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INDIVIDUAL VERSUS GROUP AFTERCARE TREATMENT

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INTRODUCTION

In this era of community psychiatry, ever increasing numbers of patients are being returned to the community after relatively short inpatient hospital stays. Unfortunately, according to an NIMH report (1), this has been accompanied by an increased readmission rate, varying from forty to sixty percent within two years of discharge. Furthermore, for large numbers of patients the level of adaptation in the community following discharge is disappointingly low (2,3). Only 15-40% of schizophrenics living in the community achieve what might be termed an average level of adjustment (i.e., being self-supporting, or successfully functioning as a housewife) (1).

Several studies clearly demonstrate the importance of aftercare treatment, including pharmacotherapy, in preventing rehospitalization and promoting adaptation to the community (2, 4, 5, 6). However, there are few clinical studies which offer guidelines for the optimal therapeutic use of personnel in aftercare clinics. Most clinics have large patient loads which are treated by a small number of staff members. The traditional approach has been for a therapist to follow a large number of patients individually for brief counseling and monitoring of drug therapy, while many clinics utilize the group therapy approach for some patients. There are few controlled studies which compare the relative efficacy of group versus individual therapy for aftercare patients (3, 7, 8). These studies as well as others comparing group and individual therapy for different patient populations (9, 10, 11) offer no basis for concluding that one treatment is superior to the other.

The most recent controlled study which compared group versus individual aftercare for schizophrenic patients offered more definitive results (12).

Outcome after 12 and 24 months of treatment based on social effectiveness and psychiatric ratings was significantly better for group therapy. Rehospitalization rates did not differ significantly. Despite the random assignment of therapists (psychiatrist, social workers, and medical students), there was an imbalance of therapists' professional training between the two experimental treatment groups. A large proportion of patients in group therapy were treated by a psychiatrist whereas those in individual therapy were most likely to have a medical student therapist.

To our knowledge, there are no studies which deal with the question: Given a specified amount of personnel time during which a given number of patients are to be seen, which treatment is more efficacious? This study compares the relative efficacy of individual vs. group therapy for aftercare patients in which an equal amount of therapists' time is allocated for each treatment.

METHOD

The study was conducted on the Washington Heights Community Service of the New York State Psychiatric Institute from July 1, 1971, to June 30, 1972. The service offers inpatient, day and night hospitalization, home care and outpatient aftercare for a catchment area with a population of 75,000 in an ethnically diverse lower income area of upper Manhattan in New York City. Therapy of aftercare patients is conducted primarily by first year psychiatric residents. Each year the new group of therapists is presented with an increasing number of aftercare patients for whom they are responsible. Prior to the study, most of these patients were seen individually for therapy sessions that ranged in duration from five or ten minutes to the traditional 45 minute session, and in frequency from less than once a month to as often as twice a week.

The potential subjects for the study included the 215 aftercare patients

who were judged in need of continued treatment as of June, 1971. Those excluded were: Thirty-three patients who were already subjects in another study: thirty-eight patients because they were either thought to require individual therapy, were particularly suited for long term psychotherapy, or were already in an ongoing group that was to be continued. The remaining 144 patients were randomly allocated to either group (N=76) or individual (N=68) therapy.

The therapists were twelve first year psychiatric residents who were stratified by presumed level of competence into three groups. Each competence group of four residents was then randomly assigned to either group or individual therapy. Each therapist was assigned approximately twelve patients who were to be seen only during a one and a half hour weekly evening clinic. The residents administering group therapy were instructed to see their patients only in the group session except for emergencies. The residents conducting the individual therapy were instructed to use the one and a half hour block of time in accordance with the needs of their patients: some patients would be seen weekly, others less often. Each therapist was supervised weekly by a senior psychiatrist. A social worker was assigned to each therapist to work with patients' families during the scheduled clinic hours as indicated.

In keeping with past experience, a number of patients were never seen by their new therapist because they could not be located, refused treatment, or moved out of the area. One hundred and eight patients remained, with 54 in each treatment, who were seen at least once in an individual session with their new therapist. At that time the patient was told that he would be seen either individually or in a group.

The focus of treatment for both modalities was dealing with current reality problems and drug management.

The demographic and diagnostic characteristics of the two treatment groups

are shown in Table 1. Thirty percent of these patients had been discharged within the preceding six months, 18% between six months and one year, and the remaining 50% had been out of the hospital over one year. As a group these patients can be described as chronically ill, and socially impaired.

DATA COLLECTION

All patients were clinically evaluated by their therapists after the initial session, and at four, seven, and eleven months using the Problem Appraisal Scales (PAS) of Spitzer and Endicott (12) and the Menninger Health Sickness Rating Scale (HSR) of Luborsky (13). The PAS provides for scaled judgments of 38 areas of disturbances including 22 five point scales covering signs and symptoms of manifest psychopathology. These 22 scales have been factor analyzed to produce a scoring system of six broad dimensions of psychopathology. The HSR is a single rating of overall mental health ranging from a theoretical zero for maximal disturbance to 100 for optimal health. The patients filled out the Symptom Distress Check List (SDCL) of Parloff et al (14) at the same times that the therapist completed his evaluations. This self-rating form permits the subject to indicate the intensity of a wide variety of subjective symptoms and has been of value as a criterion measure in psychopharmacological research. The items are scored into five factor based scales.

At each clinic session the therapists filled out a short progress note on each patient which included information on attendance, current condition and medication, and any contact outside of the scheduled clinic time. The social workers kept a record of any contact with families that occurred outside of the clinic hours.

When a patient was rehospitalized he was considered a treatment failure and was not included in subsequent cross-sectional evaluations.

Table 1

Demographic Characteristics of Group and Individual Aftercare Patients

Category	Group Patients (N=54) %	Individual Patients (N=54) %
Age		
Under 25	12	15
25-44	47	54
45-64	28	29
65 or over	13	2
Sex		
Male	38	43
Female	62	57
Race		
White	79	89
Negro	21	11
Marital Status		
Single	43	54
Married	30	31
Divorced/Separated	21	13
Widowed	6	2
Previous Hospital Admissions		
One	68	56
Two	13	26
Three of More	19	18
Official Diagnosis		
Schizophrenia	67	65
Affective Disorders	15	15
Alcoholism and Drug Dependence	6	6
Neuroses	4	6
Personality Disorders	2	0
Organic Brain Syndrome	4	2
Paranoid State	2	4
Transient Situational Disturbance	0	2

RESULTS

Termination of Treatment

By the twelfth month 18 (33%) of the group patients and 14 (26%) of the individual patients had discontinued treatment. In the majority of cases the therapists felt that these patients were still in need of treatment. Included in the above figures are patients who were considered never to have been in treatment because they appeared for only two treatment sessions or less. There were 12 group and 9 individual therapy patients who were in this initial dropout category.

Rehospitalization

By the eleventh month 13% of the group patients were rehospitalized as compared with 22% of the individual therapy patients. This difference is not statistically significant. The readmission occurred at a rather constant rate throughout the eleven months for both groups. The rehospitalization rate for the initial dropouts (2 sessions or less) was 2 out of 12 for the group patients, and 6 out of 9 for the individual patients. Neither the individual nor the group initial dropouts differed significantly from the other patients in their groups on measures of psychopathology. The readmission rate for the patients who remained in therapy for both individual and group therapy was 15%. Thus it was the patients assigned to individual therapy who did not accept it who had the highest readmission rate.

Psychopathology Measures

An analysis of covariance was applied to all psychopathology scores for the scales of the PAS, the HSRS, and the SDCL comparing initial values with those of each of the three follow-up evaluations. The results are shown in Table 2. On four scales of the PAS, the individual patients showed more improvement than the group at the four month evaluation. On one scale of

Table 2

Analysis of Covariance Comparing Individual and Group Aftercare at Three Follow-up Periods.

Measure	Initial to 4 Months				Initial to 7 Months				Initial to 11 Months			
	Individual		Group		Individual		Group		Individual		Group	
Problem Appraisal Scales	Pre (N39)[a]	Post	Pre (N33)	Post	Pre (N32)	Post	Pre (N36)	Post	Pre (N26)	Post	Pre (N27)	Post
Depression–Anxiety	2.53	2.10**	2.49	2.54	2.57	2.17	2.49	2.49	2.50	2.08	2.54	2.34
Disorganization	1.38	1.26*	1.33	1.47	1.36	1.22	1.34	1.54	1.40	1.20	1.37	1.26
Antisocial–Drugs	1.06	1.04	1.02	1.12	1.05	1.02	1.02	1.00	1.04	1.00	1.02	1.00
Social Impairment	2.59	2.28*	2.20	2.62	2.56	2.18*	2.25	2.57	2.61	2.23	2.31	2.45
Suicide	1.17	1.12	1.19	1.20	1.14	1.13	1.19	1.29	1.10	1.07	1.21	1.11
Grandiosity–Externalization	1.62	1.58*	1.69	1.79	1.65	1.56*	1.69	1.98	1.69	1.52	1.78	1.72
Health Sickness Rating Scale	(N32)		(N33)		(N29)		(N27)		(N23)		(N24)	
	51.41	49.06	50.67	52.25	49.66	51.17	47.85	49.30	48.70	49.78	47.58	52.88
Symptom Distress Check List	(N32)		(N33)		(N29)		(N27)		(N25)		(N24)	
Somatization	20.06	18.39	17.15	18.74	20.86	17.29	17.41	18.65	21.24	17.20	18.75	17.38
Irritability	28.22	26.09	25.15	23.52	28.21	25.53	25.74	22.76	28.12	24.88	28.13	23.37
Cognitive	19.41	18.86	18.15	18.93	20.21	18.32	18.70	17.91	19.84	18.39	19.96	17.47
Depression	8.34	7.40	6.97	6.68	8.31	6.89	7.04	6.38	8.20	6.24	7.54	6.08
Fear–Anxiety	9.09	9.66	8.48	8.12*	9.66	9.14	8.52	8.44	9.88	9.54	9.50	7.98

a The number of subjects for each evaluation is the number in treatment at both evaluations for whom data was available.

* Showed significantly more improvement ($p < .05$)

** Showed significantly more improvement ($p < .01$)

the SDCL the group patients showed more improvement at four months. By the seventh month evaluation only two scales of the PAS showed a significant difference in favor of the individual treatment. By the eleven month evaluation, there were no significant differences between the two groups on any of the psychopathology measures. Examination of the ratings of the HSRS shows that all the ratings for the two groups at the different follow-up periods hover between 48 and 52, indicating very small overall improvement for both groups over time.

Regarding vocational adjustment, examination of the specific role function scales of the PAS showed that, of those in the job market, or who would be expected to attend school, over 2/3 of the patients in both groups were working with at least minimal adequacy at each follow-up period.

Time

The amount of time spent by either therapist or social workers outside of clinic hours was negligible for both groups. Thus the intent of the design of equal staff time for both treatments was accomplished.

Two thirds of the group patients were seen either weekly or biweekly. In contrast, less than one third of the individual patients were seen as frequently and almost one half of the individual patients were seen less than once a month.

Medication

Only four individual and five group patients did not receive any psychotropic medication throughout the study. The majority of the patients received a phenothiazine. The dosage levels for the two groups were approximately equal except that three individual therapy patients received large amounts of Thorazine (over 500 mgm. per day).

DISCUSSION

The Washington Heights Community Service was faced with a growing roll of aftercare patients with insufficient staff to deal with these patients. This is a problem of most aftercare clinics. The question arose: How could therapists utilize their limited amount of time most effectively to help patients? A study was designed to test the relative efficacy of individual versus group treatment, given an equal amount of therapists' time allocated for each treatment. The demographic characteristics of the sample of patients studied were typical of our aftercare population, and probably similar to the population of many community programs.

Initially there were several factors which might have favored a positive outcome for individual therapy. All the patients had been in individual therapy prior to the study, and many viewed the transfer to group therapy as a loss of their own private doctor. Similarly, many staff members felt that group therapy was a second class treatment modality and that under ideal circumstances patients should be seen individually. In addition, the therapists were beginning first year residents who had a great deal more anxiety about conducting group therapy than about conducting individual therapy.

Ratings made by therapists and patients revealed that only small amounts of improvement were achieved by both treatments. Patients were maintained in the community, but there was no significant improvement in their level of psychopathology and role functioning. At 4 months the PAS data favored individual patients on 4 of 6 scales, but the differences were small. The patient self-report showed no differences between treatments. The PAS findings at 4 months may be explained by the greater stress of being in gr therapy during the early stages of group formation. It takes time for a group

to become cohesive and offer support to its members. Of interest is a comparison of the patients who did not accept treatment assignments in the two groups. Apparently those who rejected group therapy were healthier than those who rejected individual therapy since a much larger proportion of the latter were rehospitalized. Presumably many of the group therapy patients who rejected this treatment did so because it was a change to a new modality after they had become accustomed to individual treatment and some patients are unwilling to discuss personal problems in a group setting.

Unfortunately, due to changes in the residency program, we were not able to continue this study beyond the first year. We thus had no opportunity to test whether the transition to a new therapist which occurs each year for all patients might be less traumatic for the group patients, with a smaller dropout rate, than for the individual patients. A group is likely to be able to offer more support for its members during such a transitional phase and cushion the stress. On the other hand, no such support is available when the individual therapist is changed.

Concerning the therapists' attitude, there was a shift from preference for individual therapy at the beginning of the project to a preference for group therapy at the end of the project. It should be noted that all of the residents conducted individual and group therapy on the inpatient service while the outpatient study was being carried out. Those who conducted the outpatient group therapy tended to have more enthusiasm and involvement in the therapy. This factor is important since many aftercare clinics have a problem in maintaining staff morale because of the large patient load and chronicity of the patients. The groups could easily have handled patients and did add patients during the year. An introduction of more group therapy into aftercare programs might increase staff morale and ultimately benefit the patients. We did not measure patients' social adjustment or degree of satisfaction, but it was observed by many staff members that the group

patients seemed more alive and enthusiastic in the clinic waiting room. Although hospitalization rates did not differ significantly in our study or in O'Brien's (12), both had a lower readmission rate for group patients.

Patients in both treatment modalities were on approximately the same amounts of medication and it may be that the medications alone are the single most important factor in maintaining remission. Of particular concern are those patients who refuse individual treatment initially. Both in our study and the one conducted by O'Brien (12), their readmission rate was substantially higher than the rate for those who entered treatment.

CONCLUSIONS

Although there were no differences in outcome measures between individual and group therapy, we nevertheless recommend that aftercare programs shift to a much greater utilization of group therapy of a supportive relationship, reality-oriented type accompanied by appropriate use of pharmacotherapy. Staff morale is improved because instead of seeing an endless succession of patients one after another for brief periods of time, therapists can spend a much larger block of time with a group of patients. In addition, patients gain a sense of belonging and have the opportunity for increased socialization. Special efforts should be made to bring into therapy those patients who initially refuse it, because they have a high risk of rehospitalization.

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