Psychosocial treatments in schizophrenia: a review of the past 20 years

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Authors' objectives
The authors appear to study the effectiveness of psychosocial interventions in patients with schizophrenic disorders.

Searching
PubMed, MEDLINE and PsycLIT were searched from 1980 to October 1999, based on the following key terms: 'schizophrenia', 'psychotherapy', 'psychoeducation', 'psychosocial treatments', 'group therapy', 'family therapy', 'individual therapy' and 'social skills training'. Relevant references from the bibliographies of published studies were also examined. Only studies reported in the English language were reviewed.

Study selection
Study designs of evaluations included in the review
The review was limited to peer-reviewed outcome studies published within the past 20 years. The authors excluded narrative or case report studies, or studies with fewer than six participants. All of the included studies used controlled or pre-post designs.

Specific interventions included in the review
Studies of psychotherapy treatments including group, family and individual therapy were included in the review. In most studies, single treatment modalities were compared with standard care or to differing approaches within the same general modality, e.g. supportive versus psychodynamic group therapy. Some studies compared treatment modalities, e.g. family versus individual therapy, while others examined combinations of interventions, e.g. group plus individual plus family.

Participants included in the review
Patients with schizophrenic disorders. The patients in all studies were prescribed antipsychotic medications. The studies were conducted in both in- and out-patient settings.

Outcomes assessed in the review
The authors focused on outcomes that evaluated symptoms (positive or negative), clinical relapse, re-hospitalisation or days in hospital, social skills, social and vocational functioning, cognitive functioning and medication compliance.

How were decisions on the relevance of primary studies made?
The authors do not state how the papers were selected for the review, or how many of the reviewers performed the selection.

Assessment of study quality
The authors do not state that they assessed validity, although they do discuss the methodological shortcomings of the studies.

Data extraction
The authors do not state how the data were extracted for the review, or how many of the reviewers performed the data extraction.

The following data were extracted: study design; the number of participants; the type of experimental and control treatment; treatment setting; treatment duration; results; and the number of months followed-up post-intervention. The results were only reported as being positive when supported by statistical significance. When multiple measures were used to assess the outcome, positive findings on any one of the measures was considered a positive outcome.
Methods of synthesis
How were the studies combined?
A narrative synthesis was undertaken.

How were differences between studies investigated?
Heterogeneity was not formally assessed.

Results of the review
Seventy studies met the inclusion criteria for the review. Most studies utilised controlled designs (N=61) and either randomised patients to a single treatment modality versus standard care, or to differing approaches within the same general modality, e.g. supportive versus psychodynamic group therapy (N=55). Four studies compared treatment modalities, e.g. family versus individual, while 11 examined combinations of interventions, e.g. group plus individual plus family. The total number of participants was not stated.

Group therapy.
Traditional social skills training (SST) has demonstrated efficacy in a narrow range of specific communication skills. However, the failure of these skills to generalise to improved social functioning and marginal support for improvement in symptoms, suggests that such training may have limited clinical efficacy. The broad approach to SST, in combination with the teaching of specific instrumental skills offered by the UCLA Social and Independent Living Skills (SILS) modules, suggests that schizophrenic patients are capable of learning specific skills related to enhancing social functioning. Moreover, SILS training may produce better outcomes than less structured, process or discussion therapies.

Family therapy.
Family therapy clearly augments pharmacotherapies with schizophrenic patients to result in symptomatic improvement, improved social and vocational functioning, and reduced relapse. In addition, these treatments may limit re-hospitalisation and enhance medication compliance. The benefits of multiple- versus single-family therapy and differences in theoretical orientation are small. An important caveat to these conclusions is that many of the studies only examined patients from high expressed emotion families, and 78% required as a study inclusion criterion that patients live with a relative or have regular contact. Such treatments may, therefore, not generalise to patients who live separate from their family. More studies are needed to address these questions.

Individual therapy.
Studies of individual therapy found that both medication knowledge and treatment compliance improved significantly with a medication education intervention, compared with standard care, although symptoms and re-hospitalisation were not reduced. Significant symptomatic improvement was found in studies of individual psychotherapy, two of which utilised a cognitive-behavioural therapy intervention. A dynamic therapy intervention showed reduced hospitalisation and improved social and vocational functioning. Better vocational functioning was found after supportive versus insight-oriented therapy.

Comparisons between treatment modalities.
Group, family or individual therapy added to pharmacological treatments can augment the benefits of pharmacotherapy alone. These results are most compelling for family therapy, suggesting that they may be more effective than group or individual therapy with schizophrenic patients. However, to draw this conclusion, family therapy must be compared experimentally with alternative psychosocial treatments.

Combinations of treatment modalities.
Overall, it appears that combining psychosocial treatments may yield better outcomes than monotherapy when the components of treatment have independently demonstrated clinical efficacy. However, such effects may be time
Authors' conclusions
Efficacy studies of group, family and individual therapy interventions with schizophrenic patients over the past 20 years indicate the following.

1. Traditional SST improves communication skills, with no compelling evidence that the behaviours generalise to improved social competence.

2. Broad-based training like the UCLA SILS modules enhance knowledge of specific skill areas. There is suggestive evidence that such knowledge may generalise to improved social competence.

3. Less structured, discussion-focused therapies have yielded mixed results. Some demonstrate positive treatment effects for symptoms and social functioning, whereas others report no benefits.

4. Family therapy can improve symptoms, relapse, and social and vocational functioning in schizophrenic patients. Single- versus multiple-family therapies and varying theoretical models do not appear to influence the outcome differentially. However, these findings may not generalise to patients who live alone or do not have regular contact with relatives.

5. Individual medication education sessions enhance medication knowledge and treatment compliance.

6. Nonpsychoanalytic individual therapy was associated more with symptom improvement and less with social competence. No particular orientation yielded a better outcome.

7. Family therapy provided better outcomes than individual therapy. Studies comparing family with group therapy or individual and group therapy have not been reported.

8. There is suggestive evidence that when family therapy and SST are administered simultaneously there is a better outcome than with either treatment or medication alone. It remains to be seen whether other combinations of psychosocial treatments offer better outcomes than a single psychosocial treatment.

CRD commentary
The authors stated their inclusion criteria clearly. The literature search was clearly described but was not thorough. In addition, the authors did not report any attempts to identify unpublished or grey literature. Only English language studies were included. This narrow search strategy may have missed relevant studies, allowing the introduction of selection bias. Publication bias was not assessed.

The validity of the individual studies was not assessed. The authors did not report details relating to the decision-making processes for selecting the studies and extracting the data; e.g. how many of the reviewers were involved, whether the studies were examined independently, whether the reviewers were blinded to the source, and how any disagreements were resolved.

The study details that were tabulated were adequate. The synthesis of the studies was adequate.

The authors’ conclusions should be interpreted with caution owing to the limitations in the search strategy, the lack of a validity assessment, and the lack of details relating to the review process.

Implications of the review for practice and research
Practice: The authors state that the results clearly support the use of psychosocial therapies in the treatment of schizophrenia, particularly for enhancing social functioning, a domain less affected by medication alone.

Research: The authors state that several areas of research warrant further study. These should address the following
questions.

Is one treatment approach superior to others?

What patient variables predict better response to specific treatments?

Which patients do not respond to treatment?

Is more better, and which combinations of psychosocial treatment yield the best outcomes?

What dosages of medication enhance the benefits of psychosocial treatment and vice versa?

What is a recommended length of treatment?

What novel or alternative treatments warrant new research?

Bibliographic details

PubMedID
10789995

Indexing Status
Subject indexing assigned by NLM

MeSH
Activities of Daily Living; Antipsychotic Agents /therapeutic use; Cognitive Therapy; Combined Modality Therapy; Controlled Clinical Trials as Topic; Family Therapy; Female; Forecasting; Humans; Male; Psychotherapy; Psychotherapy, Group; Psychotic Disorders /psychology /therapy; Research Design /standards /trends; Schizophrenia /diagnosis /therapy; Schizophrenic Psychology; Secondary Prevention; Social Adjustment; Treatment Outcome

AccessionNumber
12000003639

Date bibliographic record published
31/01/2003

Date abstract record published
31/01/2003

Record Status
This is a critical abstract of a systematic review that meets the criteria for inclusion on DARE. Each critical abstract contains a brief summary of the review methods, results and conclusions followed by a detailed critical assessment on the reliability of the review and the conclusions drawn.