



The Importance of Structure and Connection for People Living With Schizophrenia: A 33-Year Outpatient Group Experience

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Abstract

This paper evaluates an outpatient group for persons living with schizophrenia. Qualitative changes and psychiatric admissions among group members were reviewed to measure recovery. Thirty-two members have attended sessions for up to 28 years. Meaningful interactions (e.g., supportive comments) have increased and hospitalizations have decreased. The support of the therapists and the other group members has allowed for personal recovery and developing and maintaining social connections. Prior to starting the group, 67% of members had > 1 hospitalization and 26% had none. During the group, 63% of members had no hospitalizations. Vignettes of change, peer support, fewer hospital admissions, and signs of recovery in the face of crises suggest that members benefit greatly from this outpatient group.

Keywords Schizophrenia · Psychiatric rehabilitation · Long term group therapy

Introduction

Persons with serious mental health disorders such as schizophrenia often experience a number of difficulties including increased mortality rates, disorganized thinking, distorted perception (e.g., hallucinations), and emotional difficulties (American Psychiatric Association 2013; Kring and Caponigro 2010; Kring and Moran 2008). To cope with the consequences of living with a chronic mental illness, psychotherapy is one approach that aims to decrease psychotic symptoms and restore functionality to improve quality of life (Haller et al. 2014). Practical issues, however, have been identified when trying to provide therapy to outpatients with serious mental illnesses due to the chronic relapsing and remitting nature of these disorders (Berry and Haddock 2008; Haller et al. 2014). This paper evaluates the usefulness of a real-world outpatient supportive group facilitated by a psychologist among persons with chronic mental health

disorders. Background of the group structure, barriers to the initiation of the group, summary of early outcomes, and long-term outcomes, and potential mechanisms of change of an existing outpatient group are presented with both quantitative and qualitative information.

The Thursday Group

Structure and Goals in Group Formation

The Thursday Group began in 1985 for people living with chronic mental health conditions including those diagnosed with schizophrenia. The group occurs weekly and the structure is consistent, each session begins at noon and continues for 45 min. Entry into the group requires a referral from a professional in the department of psychiatry at the Jewish General Hospital, located in Montreal, Quebec. All group members receive psychiatric follow-up, while social workers and occupational therapists are also available as part of standard care. Once referred, each potential member is asked to call the group leader, a psychologist, as an indication of their motivation. Membership in the group is open-ended, whereby, members can remain in the group indefinitely but are asked to call the group leader if unable to attend a meeting. Since 1997 the leader has had 1–2 psychology interns' training as co-therapists. To date, over 50 interns

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have worked in the group and occasionally an “observer” (an international medical practitioner) is also be present.

Broadly, the goals of the group are to provide a consistent space and setting that members can arrive at each week and talk openly about the topics they choose, or can simply be together, even if unable to speak. For many patients with psychiatric difficulties, issues of separation, isolation, and intimacy are associated with psychological crises that result in decompensation and hospitalization (Asseyer 1991; Kazadi et al. 2008; Robinson et al. 1999). It was thought that a consistent, reliable group could serve as a buffer for some of these crises. Specifically, it was recognized that the group setting may allow for the interpretation of increased psychotic behavior in a non-judgmental setting. The hope was that linking psychotic symptoms to members’ fears and current life events could help manage escalating anxiety and reduce hospitalizations. The group, as a whole, meeting at the same time and place each week provides a firm boundary within which members participate regardless of the fragility of their own structures. Members sit in a circle and are free to discuss as much or as little as they desire. Member engagement is facilitated by providing the space for members to speak about experiences personally relevant to them. A typical session often begins by one member sharing a struggle that they experienced the previous week. Typically, this facilitates other members in sharing difficulties they may be facing or successes from their past week. The leader’s main role is to ‘be there’ with the members each Thursday while tolerating the illness with them. The leader also poses questions to the group which encourage support, for example, when a member describes experiencing auditory hallucinations, the leader may follow-up by asking, “how do others cope with this?”. Aside from the weekly group or receiving calls that a member will be absent, the leader does not have additional contact with the members. The goals of the group and the function of the leader has remained unchanged since the groups inception.

Difficulty Receiving Referrals

The first Thursday Group meeting was held in March 1985 and prior to the meeting, five members had been referred from the outpatient psychiatry clinic. Only two of the five persons referred, however, actually attended the first meeting. Despite expressed enthusiasm from the psychiatric services, only four additional referrals for the group occurred over the next 2 years. At this time, the group often included just two individuals, one of whom had no other social contacts. This member would struggle to walk to the group as he described symptoms of agoraphobia with a fear that cars would jump onto the sidewalk and hit him. His attendance and perceived benefit from the group encouraged the group leader to continue with the group. In fact, to combat the

low referrals, a questionnaire was distributed to the psychiatrists in order to understand the lack of referrals. Twenty staff members completed the survey and indicated that often, “the group was not thought of when meeting with a patient”. It may be the sense of isolation and disconnect-ness that these patients can communicate that negated the psychiatrists from considering group referral (Sigman 1990). Alternatively, perhaps an unconscious repetition occurred, whereby the staff members treating persons with tenuous object relationships, paralleled their behavior by “not remembering” the group treatment option. By 1990, however, 6–9 individuals ranging in age from 28 to 52 were attending the group regularly. Since this time, the group has received peer-referrals from group members, and ongoing referrals from psychiatrists, and psychologists. Perhaps there was a delay in the perceived usefulness of the group, which became more apparent after patients had been regularly attending the group and their stability became apparent to treating psychiatrists.

Early Outcomes

From 1990 to 1994, re-hospitalization rates of the group members had reduced substantially. Of the 14 members who had participated for more than 2 years, there was a 50% reduction in cumulative days hospitalized. Prior to joining the group, members had a total of 1624 days hospitalized, as compared to 786 days in hospital after joining the group—each individual acting as his or her own control (Sigman 1996).

In 1999 after each session, the group therapists began to record each member’s involvement in the session. This recording involves noting the presence or absence of: psychotic, manic or depressed material or behavior expressed during the group. Emotions expressed are also recorded and categorized as joy, anger, anxiety, sadness, or guilt being shared in the group. Further, expressions of loneliness, loss, dreams, discussion of current or past relationships, humor, illness, current activity in members’ lives, helplessness, hopefulness, hopelessness, sexual preoccupation, and if members made supportive or insightful comments are also recorded. Overarching perception of whether each member was engaged in the group or participated minimally are also documented. The group therapists recall and note these behaviors, expressions, and/or emotions by consensus and records quotes immediately after the group finishes each week. The decision to record a member’s behaviour is based on the leader and interns’ perceptions, rather than a pre-defined coding manual.

After recording these features of the group for 7 years, substantive shifts in members capacity to engage in emotionally meaningful interactions were noticed. Four categories of data that relate to higher adaption and maturation (Bond

and Perry 2004) were reviewed. Frequencies of how often group members: (1) engaged in and related to the group as a whole, (2) made supportive comments within the group, (3) demonstrated a sense of humour, and (4) made an insightful comment, were calculated. Examples of comments that are categorized in these sections:

Group: “It helps to know others have the same issue with sisters.”

Supportive: “It sounds like the foster mother in the group home cares for you.”

Humour: “Every silver lining has a cloud.”

Insight: “When I’m not feeling well, I think people don’t like me.”

For a period of 7 years (1999–2005) the frequency of group members engaging in the four categories (Group, Supportive, Humour, and Insight) of behaviour and expressions were documented, resulting in a total of 308 sessions reviewed. Results revealed that members showed a clear trend toward becoming increasingly supportive of each other and engaging more in the group. They also demonstrated more insight and humor over the years. Furthermore, most members maintained these improvements over time (Sigman and Hassan 2006).

Long-Term Vignettes of Change

There is one member, Paul, who was severely alexithymic when he first entered the group over 20 years ago. Paul has consistently been supportive to members of the group and often shares information related to health, foods, and strategies for coping, however, for the first 18 years of being in the group, he had never expressed any emotional content within the group. Two years ago, however, his mother whom he was caring for and lived with, became very ill and died. Despite this loss, Paul never missed a session and months after his mother’s death, he shared with the group that he had been reviewing music that he and his mother would listen to and he became teary and experienced sadness with the group. After this session, he began to speak about and experience emotions (such as loss) more meaningfully in the group.

Drake, a member of the group for 5 years, also suffered the loss of his mother in recent years. He and Paul speak about this in the group and receive support from the group members and particularly from each other. In contrast, two former group members’ mothers died around the same time and these former group members both required extended admissions to the inpatient unit. Perhaps if they had the group support they may have spoken about their sadness, metabolized their feelings in the group and, avoided the incidences that necessitated their admissions.

Loss Within the Group

In the current group of 11 members, Brett has been attending for 28 years, Paul for 22, Ward for 19, Drake for 8, Wilma and Earl for 6 years, Jane for 4 years, Sherman for 2 years, Serena and Julia for 10 months, and Reesa for 5 months. Dan, a previous member of the group had attended for 23 years. After being diagnosed with cancer Dan would call in to the group while undergoing chemotherapy, however, he died last year.

Our session after his death was especially difficult. Dan’s partner Wilma was able to feel and express her great sadness and when she did not become tearful, the group facilitator did. Paul, the member that had previous presented with alexithymia, was teary eyed during the session. He was able to describe the psychological changes that Dan had made in the group and insightfully recalled that Dan had wanted to be a sports broadcaster, which was Paul’s perception of why Dan was helpful to Wilma’s son, who is heavily involved in sports. Earl, a member that continually describes psychotic material, expressed: “I’m sorry for David, but maybe there is a way to get him back”. Brett was able to say: “I’m feeling emotion” but he was otherwise wordless. Ward had recently lost his brother and was very supportive of Wilma and explained coping strategies that helped him (i.e., spending time with his cat and swimming). The other members allowed Wilma to speak as much as she needed to. The members also described feeling grateful for having had Dan participate in the group for several weeks by phone before his death.

Dan had a forward-thinking attitude even in the face of his cancer. He persisted in telling Wilma he was not going to die. Prior to his death, he was purchasing items for upcoming events (e.g., tickets for concerts). Dan was the first member to bring a joke into the group and interestingly, the joke was representative of his coping strategy for dealing with his cancer diagnosis. Dan had asked the group, “what did one Egyptian schizophrenic say to another”—“you are in de Nile”. Denial was a strategy that worked well for Dan in coping with his cancer. Dan was a good example of personal recovery from mental illness. When Dan began in the group, he had been silent for the first 6 months. He then slowly progressed to speaking in the group. During his time in the group he moved out of his family home to a supervised apartment and then to an independent apartment. While progressing through these stages of increased autonomy he continued attending the group, sharing his struggles, and receiving support.

The group may provide a firm boundary that can moderate psychotic angst. Brett, our longest member, notes each member’s and leader’s birthday with a card and CD which is passed around as if to connect the group and perhaps reinforce its boundary. Fragile boundaries within

the group have also been previously described (Lavarenne et al. 2013).

Long-Term Hospitalization Outcomes

From the groups inception in 1985 to 2018, 89 individuals have been referred to the group. Of these 89 referrals, 7 individuals did not attend any sessions. Among the 82 individuals who attended at least one session, three patterns emerged: (1) 25 individuals attended only one or two meetings, with most of these members having bipolar disorder, (2) 25 individuals attended for less than 1 year, and (3) the remaining one-third of individuals have been attending for 10 months to 27 years ($n=32$). Among 28 members of the group that have attended for 1–28 years, psychiatric hospitalizations have decreased substantially. Prior to attending the group, 26% of members had no hospitalizations. While attending the outpatient group sessions, 63% of members had no hospitalizations.

Indications of Recovery

Through talking about their daily lives, members identify and share with the group when they become distressed, whether about filling out tax forms or believing that someone is looking at them through a window. The group is secure enough for members to label and describe what the illness does to their thinking. For example, when asked about an issue with her daughter, one member stated, “oh that was probably a hallucination”.

The members are also able to relate to one another and provide support and understanding in this way. In one session, a member expressed feeling sad and anxious when he visited his father in a long-term care facility. If he did not visit, however, he described feeling guilty. Another member was able to support him by sharing that she has a brother who is disabled and lives in a group home. She explained that although she does not visit her brother often, she sings to him on the telephone. This member was able to provide a new perspective on caring and supporting a family member.

Perhaps one of the best signs of recovery and of the benefits of the group is the use of humor, which has increased over time. Members of the group also comment on themselves with humour, which demonstrates increased self-esteem and insight into their illness. An example was when one member suggested doing sessions on skype and another replied that he was not photogenic enough to use skype.

Potential Mechanisms of Change

With the support of the therapists and of other members, the group is a place and a means for personal recovery (Anthony 1993) and serves as a source of social connection.

Participation in the group is based on communication with each other. The group allows members to regain the connecting functions of language.

In line with the personal recovery concept for serious mental illness, group members recoveries have involved receiving support in allowing their lives to extend beyond their mental illness (Anthony 1993). Patients are able to talk about the experience of their symptoms and help one another find ways to cope with their struggles. It may be that some patients gain insight from hearing other patients describe their symptoms, which also helps members realize that others in the group suffer similarly. Relatedly, this understanding may facilitate the personal recovery from stigma that members had incorporated into their lives. The group is a setting that provides members with the opportunity to share their experience of the illness and acknowledge how their lives are influenced by it. From a personal recovery standpoint, meaningful recovery can occur without complete relief of symptoms (Anthony 1993), as has been demonstrated in the group members.

The group also allows for shared experiences. For example, one patient used the group as a source of support and a setting for expressing difficulties she was having when moving from her house to an apartment. Every week while she prepared for the move she would describe difficulties sleeping and new voices she was hearing. As the date of the move got closer, her anxiety escalated. With substantial support from the group, she was able to tolerate the move and she reported that the voices had stopped once she had moved. The members noticed her relief and one of them commented that “The smile says it all.” This shared experience also allowed other members to project themselves into their future and reflect back on this individual’s success when preparing for their own future moves.

Conclusion

The setting of the group is firm, it takes place once a week at noon for 45 min in the same room. Members living with schizophrenia struggle with disorganization and having a structured activity in their timetable is a therapeutic asset. The weekly gatherings offer the members a place of comfort where they can connect with each other. The data indicates that when comparing persons with schizophrenia before and during the outpatient group, the group members have considerably fewer relapses requiring admission to the hospital. Members social functioning also improves, for example through improved autonomy and engagement in social activities. This is likely related to the social connectedness and support that the members provide each other. As Wilma said: “I don’t feel alone here, it’s about the connection.”

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Compliance with Ethical Standards

Conflict of interest All authors declare that they do not have any conflict of interest.

Ethical Approval In line with the Health Research Ethics Authority, ethics approval was not required for this program evaluation study. For this type of study formal consent is not required.

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