

*IN MEMORIAM*

Gerard Hogarty, MSW: Pioneer in Clinical Social Work

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On April 7, 2006, Gerard Hogarty died at age 70. A professor of psychiatry at the University of Pittsburgh School of Medicine with an MSW from Catholic University, Hogarty was a world-class researcher in treatment of schizophrenia. While he also conducted important research on anti-psychotic medications, he spent nearly 40 years developing psychosocial interventions for schizophrenia, developing research protocols for evaluating these interventions, and conducting clinically substantive research that provided useful data on who, when and how these interventions were effective.

In the 1960's and 70's, Hogarty developed and studied an intervention model for schizophrenia he called "major role therapy". In the 70's and 80's, with another social worker, Carol Anderson, he explored an approach called "family psycho-education," described in *Schizophrenia and the Family: A Practitioner's Guide to Psychoeducation and Management* (Guilford 1986). This approach reduced the annual relapse rate in medicated schizophrenic patients from 40% to 10%.

Hogarty pursued an intervention model he called "Personal Therapy" (PT). Unlike many researchers who conduct clinical trials for 8 to 12 weeks, Hogarty had followed a cohort of the "family psychoeducation" study for two years. Studying the data, he noticed slippage in the relapse rate in the second year of treatment. He also observed that major disability persisted although relapse was significantly reduced. So he developed a new treatment model that would address these clinically significant domains. This intervention, described in his book "Personal Therapy for Schizophrenia and Related Disorders: A Guide to Individualized Treatment" (Guilford, 2002) began with a traditional social work concern with basic needs, applying for SSI pensions, stable housing and transportation funds, before progressing to issues of symptom self-management and vocational activity.

And observing that the treatment process in schizophrenia extends for years rather than months, he obtained unprecedented support from NIMH for a three year study of this approach. Research findings showed little difference between the experimental and control group (which received medications and "supportive care") over the first half of the study. But over the second half of the intervention, the control group plateaued while the PT group dramatically improved.

Characteristically, Hogarty continued to examine his data in greater detail and, in his two part report in the American Journal of Psychiatry, he reported a dramatic divergence in treatment response between patients with stable living situations (most often with families) and those in more chaotic situations. The former group responded impressively to PT while the latter group deteriorated. He hypothesized that the cognitive stimulation involved in the PT approach was only effective when patients had a stable environment.

But as the positive data regarding the PT intervention accumulated, Hogarty was still unsatisfied with the outcomes achieved in his studies. Even when stabilized with medications and PT, the schizophrenic patients in his studies still exhibited significant residual symptoms of cognitive impairment. So over the past decade, he developed an intervention called "cognitive enhancement therapy" which addressed the underlying cognitive deficits in schizophrenia. With findings published in *Archives of General Psychiatry* (2004, p. 866-876), Hogarty developed yet another approach to improving the lives of persons with schizophrenia. In all of this work with schizophrenia, Hogarty, a stalwart advocate of antipsychotic medications, recognized that medications alone are a grossly inadequate treatment. (With subtle humor, he arranged for a purple cover for his last book, mimicking the color scheme of a popular medication.) His life work truly embraced a biopsychosocial perspective that integrated biological, psychological and environmental interventions. Unfortunately, his preference for empirical data over theoretical abstraction precluded significant dialogue with many of his social work colleagues. While his work addressed the ego capacities of schizophrenic patients, he had little interest in psychoanalytic theory. At the same time, he found that the cognitive-behavioral models used by many focused on rote learning which was rarely generalized to diverse situations.

And, unlike many clinician-researchers who spend years "marketing" a specific treatment model in workshops and conferences, Hogarty's attention remained focused on the clinical problems that emerged in each new study. His commitment to the expansion of knowledge was quite remarkable, yet it often meant that his ideas received far less attention from the mental health community than they deserved.

For anyone interested in learning more about Hogarty's work with schizophrenia, consult the aforementioned books or "google" his name along with "schizophrenia" and many useful references will appear.