EIO and RAS therapies evaluated in this study were designed to approximate high-quality insight-oriented (average three times per week) and supportive (average once per week) psychotherapy as they had evolved over the preceding decades.

Following discharge from one of three Boston area hospitals, patients (mean age = 22) were randomly assigned to EIO or RAS psychotherapy. Treatment groups did not differ with respect to amount of antipsychotic medication prescribed or use of other treatment modalities.

Contrary to the investigators' expectations (an advantage for EIO was expected), neither treatment emerged as markedly superior, although differential effects across outcome domains were noted: The less intensive RAS was preferentially effective in reducing rehospitalization and improving vocational adjustment; EIO exerted a non-significant preferential effect on ego functions and cognition. Treatments were comparable in their impact on symptoms.

Significant among the findings from the Boston Psychotherapy Study was the degree to which, despite theoretical differences, the actual techniques employed by the EIO and RAS therapists tended to converge. Both therapies were found to employ substantial supportive elements (Gunderson et al. 1984). Sobering, but also significant, were the substantial attrition rates for both types of therapy. Those who remained in therapy continued to accrue benefits, but by the end of 1 year more than half (56%) and by the end of 2 years more than two-thirds (69%) of all patients had unilaterally dropped out of treatment.

Having found few differences in overall outcome between patients treated with EIO and RAS therapy, investigators searched for common factors in the treatments associated with positive therapeutic change and good outcome. Results indicated that independent of severity of psychopathology, patients able to form a good alliance with the therapist within the first 6 months of treatment were more likely to remain in therapy and comply with medication. These patients achieved better outcomes at 2 years and used less medication than those who did not form a therapeutic alliance (Frank and Gunderson 1990). Across both therapies, a strong positive correlation was found between reductions in patient denial of illness and retardation and apathy, and the therapists' demonstration of a sound dynamic understanding and accurate attunement to the patients' underlying concerns. Directive activity was associated with reductions in anxiety and depression. (Glass et al. 1989).

Findings from the Boston Psychotherapy Study have been reviewed and debated (Carpenter 1984; Docherty 1984; Karon 1984; May 1984); generally, the following conclusions have been suggested:

1. Individual cases notwithstanding (A Recovering Patient 1986; Stone 1986; Fenton and McGlashan 1987), for most patients no empirical evidence supports the efficacy of intensive investigative psychotherapy combined with medications over less intensive and less costly individual therapy approaches.

2. A convergence of techniques among therapists with different ideologies suggests that the distinction between supportive and insight-oriented therapy may not be meaningful or salient.

3. Independent of severity of psychopathology, a positive therapeutic alliance supported by a sound attunement to patients' needs is associated with better medication compliance and better outcome. These results are consistent with numerous studies that indicate that a patient's feeling of being listened to and understood by the physician is a strong predictor of medication compliance (Fenton et al. 1997).

The disappointing results of randomized clinical trials and followup studies contributed to a decline in prestige and influence of the psychodynamic paradigm generally and intensive individual psychotherapy of schizophrenia in particular. As a result, individual psychotherapy research and psychological theorizing concerning schizophrenia slowed to a near halt (Mueser and Berenbaum 1990), and several influential reviews emphasized the potentially toxic effect of ill-timed and overly demanding psychodynamic interventions (Drake and Sederer 1986; Stone 1986; Mueser and Berenbaum 1990). Lacking credible scientific support, psychosocial theories of etiology were rejected as harmful and erosive of patients', families', and professionals' efforts to work collaboratively (Dolnick 1998). The biological paradigm decisively gained ascendency as the most influential in the field.
Reappraisals of Individual Psychotherapy (1985–1995). In the context of advances in biological therapeutics, family-based interventions, and community support technologies, investigators in the United States and abroad called for a reappraisal of the role of individual psychotherapy in the treatment of schizophrenia.

Carpenter (1986) noted that parochialism undermined efforts to integrate what ought to be complementary approaches. He described the clinical relationship as a foundation for treating schizophrenia, providing continuity of care, and integrating treatment modalities based on a phenomenological understanding of the patient’s individual needs. According to Carpenter, illness heterogeneity dictated that treatment would need to be individualized. Drake and Sederer (1986) identified the development of a trusting alliance as the crucial step in all psychological treatments, warned against overly intrusive intervention, and advocated supporting the patient’s role as an active agent in managing his or her own illness.

Coursey (1989) proposed a redefinition of the aims and goals of individual psychotherapy in view of unequivocal evidence of schizophrenia’s biological determinants. He identified the following as appropriate foci for individual psychotherapy: (1) the human issues raised by having a chronic debilitating disorder, (2) efforts to help patients learn about and self-manage the disorder, and (3) attention to the problems of living that people with schizophrenia have to deal with. Coursey advocated an eclectic approach, including education, crisis intervention, empowerment, support for existential anguish, practical advice, and insight.

Dingman and McGlashan (1989) proposed broadly reformulating psychotherapy to refer to the relationship between clinician and patient. Acknowledging the validity of clinical descriptions of schizophrenia patients’ difficulties observed during the era of investigative psychotherapy, they identified the vulnerability-stress model as best guiding psychotherapeutic efforts. Relationship building, administration (coordinating other prescribed psychosocial interventions), and one-to-one interaction using both supportive and investigative techniques as dictated by the patient’s situation were described as key elements in Dingman and McGlashan’s broadly conceived psychotherapy.

Katz (1989) urged selectivity in both the target symptoms for psychotherapy and timing of interventions over the illness course. Sarti and Cournos (1990) pointed out that medication noncompliance, high relapse rates, and social disability defined the limits of a strictly pharmacological approach to schizophrenia. They emphasized the utility of integrated, practically oriented treatment that aimed fundamentally to strengthen the physician-patient alliance and educate the patient about the illness.

Also guided by the stress-vulnerability model, Falloon (1992) described efforts to strengthen patients’ coping capacity as the appropriate target of psychotherapeutic strategies in schizophrenia. Beyond education and stress management for patients (and caregivers), he advised that the choice and amount of other psychological interventions be determined by the patient’s particular illness type. Alanen (Alanen et al. 1991; Alanen 1997) used the term “need-adapted treatment” to describe a comprehensive therapeutic approach developed over three decades in Turku, Finland, that attempted to integrate dynamically informed individual psychotherapy, pharmacological, and rehabilitative efforts. Perris (1989) described the integration of cognitive-based individual psychotherapy with pharmacotherapy and rehabilitation in a comprehensive treatment approach provided in ideologically supportive specialized group homes (cognitive-behavioral centers) in the Umea, Sweden, region. Individual psychotherapy in this approach emphasizes relationship building, problem identification, and correction of dysfunctional cognition that impedes interpersonal interactions and social skills acquisition.

Although psychodynamic theories of the etiology of schizophrenia hold no currency in reformulations of psychotherapy, Dingman and McGlashan (1989) and Sarti and Cournos (1990) viewed clinical psychodynamic concepts such as countertransference as helping clinicians avoid inappropriate power struggles or other damaging reactions in the course of treating patients with schizophrenia. Others view psychodynamic understanding as facilitating management of clinical problems such as paranoia and denial (Weiden and Havens 1994), medication noncompliance (Diamond 1983; Book 1987), establishment of clinical contact (Huszonek 1987), and tracking of suicidality and maintenance of self-esteem (Drake et al. 1984; Cotton et al. 1985; Drake and Cotton 1986; Hingley 1997).

Disorder-Specific and Targeted Individual Psychotherapies

Personal psychotherapy. Informed by reappraisals of individual psychotherapy over the preceding decade, Gerald Hogarty and his colleagues at the University of Pittsburgh developed personal therapy (PT) as a disorder-specific individual psychotherapy that could both accommodate individual patient differences yet be operationalized for empirical testing (Hogarty et al. 1995). PT is designed for recently discharged outpatients with chronic or subchronic schizophrenia. Its objective is to enhance personal and social adjustment and forestall late (third year) relapse. A graduated approach accommodates neuropsychological aspects of schizophrenia and attempts to avoid the adverse effect of poorly timed interventions.
Individual-specific stress, often interpersonal, is seen as precipitating affective dysregulation in vulnerable patients. This loss of control over mood is seen as resulting in poorly reasoned dysfunctional behavior that negatively influences the reciprocal behavior of others in a cycle that may end in relapse. Based on individual patients' needs and preferences, PT uses a range of interventions to promote patients' self-awareness and foresight and equip them with adaptive strategies that facilitate self-monitoring and self-control of affect.

PT includes three phases, each with explicitly defined goals and corresponding interventions. The achievement of these goals is carefully assessed before the patient advances to the next level of treatment. Phases of treatment, goals, and operational criteria defining readiness to move to more advanced phases are summarized in Table 2. Within each phase, the exposure of patients to specific interventions is varied based on individual need. While the therapy was designed to be given over a 3-year time span, patients spend as much time at each level as required to meet advancement criteria and not all patients progress through all three phases. PT is administered against a backdrop of psychopharmacological treatment that aims to minimize side effects by using the lowest medication dose needed to prevent symptom exacerbation (Hogarty and Ulrich 1998).

Investigators at the University of Pittsburgh have completed two 3-year randomized clinical trials of PT for newly discharged patients with schizophrenia and schizoaffective disorders (Hogarty et al. 1997a, 1997b). Patients residing with their families were assigned to supportive therapy, personal therapy, family psychoeducation/management, or a combination of the latter two treatments. Patients living alone, who were generally more disabled, were assigned to personal therapy or supportive therapy.

Results indicated that PT was remarkably well accepted by patients participating in the trials. Over 3 years, only 8 percent of patients receiving PT, and 23 percent of patients in contrasting treatments, were dropped for noncompliance or administrative reasons. Eight percent of patients remained in basic-phase PT, 38 percent of patients progressed beyond intermediate-phase PT, and 54 percent of patients progressed to advanced-phase PT over the 3-year trial period.

The efficacy of PT in relapse reduction was tied to residential status. Patients receiving PT who were living with family experienced fewer relapses. The more impaired group of patients receiving PT, who were living alone, experienced a greater relapse rate. Consistent with the clinical dictum that psychologically oriented treatments can be futile or harmful when applied before basic human service needs are addressed, PT patients who relapsed were more likely to have unstable housing and difficulty securing food and clothing. Independent of relapse reduction, PT produced substantial differential improvements in social adjustment and role performance. While improvements in social adjustment among patients receiving supportive and family therapy reached a plateau at 12 months, the personal adjustment of PT patients continued to improve in the second and third postdischarge years with no evidence of a plateau. Relative to supportive and family therapy, individual psychotherapy was superior in promoting a progressive improvement in psychosocial adjustment.

From a clinical perspective, it is important to recognize that while structured, PT is not a tightly prescriptive manualized treatment. Rather, PT outlines a set of principles and priorities that leave considerable room for individualization (Fenton and McGlashan 1997).

**Phase-specific cognitive-behavioral therapy**

**Targeted individual psychotherapy.** While PT is organized as a broad strategic outline for psychotherapy for schizophrenia patients following hospital discharge, empirical support for the efficacy of briefer and more targeted disorder-specific individual psychotherapies comes from a series of RCTs of individual cognitive-behavioral therapy (CBT) from the United Kingdom. These treatments are time limited, illness phase specific, and they target specific clinical problems that may be experienced by subpopulations of schizophrenia patients.

**Acute phase.** Table 3 summarizes RCTs of three targeted individual CBT interventions for inpatients in the acute phase of illness. Compliance therapy, conceptually based in motivational interviewing (Rollnick et al. 1992), is an effective four- to six-session intervention for acutely ill inpatients that targets improved attitude toward medication and postdischarge compliance as treatment goals (Kemp et al. 1996a, 1996b; Kemp et al. 1998). Drury et al. (1996a, 1996b) found intensive (3 hours per week) CBT designed to reduce duration of acute psychosis and level of residual positive symptoms to be effective in combination with family intervention and structured activities during inpatient treatment. Haddock et al. (1999) compared short-term CBT to supportive counseling and education in a small number of recent-onset acute inpatients and found comparable efficacy for both treatments. In contrast to Drury et al.'s (1996a, 1996b) intensive program that included continued treatment for at least 8 weeks postdischarge, most patients treated with the short-term CBT evaluated by Haddock et al. did not participate in aftercare “booster sessions.”

**Postacute phase.** CBT targeting delusions and hallucinations that have not fully responded to pharmacological treatment has also been developed and tested for out-
<table>
<thead>
<tr>
<th>Initiation criteria</th>
<th>Goals</th>
<th>Techniques</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phase I</strong>&lt;br&gt;(3–6 months)</td>
<td>Hospital discharge&lt;br&gt;Therapeutic joining&lt;br&gt;Stabilization&lt;br&gt;Treatment contract&lt;br&gt;Basic psychoeducation (stress-vulnerability model)&lt;br&gt;Establish lowest effective medication dose</td>
<td>Supportive techniques (acceptance, empathy, problem solving)&lt;br&gt;Basic stress identification and avoidance&lt;br&gt;Support gradual resumption of responsibilities&lt;br&gt;Basic social skills training&lt;br&gt;Basic psychoeducation workshop</td>
</tr>
<tr>
<td><strong>Phase II</strong>&lt;br&gt;(6–18 months)</td>
<td>Positive symptoms stable&lt;br&gt;Maintenance dose of medication achieved&lt;br&gt;Ability to maintain attention for 30 minutes&lt;br&gt;Basic understanding of illness&lt;br&gt;Regular appointment attendance&lt;br&gt;Appropriate basic social skills</td>
<td>Self-awareness of affective, cognitive, and behavioral states&lt;br&gt;Awareness of individual stressors, internal cues of stress&lt;br&gt;Self-protective strategies learned&lt;br&gt;Awareness of individual dysfunctional responses to stress&lt;br&gt;Improved social perception and functioning</td>
</tr>
<tr>
<td><strong>Phase III</strong>&lt;br&gt;(18–36 months)</td>
<td>Continued clinical stability&lt;br&gt;Recognition of role of stress as potential precipitant of psychosis&lt;br&gt;Regular participation in role-playing exercises (if social skills deficit present)&lt;br&gt;Evidence of accurate social perception&lt;br&gt;Identification of at least one affect and physical or cognitive cue of vulnerability&lt;br&gt;Basic relaxation techniques learned</td>
<td>Learn relationship between life circumstance and internal state&lt;br&gt;Learn relationship between felt affect and expressions of affect&lt;br&gt;Learn to predict significant other's reactions to expressions of affect&lt;br&gt;Learn criticism management&lt;br&gt;Recognize prodrome, need for prophylactic medication—avoid late relapse</td>
</tr>
<tr>
<td>------------------</td>
<td>--------------------</td>
<td>--------------------------------</td>
</tr>
</tbody>
</table>
| **Goals**        | Reduce duration of acute psychosis  
 Reduce level of residual positive symptoms | Improve compliance with medication after discharge 
 Improve attitude toward treatment and insight into illness | Increase rate and amount of acute symptom reduction |
| **Treatment / Comparison** | Cognitive therapy (individual and family) vs. matched hrs of recreational therapy and informal support | Compliance therapy vs. nonspecific counseling | Short-term CBT vs. supportive counseling + psychoeducation |
| **Patients**     | 40 inpatients with functional psychosis | 74 inpatients with psychosis | 21 inpatients with DSM-IV schizophrenia or schizoaffective, ill < 5 yrs, with hallucinations disorder or delusions present |
| **Design**       | RCT stratified by predictors, with 9-mo followup | RCT with 18-month postdischarge followup | RCT (pilot) with 2-yr chart followup |
| **Therapists**   | Research psychologists | Research psychiatrist and clinical psychologist | Two expert clinical psychologists |
| **Therapy duration and intensity** | Mean 3 1-hr individual + group CBT sessions + 1–2 family interventions for 12 wks + structured activity program, integrated with intensive aftercare for 8 wks | 4–6 sessions 10–60 min each | 10 50-min sessions, over 5 wks or until discharge, with 4 postdischarge boosters offered |
| **Medications**  | “Routine” pharmacotherapy  
 Pharmacotherapy + length of stay determined by psychiatrist blind to treatment, groups comparable to stelazine equivalents | Typical antipsychotics  
 PO and Decanoate  
 Mean dose = 977 CPZ equivalents for compliance therapy group, 698 for control | Prescribed by medical consultants blind to treatment |
| **Outcome measures** | PAS  
 Self-report of delusional conviction  
 Time to recovery  
 Days in hospital | Composite compliance measure  
 Social functioning  
 BPRS modified  
 GAF  
 Insight  
 Drug Attitude Inventory | BPRS  
 Psychiatric Symptom Rating Scale  
 Time to discharge  
 2-yr relapse and rehospitalization |
<table>
<thead>
<tr>
<th>Results</th>
<th>Predictors of good outcome</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Faster rate of positive symptom reduction for CBT</td>
<td>Female</td>
<td>Of 62 randomized, 22 excluded as not suitable</td>
</tr>
<tr>
<td>Greater positive symptom reduction for CBT, persisted at followup</td>
<td>Shorter duration of illness</td>
<td>Requires patients to be willing and able to engage in dialogue about symptoms</td>
</tr>
<tr>
<td>Less delusional conviction for CBT group</td>
<td>Shorter average untreated illness</td>
<td>Nonblind assessors</td>
</tr>
<tr>
<td>CBT group had 50% time in hospital relative to controls</td>
<td></td>
<td>30% nonparticipation rate</td>
</tr>
<tr>
<td>Lower relapse rate for CBT over 9 mos</td>
<td>Higher IQ</td>
<td>One-third eligible, refused treatment</td>
</tr>
<tr>
<td></td>
<td>Voluntary status</td>
<td>Independent assessors</td>
</tr>
<tr>
<td></td>
<td>Fewer EPS</td>
<td>Poor patient compliance with postdischarge booster session</td>
</tr>
</tbody>
</table>

Note.—BPRS = Brief Psychiatric Rating Scale; CBT = cognitive-behavioral therapy; CPZ = chlorpromazine; EPS = extrapyramidal symptoms; GAF = global assessment of functioning; PAS = Psychiatric Assessment Scale; RCT = randomized clinical trial.
patients at a postacute phase of illness (table 4). Conceptually, these treatments are based on the observation that patients are able to discover, learn, and use coping strategies to reduce symptom severity or distress associated with medication-resistant symptoms (Falloon and Talbot 1981; Breier and Strauss 1983). Techniques employed derive from individualized assessment and vary based on individual patient preference. They may include belief modification; self-management techniques; and coping strategy enhancements such as attention switching, attention narrowing, increasing or decreasing social activity, modifying sensory input, using relaxation strategies, and psychoeducation. In vivo practice and homework assignments are often prescribed, and an overall attempt is made to build on coping methods already used by the patient (Tarrier 1992a, 1992b; Haddock et al. 1994; Beck and Rector 1998; Tarrier et al. 1998b).

Tarrier et al. (1993a, 1993b) compared the efficacy of coping strategy enhancement to problem solving among stable outpatients with residual positive symptoms. Symptoms experienced by patients in both treatment groups improved relative to waiting-list controls, and changes in coping were significantly related to decreases in psychotic symptoms during treatment. A second larger trial of more intensive CBT combined training in coping, problem solving, and relapse prevention. This trial found that CBT added to routine care (medication and outpatient management) reduced residual positive symptoms, exacerbations, and days spent in hospital relative to generic supportive counseling and routine care (Tarrier et al. 1998b). A significant effect of CBT on residual positive symptoms remained at 12-month followup (Tarrier et al., in press).

Following a small pilot trial (Garety et al. 1994), the efficacy of CBT for medication-resistant symptoms in the stable plateau illness phase (including evidence for the durability of improvement and cost-effectiveness over 18 months) has recently been independently validated by Garety and her colleagues (Garety et al. 1997; Kuipers et al. 1997, 1998). A detailed clinical and empirical overview of cognitive-behavioral treatment for medication-resistant symptoms is provided by Garety et al. in this issue.

Results of RCTs consistently demonstrate an advantage of adding time-limited illness-specific cognitive-behavioral therapies to usual care for schizophrenia patients at both the acute and stable plateau phases of illness. At the same time, substantial initial dropout or refusal rates following randomization indicate that these treatments will not be appropriate for all patients. Those studies that have evaluated predictors of response have pointed to subjective distress associated with symptoms and some pretreatment insight as predictors of patients most likely to benefit from targeted CBT interventions.

Current Clinical Practice

How can available research concerning effective approaches to individual psychotherapy inform clinical practice? The techniques employed in empirically tested therapies differ based on the treatment’s specific goals. However, all effective individual psychotherapies share the following characteristics: (1) schizophrenia is understood as a biologically based disorder that can be partially managed by learned and practiced coping strategies; (2) a stress-vulnerability model is used to explain symptoms and illness course; (3) a therapeutic alliance is established as a prerequisite for all other activities; (4) a focus on understanding the patient’s subjective experience and strengthening natural coping mechanisms is emphasized; (5) treatment is flexibly based on individual patient needs and capacities; and (6) each intervention presupposes that the patient is receiving ongoing supportive care and management, including attention to pharmacological treatment, human service needs, and rehabilitation.

In an effort to outline practice that reflected various reappraisals of psychotherapy, Fenton and McGlashan (1995) defined “flexible psychotherapy,” a disorder-specific treatment informed by current scientific conceptions of schizophrenia. This pragmatic approach to psychotherapy relies on a variety of strategies applied flexibly depending on the individual patient’s type of schizophrenia and phase of illness. At various times, supportive, directive, educational, or insight-oriented activity is provided in the context of a stable doctor-patient relationship. Dogmatic adherence to a single technique applied to all patients is considered least likely to be helpful. Flexible psychotherapy can be described in terms of assumptions, clinical tasks, and interventions and likely approximates how most patients are treated in current practice (Kane and McGlashan 1996).

Flexible Psychotherapy: Assumptions. A flexible approach to psychotherapy is based on assumptions about schizophrenia that recognize the joint contributions of biological, psychological, and social/environmental factors:

1. The vulnerability-stress model represents the best available integration of data pertinent to the etiology, course, and outcome of schizophrenia. This model posits that schizophrenia results from a dynamic interaction between environmental or experiential stress in a person who is “vulnerable” to react to this stress with schizophrenic symptom formation (Meehl 1962; Zubin 1981; McGlashan 1986). Aspects of vulnerability are undoubtedly genetic, although some may be acquired biologically through intrauterine, birth, and postnatal complications (Falloon 1992; Hollister et al. 1996; Olin and Mednick 1996; Susser...
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients, n</td>
<td>27 with DSM-III-R</td>
<td>34 with &gt; 2–3 auditory hallucinations/wk for &gt; 6 mos, experienced as unpleasant</td>
<td>60 with psychosis (schizophrenia, schizoaffective, delusional disorder), with at least one positive symptom that was distressing, unremitting for 6 mos, and medication resistant</td>
<td>82 with DSM-III-R schizophrenia, schizoaffective, or delusional disorder, with persistent hallucinations or delusions for 6 mos despite medication, stable at least 1 mo</td>
<td></td>
</tr>
<tr>
<td>Design</td>
<td>RCT with 6-mo followup</td>
<td>RCT</td>
<td>RCT</td>
<td>RCT stratified by symptom severity, sex, with 12-mo followup</td>
<td></td>
</tr>
<tr>
<td>Therapists</td>
<td>4 research psychologists</td>
<td>Expert psychologist</td>
<td>Experienced clinical psychologist</td>
<td>3 experienced clinical psychologists using protocol manual</td>
<td></td>
</tr>
<tr>
<td>Therapy duration and intensity</td>
<td>2 1-hr sessions/wk for 5 wks</td>
<td>1 hr/wk</td>
<td>1 hr/wk (flexible), then 2 times/mo for 9 mos</td>
<td>2 hrs/wk in clinic for 10 wks</td>
<td></td>
</tr>
<tr>
<td>Medications</td>
<td>&quot;Regular and stable neuroleptic medications&quot;</td>
<td>Prescribed by medical consultants</td>
<td>As prescribed by treatment team</td>
<td>Approximately 425–500 CPZ equivalents, no differences across groups</td>
<td></td>
</tr>
<tr>
<td>Goals</td>
<td>Reduce delusions and hallucinations that have been unresponsive to medication, Teach coping strategies to reduce symptom and distress</td>
<td>Medication-resistant auditory hallucination</td>
<td>Reduce distress from positive symptoms, Reduce depression, anxiety, hopelessness, Promote self-regulation of relapse risk and social disability</td>
<td>Treat delusions and hallucinations resistant to medication, Teach patients means of reducing distress associated with symptoms</td>
<td></td>
</tr>
<tr>
<td>Outcome measures</td>
<td>BPRS</td>
<td>PSE</td>
<td>BPRS</td>
<td>Present State Exam</td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td>------</td>
<td>-----</td>
<td>------</td>
<td>-------------------</td>
<td></td>
</tr>
<tr>
<td>Symptom change score</td>
<td>Self-report hallucinations</td>
<td>Maudsley Assessment of Delusions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric Assessment Scale</td>
<td>Anxiety/depression scale</td>
<td>Beck Depression Inventory</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Functioning Scale</td>
<td>Self-esteem</td>
<td>Beck Anxiety Inventory</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coping skills and problem solving</td>
<td></td>
<td>Social functioning scale</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subjective benefit of treatment</td>
<td></td>
<td>Insight Assessment (Amdur)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Self-concept and attitude scales</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Self-report of symptom severity</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Results</th>
<th>Both groups showed improved symptoms at end of treatment and followup</th>
<th>Both groups show reduction in frequency of hallucinations and life disruption</th>
<th>CBT had significantly greater decrease in BPRS than controls</th>
<th>CBT group showed greater improvement in positive symptom number and severity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Advantage for CSE in total delusions, symptom improvement</td>
<td>No change in attribution of voices</td>
<td>No change in other outcomes</td>
<td>CBT group more likely to have 50% symptom reduction</td>
</tr>
<tr>
<td></td>
<td>Expectancy not associated with outcome (therapists’ high or low expectation of improvement)</td>
<td></td>
<td>21% of CBT vs. 3% of controls dropped 10 points in BPRS</td>
<td>Routine care alone patients spent more days in hospital</td>
</tr>
<tr>
<td></td>
<td>Treatment-specific skill improvement in coping or problem solving</td>
<td></td>
<td>CBT had low (11%) dropout; 80% highly satisfied</td>
<td>Advantage of CBT on positive symptoms maintained at 12 mos, differences less clinically significant</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Predictors of good outcome</th>
<th>Patients with higher pretreatment scores improved most</th>
<th>No report</th>
<th>“Chink of insight at baseline”</th>
<th>Shorter duration of illness</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Acknowledge possibility of being mistaken; cognitive flexibility</td>
<td>Less severity at baseline</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Greater number of admissions in last 5 yrs, other baseline measures (e.g., IQ) not predictive</td>
<td>Male, low IQ, unemployed, low education most likely to drop out</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Comments</th>
<th>Of 48 suitable patients, 27 (56%) continued to posttreatment 23 (48%) to 6-mo followup</th>
<th>Narrow focus on alternate strategies for auditory hallucinations, high attrition over trial</th>
<th>50% of patients responded to treatment</th>
<th>87/138 treated after allocation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Independent assessors</td>
<td>87/138 treated after allocation</td>
<td>Assessors blind to treatment assignments</td>
<td>Booster sessions advisable?</td>
</tr>
</tbody>
</table>

Note.—BPRS = Brief Psychiatric Rating Scale; CBT = cognitive-behavioral therapy; CPZ = chlorpromazine; CSE = coping strategy enhancement; PSE = Present State Exam; RCT = randomized clinical trial; SANS = Scale for the Assessment of Negative Symptoms.
et al. 1996). At the same time, vulnerability is not static but shaped epigenetically over time by environmental influences. A "stress" sufficient to precipitate relapse at one time, for example, may be less likely to do so at a later point when new coping strategies or better supports have been acquired (Strauss et al. 1985).

2. The stress side of the vulnerability-stress model postulates that a variety of stressors (internal or external events requiring adaptation) can precipitate the emergence of symptoms in a vulnerable individual. Given biologically based vulnerability, the onset, course, and outcome of an individual's disorder may be shaped by interactions between the person and the environment. Among psychosocial factors, stressful life events, cultural milieu (egocentric vs. sociocentric), social class, social network size and density, and emotional quality of the living environment have been demonstrated to be associated with the onset and course of schizophrenia (Nuechterlein and Dawson 1984; McGlashan 1986; Lin and Kleinman 1988; Wyatt et al. 1988).

3. Schizophrenia is heterogeneous, as are individuals afflicted with it. The clinical diversity of schizophrenia in relation to vulnerabilities and risk factors, age and type of onset, manifest signs and symptoms, longitudinal course, and long-term outcome suggest that the disorder may be heterogeneous in regard to underlying etiology. This heterogeneity may be partially captured by currently available subtyping systems such as deficit versus nondeficit schizophrenia, but at a minimum, schizophrenic illnesses of greater and lesser severity and "virulence" can be identified and the "biological" vulnerability of individuals may differ (McGlashan and Fenton 1993). As with the illness itself, individuals afflicted with schizophrenia differ substantially in adaptive capacities, intelligence, and instrumental and verbal competence.

4. Schizophrenia is often phasic in course. Systematic investigation of longitudinal course has only recently begun, and our understanding of illness phases is preliminary (Strauss et al. 1985). Phases may include the following: (1) prodromal periods, during which time a highly individualized constellation of symptoms that represent early manifestation of clinical decompensation emerge; (2) acute or active phases, often associated with the full-blown emergence of positive symptoms superimposed onto preexisting deficits; (3) subacute, convalescent, or stabilization phases, characterized by gradual restoration of some functioning perhaps associated with postsy psychotic depression; (4) moratoriums or adaptive plateaus, characterized by a gradual reconstitution of identity, gathering of support, and strengthening of skills; (5) change points or shifts in functioning over a relatively brief period of time, initiated by the patient's own desires or pressure from others and associated with the potential for either quantum improvement or decompensation; or (6) end state or stable plateaus, relatively enduring periods of stability characterized by greater or lesser fixed deficits, chronic levels of positive symptoms, or both.

Flexible Psychotherapy: Clinical Tasks and Technical Strategies. To treat schizophrenia, the therapist must use a variety of interventions and strategies. The crucial question becomes which interventions are of potential value for a particular individual at a particular phase of illness. The range of therapeutic tasks and associated goals and interventions can be roughly ordered hierarchically. Although attention to issues such as relationship building cuts across all phases of therapy, as outlined in table 5, different therapeutic tasks are of particular importance during different illness phases. In addition, while some tasks are clearly relevant for all patients, others, particularly those relating to the goals of intensive psychotherapy, are pertinent for only a small subgroup. This model assumes the therapist's capacity to "shift gears" flexibly and change roles with all patients based on changing circumstances, always holding in mind the goal of helping the patient accept, learn about, and self-manage what may often be a chronic and devastating illness.

Consideration of the patient's schizophrenia subtype, current and premorbid functioning, and self-defined treatment goals are all relevant to the determination of appropriate treatment tasks. For patients with severe hebephrenic and deficit forms of schizophrenia, for example, the most humane and practical goal may be establishing a supportive ongoing treatment within a sheltered setting that minimizes stress and provides for basic human needs. For the majority of patients who reside in the community, some psychoeducation and rehabilitative tasks should be planned with the aim of minimizing acute relapses and promoting maximal functioning and quality of life. A focus on investigative tasks is reserved for motivated patients who have established a good therapeutic relationship and exhibit an interest in and ability to make constructive use of such techniques. Attunement to psychological concerns may be particularly important for patients who have a dramatic response to new medications (Duckworth et al. 1997).

The use of multiple treatment modalities is anticipated and creates the need for someone to orchestrate and coordinate them. As is true in medicine generally, the quality of the individual doctor-patient relationship is viewed as a major factor in the success of all prescribed therapies. Thus, a focus on the skillful use of this relationship usefully informs all tasks at all levels. Here, removed
<table>
<thead>
<tr>
<th>Therapeutic task</th>
<th>Illness phase</th>
<th>Clinical focus</th>
<th>Interventions</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and psychiatric assessment and stabilization</td>
<td>Prodromal, acute</td>
<td>Crisis intervention</td>
<td>Clinical, medical, neurological assessment</td>
<td>Diagnose or rule out medical, neurological disorders</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Psychiatric/medical diagnosis Safety</td>
<td>Hospitalization or community alternative acute care</td>
<td>Ensure safety</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Acute symptom management</td>
<td>Directive and supportive communication, limit setting</td>
<td>Minimize effect of acute episode on life situation (housing, job, family)</td>
</tr>
<tr>
<td>Psychosocial assessment and case management</td>
<td>Subacute, convalescent, stabilization</td>
<td>Stress and vulnerabilities</td>
<td>Skilled psychological and psychosocial assessment</td>
<td>Effect rapid symptom reduction</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Social supports</td>
<td>Evaluation of human service needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Living arrangements, daily activities</td>
<td>Linkage with social service, human service, and community support services</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Adaptive capacities</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Access to economic and treatment resources</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establishment of supportive treatment</td>
<td>Early maintenance, moratorium, or adaptive plateau</td>
<td>Treatment relationship and alliance Denial, suspiciousness, disorganization Self-esteem</td>
<td>Continued medication—attention to complaints and medication side-effects Support, positive regard, reassurance, bolstering defenses Promote comfort with therapist and treatment—encourage benign positive transference Assertive outreach (if needed) and direct assistance with situational problems</td>
<td>Encourage sufficient acceptance of illness to allow cooperation with treatment Promote trust in therapist and comfort with therapeutic routine Support strengths, adaptive defenses Monitor for relapse</td>
</tr>
<tr>
<td>Psychoeducation</td>
<td>Maintenance, moratorium, change points</td>
<td>Understanding and acceptance of illness Human concerns associated with disability Self-management of illness</td>
<td>Teaching and support Identification of individual-specific stresses Awareness of individual-specific prodromal and active symptoms Determine lowest effective prophylactic medication dose</td>
<td>Prevent relapse Teach stress management strategies Achieve self-recognition of prodromal symptoms Establish maintenance regime Achieve collaborative self-management of illness</td>
</tr>
</tbody>
</table>
Table 5. Flexible psychotherapy: Phase-specific tasks, intervention, and goals—Continued

<table>
<thead>
<tr>
<th>Therapeutic task</th>
<th>Illness phase</th>
<th>Clinical focus</th>
<th>Interventions</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitation or habilitation</td>
<td>Maintenance, end state, stable plateau</td>
<td>Social, vocational, self-care skills</td>
<td>Attention to details of daily self-care, social and occupational functioning</td>
<td>Promote highest adaptive functioning within limitations imposed by defeats</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Learning or relearning</td>
<td>Modeling and practice of new skills</td>
<td>Promote activities that enhance self-esteem through accomplishment and productivity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Establishing realistic expectations</td>
<td>Cognitive, problem-solving, and social skills enhancement</td>
<td>Encourage activities that improve quality of life</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Adaptation to deficits</td>
<td>Environmental intervention, family education, supported employment</td>
<td>Promote attainment of self-defined goals</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Exploration of feelings, conflicts, ambivalence</td>
<td>Learn strategies that allow functioning despite deficits</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Focus on unconscious, past events, life history, hidden meanings</td>
<td>Enhance cognitive flexibility</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Examination of important relationships, including relationship with therapist</td>
<td></td>
</tr>
<tr>
<td>Investigative and insight-oriented tasks</td>
<td>Selected and motivated patients during stable periods</td>
<td>Conflicts, transference, countertransference, life goals, motivations</td>
<td>Interpretation</td>
<td>Integrate psychosis into expanded concept of self</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Construct life narrative</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Work through conflicts</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Improve capacity for intimacy and productivity</td>
</tr>
</tbody>
</table>
from its outdated etiologic assumptions and overly ambitious goals, the substantial clinical knowledge derived from the tradition of investigative psychotherapy can be applied pragmatically in a contemporary context.

Depending upon the administrative structure in which treatment is provided, many of the tasks outlined in table 5 may overlap with the concerns and expertise of other service providers. All, however, should be the concern of the individual psychotherapist and a focus for individual psychotherapy (Jeffries 1995). A focus on higher level educational and psychological tasks is generally inappropriate in the presence of overwhelming difficulties at the level of basic human services. Thus, the necessary first goal of psychotherapy with a homeless person may be direct assistance in finding housing. Although other professionals may be relied upon to accomplish specific tasks, the individual psychotherapist should consider himself or herself responsible for ensuring the results of these efforts. While the majority of therapeutic time may be spent "sitting in an office talking," this approach assumes that the therapist should be prepared to participate in outreach, family consultation and education, and environmental intervention to an extent required by individual circumstances and the ability and availability of other treatment team members. The therapist operating in the way described here should be prepared to directly participate in environmental interventions when needed.

The following general treatment strategies are common to all of the specific therapeutic tasks outlined: evaluation, continuous reevaluation, timing, titration, and integration with psychopharmacology.

**Evaluation.** A thorough evaluation of the patient initiates the treatment process and should include a determination of whether other treatments of demonstrated efficacy such as family psychoeducation or assertive outreach are indicated. During medical assessment and stabilization, evaluation includes ruling out identifiable physical conditions, assessing competence to consent to treatment and dangerousness, and determining the responsiveness of symptoms to acute pharmacological intervention. Psychosocial assessment inventories available support and aim to measure the degree to which the patient’s adaptive capacities measure up against the stresses and demands of his or her living environment. Efforts to establish a supportive ongoing treatment test the patient’s capacity to trust and rely upon another human being for support and guidance. When applicable, psychoeducational, rehabilitative, and investigative interventions are preceded by an assessment of the patient’s cognitive strengths and deficits, allowing interventions to be formulated that match the patient’s talents.

**Continuous reevaluation.** The fluid nature of schizophrenia and an individual’s adaptation to it over time demands periodic reassessment of course, prognosis, phase of illness, and target problems. As these change, so do treatment goals. Providing concrete support in the form of a ride to work may be helpful early in the effort to promote vocational rehabilitation, but later may promote unwarranted dependency and prolong disability.

**Timing.** The phasic natural history of schizophrenia requires attention to when particular therapeutic tasks are attempted. For many patients, in order to minimize stress and forestall relapse, relatively little beyond assessment, stabilization with medication, and establishment of a supportive ongoing treatment should be attempted during the first 6 to 12 months following an acute episode. Once the patient is asymptomatic and shows signs of revitalization, rehabilitation and more complex psychoeducational elements may be gradually introduced.

**Titration.** Treatment interventions should be applied with graded increases of intensity and complexity. Higher level therapeutic tasks should be attempted and higher levels of work or social functioning expected only after completion and consolidation of earlier gains. Substantial rehabilitation, for example, will rarely be possible until progress has been made in attaining a stable supportive treatment relationship. Likewise, there is evidence that early, active, and ambitious psychologically oriented treatment may be disorganizing or toxic for certain patients. In general, treatment changes should be pursued cautiously, modifying only one element at a time.

**Integration with psychopharmacology.** Each of the tasks outlined above assumes most patients will be prescribed acute and prophylactic neuroleptic drugs. Control and prevention of psychotic symptoms using the lowest effective dosage of medication is the overall treatment goal. Decisions regarding pharmacological management are often linked to the relative success or failure of accomplishing various psychotherapeutic tasks. Considerable psychoeducation, for example, should be accomplished before attempting maintenance medication dose reduction or the initiation of a targeted (intermittent) medication strategy. Long-acting injectable neuroleptics may be useful for patients unable to tolerate the daily reminder of illness associated with oral medication and for patients unable to maintain a reliable treatment relationship.

**Discussion**

As noted by Carpenter (1986), in clinical practice the irreducible essence of our interest in schizophrenia is the nature of another person’s experience. One-to-one interaction between physician or therapist and patient has characterized efforts to treat schizophrenia throughout much of the century. In the absence of a firm empirical grounding, individual therapy as practiced was most often guided...
by ideology and deference to authority. Research advances were hampered by a focus on global questions such as the relative merits of drugs versus psychotherapy or supportive versus investigative techniques.

For a long period, empirical research on one-to-one intervention virtually ceased. A reformulation of schizophrenia as a disease requiring individualized, comprehensive treatment has allowed the development and empirical testing of new targeted and illness-phase-specific individual psychotherapies. In these models, each component of a comprehensive treatment plan for a patient with schizophrenia targets specific aspects of the disease and its common sequelae. Individual psychotherapy addresses the human aspects of adaptation to a serious psychiatric illness and targets problems such as residual symptoms, relapse prevention, denial, demoralization, treatment compliance, personal relationships, and self-esteem. Its focus is on understanding the patient's beliefs, attitudes, aspirations, and experiences. The coordination, timing, and titration of all specific treatment elements is informed by this understanding and by an ongoing assessment of individual patient needs that can often best be achieved within a long-term physician-patient or therapist-patient relationship.

Defining individual psychotherapy for research continues to be problematic. If individualization and integration of multiple modalities are the core features of effective therapy, it is unlikely that a search for a single effective ingredient common to successful psychotherapy will be fruitful; in fact, it could once again lead to a rancorous focus on minutia.

Empirical studies validate two seemingly divergent approaches to further development of evidence-based individual psychotherapy for schizophrenia. Hogarty's PT is a broadly defined strategic outline that sequentially organizes the focus of therapeutic interaction across illness phases over a period of years. It resembles case management when human service needs are most pressing, but changes focus over time to accommodate changing patient needs. Like PT, flexible psychotherapy provides a broad outline of what might be considered adequate clinical care in the context of a one-to-one psychotherapeutic relationship. The challenge for future development of approaches such as these is to outline sequenced interventions with sufficient specificity to allow them to be operationalized, taught, and measured, while retaining sufficient flexibility to accommodate patient heterogeneity. This will require description of therapeutic approaches at a level intermediate between a tightly prescriptive process and global strategic outline—along with identification of measurable quality indicators associated with adherence to the treatment model. These indicators will include the therapist's provision or prescription of other effective interventions (such as outreach and family psychoeducation) when required.

In contrast to global strategic approaches, British CBT models are time limited, illness phase specific, and targeted toward specific medication-resistant symptoms and distress. These interventions involve application of specific and more readily defined therapeutic techniques. The major challenge in their development appears to be better definition of the specific patient subgroups for whom these interventions are effective: specification of what works for whom. A psychotherapist operating within a broad strategic outline might then be in a position to select or prescribe from a menu of effective, targeted, time-limited interventions for particular patients at particular times. Targeted approaches to medication-resistant hallucinations and delusions are already validated. Depression, impaired self-concept, and substance abuse may be appropriate targets for future CBT methodology.

With or without data to inform it, clinicians will continue to practice individual psychotherapy. New antipsychotic agents with greater efficacy and fewer side effects raise the functional ceiling previously imposed on many patients treated with first generation medications. Effectiveness studies that include use of new medications are clearly required to test the generalizability of both broad and targeted psychotherapy approaches. Moving studies validated in the laboratory to myriad real world settings where patients and therapists meet will define the standard of care for schizophrenia treatment for the future.

References


Acknowledgment

The views expressed in this article are those of the author and do not necessarily reflect the official views of the National Institute of Mental Health, the National Institutes of Health, or any other branch of the U.S. Department of Health and Human Services.

The Author

Wayne S. Fenton, M.D., is Deputy Director Clinical Affairs, Division of Mental Disorders, Behavioral Research and AIDS, National Institute of Mental Health, National Institutes of Health, Bethesda, MD.