Why Are the Results of Milieu Therapy for Schizophrenic Patients Contradictory? An Analysis Based on Four Empirical Studies

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The results of milieu therapy with psychotic patients have been highly conflicting because of unrecognized differences among the wards investigated.

Our own research indicates that for psychotic patients in short- and intermediate-term wards:

1. A beneficial milieu has a low perceived level of anger and aggression and a high level of support, practical orientation, and order and organization.
2. Confronting group therapy is detrimental and individually oriented milieu therapy beneficial.
3. Community groups may become anti-therapeutic pseudo-groups.
4. Extensive use of confrontational groups may contribute to a detrimental ward atmosphere.
5. A high mean age of patients may contribute to a favorable low level of aggression.
6. A high percentage of psychotic patients, a high number of patients, and a high staff turnover may lead to a detrimental atmosphere.

On this basis we tried to change the milieu on a 26-bed therapeutic community ward which proved to have pseudo-groups and a detrimental ward atmosphere. The amount of compulsory group activities was reduced, the groups made more task-oriented, the amount of individually oriented milieu therapy increased, and the number of beds reduced. At re-evaluation the ward atmosphere had improved considerably.

The social environment influences the course of functional psychoses. This fact has been known for a very long time. The institutional milieu also influences psychotic patients, either positively or negatively. “There is no patient untreated by his environment” [1].

After World War II, this knowledge led to the idea of creating a social setting and a set of patient and staff activities which would promote specific, beneficial emotional and learning experiences for the patients: a milieu therapy. This theory and practice of the therapeutic community came to influence the organization and treatment activities of many psychiatric institutions in different countries. Some developed a “therapeutic community proper,” others used elements or modifications [2].

Because milieu therapy for a long time was looked upon as a panacea beneficial for all patients, patients with schizophrenic psychoses have also been exposed to such treatment. The question of whether milieu therapy in fact influences the course of acute and subchronic schizophrenia positively is, however, still not answered conclu-
sively. Both clinical and research reports have given contradictory results. May and
Simpson [3] found, in their extensive and highly critical review of the experimental
studies of inpatient milieu treatment, 14 with positive results, nine with doubtful
positive, and nine with negative results. The question: "Does milieu therapy work for
schizophrenic patients?" must therefore so far be answered with: "Sometimes yes,
sometimes no."

Why are the results so contradictory? A main cause of the extremely varying results
of these reports may have been unrecognized differences among the wards. Even if the
institutions all claimed to give milieu therapy or to be therapeutic communities, they
may have been very different with regard to the milieu characteristics which most
strongly influence the course of psychoses. The problem remains; we still do not know
exactly what these characteristics are. Our knowledge in this field of research has not
yet reached the level where experimental investigations using ward comparison designs
can give us meaningful results. Before applying such designs, it is necessary to identify
more specifically milieu variables which are correlated to the course of functional
psychoses by use of correlational designs.

From a theoretical point of view, the patients' apprehension of the milieu is an
important intervening variable between the setting variables and behavioral variables
on one side, and the course of the psychopathological condition of the patients on the
other. This has also been clearly demonstrated by the life-event research: the person's
apprehension of the event is more important for the outcome than what exactly
happened. Theoretically it is highly possible that ward milieus both intended and
perceived to be different by the staff may be perceived as rather similar by the patients.
This view was also demonstrated in a comparison between therapeutic community
wards and traditional wards in a recent study by Steiner, Haldipur, and Stack [4].

A second main cause of the contradictory results of the milieu therapy studies may
therefore be that milieus which were meant and thought to be different actually
influence the patients similarly, and vice versa. A meaningful comparison of treatment
results across wards requires at least a measurement of both the perceived ward milieu
and post-hospital outcome. We also need to identify setting and treatment variables
influencing the perceived milieu and the outcome in a favorable direction.

Consequently, the milieu therapy research should, at our present level of knowledge,
study the relationships among five types of variables: setting variables (such as number
of patients, staff turnover), treatment variables (for example, types of psychotherapy
and use of drugs), human interaction (that is, staff-patient and patient-patient
interaction as described by an observer or measured by the Staff Resident Interaction
Chronograph (SRIC) [5]), perceived milieu variables (as measured by the Ward
Atmosphere Scale (WAS) [6]), and treatment outcome variables (post-hospital
functioning).

We suggest that setting and treatment variables influence the human interaction of
the ward, which again influences the patients' perceived milieu. The perceived milieu
can be regarded as the final common path of the other milieu variables. We therefore
need to know more about how these variables influence the perceived milieu. But as we
only can measure parts of the perceived milieu (that is to say, those parts which are
conscious and reported by the patients), it is also necessary to study the interrelation
among all five types of variables. Only when important variables of all types are
identified and measured can we know whether the milieus which we compare really are
different or not.
The purpose of this paper is to report some results from four research projects of our group, which tried to identify such variables and some of their interrelations.

THE RELATION BETWEEN PERCEIVED MILIEU AND OUTCOME

Moos and Houts [7] brought this field of research a significant step forward by the construction of the Ward Atmosphere Scale (WAS). The scale measures the patients' and staff's perceived level of involvement, support, spontaneity, autonomy, practical orientation, personal problem orientation, anger and aggression, order and organization (structure and predictability), program clarity, and staff control.

Unfortunately, WAS has until now been used only in a few investigations of post-hospital outcome. Based upon the reviews by Mosher [8] and Gunderson [9], and the theoretical considerations of Kernberg [10], one would expect the beneficial perceived milieu of psychotic patients to be characterized in WAS terms by a low level of anger and aggression, and a high level of order and organization, support, and practical orientation.

A re-examination of the WAS data from a study of seven VA wards by Moos and Schwartz [11] gives some support to this hypothesis. Comparing the WAS data from the wards with the best and the poorest outcomes, one finds that the best ward was characterized by a high level of order and organization and practical orientation (and program clarity and staff control), and a low level of anger and aggression.

The importance of these variables was confirmed by Klass, Growe, and Strizich [12]. They found that the post-hospital outcome (measured as community tenure rate) was positively correlated to the perceived level of order and organization and negatively to the level of anger and aggression. In this study, there were no significant differences among the wards as to support and practical orientation, and these variables could therefore not be studied.

The importance of the perceived levels of anger and aggression and of order and organization was also supported by a study from our own institute. Friis [13] asked patients from 12 Norwegian wards, with mainly psychotic patients, to answer both WAS and a Good Milieu index (based on Moos [6]) which directly measures their appreciation of the ward. The patients' appreciation was strongly positively correlated with the perceived levels of support, practical orientation, and order and organization, and negatively with the level of anger and aggression. It therefore seems that psychotic patients "prefer" wards with the same profile that the study of Klass, Growe, and Strizich [12] found was correlated to a positive post-hospital outcome.

So far, these investigations only permit suggestions. The relationship between a good outcome and both a high level of order and organization and a low level of anger and aggression seems to be most convincingly documented. Evidence also suggests that a high level of support and of practical orientation may be important characteristics of milieus for psychotic patients. Findings that a low degree of anger and aggression may be related to a positive outcome are a parallel to the finding in studies of family milieus that the degree of aggression in the family is strongly correlated to the post-hospital outcome of psychotic patients [14].

If the perceived levels of anger and aggression, order and organization, practical orientation, and support are crucial milieu variables, it may explain why Lehman et al. [15] found no differences in outcome when comparing two groups of first-admission patients (40–50 percent psychotic), one treated in a medically oriented ward and the other in a therapeutic community in statu nascendi. In spite of the differences between
the two wards, both concerning the ideology and the ward atmosphere, they seem to have been just about as successful (or unsuccessful) in their attempts to create a therapeutic atmosphere for psychotic patients. Compared to the medically oriented ward, the therapeutic community was perceived by patients and staff collectively as higher on practical orientation (probably beneficial), higher on anger and aggression (probably detrimental), lower on order and organization (probably detrimental), and equal on support.

A methodological weakness of the Lehman et al. study [15] makes it, however, even more difficult to interpret their results: the WAS means were calculated from the pooled scores of both patients and staff. It is therefore not possible to know whether the patients alone perceived the wards as being significantly different on the most important four WAS subscales. It is our experience that ideologically different wards are perceived as less different by patients than by staff.

The findings indicate that a therapeutic community ward may have both a partly "unfavorable" WAS profile and a treatment outcome no better than a traditional, medically oriented ward, even if it has fulfilled all the four criteria mentioned by Gunderson [9] as characteristics of three successful milieu therapy programs:

First, all of the units had a high staff/patient ratio and were relatively small units. The staff members were predominantly youthful contemporaries of the patients. Second, there was a distribution of responsibility among all staff members, and the patients were believed capable of assuming social responsibility. Third, all three units viewed psychosis as a process to be understood, lived through and accepted. Fourth, all of the units were attempting something iconoclastic, i.e., a mode of therapy at variance with the norms of treatment.

Consequently, it is necessary to look for other and possibly more influential treatment and setting characteristics than those mentioned by Gunderson [9].

THE RELATION AMONG GROUP TREATMENT, OUTCOME, HUMAN INTERACTION, AND PERCEIVED MILIEU

One of the central therapeutic tools in milieu therapy of both acute and chronic schizophrenic patients has been the use of different kinds of large and small groups. It is therefore rather surprising to find that, in most milieu therapeutic studies, the description of quality and quantity of group exposure and the relative amount of groups and individual therapy is either neglected or rather vague. Also, in comparisons among milieu programs, the group variable is usually neglected. In the following account, we will report some results showing the influence of group variables on outcome, human interaction, and the perceived milieu.

The Relation Between Group Treatment and Outcome

Vaglum and Bøe [16,17] studied in a quasi-experimental way what happened to the post-hospital outcome of schizophrenic and drug-abusing patients, when a therapeutic community ward at a certain point in time increased the amount of compulsory group activities from 13 to 23 hours a week. The relative amount of individual care and support was simultaneously significantly reduced. The level of aggression at the ward was observed to increase considerably as the milieu therapists became more confronting.
The Course of the Group Treated:

- In Individual Oriented Program
  - (n=20)

- In Group Oriented Program
  - (n=42)

Figure 1. Percentage of schizophrenic patients with a score 3-5 (best) on the social functioning index each year after admittance.

Figure 1 shows the course of the social functioning, an index of work, education, lodging, economy, treatment, and social contacts, in two groups of schizophrenic patients treated before and after the increased group exposure. At admittance, the two groups were nearly equal as to prognostic variables. But during a follow-up period of four years the course became significantly poorer in the group treated in the highly group-oriented program. When the patients at follow-up were asked to describe factors which they thought to be therapeutic or not, they first of all emphasized the lack of a good one-to-one relationship as the most anti-therapeutic factor [17].

In the group of non-psychotic opiate abusers, treated in the same two programs, the opposite result was found [18]. Here, the outcome was significantly better when the amount of compulsory, confrontative group activities was increased. This result shows the necessity of different milieus for different patient groups.

If the amount of confrontative group exposure and the relative amount of individual-versus group-oriented milieu therapy are important treatment variables, some of the contradictory treatment results published seem more understandable. Re-examination of the papers by Letemendia, Harris, and Willems [19], Spadoni and Smith [20], and van Putten [21] shows that these experiences came from wards with a high amount of group exposure, and with little or no individual psychotherapy or formation of one-to-one relationships. The positive experiences of Madew, Singer, and Macindoe [22], Denber, Tours, and Seeman [23], and Jeffrey, Kleban, and Papernik [24], among others, seem on the other hand to arise from programs with an opposite profile.

The Relation Between Group Treatment and Human Interaction

The effect of group exposure on the outcome is thought to be mediated partly through the effect on human interaction and on the perceived milieu. Further knowledge about the relationship between group activities on one hand and human interaction and the perceived milieu on the other would therefore be highly desirable.
The relationships between the quality of group activities and the human interactions were investigated by Karterud [25]. For six months he studied by non-participant observation all kinds of small and large group meetings in three highly group-oriented therapeutic community wards. A main finding was that several of these therapeutic community groups, especially if they contained a high percentage (>40–50 percent) of psychotic patients, periodically did not function as groups in an ordinary psychological sense. Instead, they functioned as "pseudo-groups" which were defined as: "An organized assembly of people who, in spite of several attempts and meetings, do not succeed in establishing a shared opinion of rules, standards, hierarchy, purpose and intent, but nevertheless continue to meet." These group members were apparently not attached to each other through libidinous bonds but were kept together by the social pressure of the ward. The behavioral characteristics of the "pseudo-group" on a group session level, were:

1. The group was difficult to assemble. The staff must endeavor to gather the group members.
2. When a therapy session was finished, the group immediately dissolved. In ordinary groups the patients continued "small-talking" when the session was over.
3. There was no conflictual and thematic continuity in subsequent sessions. The themes, conflicts, and actors changed in an incoherent way.
4. The level of free-floating anxiety and aggression was high.
5. There was an absence of "pairing phenomenas" [26]; that is, a group atmosphere of hope and expectations.
6. The group lacked an adequate "containing function" [26].
7. The conflict analysis a.m. Whitaker [27] indicated no shared group solutions, or, if present, they were of a very primitive and restrictive kind.
8. The patients were placed in a double-bind situation, because staff members were referring to the group as a psychological entity, while in fact there existed no group in a psychological sense.

Such "pseudo-groups" undermined the therapeutic community as a whole. They were observed to be highly anti-therapeutic, making the psychotic patients confused, frustrated, and anxious.

The Relation Between Group Treatment and the Perceived Milieu

The quality of the group work may also influence the patients' perception of the milieu. All three wards studied by Karterud [25] were also evaluated with the WAS. On the two wards where "psuedo-groups" were observed, the patients perceived the milieu unfavorably: a high level of anger and aggression and low levels of order and organization and of practical orientation.

The relationship between group treatment and perceived milieu was further explored by Friis, as part of a larger investigation [13]. Correlations were calculated between the patient WAS-R means and several setting and treatment variables on 35 short-term wards. The seven most important variables were entered into a hierarchical multiple-regression analysis. Among these seven variables there was only one treatment variable: the interaction score. This was calculated by combining the z-transformed scores of two strongly correlated variables: the amount of group
exposure (in hours per week) and the percentage of patients who were not given psychotropic medication. The interaction score was deliberately entered as the last of the seven variables, in order to subject it to the following hard test: if the influence of six important setting variables was controlled for, did it then matter to what extent the ward put emphasis on human interaction? It obviously did. Even when entered as the last variable, the interaction score was able to explain additional variance for nine of the ten subscales. The interaction score was, however, fairly strongly related to only one of those WAS subscales which seem to be of prime importance for psychotic patients: it was positively correlated to the perceived level of anger and aggression. This result indicates that an increased exposure to groups may be anti-therapeutic for psychotic patients and supports the findings of Vaglum and Bøe [16].

Summing up this section, our findings underline the necessity of describing the amount, type, and quality of group work and the ratio between individual- and group-oriented milieu therapy.

*The Relation Among Setting Variables and the Perceived Milieu*

In addition to treatment and human interaction variables, setting variables may also influence the perceived milieu. As mentioned previously, Friis [13] entered six setting variables into a hierarchical multiple-regression analysis of the perceived milieu. The following four variables were found to be most important for the treatment of psychotic patients:

*The Number of Patients* An increased absolute number of patients seemed to create a perceived milieu unfavorable for psychotic patients; i.e., a milieu perceived as low in order and organization, support, and practical orientation, and high in anger and aggression. This profile was found mainly on wards with more than 15 beds.

*The Percentage of Psychotic Patients* An increased percentage of psychotic patients seemed to change the perceived milieu in an unfavorable way. It therefore seems to require special efforts from the staff to create a beneficial atmosphere on wards with mainly psychotic patients.

*The Mean Age of the Patients* An increased mean age of the patients was related to an atmosphere with a higher level of order and organization and a lower level of involvement, spontaneity, autonomy, personal problem orientation, and anger and aggression. Older patients, as a group, seem to be less aggressive. This may contribute to a more beneficial atmosphere for psychotic patients.

*Staff Turnover* A high staff turnover seemed to create an unfavorable atmosphere both for psychotic and non-psychotic patients.

Other variables, such as the mean length of stay and the staffing, were rather weakly related to the atmosphere. This may be due to a fairly low variability of these variables in this study. The mean length of stay ranged from one to three months (except for one ward with a fairly high number of chronic psychotic patients, where the mean length of stay was six to seven months), and the total day staff/patient ratio ranged from 0.53 to 1.14.

Summing up, this study indicated that setting variables also may strongly influence the perceived milieu. When comparing psychiatric wards, one should therefore describe the age and the number of patients, the percentage of psychotic patients, and the staff turnover.
IS IT POSSIBLE TO CREATE A MORE BENEFICIAL PERCEIVED MILIEU BY MANIPULATING CERTAIN SETTING AND TREATMENT VARIABLES?—A QUASI-EXPERIMENTAL STUDY

Both from a theoretical and an empirical perspective, the perceived milieu may influence the treatment outcome for psychotic inpatients. Our three studies have indicated that the perceived milieu is influenced by the following factors:

1. The amount of group exposure, especially compulsory exposure to confronting groups
2. The quality of group activities (group culture)
3. The amount of individual support and care compared to the amount of group exposure
4. The number of patients
5. The mean age of patients
6. The percentage of psychotic patients
7. The staff turnover

At least the first four of these variables may be deliberately manipulated. By manipulating one or more of them, it should be possible to change the perceived milieu in a beneficial way. We shall end this paper by describing such an attempt.

From a Group-Oriented to an Individual-Oriented Therapeutic Community

We were almost forced to do this experiment when our own therapeutic community, as a result of the sectorization in Oslo, developed a manifest burnout syndrome some years ago. Before the sectorization, the ward was a 26-bed therapeutic community of the “Maxwell Jones type” with strong emphasis on group activities. The percentage of psychotic and acutely admitted patients was never above 30. After the sectorization, the percentage rose to 60–70, and the mean length of stay had to be reduced from six to eight to three to four weeks. The therapists tried heroically, nevertheless, to continue the old treatment program, but more and more patients were unable to participate fully and to take on the responsibility and duties demanded by the therapeutic community. In two years, a full burnout syndrome developed in the staff.

An examination of the ward by use of the WAS, the Good Milieu index [13], a questionnaire to the staff members, a semistructured interview with the different leaders in the staff, diaries written by nurses, and non-participant observation of the ward a.m. Thelen and Whitaker [25] revealed an alarming picture:

The patients perceived the ward very unfavorably. They reported a high level of anger and aggression and a low level of order and organization (structure and predictability) and also a low level on the Good Milieu index (Fig. 2).

The groups functioned periodically as “pseudo-groups.” They were very fragile and primitive. Collective group regressions took place very easily.

The examination of the staff showed a high level of staff conflicts. The milieu therapists experienced a common feeling of always having to perform several tasks at the same time. There was an ongoing conflict between the demand for work on acroup level and on an individual level. Individual care had to be given unofficially. Officially the real therapy was to be in the multitude of group activities which occupied most of the day.
FIG. 2. The WAS-R and GMI scores for patients before the changes, indicated as the deviances (in SD) from the mean scores for 12 Norwegian psychosis wards. Hatched columns indicate deviations in the desired direction; open columns indicate deviations in the undesired direction. Su: Support Pr: Practical orientation An: Anger and aggression Or: Order and organization GM: Good Milieu Index.

CHANGES

The need for change was obvious. The burnout syndrome in the staff seemed to be the result of a lack of congruence between what the psychotic patients needed and what the treatment program offered them. Therefore the changes should aim at both a more favorable milieu as perceived by the patients and a less conflicting and distressing work situation for the therapists.

Based on the results of our three previous studies [13,16,17,25], the department decided to make the following four changes:

1. Compulsory group activities were reduced from 23 to five hours a week.
2. The quality of group work was expected to improve by removing the process-oriented, partly unstructured, and confrontational group meetings. All group activities, including the community meeting, should be task-oriented with a staff member as a leader. The tasks should be clearly defined. The staff should take full leadership responsibility and be more concerned about their roles and the boundary conditions.
3. The ratio of individual- versus group-oriented milieu therapy was altered by removing the group as the main organizational principle of the ward. In addition, individual-oriented milieu therapy was given priority over work with groups.
4. The number of beds was reduced from 26 to 17.

The rest of the program was kept unchanged. This meant that psychiatric disorders still were to be seen as results of the interplay of social, psychological, and biological factors. All activities should be looked upon from the perspective of their psychotherapeutic implications. It was still assumed that most of the patients would regain their functions as responsible adults and that they should do this stepwise within the ward community.

It also meant that the staff continued to work in teams, and that they continuously worked to reduce destructive conflicts within the staff. Open communication between staff and patients was encouraged. Community meetings were continued five days a week but were no longer compulsory. Activities together with the patients were still the main element of the milieu therapy. The use of individual psychotherapy, psychopharmacological treatment, family therapy, day treatment, and outpatient treatment remained unchanged.
FIG. 3. The WAS-R and the GMI scores for patients after the changes, indicated as the deviations (in SD) from the mean scores for 12 Norwegian psychosis wards. Hatched columns indicate deviations in the desired direction; open columns indicate deviations in the undesired direction. Su: Support  Pr: Practical orientation  An: Anger and aggression  Or: Order and organization  GM: Good Milieu Index.

WHAT HAPPENED?

A re-examination using the same methods, one year after the change, showed the following [28]:

1. The expected changes had taken place with regard to the degree of group exposure, the quality of group activities, and the amount of individual milieu therapy. The number of beds had been reduced.
2. The staff members reported considerably less conflict among themselves \((p = .05)\) (one-tailed \(t\)-test), considerably fewer situations where they were expected to be in several places at the same time \((p < .005)\), and much less conflict between individual- and group-oriented work \((p = .05)\). In short, the burnout syndrome was ameliorated.
3. The ward milieu as perceived by the patients had become considerably more favorable. The perceived level of order and organization (structure and predictability) and of practical orientation had become significantly higher \((p < .05)\), while the level of anger and aggression had become significantly lower \((p < .05)\). The Good Milieu index score was significantly higher \((p < .05)\) (Fig. 3).

One year later, the department was examined, using the same methods. The findings were about the same.

Summing up, this study shows that the patients' perception of the ward milieu became significantly more favorable for psychotic patients when we made changes on the four variables which our earlier studies had identified as important for psychotic patients. The results may therefore be seen as a quasi-experimental confirmation of the findings of our three earlier studies. Ideally, we would of course have wanted to vary only one of these four milieu variables at a time. Clinical reality, however, made this impossible. We therefore do not know which of these variables are the most important ones.

FINAL DISCUSSION

In this paper we propose some reasons why clinical experiences with and research on milieu therapy of schizophrenic patients are so contradictory. We point to the fact that we still do not know the crucial milieu factors and characteristics of the perceived milieu on which different wards should be compared. More correlational studies are needed.
Based on the literature and our own research, mostly from short- and intermediate-term wards, we have found evidence which seems to identify the patients' perceived levels of anger and aggression, order and organization, support, and practical orientation as crucial factors which are related to the post-hospital outcome of short- and intermediate-term treatment.

The importance of the aggression variable is in accordance with findings from family studies [14]. It is also supported by the outcome study of milieu therapy by Klass, Growe, and Strizich [12], who found better outcome for psychotic patients treated in wards with a low perceived level of anger and aggression and a high level of order and organization. It must be mentioned, however, that Wendt and co-workers [29] found that the experimental setting of Soteria House was beneficial for psychotic patients, even if it seemed to have a high level of anger and aggression and a low level of order and organization. Even if methodological weaknesses (small number of respondents and the COPES scores treated as if they were WAS scores) make it difficult to interpret the results of this study; they seem to imply that in a very small setting (only six patients) with an intermediate length of stay (four to six months), schizophrenic patients may benefit from a somewhat different milieu than we have suggested, a milieu with less structure and more expression of feelings.

The four variables of the patients' perceived milieu, as well as the post-hospital outcome, seem to be influenced by several treatment variables, that is, the quantity and quality of group exposure and the ratio between the use of individual versus confrontative group oriented methods, and by several setting variables, that is, age and number of patients, percentage of psychotic patients, and staff turnover. In forthcoming milieu therapy research, these variables should therefore be described and if possible varied one by one. In milieu therapy research where these variables are measured, it should now be possible to study the consequences of variations in the length of stay, in medication, in supplementary psychotherapy (family, individual), in percentages of non-psychotic patients, and so on. It should also be possible to study whether similar ward milieus may have different effects on different patient groups and vice versa.

Such studies probably ought to include systematic registrations of human interaction, for example, by use of the SRIC [5]. The field also needs, however, a further development of instruments, as there are dimensions not measured by either the SRIC or the WAS. The SRIC seems to need further development in the area of less deviant behavior, and the WAS lacks important variables such as containment and validation [30].

It must be emphasized that the verbal group therapy part of the group exposure in the studies reported in this paper was of a confrontational kind. Furthermore, the composition of the groups was heterogeneous, and we could often observe that the schizophrenic patients could not cope with the conflicts initiated by the patients with personality disorders. Inpatient group therapy for schizophrenic patients is obviously a very difficult task to perform, as it is hard to avoid detrimental outbursts of destructiveness. We have no reason to question the effect of skillful supportive group therapy for these patients, although we will mention that the reported evidence for a beneficial effect of group therapy for schizophrenic patients comes mainly from outpatient groups [31]. It is highly debatable whether and how inpatient groups should be organized on short-term wards. For intermediate- and long-term wards there are evidences of a beneficial effect of highly structured groups within an overall culture of social and work rehabilitation [32].
CONCLUSION

In spite of 40 years of milieu treatment, we still do not know enough about how to develop and maintain an optimal milieu therapy for patients with schizophrenic psychoses. A cluster of milieu characteristics which should be expected to constitute a more optimal therapeutic milieu seems, however, to be emerging now. The outcome seems to be correlated to the patients’ perception of the milieu. A favorably perceived milieu of short- and intermediate-term wards is supposed to be characterized by a combination of a high level of order and organization, practical orientation, and support and a low level of anger and aggression. Such a profile may be promoted by a high staff/patient ratio, a low staff turnover, a relatively small number of patients, an adequate quantity and quality of group work, and a relatively high ratio between individual-oriented and group-oriented treatment methods. A challenge to clinicians and researchers is to carry out such milieu therapy in practice and continuously to evaluate whether it works, under what conditions, for how long, and for whom.

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