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EVIDENCE BASED PSYCHOSOCIAL INTERVENTIONS FOR PEOPLE WITH SCHIZOFRENIA.

José Guimón (Catedrático de psiquiatría, Universidad del País Vasco-Euskal Herriko Unibertsitatea)

E-mail: onpquugj@lg.ehu.es

RESUMEN

En conjunto, las estrategias de prevención precoz de la esquizofrenia parecen proteger de recaídas aunque no está claro todavía la influencia respectiva de los ingredientes psicoterápicos y medicamentosos. No está claro que los tratamientos de entrenamiento de la atención sean útiles. Otros tratamientos cognitivos todavía no ofrecen tampoco datos concluyentes, según dos informes Cochrane.

La terapia psicológica integrada (IPT) realizada por Volker y basada en los trabajos de Brenner y la "Terapia de mejoría cognitive" (CRT) parecen útiles pero los resultados son variables.

El *Assertive Community Treatment* (ACT) parece útil para mantener en la Comunidad a pacientes graves , reduciendo los costes, según un informe Cochrane. Por el contrario, en otro informe del mismo autor, el *case management* aumenta el número de hospitalizaciones, no mejora el estado clínico y es más costoso que un tratamento habitual.

La terapia familiar y mejor aún la multifamiliar parecen eficaces en disminuir las recaídas.

Los tratamientos de intervención en crisis alternativos a la hospitalización son difíciles de evaluar, según un informe Cochrane.

El tratamiento con equipos comunitarios (community mental health team (CMHT) parece asociarse con menos muertes por suicidio y con mayor satisfacción de los pacientes, aunque no hay pruebas de que se logre disminuir los ingresos, ni la duración de la hospitalización, según un informe Cochrane.

La nomenclatura sobre centros y hospitales de día para enfermos graves es imprecisa y no hay estudios randomizado respecto a su eficacia, excepto un estudio que parece sugerir mayor eficacia que el tratamiento ambulatorio y la impresión de que son más caros que el tratamiento habitual.

No hay estudios controlados sobre la eficacia de la psicoterapia psicoanalítica en enfermedades psiquiátricas graves y, en concreto, esquizofrénicos hospitalizados.

Las intervenciones familiares destinadas a disminuir la emoción expresada tal vez disminuyan las recaídas y mejoren la cumplimentación, pero los datos no son concluyentes, según un estudio Cochrane. Los resultados de los programas educacionales para adquirir

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habilidaders de la vida independiente no tienen eficacia probada y pueden crear problemas éticos

Hay pruebas, según un estudio Cochrane, de que los abordajes psicoeducativos son útiles y eficaces en cuanto al costo en esquizofrénicos

Las hospitalizaciones planificadas como cortas no provocan más fenómenos de puerta batiente y no empeoran el seguimiento de los pacientes esquizofrénnicos ,según un informe Cochrane

No está claro que la economía de fichas tenga efectos clínicos significativos en esquizofrénicos según un informe Cochrane. El trabajo protegido es más útil que la rehabilitación vocacional en esquizofrénicos según un informe Cochrane.

PALABRAS CLAVE

Basado en las pruebas, esquizofrenia.

SUMMARY

In spite of all the efforts made to avoid it, schizophrenic deterioration is frequent; it is not only a difficulty on an intellectual level, but also a lack of interest and energy that lead the patient to avoid the efforts of everyday life. Under the name of "absence of social competence", a series of characteristics has been described which make the chronic schizophrenic less able to live in the community, at least in Western society.

Among the most important factors aggravating social ineptitude, the role played by hospitalisation has been widely discussed (Guimón & Ozamiz, 1982; Guimón, Villasana, Totorika, & Ozamiz, 1981). Therefore, some authors tend to differentiate between the concepts of clinical remission and social remission (Brouwn, Monck, Carstairs, & Wing, 1958; Seva Diaz, 1979).

In this paper we will first review the efficacy of different psychosocial approaches have been proposed for the management of "social incompetence" and relapses in these patients. Then we will discuss the scope and limits of the concept of "evidence based studies" when applied to these interventions

KEY WORDS

Evidence based, schizophrenia.

1. THE EFFICACY OF INDIVIDUAL PSYCHOTHERAPY

1.1.Psychoanalytically oriented psychotherapy

Psychoanalytically oriented psychotherapy has, until recently, been shown to be of only slight utility in schizophrenia, except in a subgroup of patients with sufficient ego strength, and who remain as inpatients for long periods in special therapeutic settings. However, there is a general consensus that a dynamic understanding of the patient's psychopathology and relationships with family and social networks could be very helpful (Fenton & Schooler, 2000). On the other hand, a recent, randomised study showed that analytical psychotherapy could produce improvement in the social and professional

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functioning of some schizophrenics that was unattainable any other way (Hogarty, Kornblith, & Greenwald, 1997).

Gabbard (Gabbard, 1995) proposes some general guidelines for psychotherapy with schizophrenia: the main goal should be to establish a relationship; flexibility is necessary regarding therapeutic approach and content; an optimal distance between the therapist and the patient should be established; the therapist must create a setting (holding) that serves as a 'container'; he should set himself up as an 'auxiliary ego', showing himself to be open, respectful, and candid; and he should postpone making any kind of interpretation until a good relationship has been established.

However, Malmberg et al (Malmberg & Fenton, 2002) reviewing the effects of individual psychodynamic psychotherapy for people with schizophrenia conclude that, although the psychodynamic approach may be more acceptable to people than a more cognitive reality-adaptive therapy, current data do not support the use of psychodynamic psychotherapy techniques for hospitalised people with schizophrenia.

1.2.Cognitive behavioural interventions

As Roder et al (Roder, Zorn, Muller, & Brenner, 2001) propose, we have seen three eras in the development and refinement of social skills training for individuals with schizophrenia. In the 1960s, skills training relied on the use of operant conditioning, as exemplified by the token economy, which is still used to motivate anergic individuals to participate actively in community-based programs.

In the 1970s, social learning was introduced to improve nonverbal skills, as well as conversational skills, assertiveness, and emotional expressiveness. Tsang (2001) proposes that a social skills training module together with appropriate professional support afterward is effective in enhancing the social competence and vocational outcomes of persons with schizophrenia.

In the third and current era, cognitive methods for training social and independent living skills (Liberman, 1986) and techniques to improve attention, memory, and verbal learning have been introduced. Thanks to better knowledge of deficit symptoms, it has been observed that even simple learning activities are often difficult, due to certain patients' cognitive deficits. Therefore, it has been decided to improve this deficit with cognitive rehabilitation modules. Thus Hans Brenner (Brenner & Pfammatter, 2000), Roder, and other authors have developed an integrated psychological therapy (IPT) addressing deficits in the residential, vocational, and recreational domains of community functioning and they propose that is more effective than other psychosocial treatments, such as supportive group therapy and pure behavioural methods. However, Suslow et al (Suslow, Schonauer, & Arolt, 2001) reviewing the literature on training on attentional functioning contend that there is inconclusive evidence that attention training is effective in schizophrenia.

In a Cochrane review, Nicol et al (Nicol, Robertson, & Connaughton, 2002) evaluate all relevant randomised or quasi-randomised controlled trials on life skills programmes and consider that data are sparse and that no clear effects were demonstrated, concluding that " if life skills training is to continue as part of rehabilitation programmes a large, well designed, conducted and reported pragmatic randomised trial is an urgent necessity. There may even be an argument for stating that maintenance of current practice, outside of a randomised trial, is unethical". In another Cochrane study, Cormac et al (Cormac, Jones, & Campbell, 2002) review the effectiveness of cognitive behavioural therapy for people with schizophrenia, and conclude that it did not significantly reduce the rate of relapse and readmission to hospital when compared with standard care alone. A significant difference was observed, however,

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favouring cognitive behavioural therapy over standard care alone, in terms of being able to be discharged from hospital but after one year the difference was no longer significant. A cognitive behavioural therapy approach focusing on compliance may have some effects on insight and attitudes to medication, but the clinical meaning of these data is unclear. When compared with supportive psychotherapy, cognitive behavioural therapy had no effects on relapse rate and clinically meaningful improvements in mental state.

A modification of CBT "Assertive Community Treatment (ACT)"has been shown in a Cochrane review (Marshall & Lockwood, 2002)to facilitate that patients remain in contact with services. People allocated to ACT were less likely to be admitted to hospital than those receiving standard community care and spent less time in hospital. In terms of clinical and social outcome, significant and robust differences between ACT and standard community care were found on some socials variables but not on mental state or social functioning or quality of life. Present evidence suggests that case management increases health care costs, perhaps substantially, although this is not certain. In summary, thy say, " case management is an intervention of questionable value, to the extent that it is doubtful whether it should be offered by community psychiatric services. It is hard to see how policy makers who subscribe to an evidence-based approach can justify retaining case management as 'the cornerstone' of community mental health care.

1.3. Psycoeducational techniques.

Psycoeducational techniques enhance medication compliance including attitudes to treatment, substance misuse and insight (Thornicroft , 2001). Thus, Amenson and Liberman (Amenson & Liberman, 2001) underline the need of overcoming the barriers to the incorporation of family psychoeducation into the routine care provided at community mental health .

However, in a Cochane review, Henderson et al (Henderson & Laugharne, 2002) warn about the need of a tactful information of the patients because it cannot be assumed that patient-held information is beneficial or cost-effective without evidence from well planned, conducted and reported randomised trials, still lacking

In any case, it seems that psychoeducation (Pekkala et al., 2002) significantly reduces relapse in schizophrenic patients and improve compliance to treatment

1.4."Personal"therapy.

The so-called "Personal therapy" (Hogarty et al., 1997) and "Cognitive enhancement therapy" (CET) (Thornicroft , 2001) are long-term interventions for individuals with schizophrenia designed to increase the accurate appraisal of emotional states through psycho-education and behavior therapy techniques. It seems that personal therapy improves social adjustment but can increase the rate of psychotic relapse for some patients living independently of their families.

1.5.Family therapy

Family therapy has been useful for treating the patient in his own environment, and reducing relapse. The techniques are not based so much on the systemic model (which assumes that alterations in family communication can produce schizophrenia) as on psycho-educational techniques (explaining symptoms and therapeutic options to the family). They

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are based on the finding that the patient's presence produces alterations within the family, especially in those families, which tend to adopt excessively emotional attitudes ('high emotional expression') (Guimon & Cuperman, 1982). These psychosocial family interventions tend to improve the alliance with relatives reducing the adverse expressions of anger and guilt by the family, encouraging the relatives to appropriate limits (Thornicroft (2001).

Family interventions (Dixon, Adams, & Lucksted, 2000) seem to be of help in keeping patients in the community. A Cochrane collaboration systematic review has concluded that families receiving this intervention can expect less-frequent relapse and admission in their relatives with schizophrenia, without any additional burden of care. Multiple family models seem to be more effective than interventions for single families (McFarlane, 2000) in terms of reduced relapse rates and offering an expanded social network. Dixon (Dixon et al., 2000) in a review contend that the data supporting the efficacy of family psychoeducation remain compelling.

However, Pharoah et al (Pharoah, Mari, & Streiner, 2002), in a Cochrane review, evaluate the randomised or quasi-randomised studies and finds that family intervention may decrease hospitalisation and encourage compliance with medication but does not obviously effect the tendency of individuals/families to drop out of care. It may improve general social impairment and the levels of expressed emotion within the family. Professionals "cannot be confident of the effects of family intervention from the findings of this review"

On the other hand, there is a poor availability of these treatments in ordinary clinical settings (Penn, Kommana, Mansfield, & Link, 1999) and a substantial proportion of relatives refuse to attend a group and need sessions in the home (Leff, 2000).

2.USES AND ABUSES OF GROUP AND MILLIEU PSYCHOTHERAPY

2.1.Group psychotherapy

Even now, in certain developed countries (Sultenfuss & Geczy, 1996), schizophrenics who remain in long-stay units at psychiatric hospitals receive only pharmacological treatment. Group psychotherapy, above all when the therapist actively tries to develop the social abilities and strategies for coping with stress, has been supposed to be useful, especially once florid symptoms are under control. The results seem to be better than those obtained with individual psychotherapy individual, which can be explained by the fact that the group offers socialisation experiences, behavioural models, and a more shared transference which is less dependent on the therapist (Guimón & Totorika, 1983). However, the treatment of chronic schizophrenics using analytical group psychotherapy has often been an exasperating, fruitless experience (Frankel, 1993), creating a strong emotional responses in the leaders which also reinforces a spiral of repeated failures.

Overall, the relatively few controlled trials of group psychotherapy present major methodological problems which limit their generalisability. Scott and Dixon (Scott & Dixon, 1995), in a review of the literature on the clinical outcomes obtained by support and dynamic psychotherapy (both group and individual) and psychosocial skills training, found that the reality-oriented approaches seem better than insight-oriented dynamic psychotherapy.

The so called Integrated Psychological Therapy (IPT),is a group-therapy modality intended to reestablish basic neurocognitive functions (Spaulding, Reed, Sullivan, Richardson, & Weiler, 1999) that showed incrementally greater gains compared with controls on the primary outcome measure, the Assessment of Interpersonal Problem-Solving Skills, after a six month intensive trial

2.2. Milieu therapy

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2.2.1.Therapeutic Communities

The use of principles from the so-called milieu therapy, based on the experiences of therapeutic communities organised into inpatient units, day hospitals, halfway houses and sheltered workshops, have improved the clinical prognosis and socio-occupational adaptation of chronic schizophrenics.

The best early study are that of Rapoport (Rapaport, 1974) on the Henderson Hospital followed by that of Whiteley (Whiteley et al., 1987) in the same place and that of The Association of Therapeutic Communities Research Group studied. More recently, other studies have been made at the UK . The methodologies used to carry out this studieas are: descriptive or evaluative, ideographic or nomothetic, sociological vs. psychological, or a combination of the above.

A controlled experimental study at Kingswood House concluded that it was almost impossible to link effect to cause when talking about multidimensional treatments such as those which are offered in a therapeutic community. An alternative method to experimental design is represented by the « cross-institutional design » which can be completed by several quantitative methods. An example of this methodology is that proposed by Moos for whom the « ward atmosphere scale » has been utilized in therapeutic communities (Moos, 1987, 1997) (Guimón, 2001) evaluates the social and physical atmospheres of units of treatment.

Several studies, of variable methodological quality, saw a favorable result with this type of approach in psychotic patients. Thus, De Hert et al. ((De Hert, Thys, Vercruyssen, & Peuskens, 1996) who followed up 120 young, chronic patients who took part in the rehabilitation program at the Night Hospital in Brussels, showed that most of them maintained the level of adaptation obtained and continued to live in the community, engaged in useful pursuits. Dauwalder and Ciompi (Dauwalder & Ciompi, 1995) proved the efficacy in the long term of a community-based program for chronic mental patients which resulted in a great number of them having jobs and independent lives even if most patients still needed professional help. On their side, Jin and Li (1994) observed that the number of suicides decreased and that the active participation increased at Yanbian Community Psychiatric Hospital, after its transformation from a residential facility for chronic psychiatric patients into a therapeutic community. Coombe (Coombe, 1996), in an account of principles and treatment practices given to the therapeutic community at the Cassel Hospital in London, underlined the ability of the therapeutic network to render possible, successfully, the treatment of families and individuals suffering from serious disorders.

Mosher (Mosher & Feinsilver, 1971) compared the treatment program for young schizophrenic patients in the Soteria project with that of a small social environment, generally without neuroleptics. The atmospheres of treatment settings were evaluated using the Moos (Moos, 1997) COPES or WAS scales. The two systems managed to reduce, in a similar fashion, the serious psychotic symptomatology in six weeks, in general without anti-psychotic medication, as effectively as the normal hospital treatment, which included the routine utilization of neuroleptics. Shepherd (Shepherd & Murray, 2001) presented benefits and limitations of a new type of institutional solution - « the unit in a home » for patients suffering from severe disorders, who came forward in a health sector (Cambridge) in the United Kingdom. Another study (Nieminen, Isohanni, & Winblad, 1994) carried out in a therapeutic community unit for severely affected patients with an average hospital stay of 40 days, reported that the patients having obtained a better immediate result stayed 10 to 20 days longer in the hospital than did those who had an inferior result. A longer stay was associated with a younger age, a diagnosis of psychosis and the active and motivated participation in individual and milieu io

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Insofar as variables associated with therapeutic results (Guimón, 2001) were concerned, Holmqvist (Holmqvist et al., 1996) who carried out an analysis of the relationship between psychiatric diagnoses of patients, their self-image and the feelings of personnel towards patients in 17 treatment units for psychiatric patients presenting severe disorders, did not find important differences in any comparison. Werbart studied the exploratory factors and those of support in the milieu therapy oriented towards insight into three Swedish therapeutic communities with psychotic patients, by using the scales of the Community-Oriented Programs Environment Scales (COPES). The study showed that a beneficial psychotherapeutic environment needs organization and a setting, which corresponds to a well-defined treatment philosophy. The several structured studies that have been carried out showed that community meetings had the effect of reducing unfavorable ward incidents, in particular incidents with an aggressive character (Ng, 1992).

In regard to the value of specific techniques used in the programs, Winer and Klamen (Winer et al., 1997) presented a model of community relations for hospitalized patients which was led as a large-group interpretative psychotherapy centered on the examination of relationships between patients and personnel in the here-and-now. This model is useful even in short-term hospital units and with serious patients because it can provide a gauge of milieu, throwing light on undesirable conduct of both staff and patients, discovering anti-therapeutic attitudes in personnel, helping to improve compliance with treatment in patients and reducing the tension in the unit.

Several studies indicated the fundamental value of group therapy in these programs. Kahn et al. (Kahn et al., 1992), in a short-term hospital unit, made a comparison between the dynamics of groups which took place there and the atmosphere in the unit, finding very clear parallels between the process of group therapy and those of the ward. Isohanni et al (Isohanni et al., 1992) studied the degree of participation in group psychotherapies in a therapeutic community for severe patients and observed, for example, that the lack of participation (4% in all episodes) or the passiveness (14%) were associated with an inferior therapeutic result and depended principally on program characteristics (ward policy, short treatment times) and to diagnoses to personality disorder. The results suggested that the participation in the group, the therapeutic program, the patient's characteristics and the success of treatment are inter-related.

Concerning the efficacy of the different therapeutic mechanisms, (Holmqvist et al., 1994; Holmqvist et al., 1996) proposed a method to follow up the development of relations and to study those which are useful and useless, through a recapitulative list of words given to nurses, this list permits the measurement of the quantity of emotional arousal in a reliable manner. In another article, Holmqvist and Fogelstam (Holmqvist & Fogelstam, 1996) studied, in 21 small treatment houses, the feelings of countertransference of therapists in the milieu towards patients and their influence on the psychological climate in the unit .

2.2.2. Ward atmosphere in short stay units

In the short stay psychiatric units the patients have to deal with a high degree of stress, arising from short stays, acute symptomatology, auto and heteroaggression, rapid turnover of patients, limited space, etc.

During the last 25 years we have organised programs of milieu therapy in a certain number of short satay units through the organisation of a variety of groups of patients and staff (Guimón, Luna, Totorika, Diez, & Puertas, 1983). Group-analysis, with its particular emphasis on the "here and now" and on intermember cohesiveness, has shown itself to be, in the present study, a usefull stabilizing ("buffer") tool, through fostering involvement and support and allowing a controlled expression of anger and aggresiveness.

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The patients-staff group is the key holding element of our group analytic program on account of its basic contribution in the creation of a "continent" for the anxieties arising in the ward. It is also of invaluable help because of the information it provides concerning each patient. The other groups also provide the patient with orientation and emotional support.
On the personnel side, tensions among the therapeutic team are reduced and incoming nursing personnel notice how their previous fears and appréhensions diminish.

On the whole, we had the impression that, despite a personnel shortage, a pleasant and supportive atmosphere was created in the wards. constitute a group-analytical network that makes for a more harmonious communication among the various units of the hospitasl. This systemic vision of the institution gives invaluable help in the understanding of the organizational problems and internal struggles that can soon be detected. This provides the input for the "healthy anticipatory paranoia" needed (Kernberg, 1979) in the management of these organisations.

3. RELAPSE PREVENTION AND AVOIDANCE

Relapse can occur in any moment of the evolution of the disorder but there are some specific moments where it is more likely such the periods of transition from psychiatric institutions to community housing. ‘Critically timed’ psychosocial interventions (Thornicroft ,2001) are proposed and have been tested in randomized trials

3.1. Detection of high-risk subjects

If, in schizophrenia, we focus on the problem of primary prevention, we have to settle for a genetic counselling and some basic mental hygiene, insofar as there is little clinical evidence of any truly effective preventive measures. However different authors different research findings on children at risk have identified some vulnerability markers, so pessimism on this subject has diminished somewhat.

Schizophrenia prevention could work to lessen stressful conditions, or increase defence and coping mechanisms; but mainly, it could focus on actions applicable from birth, or even before, to inhibit the expression of the illness in those prone to it. But these are non-specific and expensive strategies.

Currently, efforts are centred on identifying groups having an attribute that predicts very high risk for schizophrenia. However, until recently, the only reliable marker for schizophrenia was having a schizophrenic parent, since 10 - 16% of a schizophrenic parent's children develop the illness. However, it would not be justifiable to engage in wide-ranging prevention projects, given that 86 - 90% of the cohort is not at risk.

Studies on high-risk individuals are based on genetics, development psychology, studies on attention and information-processing, and measurements of intra-family processes. They include prospective studies, following a cohort over time to identify attributes of individuals or families existing before onset of the illness. It is possible that such a marker could reflect a pathophysiological or psychopathological process that contributes to the development of schizophrenia, which could possibly have aetiological implications.

There are antecedents and early warning signals of dysfunction that identify children and adolescents at risk. Various studies, covering conception to two years, have shown that some of these individuals are subject to identifiable stressful circumstances, and show early delusional symptoms.

Regarding whether these markers identify persons with a specific risk of developing schizophrenia, or merely any psychopathology, most studies show little specificity, except for a one that showed higher cognitive and attention deficits in the children of schizophrenics.

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The detection of children at risk would make it possible to work with them in order to modify some vulnerability factors. In a prospective study, it was found that in children with schizoid personalities, their psychosocial adjustments was somewhat worse than other children who attended a child psychiatry clinic; as a group, they tended to be more solitary, lacking in empathy, hypersensitive, with odd ways of communicating, and often with limited interests. As adults, fewer of them had had heterosexual experiences, and more of them had sought psychiatric help at some time. Although the majority developed schizophrenic spectrum disorders, the risk of developing schizophrenia was small (Wolff, 1991)

Various studies indicate that the more serious the mother's illness, the worse her interaction with her child; it has also been shown that low socio-economic status is correlated with poor mother-child relations. Stress and the woman's risk behaviours can produce childbirth complications and create neurointegrative abnormalities, so that the child may have a difficult temperament, and the stressed mother may treat him inadequately.

3.2. Prevention strategies

Possible prevention strategies are partly based on findings (e.g. early signs of neurointegrative disorder and alteration in parent-child relations) linked to psychiatric disorders in the mother, or problems during pregnancy and childbirth. In these cases, prevention focuses on improving prenatal care, and stimulating a more favourable parent-child relationship.

Another prevention strategy centres on children with attention deficit disorder aiming at detecting families at risk in order to help their children, improving alterations in communication, affective style, and expression of emotions.

It is also known that programmes aimed at lessening negative attitudes towards psychopharmacological medication and those that aim to reduce 'expressed emotion' within the family can lower relapses.

In Scandinavia, Johannessen et al. (Johannessen, Larsen, McGlashan, & Vaglum, 2000) carried out a campaign to inform the public of the early signs of schizophrenia, aimed at increasing early intervention and reducing the duration of untreated psychosis (DUP), which had positive results. Alanen et al. (Alanen, Lehtinen, Lehtinen, Aaltonen, & Räkköläinen, 2000), in Finland, successfully used an integrated model of early treatment of schizophrenia (primarily psychotherapeutic and dynamic-systemic approaches), working intensely with families and making housecalls. This programme reduced the country's annual incidence of schizophrenia from 24.6 per 100,000 (in 1985-89) to 10.4 per 100,000 between 1990 and 1994, when the system was in place. Of the patients who had been formerly hospitalised, 40% were treated on an outpatient basis. The rate of long-term schizophrenic patients in hospital fell to zero in a few years and remained there afterwards.

Although there were some pioneers, such as Sullivan (Sullivan, 1927), only in recent years has there been interest in early intervention, and a more optimistic attitude, encouraged by the Scandinavian countries and by the International Society for the Psychological Treatment of the Schizophrenias and other Psychoses (ISPS).

The Early Psychoses Prevention and Intervention Centre (EPPIC) Programme, in Australia, proposed a similar programme.

Klosterkotter et al (2001) shows results of the "Cologne/Bonn Early Recognition - CER" project on schizophrenia.. At re-examination at an average of 9.6 years later, 79 of 160 patients had subsequently developed a schizophrenic. Best prediction values with a high positive predictive power and a low rate of false-positive predictions were achieved for 10

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symptoms and symptom complexes mainly out of the group of thought, speech and perception disturbances.

McGorry (McGorry, 2001) pointed out that until 1960, dynamic psychotherapy dominated the treatment of psychoses, but later fell into disfavour, and personnel were no longer trained as much in these techniques. The trend swung towards a 'dehumanising and inefficient' behaviourism, to which cognitive techniques were later added as a compromise. However, there has recently been resurgence in interest, because the efficacy of a dynamic psychotherapeutic approach has been shown in certain kinds of cases (Hogarty, Kornblith, & Greenwald, 1995; Hogarty et al., 1997).

Birchwood and Spencer (2001) contend that even if the early detection and treatment of early signs appears to confer protection from relapse, the active ingredients of the pharmacological and psychological based treatment studies are as yet unclear

4. SCOPE AND LIMITS OF AN EVIDENCE BASED APPROACH IN MENTAL HEALTH

The above review on psycosocial interventions in schizophrenia is mainly based in empirically based studies. But this approach has, besides its obvious advantages, some important shortcomings

4.1. The need for empirical studies in Mental Health

The language of medicine is at once scientific, moral and political. These three languages make up a social body – which has come to be known as the « body of medicine ». Medicine is a "practical", "operational science". But as Gracia say, it is no longer quite as easy as it was a few decades ago to defend the scientific nature of medicine. Admittedly anatomy is a science, just like physiology, biochemistry or microbiology. But none of these sciences strictly identifies with medicine, even if the doctor has to be familiar with all of them to do his job. « The doctor is in fact a social agent like any other, night watchman or street cleaner. The difference, it is true, is that the doctor needs complex scientific training to carry out his work effectively. But although he requires scientific knowledge, the doctor is not a scientist».

Be that as it may, the assessment of efficacy and efficiency of treatment are presently taking on growing importance for medical practice. An "evidence-based" movement has appeared in medicine as a regulative idea, a a method and a socio-political endeavour (Henningsen, 2000). Scientifically proven therapeutic measures or "Empirically Supported Treatments" are proposed through techniques such as randomized controlled trials, the meta-analysis and the "Consumer Reports" studies. However these procedures have advantages, disadvantages (Henningsen, 2000). They have also important ethical implications (Helmchen , 2001) since moral neutrality is a myth when referring to the incompatible ethical positions inherent in clinical and research practices (Miller, 2001)

Even if Psychiatry was one of the first medical specialties to use the tools of evidence-based medicine this approach so far has been applied more often to pharmacological than to psychological treatments, but Cochrane collaboration systematic reviews and other forms of review (i.e.The Patient Outcomes Research Team programme in Baltimore) have begun to appear(Thornicroft, 2001).This growing interest has led to the formation of task forces to define, identify, and disseminate information about empirically supported psychological interventions (Sanderson, 1998;Chambless, 1998 ;Barlow, 1999). The American Psychological Association Task Force on the Promotion and Dissemination of

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Psychological Procedures proposes some characteristics of empirically supported treatments (O'Donohue, 2000):they involve skill building, have a specific problem focus, incorporate continuous assessment of client progress, and involve brief treatment contact, requiring 20 or fewer sessions. To be "well-established," treatments for specific disorders must be shown efficacious in at least two independent randomized clinical trials. However, the task force recognizes that these findings are in part an artefact of sociological factors present in contemporary psychotherapy

4.2. The limits of an evidence-based approach.

Traditional clinical methods of assessing the effectiveness of psychological treatments (such as intelligence testing, projective tests, or "objective" personality tests such as the MMPI-2), are rarely used in empirically supported treatments have come under attack (O'Donohue, 2000).

On the other hand, many psychiatrists have reservations about the evidence-based medicine' approach because of perceived limitations in methodology gaps in interpreting the available evidence and neglect of individual patient uniqueness in quantitative research thru manualized treatment procedures (Beutler, 2000).

Furthermore, Cochrane also sheds light on psychological and practical obstacles which must be overcome before public health care systems can utilize new scientific results. The settings of psychotherapy randomized controlled trials are highly artificial naturalistic psychotherapy and studies should be complemented by efficiency studies and evaluation of whole health care systems if they pretend to be relevant to practice (Mundt, 2001). Finally, empirically supported psychological treatments are not been effectively disseminated to the mental health professionals who deliver them and thus are not readily available to the public who requires them (Barlow, 1999, Goldfried, 1999).

Therapists complain that therapy research has only a remote resemblance to what goes on in actual clinical practice. There is a need of training of staff to implement new psychological treatments, addressing professional barriers that may limit uptake, and investigations of the 'minimum effective dose' or the key active ingredients of the intervention (Lehman & Steinwachs, 1998; National Institute for Mental Health, 1998).

To overcome these difficulties some authors propose to make more naturalistic studies and other plead to ad criteria deriving from mental health policy and economics (Buchkremer, 2001). In this sense, Barlow (Barlow, 1999) offers a way to overcome the problems of rigid manuals as well as those associated with forcing clinicians to adhere to theories and practices that are outside of their interest, experience, and expertise.

New models of research have also been proposed . Margison (Margison, 2000) supports a model of professional self-management 'practice-based evidence', as a complementary paradigm to improve clinical effectiveness in routine practice via the infrastructure of "Practice Research Networks". For the prediction of courses of treatment response Lutz et al (Lutz, 2001) combines a dose-response model with growth curve modeling to determine dose-response relations for well-being, symptoms, and functioning. Barkham (Barkham, 2001) argues for a core outcome measure (the "Clinical Outcomes in Routine Evaluation-Outcome Measure") to provide practice-based evidence for the psychological therapies to complement the evidence-based practice paradigm. Kendall et al (Kendall, 1999) proposes "normative comparisons", a procedure for evaluating the clinical significance of therapeutic interventions, consisting of comparing data on treated individuals with that of normative individuals. Mundt and Backenstrass emphasize the importance of more detailed psychopathology (thru data that can be expected from neurosciences) that can then be matched to specific psychotherapy tools

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(Mundt, 2001) . In addition to scientific criteria, those deriving from mental health policy and economics are also important (Buchkremer G, Klingberg S, 2001).

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