Psychological Interventions with Patients and Their Families: An Overview

Henry Olders, MD, FRCPC
Coordinator, Continuing Care Training
Douglas Hospital
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I. The Client Population

A. patients

1. needs of patients

Mechanic (1978) places the individual deficiencies of chronic patients into five categories:

- a lack of material resources: money, food, clothing, housing, and other necessities;
- a lack of the skills needed to function in the community and thus an increased dependence on others;
- a lack of adequate defenses that would allow them to handle their own anger, impulses, and sense of isolation;
- a lack of adequate social supports - difficulty in establishing and maintaining close relationships with others, including their families;
- a lack of sustained motivation - a tendency to withdraw from both situations and people.

2. heterogeneity of diagnosis

While many articles dealing with chronically mentally ill patients refer to their diagnostic category as being mainly schizophrenia, it is becoming clearer that many patients being treated in continuing care settings have other diagnoses, such as bipolar affective disorder or personality disorder. One reason is the tendency, well documented in several studies, for American psychiatrists to overdiagnose schizophrenia compared to their European counterparts.

This means that treatment programs must be individualized, and not attempt to fit patients into stereotyped categories; for example, not all chronic patients will be withdrawn and afraid of closeness; those that seek out relationships with others are less likely to benefit from programs designed to reduce schizophrenics' anxiety in interpersonal relationships.

3. arousing life events

The occurrence of arousing life events may provoke relapse in chronic patients. Two studies showed that this interacted with medication: almost all patients who relapsed on medication had had a life event in the preceding five weeks, but life events were not more common in patients who relapsed off medication. In the second study, patients who relapsed while on medication were more likely to have both life events and high EE relatives, but most patients who relapsed while off medication had just one or the other of life events or high EE relatives (Hirsch, 1983).

4. institutionalized and ex-institutionalized patients

Over the years, patients in public mental hospitals have been described as apathetic, withdrawn, and isolated from other patients and their families. They have been described as possessing only the minimum of interpersonal skills. The process leading to impoverished interpersonal relations has been thought not to be a primary symptom of their mental illness, but rather a secondary symptom resulting from adaptation to life in a rigid and nonstimulating environment. The term "social breakdown syndrome" was coined to describe the progressive deterioration of the social and interpersonal skills of long-term psychiatric patients (Gruenberg, 1967). However, evidence is accumulating that chronically mentally ill patients who have spent most of their life in the community, with brief periods of hospitalization during acute crises, have the same deterioration of social and interpersonal skills as those who have had long-term hospitalizations.

A comparison of Feighner criteria schizophrenic inpatients with a group discharged 5-9 years earlier, showed no differences between groups in positive or negative schizophrenic features or behavioral performance, when age and duration of illness were taken into account. However, inpatients performed less well on cognitive tests. The authors concluded that the deficits of chronic schizophrenia are integral to the disease process, and that any effects of institutionalization are relatively small (Johnstone et al, 1981).

5. never-institutionalized patients

A population of "new" chronic patients is emerging. They have been referred to as "young adult" chronic patients, but many are now getting into their forties'. They often present for therapy in puzzling and discouraging ways.

Most often, these patients are schizophrenic, but some are manic-depressive, and many suffer from personality disorders.

According to Leona Bachrach, we should have been able to "see them coming", but we didn't. These patients are truly de-institutionalized, in that they have never been institutionalized, and theoretically are the beneficiaries of deinstitutionalization. They are found in all service systems, but many do not use any system - typically, vagrant street people. Many are dealt with by the criminal justice system. They can be frequently found among the users of regular general hospital emergency rooms.

Drug abuse can be a major factor; in general, there is a high risk for suicide, as these people often have fragile egos and difficulty dealing with rejection. Most are active demanders of services, but compliance with treatment plans is often poor.

No one expects these patients to change. They have been described as "surly, and perceived by staff as negativistic and frightening". They often evoke anger and frustration in staff.

Twenty-five years ago, these patients would likely have been institutionalized, possibly for life, in which case they would have had a low profile. In some ways, however, these patients fit the demographic profile of their generation, the "baby boomers": they are geographically mobile, moving a lot. This results in their often being homeless street people, especially in urban areas, but also in rural vacation and tourist areas. Some are on a seasonal migration circuit.

These people need different kinds of programs than the traditional ones. In years past, the norms of social behavior in institutions were very clear. This is no longer so, and the individual may have to discover his own norms of social behavior based on the role he tries to fit into. In general, however, these people look to their peers for norms, which are vastly different from the norms of their treaters: they have different goals, values, and culture. Because of these differences, some people advocate unstructured "drop-in centres", while others suggest even more structure than in traditional programs.

The lack of family support which is frequently found, combined with high mobility, means that providing comprehensive care becomes very difficult.

Housing is often important, but we are faced with a paradox: we may not want them in institutions, but we often don't want them in our communities either.

B. families

1. family reactions to mental illness

a) emotional reactions

(Bernheim & Lehman, 1985) The emotional anguish suffered by parents, siblings, children, and spouses of the mentally ll can hardly be overstated.

(1) guilt

For parents, guilt represents a common and substantial hurdle to effective coping. For several decades, the psychiatric literature and the lay press have emphasized environmental determinism. In short, it is common, although faulty, knowledge that crazy children are invariably produced by crazy, bad, or, at the very least, incompetent parents.

In the case of spouses, guilty feelings may result from being unsupportive or short-tempered with their sick partner, or from feeling that they caused a relapse. Children of patients may be concerned about having had angry, hateful thoughts about the ill parent, or about having caused the illness by some other shortcoming in themselves.

(2) anger

Family members search for an explanation of the illness outside of themselves as well, which may result in feelings of anger - at the ill relative who is often seen as malingering or manipulative, at other family members, at the ineffective professional "helpers", at unsupportive extended family or friends, at God. Anger and guilt frequently alternate, one leading to the other.

(3) grief

The growing awareness that the ill relative may never meet his own or others' expectations leads to a sense of loss, of grieving. Of course, the mourning process can never be completed, as it might after a loss by death. There are often events which arouse some hope, temporarily, which will lead to a renewed sense of loss.

(4) worry

Anxiety may be a consuming, ever-present sensation. Will the ill person yell at hallucinated voices in the supermarket today? Will a sibling get angry and storm out of the house in frustration? Fears that the patient may hurt himself or someone else are common, and well-grounded, given the high suicide rates or impaired judgment found in chronic mental illnesses.

Fears of the future include worry about relapse, about what will happen when caretakers grow old and die. Siblings and children have a special fear: "Will it happen to me?" They will also worry about the possibility that the burden of caretaking will shift to them in the future.

(5) other feelings

Other feelings commonly experienced by family members include denial, helplessness, and hopelessness. These emotions may result in withdrawal from the patient and from other people or interests.

b) symptomatology

We should not be surprised to find that families commonly report markedly increased tension, risk of marital discord, and stress-related physical symptoms.

(1) magnification of conflict

Having a mentally ill member in the family provokes conflict between family members and magnifies normal conflict, for example, the different approaches to parenting. With a mentally ill child, normal differences in style tend to become loaded with too much importance, as parents search for the cause of the disorder in their own and each other's behavior.

Siblings may feel that they are forced to make sacrifices for the ill person; they may also become enraged over their parents' "taking it" from their sick brother or sister.

(2) inability to plan

Many of life's pleasures derive from expectations and plans we have for the future. But because of the uncertainty generated by the illness, planning becomes very difficult.

(3) "economy of coping"

The "economy of coping" is profoundly affected by mental illness in the family. Because of the vast expenditure of time and energy on illness-related issues, little is left over for other potentially more satisfying relationships or rewarding activities.

c) social effects

Families often find that their social network is constricted over time. Families may be embarrassed by the ill relative's behavior, and thus invite few people in; this results in fewer invitations to go out. The family may be afraid to leave an unpredictable person, or one with poor self-care skills, alone to go out; and too embarrassed to hire a "baby-sitter". Extended family and friends may avoid the family because of the stigma associated with mental illness.

d) role impairment or role confusion

Role confusion is the inability to count on all family members to do their own chores and live up to expectations. For example, the wife of an ill man may find that he is unable to provide the financial and emotional support usually provided by a husband. She may have to take on some of his parenting functions, in addition to her own, as well as a quasi-parental role with respect to her mate. All these responsibilities may prevent her from being as successful in her own role as wife, mother, employee, etc. as she might otherwise be.

2. "expressed emotion"

Back in the 1950's, a British survey of outcomes among discharged schizophrenic patients found that close emotional ties with families were associated with higher relapse rates. These investigators (Brown, Birley, & Wing, 1972) developed specific measures of the family's emotional involvement with the patient, which they called "Expressed Emotion". Using a semi-structured interview technique, they recorded various negative emotional responses of the family and categorized them into subscales: critical comments, hostility, and emotional overinvolvement. A composite index could be separated into two groups: high EE and low EE. They found that 58% of patients with high EE relatives relapsed within nine months after discharge, compared to only 16% of those in low EE families. If there was less than 35 hours per week of face-to-face contact, the relapse rate (about 27%) did not differ between high or low EE families. However, for more than 35 hours per week of contact, relapse rates were 79% for high EE families and only 12% for low EE. This difference could not be explained by differences in patients' symptoms, behavior, or level of functioning.

These results were replicated and extended in a study involving both schizophrenic and depressed patients (Vaughn & Leff, 1976), which found that antipsychotic medications added some protection against relapse among patients with frequent contact with high EE families, but made no difference for patients from low EE families. In depressed patients, an even higher vulnerability to relapse related to high EE was found. The relationship between high EE and relapse was also found in a California study (Vaughn et al, 1984).

This line of inquiry is attractive because it integrates the evidence for biological vulnerability in schizophrenia with evidence that environmental stress affects the course of the illness. Family members are not assumed to have caused the patient's illness but can play a major role in the patient's adaptation or maladaptation to it. Nevertheless, because the literature tends to reduce families to either "good" (low EE) or "bad", it may not differ in a practical sense from the older "family as causal agent" theories. Is it that much different to be labelled "schizophrenogenic" or to be identified as contributing to relapse through communication of negative emotions?

A more specific criticism is rendered by Kanter et al, (1987), who reviewed the literature to show that it fails to provide evidence that expressed emotion causes relapse, only that it may predict relapse. Neither does the evidence support linking the three components - criticism, hostility, and emotional overinvolvement - in a single global variable. The authors question the clinical relevance of expressed emotion ratings, believing that treatment strategies based on them tend to blame relatives for the patient's continuing difficulties.

a) the social control hypothesis

James Greenley (1986) has attempted to reconceptualize the "expressed emotion" measure as an indicator of family attempts to socially control the schizophrenic's behavior in a particular way, and supports this hypothesis by his review of the literature. He suggests that attempts at control reflect ways that anxious and fearful families try to cope. When they learn that the schizophrenic's problem is mental illness, they are likely to abandon their attempts to control the patient's behaviors in the same ways, which explains the effectiveness of psychoeducational interventions.

C. networks

According to Cutler (1984), networks are beginning to be regarded as a panacea, as the search for cost-effective strategies for the development of services for the chronically mentally ill continues. Popular methods such as "Community Support Systems" and "Case Management" are hoped to provide a buffer against relapse. Although there is little evidence that network approaches have had much effect on service delivery systems, nevertheless a better understanding of the normal development of social networks will be necessary before practitioners can successfully apply these ideas.

1. characteristics of networks

a) size

Whereas emotionally healthy individuals live in functional psychosocial kinship systems of between 20 and 25 persons with whom they share interdependence for affective and instrumental support, psychotics have been found to have 4-6 persons in their networks, and persons with thought disorders had networks averaging about 13 in size. Schizophrenics averaged 10.2 persons in their networks. Smaller networks are associated with hospital treatment compared to outpatient settings.

b) number of kin

Outpatients have greater contact with friends and kin than inpatients. Generally, the smaller the network, the larger the proportion of kin.

c) clustering and density

Clustering is the number of mostly separate groups of three of more individuals in the network, whereas density is defined as the rate of actual to possible connections among a set of individuals. An average network may have five of six clusters with six persons each, but schizophrenics may have only one or possibly no definable clusters. High density and lack of clustering leave the patient trapped in a dense, intensive context with high EE factors, which does not allow room for new relationships or for roles which lead to improved self-esteem.

d) long-term relationships

Chronic mental patients have few long-term relationships except with kin.

e) multi-dimensionality

This refers to the number of different functional areas, role relationships, or types of exchanges which characterize the ties between the focal person and other network members. It has been found that fewer multidimensional relationships is related to higher symptomatology and lower rates of hospitalization. It must be kept in mind, however, that these are not cause-and-effect relationships. For example, having more symptoms or being hospitalized more is likely to result in smaller networks which are characterized by unidimensional relationships (eg patient-therapist).

f) reciprocity

This refers to the mutuality of affective and instrumental exchanges between individuals. Psychiatric patients have been found to receive more functional support from their network than they give in return.

2. network strategies

Clinicians should consider the following strategies when attempting to normalize networks of chronically mentally ill persons:

- networks should be carefully enlarged to include new clusters;
- family members should be counselled or educated to be involved in other activities that will take their focus off of the patient in order to diminish the amount of expressed emotion in their relationship;
- long term relationships should be established with an integrated spectrum of service providers and also with permanent socialization segments in the community;
- patients cam be helped to assume some responsibilities and activities that they can perform for other people, to increase the reciprocity and multidimensionality of their networks gradually, leading to improved self-esteem and longer-term relationships.

D. the community

1. foster parents

A foster home has been defined as "a traditional family setting in which a patient lives with at least one responsible adult". A study (Linn et al, 1982) has shown that foster home placement results in a greater degree of improvement in social functioning than institutionalized patients. Factors which were associated with improved outcome in foster homes were: more children in the home; fewer boarders, and smaller size. The study also showed that a high degree of environmental stimulation, more supervision by foster parents, and more intensive followup by social workers, were bad for schizophrenic patients but good for non-schizophrenic patients.

The above suggests that foster parents can be educated, using similar psychoducational approaches as are used with more traditional families, to relate to patients in ways which reduce relapse and improve functioning.

2. others

Although there does not appear to be much literature on the usefulness of interventions with other groups in the community, such as employers, landlords, or merchants, it is clear that a better understanding of mental illness by such individuals might result in fewer misunderstandings and improved self-esteem for patients. The psychiatric rehabilitation programs offered by clubhouses such as Fountain House and others based on the same model, work to educate employers who participate in rehabilitation about what they might expect when hiring mental patients.

II. Psychological Interventions

A. common elements of psychosocial interventions

According to Frank (1961), all psychosocial treatments, whether clearly defined entities like individual psychotherapy or not, share common non-specific elements:

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

B. interactions with psychotropic medications

While it has been clear for many years that relapse rates in schizophrenia can be significantly reduced with antipsychotic medications, it is only more recently that the interactions between psychosocial factors and medication has ben studied. Vaughn and Leff (1976) demonstrated that antipsychotics reduced relapse in patients with high EE relatives that they spent more than 35 hours per week with, but that fewer contact hours meant that medication had little effect.

Besides the often stated truism that a supportive psychotherapeutic relationship helps to improve medication compliance, the possibility that there may be a synergistic effect between antipsychotic medication and psychological interventions for chronic schizophrenic patients deserves further study. The model in this case is the demonstrated synergy between antidepressant medication and certain forms of psychotherapy in improving depression.

On the other hand, the side effects of antipsychotic medications, such as mask-like facies, amotivational syndrome, and disorders of movement, may make rehabilitation treatments less likely to be successful, in that such side effects will impair communication of affect (vital for social skills), reduce patients' motivation to begin and to stay in treatment, and further alienate people (including treatment staff) who are repelled by bizarre behaviors and movements.

III. Interventions with Patients

A. by type of patient

1. patients with unremitting symptoms and flagrant behavioral disabilities

Gudeman & Shore (1984) discuss the deinstitutionalization program in Massachusetts, with particular reference to the experience of the Massachusetts Mental Health Centre, which is responsible for an urban catchment area of 200,000 population, and has had no state hospital backup since 1971. It looks after almost all the former state hospital back ward patients who formerly resided in the center's catchment area. Since 1981, the center has had 2 day hospitals, each treating 40 to 50 patients (avg stay 28 days); a 30-bed intensive care unit (10 days average length of stay), and a 35-bed "inn" to temporarily house day-hospital patients (avg stay 21 days). There are 200 nursing-home places, and 20 special psychiatric-geriatric nursing-home places. The total hospital-residential care serves about 500 patients daily.

The above length of stay figures do not include 30 patients (ie 6%) who stay in the facility continuously, despite an average of 5 years' exposure to a full range of treatments. The authors believe that these patients would be better served in specialized-care facilities, because of unremitting symptoms and flagrant behavioral disabilities. The patients fall into 5 groups:

I. Elderly, demented, and behaviorally disturbed. These would require containment and supportive care (3/100,000 population).

II. Mentally retarded and psychotic. These require re-education and behavioral modification in a low-stimulus environment (3/100,000).

III. Brain-damaged, assaultive pts. These need containment and supportive (including medical) care (1.5/100,000).

IV. Psychotic and assaultive, suicidal, or obstreperous. Need secure, long-term setting (2.5/100,000).

V. Chronically schizophrenic, disruptive, and endangered, with behavior unacceptable in most settings. Need a structured milieu (5/100,000).

Such specialized treatment settings could consist of 25 to 30 bed units, grouped on one or more campuses, to serve regional or state needs, with a total facility size not exceeding 150-200 pts. There should be stringent preadmission screening, specialized treatment programs for each type of patient (see article for details), and multidisciplinary staffing; units could be on the grounds of state hospitals; they should be affiliated with an acute-care psychiatric unit for emergency backup; careful attention to political matters is required because of anxiety about re-institutionalization.

B. by type of treatment

1. individual psychotherapy

Mosher & Keith (1979) in their overview of research on psychosocial treatments for schizophrenia, pointed out that doubts about the usefulness of individual psychotherapy stems from the negative results of controlled outcome studies in the 1960's, as well as the development of clearly effective drug treatment. They cite four studies, two of which had largely negative results, but emphasize the critical design flaws in all four, even those which had more positive results.

When compared to group therapy, the latter seems to have some advantages, in terms of patient and therapist satisfaction, for more chronic patients.

2. group psychotherapy

The same review by Mosher & Keith (1979) reported on six comparisons of group therapy of schizophrenics against a no-group-therapy hospital condition. Four of these failed to reveal any unique or impressive contribution assignable to group therapy. They noted, however, that the two studies with positive results were better designed.

Five out of six studies in which group therapy in combination with another treatment approach (such as neuroleptic medication, videotape feedback, ward activity, or dyadic social interaction) reported that the combination was superior to the treatment forms offered singly.

The authors referred to six major studies on group therapy given to posthospitalization schizophrenics, which failed to yield strong or consistent evidence for reduced rehospitalization rates, improved vocational adjustment, diminished psychopathology, or enhanced social effectiveness for group therapy as compared to individual therapy or no-group-therapy controls. However, group treatment did affect socialization and interpersonal skills positively.

3. self-help

One can define self-help groups as organizations of persons who meet regularly on a face-to-face basis and assist one another in changing behaviors or attitudes (Barter, 1984). They often define themselves as dealing with problem areas which lie outside the traditional medical or mental health care system. They usually have lay leadership and are nonprofit.

There has been an explosion in the number of such groups in the health field. There are three basic types:

- loss-transition groups, in which members deal with a major event involving a loss or disruption of a relationship with a loved one;
- one-step-removed groups, composed of relatives or friends of an affected person;
- stress-coping or stress-support groups, in which members have a clinically diagnosable illness.

The functions of self-help groups include:

- to provide a context within which meaningful interactions can occur;
- to share factual information about the disease process and how to deal with it;
- to share suggestions for altering the attitudes of professionals;
- to provide emotional peer support;
- to serve as reference groups and role models to redefine feelings of stigma, guilt, or inadequacy;
- to increase participants' self-esteem by helping others;
- to increase consumer consciousness about treatment delivery systems.

Formal psychoeducation is an important part of many self-help groups, whether by the publication of newsletters, pamphlets, or books, or by inviting professionals to speak at meetings or to give advice.

In Québec, self-help groups involved in mental illness include AMI-Québec, for relatives and friends of the mentally ill, which holds information meetings, sponsors support groups, and runs socialization programs for patients. Many patients benefit from Alcoholics Anonymous and its counterpart for drug abusers, while their relatives can get support from Al-Anon and Ala-Teen. Less well known is Recovery, Incorporated" which is geared directly to 'patients themselves. This organization encourages its members to cooperate with the treatments prescribed by psychiatrists.

4. long-term inpatient treatment

An excellent article by Talbott & Glick (1986) provides a comprehensive, although brief, review of what is known about the treatment of chronic mental patients. In spite of its title, it considers outpatient settings as well. A very selective review of the literature highlights the points that psychotherapy is not essential for inpatient treatment of chronic schizophrenia, but is essential in outpatient care; group therapy is more effective than individual treatment; drugs alone are not sufficient to prevent relapses; a highly structured, organized, expectant milieu that stresses adaptive skills, while suppressing symptoms and maladjustive behavior, is helpful in hospital treatment of chronic schizophrenia; a highly organized resocialization-relearning program, with a behavior treatment orientation (eg token economy), enables chronic schizophrenics to stay in the community much longer than those receiving milieu therapy or traditional State hospital care; alternatives to hospital treatment, whether home care, family treatment, day hospital care, residential nonhospital treatment, or community-based community support, are as, if not more, effective than inpatient treatment in reducing symptomatology, rehospitalization, interpersonal difficulties, and vocational disablement; the cost of high quality community care, while quite high, is a bit less than hospital care plus traditional followup; there are no data to support the use of hospitalization instead of outpatient treatment for most of these patients; the drawbacks of hospitalization, often overlooked, include the financial costs, potential harm to patient self-esteem and role functioning, and conditioning of patients to use and depend on the hospital to deal with crises. With regard to length of hospitalization, the authors feel that most patients requiring inhospital settings can be effectively treated in relatively short-term settings, so long as day treatment and supportive residential treatment are readily available.

Indications for hospitalization include: reevaluation of diagnosis and functioning of chronic patients; re-equilibration of medication; to effect changes in treatment plans; when a patient cannot be optimally managed as an outpatient; if treatment that is not available in community settings is required (eg ECT); to deal with transference crises or countertransference problems; detoxification from alcohol or drugs; "respite care".

Inhospital treatment includes the following elements: evaluation/assessment (the authors stress that, since withdrawal, depression, and lack of spontaneity are common to chronic schizophrenia, chronic affective disorders, chronic institutionalization, and organic mental conditions, these differential diagnoses must be considered from the start); medication; psychotherapy; family treatment/psychoeducation; instruction in skills of everyday living; vocational rehabilitation; and socialization. Finally, discharge planning should begin at admission, and should include provision for psychiatric care, medical care, housing, socialization and social rehabilitation, vocational rehabilitation and work, income, and continuity of care. The authors also briefly discuss long-term hospitalization, and the need for asylum and how it can be met.

C. by phase of treatment or illness

1. acute phase of chronic mental illness

a) hospitalization

(1) reasons for hospitalization (Diamond, 1979)

(a) evaluation

A. To make extended and careful observations of the patient's behavior:

- interactions with others;
- behavior away from family or other normal environmental stress;
- to clarify discrepancies between the patient's report and the report of the family, employers, or other informants.

B. To execute extensive medical and psychological diagnostic tests, such as arteriograms and neuropsychological tests.

(b) intervention

A. To administer medications to an uncooperative patient who is very likely to demonstrate serious maladaptive behavior unless medication is started or controlled:

- for medication too complex or dangerous to be given at home;
- to be sure that confused or uncooperative patients actually take their medication;

B. To manage special procedures, such as electroconvulsive therapy.

C. To control the withdrawal of alcohol, depressants, or other drugs that cannot safely be withdrawn without close medical observation.

D. To motivate a patient and his family to change:

- to help the patient and family accept and support treatment;
- to encourage the patient and his family to make necessary life changes.

E. To provide the support and structure needed for short periods (days to weeks):

- to relieve family tensions so that explorations of critical relationships can proceed without generating a family crisis;
- to provide a locus in which the staff can intervene in a patient's environment;
- to remove the patient from stress with which he or she cannot cope.

(c) protection

A. To protect a patient from his own imminent physical self-destructive acts.

B. To protect the community from the likelihood that the patient will cause physical harm to others.

C. To meet the patient's basic needs for shelter, food, and clothing when the person cannot provide them.

(d) systems support and maintenance

A. When required because of patient factors:

- to protect the family and community from exhaustion of their resources during periods of crisis.
- to provide temporary relief for the family and other close associates from the ongoing drain of providing support and care.
- to protect family members (especially children) from the harmful effects of the patient's behavior.

B. To provide a place of safety, stability, and support during periods of disruption in the patient's community support system (caused by illness in patient's family, a therapist's vacation, and so on).

C. To provide an environment that can contain the patient when he demonstrates both severely disturbed behavior and an incapacitating medical illness that cannot be handled well by a medical or surgical service.

(2) length of hospitalization

Carol Caton (1984) reviewed studies on the effect of length of hospital stay for chronic patients. She concluded that the evidence convincingly showed that long stays were not superior to brief hospitalizations in terms of number of rehospitalizations, aftercare treatment compliance, or clinical or social functioning.

b) intensive care inpatient settings

These units have been the time-honored locus of care for acutely ill psychiatric patients (Klar, 1987), and are considered the safest and most obvious choice for severely ill patients. Within the highly structured, restrictive setting, a highly trained staff can efficiently acquire diagnostic information, protect the patient from dangerous acting out (using seclusion and restraint if necessary), institute pharmacologic treatment (at times against the patient's will), and plan further treatment. Because these units are based on the medical model - the patient is "sick" - they can foster regressive behavior and disrupt social role functioning. Typical length of stay is 10 to 30 days.

c) intensive care partial hospital programs

These settings are like acute inpatient settings in that they are highly structured, based on the medical model, and aimed at rapid diagnosis, they differ also in that they are less accepting of the "sick-role" (Klar, 1987), and encourage the patient's active participation in treatment. Since patients live at home, hospitalization is like a full-time job, and is consequently less disruptive to social and family roles and is less stigmatizing.

Gudeman et al (1985) report on a system of care in which all patients who require psychiatric hospitalization are admitted to a day hospital with an inn and an intensive care unit. Data on use of services, length of stay, recidivism, security, medical emergencies, staff accidents, and seclusion and restraint over a 4-year period suggest that the new delivery system provides care which is at least as effective as the previous system of care. Evidence is presented that the new system offers certain advantages, including less seclusion and restraint, fewer episodes of escape, and substantial cost savings.

d) outpatient crisis intervention

Klar (1987) identifies crisis intervention as a brief, time-limited, intense treatment requiring frequent sessions, a well mobilized support network, a staff that is available and reachable, and a versatile, multidisciplinary staff.

A growing variation is home care, in which patients in crisis who have viable support networks are regularly visited by a team, often a physician and a nurse clinician or social worker.

2. rehabilitation

a) principles of rehabilitation

Anthony et al (1984) have identified the essential principles of rehabilitation as follows:

1. The primary focus of psychiatric rehabilitation is on improving the psychiatrically disabled person's capabilities and competence.
2. The benefit of psychiatric rehabilitation for the clients is behavioral improvement in their environments of need.
3. Psychiatric rehabilitation is atheoretical and eclectic in the use of a variety of therapeutic constructs.
4. A central focus of psychiatric rehabilitation is on improving vocational outcome for the psychiatrically disabled.
5. Hope is an essential ingredient of the rehabilitation process.
6. The deliberate increase in client dependency can lead to an eventual increase in the client's independent functioning.

7. Active participation and involvement of clients in their rehabilitation process is sought.
8. The two fundamental interventions of psychiatric rehabilitation are client skill development and environment resource development.

b) rehabilitation approaches

(1) client skills development

The research studies undertaken in client skills development are listed by Anthony et al (1984) under the following headings:

- social behaviors
  - social behaviors and activities of daily living
  - interpersonal behaviors
  - conversation and assertiveness
  - controlling aggression
  - vocational skills
  - problem-solving skills

Two general approaches consist of: 1) training clients directly, and 2) behavioristic approaches, including token economies. The problem of skills generalization (ie the transfer of skills from the training setting to other settings can be particularly acute with behavioral approaches which depend on specific reinforcements. Generalization does not just occur - it must be programmed. The following principles may be helpful:

- use the natural reinforcers present in the environment of need to reward appropriate responses in the training environment;
- provide support services to follow along the client in the environment of need;
- teach support persons the skill of selective reward to be applied in the environment of need;
- teach the client to identify intrinsic motivation as a replacement for extrinsic reward;
- increase the delay of reward gradually;
- teach in a variety of situations;
- teach variations of response in the same situations;
- teach self-evaluation and self-reward;
- teach the rules or principles which underlie the skill;
- use gradually more difficult homework assignments.;
- involve the client in setting goals and selecting intervention strategies.

An important aspect of skills training is the use of community resources; for example, volunteer work in various community settings can be a very valuable component of practice in work skills training. Similarly, making use of community resources such as parks departments, bowling alleys, YMCA's, etc. can provide a normalizing experience for clients in leisure skills training.

c) inpatient settings

(1) social learning

An article by Glynn and Mueser (1986) summarizes the landmark study reported on in 1977 by Paul and Lentz, which compared a social-learning program (token economy) with a therapeutic milieu and with the usual custodial public mental hospital care. Both treatment conditions were comprehensive psychosocial treatment programs that actively sought to enhance patients' functional independence. The social learning program was based on learning principles such as associative learning, problem solving, reinforcement, modeling, punishment, and shaping.

Outcome was measured by determining to which extent the following three goals were met:

- increasing patients' adaptive functioning (eg self-care and social skills) and decreasing patients' psychotic functioning and extremely bizarre behavior;
- reducing the psychotropic medications necessary to stabilize patients;
- facilitating discharge and successful maintenance in the community.

In all three domains, while milieu therapy resulted in greater gains than seen in the hospital comparison group, the social-learning program yielded strikingly better results than the milieu treatment. Moreover, the social-learning program treated nearly 30% more patients than either the milieu of hospital programs with essentially identical resources. Consequently, it was three to four times as cost-effective as traditional programs.

Although many of the behavioral paradigms applied in the social-learning program have become familiar to clinicians, total treatment programs remain quite rare. One exists at Camarillo State Hospital, and is described by Glynn and Mueser (1986). It appears that Paul and Lentz have not been idle, either; they will soon be publishing a second edition of their study, and will make available to others the comprehensive and detailed schedules, reports, etc. needed to implement a total token economy program, in a computerized format.

(2) combined social learning and milieu program

(Greenberg et al, 1975) [authors' abstract] To determine whether the addition of milieu principles to a contingency program increases its effectiveness, the investigators compared two treatment programs in a mental hospital: (a) a social learning or token economy approach and (b) a combined social learning and milieu approach in which patients were given increased decision-making responsibilities, group pressures were used, and both were integrated with response-contingent management. Because the patients in the combined social-learning/milieu program spent significantly more days out of the hospital during the 1-year experimental period, the authors concluded that that program was more effective than the token economy in promoting the generalization of adaptive inhospital behavior to community settings.

d) Partial hospitalization

Meyerson & Herman (1984) reviewed studies which looked at whether partial hospitalization programs could be considered an alternative to in-patient care. They concluded that there is evidence tha. day treatment of a supportive and perhaps long-term nature can help to prevent relapse, enhance functioning, and decrease symptomatology. However, it can be difficult to find an equilibrium between too much stimulation (which produces relapse) and too little stimulation (which fosters apathy).

One study showed that day treatment centres characterized by more occupational therapy and a sustained nonthreatening environment, could delay relapse significantly, reduce symptoms, and modify patient attitudes. The effects were most pronounced at 24 months.

e) outpatient settings

(1) transitional residences

According to Meyerson & Herman (1984), transitional residences provide supervision and support for newly discharged patients for a limited period while they adjust to more independent living and reintegration into the community. The sponsoring agency usually assumes responsibility for helping residents move to long-term living situations in the community, and for determining when residents are ready to make such moves.

a typical transitional residence might be a cooperative apartment, for which a consultant mental health professional is provided who visits regularly, meets with residents and residential managers to review residents' progress, and is available in crises. the agency acts as lessee of the apartment, obtains and screens referrals, and selects residents. Rent payments and maintenance charges are shared by residents who not only pool resources but also emotional support.

f) problems

Attempts to rehabilitate patients too rapidly may provoke acute symptoms of hallucinations and delusions (Hirsch, 1983).

3. maintenance

Lamb (1984) cites studies showing that about half of the chronic population in California lives with relatives, and that most of the other half need to live in supportive settings as they are unable to live independently. There is a wide range of out-of-home living arrangements run as governmental, private non-profit, or proprietary facilities. Some are transitional, others long-term.

a) board-and-care homes

About one-third of long-term psychotic patients under 65 live in boarding homes, in one California study. In general, such homes are not the result of careful planning, but instead have sprung up to fill the vacuum created by deinstitutionalization. They house between one and more than a hundred patients each, and usually provide a shared room, supervision of medications, three meals a day, and minimal staff supervision. The better homes do more than provide asylum: they can often warn treatment teams of impending relapse; they can reduce stresses by, for example, managing residents' money.

It is possible to improve these facilities in two ways: 1) professionals can be sent out from community service systems to work with each patient, and 2) a mental health professional can take over the facility and hire and train sufficient staff to work with each patient, individually, in groups, and in activity programs.

b) locked skilled-nursing facilities

Again in California, locked skilled-nursing facilities have been set up to look after patients characterized by assaultive behavior, severe overt major psychopathology, lack of internal controls ,reluctance to take medication, inability to adjust to open settings, drug/alcohol problems, or self-destructive behavior. Instead of being kept in state hospitals, such patients can be given active treatment and rehabilitation in their home community. An intensive program that structures most of a patient's day is a key element. Small size (100 beds or less) makes it possible for every staff member to know every patient. Primary goals should include preparing such patients to live in less structured settings.

c) foster care

The prototype of foster care is in Geel, a small Belgian town in which mental patients have been cared for in townspeople's homes for over 700 years (Srole, 1977). There are no more than 2 patients per home; they have their own bedrooms, but share meals and leisure activities wth the family. They participate to some extent in the family's domestic and income-producing work, which supplements the payments made by the state towards their care.

More children in the home, fewer fellow patients in the home, and fewer total occupants are associated with improvement in social functioning. For schizophrenics, more activity and more intense supervision were associated with deterioration in social adjustment.

d) jail

Several studies describe a "criminalization" of mentally disordered behavior, that is, a shunting of mentally ill persons in need of treatment into the criminal justice system instead of the mental health system. This is partially th result of increasing legal restrictions placed on hospitalizing patients involuntarily.

D. by treatment setting

1. the mental hospital

a) functions of mental hospitals

Institutional care has historically included a complex and extensive set of functions extending beyond the mere provision of long-term residential care. These services include (Bachrach 1984):

- providing comprehensive medical care and regular monitoring;
- rendering relief to overburdened families;
- providing the patient with a social network when he or she has difficulty creating his or her own;
- serving as advocate for the patient when he or she is unable to gain independent access to goods or services.

The hospital is used for social control, to "get rid of" people who scare or bother the larger community. This is a function society needs to have fulfilled.

b) variables affecting hospitalization

In addition to the usual factors which determine whether a patient will be admitted or not, such as the degree of psychopathology, manifest symptoms, presence of bizarre behavior, and whether the person has been previously hospitalized, there are other less-well-known factors.

(1) role of admitting clinician

(a) professional status

Psychologists admit more than psychiatrists, who admit more than social workers.

(b) experience

Decision-makers with less than 6 months' experience hospitalized significantly more frequently than those with more than 3 years' experience.

(2) time when patient presents

Patients presenting at night or on weekends were more likely to be admitted than those who came in for evaluation during the working day.

(3) sociodemographic variables

Studies looking at age, sex, education, occupation, or marital status have produced conflicting results

(4) family variables

One study suggests that families' tolerance for symptomatic behavior is inversely correlated with more rapid hospitalization of family members. Once families make the decision to admit, they may experience and report symptoms as more severe from their point of view.

c) problems with hospitalization

Chronic symptoms, such as social withdrawal and poverty of speech, have been found to vary from one hospital to another according to the severity of ward restrictiveness, absence of personal belongings, and the length of time that patients were left to do nothing (Hirsch, 1983).

Hospitalization tends to take the focus, as well as the money and energy, away from alternative ways of treating the deficiencies of patients referred to above. It also separates the crises leading to hospitalization from the events of the rest of the patient's life. (Diamond, 1979)

Because the hospital can clearly be a place of refuge and safety from a threatening world, the availability of this refuge can often become the problem, as even normal stresses encourage tha patient to cope as he has before - by again becoming hospitalized.

Whenever services are provided for patients that they can provide for themselves, the patients' movement toward autonomy and self-esteem is hampered.

It is less likely that clinicians will help patients establish ways of coping with the stresses of the real world if the patients are not even partially involved in that world.

Clinicians develop the habit of using the entire inpatient setting, although only bits and pieces of it are usually needed in any particular case.

The hospital is costly in a social and psychological sense, because it disrupts a support system that is typically difficult to establish and maintain. It results in, for example, losses:

- of rooms or apartments;
- jobs;
- rapport with outpatient treatment staff;
- pride and sense of success and competence in dealing with the outside world.

The hospital is inefficient in terms of providing what most patients need, because it tends to provide more than is needed in any particular case. It usually provides a complete world that supercedes the outside community.

Nurses, doctors, and hospitals tend to reinforce the view that patients are "sick" and therefore not responsible for their own behavior. Similarly, the hospital not only tolerates but sometimes teaches and encourages crazy behavior: because the hospital is a place of safety that is taken away when patients act normally, they sometimes attempt to return to this refuge by escalating their bizarre or suicidal behavior.

d) Planning principles

Bachrach (1984) spelled out the basic planning principles which may be applied in the development of networks of service systems for chronically ill psychiatric patients. Because of the heterogeneity of patients, a variety of treatment modalities and approaches are necessary. The planning principles she enumerated were:

(1) functional equivalence

Very often, a variety of service interventions can potentially meet the same need. For example, halfway houses, foster homes, cooperative apartments, supervised apartments, or other types of residence can all meet patients' needs for housing. One type can substitute for another, if circumstances dictate.

(2) cultural relevance

This planning principle acknowledges that the specifics of service systems vary from one community to the next. The factors which are important in what services a particular community should offer are:

- character of the patient population: diagnosis, symptoms, treatment history, level of care required;
- goals of the community for its chronically psychiatrically ill members: eg, quality of care; where patients live; aspirations to "mainstream" everyone; provision of sanctuary;
- availability of resources: funding, attitudes, involvement of families.

(3) potential tradeoffs

Where a range of alternatives can potentially fulfill the same function, not every community must provide every possible intervention (Bachrach 1983). For example, if a community has enough halfway houses and cooperative apartments, it may not need foster homes.

e) community attitudes

Rabkin (1984) reviewed studies of community attitudes towards mental illness and community mental health facilities. She discovered several common themes:

- neighbours are frequently unaware of local psychiatric facilities in their immediate proximity;
- when aware, they are usually not distressed about their presence;
- hypothetical or proposed neighborhood facilities evoke much more expressed resistance than do existing facilities.

The available evidence does not support the notion that communities are united in their rejection of the mentally ill and the facilities that serve them, or that a special stigma characterizes them. In general, neighborhoods do not welcome any groups brought in from the outside, and do not make special distinctions for mentally ill patient groups. This suggests that pragmatic politics may require the offer of community trade-offs (such as simultaneous introduction of a psychiatric facility and a new playground) as well as reliance upon good will for the successful establishment and management of local services for the chronically mentally ill.

IV. Interventions with Families

A. The family task

(Bernheim & Lehman, 1985) The purpose of intervening with families is to improve their functioning in their task. This task is easy to state but difficult to achieve. Simply put, the family must provide a highly structured, moderately stimulating, emotionally benign environment for its ill member while minimizing the inevitable stress and constriction in the lives of its well members.

Because persons with thought disorder become more disorganized with overstimulation, while deficit symptoms may be exacerbated by lack of stimulation, the family must learn to support, encourage, and motivate its ill member without creating undue stress. Learning to respect the person's need for interpersonal distance, and read their "signals" is critical. Because of the "expressed emotion" paradigm, the family must work towards managing conflict (already magnified, as discussed above) in a noncritical, non-emotionally overinvolved way whenever possible.

Perhaps most important, well family members must somehow provide for their own needs, or risk "burn-out".

B. subtasks

- development of realistic expectations of the ill member with respect to personal, social, and occupational behavior;
- setting of priorities for behavior change and developing effective behavior change strategies;
- monitoring the level of stress and symptoms in the ill member;
- encouraging the patient's compliance with treatment;
- reducing the impact of the illness on healthy family members;
- coping with the stigma associated with mental illness.

C. goals of professional intervention

1. information

Although labeling may have negative effects, the advantages outweigh the disadvantages. Advantages include:

- labelling the illness provides a cognitive framework within which to understand various treatment options and management techniques;
- it decreases the tendency to perceive the patient as malicious or malingering;
- it empowers families as concerned and educated members of the treatment network, rather than instigators or perpetuators off psychopathology.

Some knowledge of the role biochemistry and environmental stress play in symptom production alleviates unnecessary guilt and anger. Knowledge about prognosis makes planning for the future easier. Information about behaviors which may signal an impending relapse may help to prevent needless hospitalization.

The provision of information helps develop a cooperative partnership with the family. While the professional becomes relatively less powerful, the ill person and his family become less helpless and resistive.

2. help with problems in daily living

Common questions families want help with include how to:

- respond to psychotic and deficit symptoms;
- foresee and manage crises;
- set limits on disturbing behavior;
- motivate without causing too much stress;
- increase structure in the patient's environment;
- plan for the relative's care when caretakers have died;
- respond to questions or withdrawal by extended family or friends;
- develop their own support network.

3. education about the mental health system

The professional may need to be the family's advocate within the complex mental health network. The "case manager" concept has evolved to partially meet this need.

4. contact with other families

Interfamily networking reduces isolation and stigma, and provides a nonthreatening supportive environment for families to learn new skills and approaches. It also provides an outlet for families' needs to be of service through advocacy and public information projects. This can be done through professionally led multifamily support groups, informational lectures offered to groups of families, and referral to self-help organizations such as AMI-Quebec.

D. psychoeducation

There are four major Psychoeducational Family Programs which have been extensively described in the literature.

1. a three-part intervention project

This project (Leff et al, 1982) includes three different types of intervention, as follows:

a) joint interview

As soon as possible after discharge, a joint interview in the family's home is conducted by a psychologist and a psychiatrist with both the patient and his relatives, with the purpose of identifying areas of conflict and to discuss ways of reducing the amount of contact between patient and family, especially in high-EE families. These joint interviews are repeated as needed over a nine-month followup.

b) mental health education

Four brief educational talks are given to the families prior to the patient's discharge from hospital, covering diagnosis, symptoms, etiology, course, and prognosis of schizophrenia. Questions and discussion are encouraged.

c) relatives' group

This group, led by two therapists, meets every two weeks for an hour and a half and includes relatives from several families, but no patients. Low EE relatives are placed with high EE families, hopefully to serve as role models. The group provides mutual support, a safe setting to express feelings, and sharing of information and solutions.

2. a short-term crisis-oriented family program

This program, developed at UCLA by Goldstein and his associates (Kopeikin et al, 1983) consists of six sessions of family crisis therapy, during the six weeks following discharge from brief inpatient stays, and involving the patient, family members, and one therapist. Objectives are:

- to agree on two or three current, potentially stressful circumstances, especially precipitants to the episode;
- to develop strategies to avoid/cope with stress;
- to get patients and families to implement these prevention/coping strategies;
- to anticipate and plan for future stressful experiences.

3. a home-based family intervention approach

Falloon and his colleagues (Falloon et al, 1982) in Los Angeles implemented a behavioral family program for schizophrenic outpatients and their families, consisting of 40 family therapy sessions, held at home during the first 9 months, and consisting of weekly sessions for the first 3 months, biweekly for another 3 months, and monthly for 15 months.

Objectives are to pinpoint a small number of critical deficits in the family's communication and problem-solving behaviors and change them to bring about major improvements in family functioning. Change is effected through a behavioral, educational and supportive program, and 24-hour crisis intervention is provided.

4. a four-phase program in survival skills

Perhaps the most extensive program is that of Anderson and associates in Pittsburg (Anderson et al, 1980). This program has 4 phases:

a) phase I. family sessions without patient
In these twice-weekly sessions, beginning shortly after admission of the schizophrenic patient, the clinician elicits the family's feelings and beliefs about the illness, acts as their ombudsman with the treatment team, and makes concrete suggestions about how the family can contribute to the treatment process.

b) phase II. survival skills workshop
This is a daylong, multiple-family educational workshop held early in the treatment. Information about schizophrenia, medication, and management at home is covered. Experiences, problems, and potential coping strategies can be shared by the families.

c) phase III. family sessions with patient
In this phase, the patient joins the family therapy sessions after the acute symptoms have lessened. Sessions are held every 2-3 weeks over 6-12 months. Stress is placed on increasing structure in the home, strengthening interpersonal and intergenerational boundaries, closer ties to community networks, and a gradual resumption of responsibilities by the patient.

d) phase IV. continued treatment or disengagement
At the end of phase III, the family has the option of either moving to more intensive weekly family therapy sessions or gradually disengaging from treatment.

E. self-help groups

Professionals can support self-help groups composed of the families of mentally ill patients (such as AMI-Québec), by referring families to such groups, by speaking to them or by providing psychoeducational programs for their members, and by financial support.

F. family therapy

Falloon and colleagues (1982) compared family therapy at home with clinic based individual supportive care in 36 patients taking neuroleptic medication who were considered to be at high risk of relapse because of strong expressed emotion among relatives or for other reasons. At the end of nine months only one family treated patient (6%) had relapsed compared with eight patients (44%) in the individually treated group.

V. Countertransference Issues

A. neglect of the long-term mentally ill

In a critical paper, Lamb (1979) maintains that a pattern of neglect of the severely mentally ill, then outrage and movements for reform, followed again by a lapse into neglect, has bee characteristic of the mental health professions and society generally. He posits that the roots of neglect of the long-term mentally ill are in professionals' dissatisfaction with meeting chronic dependency needs, a moral disapproval of dependency and passivity, a distaste for the lower social classes, and an inclination, like that in the larger society, to exclude the mentally ill. When we do finally turn our attention to them, our neglect gives way to unrealistic expectations of rehabilitation. He suggests that there is a need for a reorientation of training so that a high priority is given to learning to tolerate chronic dependency needs and to bridging the gap between the middle-class professional and the lower-class patient.

B. labeling and depersonalization

Rosenhan, a professor of psychology and law at Stanford University, reported in "Science" (Rosenhan, 1973) an interesting experiment in which 8 "pseudopatients" arranged to have themselves admitted to 12 psychiatric hospitals. Except in one case, they were diagnosed as schizophrenic, based on simulated symptoms. Immediately after admission, they began to behave normally again, but were never detected as pseudopatients. The average length of hospitalization was 19 days.

The author suggests that psychodiagnostic labels are "sticky"; once applied to a person, there is little he can do to remove the tag, which profoundly colors others' perceptions of him and his behavior. He believes that we cannot distinguish the sane from the insane in psychiatric hospitals.

The reports of the pseudopatients about their hospital experiences recorded that they were given little eye contact or verbal contact, pointing out the powerlessness and depersonalization that patients experience.

VI. Effectiveness of Interventions

A. psychoeducational approaches

1. three-part intervention project (Leff et al, 1985)

High EE relatives of schizophrenic patients (24 total) were randomly assigned to the experimental program or a control treatment of "routine clinical care". Inclusion criteria included at least 35 hours per week of face-to-face contact. In 9 months, 9% of the experimental group relapsed, compared to 50% of controls. All patients were on neuroleptics.

2. a short-term crisis-oriented family program (Kopeikin et al, 1983)

104 acute schizophrenic patients and their families were randomly assigned to one of 4 treatment conditions: family therapy with either a low dose or a moderate dose of neuroleptic (modecate 6.5 mg or 25 mg IM q 2 weeks), or the low or moderate dose neuroleptic without family therapy. Over six months, none of the family therapy plus moderate dose relapsed, compared to 48% of the low-dose no therapy group. The other two groups had about 20% relapse rates. The conclusion was that moderate doses of neuroleptic as well as the family therapy both improved outcome and were most effective when used together.

3. a home-based family intervention approach (Falloon et al, 1982)

A comparison of patients treated with the behavioral family therapy with those in individual therapy showed significantly more favorable outcomes for family treatment: hospital readmissions were 11% vs. 50%, and clinical symptom exacerbation in 6% vs. 44%.

4. other studies

(Barter, 1984) In a randomized trial 24 patients from high EE homes were given maintenance phenothiazines (usually depot), and either followed up as controls in normal outpatient followup or put into an experimental intensive family treatment program consisting of two lectures about schizophrenia, a relatives' group to help those with high expressed emotion cope better with everyday problems posed by the patient and reduce their own isolation, and sessions with the patient and parent ot reduce expressed emotion and encourage the relatives to have less contact with the patient (Leff et al, 1982).

The results showed a significant fall in critical comments or contact between patient and relative in eight of the 11 experimental families but no fall in the control families. Over nine months, half of the control group but only 9% of the experimental group relapsed.

B. quality of life

Lehman et al (1982) surveyed 278 mentally disabled residents in 30 large board-and-care homes in Los Angeles,to obtain their descriptions of life conditions and satisfaction in eight areas: living situation, family relations, social relations, leisure activities, work, finances, safety, and health. They found that residents were less satisfied than the general population in most life areas, especially finances, unemployment., safety, and family and social relations. Of particular concern was the finding that 34% had been recent victims of crime.

VII. Policy and Planning

A. problem areas

Leona Bachrach has written extensively on systems issues in treating chronically mentally ill patients. In one article (Bachrach, 1984) she discusses the problems and principles of planning for these patients. Among the problems she identifies are:

- the process of service planning is far more complex today than it was in the pre-deinstitutionalization days. There are so many sub-groups of chronic patients that programs must be highly diversified.
- the service needs of these patients tend to endure, whereas community-based programs tend to ignore the long-term aspects of chronic disability.
- comprehensive care involves a combination of psychiatric, medical, social, rehabilitative, and vocational services. In the past, all these could be provided "under one roof".
- many efforts ostensibly designed as services for chronic psychiatric patients actually resist treating the most severely ill individuals.
- the stigma of mental illness is reflected in the difficulties of obtaining funding, even for successful model programs.
- there is an informational vacuum: good research is sparse.

B. principles of planning

Based on the experience of a quarter-century in program design, it is now possible to enunciate principles of planning for service delivery systems for chronically mentally ill patients (Bachrach, 1984):

- be precise in stating goals and objectives
- assign top priority to chronic patients in any programs designed for their care
- reassess the place of institutions in the spectrum of services
- service systems must consist of a network of interrelated programs that meet the varied needs of a very diverse patient population
- there is a need for cooperation, communication, and linkages among the agencies and personnel involved
- individually-designed treatment regimens are necessary: match the patient to the program
- services for patients must be culture-specific and culturally relevant
- program formats need to be flexible enough to respond to the ever-changing needs of individual patients
- be on guard against the "quick fix": there are no quick-and-easy solutions

VIII. Research

A. flaws of psychosocial research

According to Mosher and Keith (1980), although we have learned a great deal about the design of research on psychosocial treatment, the data now available often is flawed because of failings in the studies:

- insufficient exposure to the intervention;
- inadequate characterization of treatment, therapists, and patients;
- inappropriate outcome measures.

In spite of these flaws, they concluded that we know more about the effectiveness of psychosocial treatment than is generally acknowledged and that there is consistent evidence of its effectiveness. Klein (1980) takes issue with this conclusion, noting from his own review that researchers studying the efficacy of psychosocial treatment have contributed little in the way of demonstrated facts and even less in affirming the value of psychosocial treatment for schizophrenia. He found several studies indicating a negative effect in some patients.

B. suggestions for future research

Bachrach (1984) identifies the following as areas in which work needs to be done:

- definition of treatment goals
- identification of suitable outcomes of treatment
- development of measures to test those outcomes
- definition of appropriate baseline premorbid measures of patient status
- design of instruments sensitive enough to measure small increments of progress in patient status
- identification of sources of variance within the large and complex field of factors, including drug treatments, that affect outcomes.

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