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LONG TERM GROUPS FOR PATIENTS WITH PSYCHOSIS IN PARTIAL REMISSION - Evaluation of ten years' work

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SUMMARY

Outpatients with psychosis who attended long term psychotherapeutic groups were evaluated regarding their quality of life and attitude towards medication with self-report questionnaires. The DAI-10, Quality of life Brief questionnaires and clinical observation were used for evaluation.

Most of the patients' participation in group therapy was rated as satisfactory or very productive by their group therapist.

More than half of our patients rated the group therapy's influence on their life as important; only three of them noticed no importance of the group therapy on their life.

The sample may be too small to show a statistically significant correlation between participation in the group and time spent in group therapy and attitude towards medication.

Key words: *psychosis-schizophrenia - group therapy - quality of life - medication attitude*

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Introduction

Long term group work has important short and long term effects on quality of life, compliance with treatment, social functioning and stigma reduction (Martindale et al. 2002). Patients should be intrinsically motivated and well prepared for group work. In the first phases patients gain better control and differentiation of their psychotic symptoms, emotions and improve their social functioning (Addington et al. 2006). Group cohesiveness develops very slowly, but once formed remains very strong (Lakeman 2006).

With the progression of group process, we observe more constant membership, honest and open conversation about symptoms and real life problems. Some patients left the groups early, but the remaining members were constant and some of them couldn't end the group process. After termination the patients were engaged in social networks that carried on some of the beneficial effects of the groups. Some patients developed transient worsening of their psychotic symptoms during group therapy.

Method

All the included patients were diagnosed as having schizophrenia or schizoaffective disorder based on DSM-IV criteria. They were treated by regular psychiatric care which included individually prescribed medication. All of them have been in remission of acute psychotic symptoms most of the time spent in group therapy.

Three small groups of 6 to 10 medicated patients were run over a period of ten years. All groups were ongoing, new patients were included after the termination of a previous member. The groups were run in co-therapy. One of the co-therapists was an experienced psychiatrist, the other a psychiatric nurse in one group and a young psychiatrist or psychiatric resident in the other two groups. Sessions were run every two weeks for 90 minutes.

A modified, non-structured, psychoanalytic group technique which included psycho education, cognitive techniques, non-structured conversation and clarifications was used.

A total of 47 patients were recruited; 16 were excluded, 6 of them dropped out of group therapy after four sessions or less, 7 were lost to follow up and 3 refused to participate in the study. All 32 included patients (68% recruitment rate) were assessed in the same week.

Demographic characteristics of the sample are summarised in Table 2.

Two self-report questionnaires were administered (1, 2) in order to assess the quality of life and drug attitude of the patients. Both questionnaires were translated into Slovene. All the patients also evaluated the importance of group therapy on a scale of one to three. The treating psychiatrist evaluated the patients' present severity of illness using the Clinical global impression scale. The group therapist evaluated the patients' quality of their participation in group therapy.

1. ***Drug Attitude Inventory (DAI-10) by Daniel J. Dugan*** *(*Dugan 2006*). The questionnaire consists of 10 statements about the perceived effects and benefits of antipsychotic medication. Higher scores indicate a more positive attitude towards medication.*

2. ***World Health Organisation Quality of Life – BRÈF*** *(*WHOQOL Group 1996*). It contains a total of 26 questions which produce a quality of life profile. We analysed 4 domain scores: physical health, psychological health, social relationships and environment. Higher scores denote higher quality of life. It is applicable to people living under different circumstances, conditions and cultures.*

Table 1. WHOQOL-BRÈF domains

Domain	Facets incorporated within domains
Physical health	Activities of daily living
	Dependence on medicinal substances and medical aids
	Energy and fatigue
	Mobility
	Pain and discomfort
	Sleep and rest
	Work Capacity
Psychological	Bodily image and appearance
	Negative feelings
	Positive feelings
	Self-esteem
	Spirituality / Religion / Personal beliefs
	Thinking, learning, memory and concentration
Social relationships	Personal relationships
	Social support
	Sexual activity
Environment	Financial resources
	Freedom, physical safety and security
	Health and social care: accessibility and quality
	Home environment
	Opportunities for acquiring new information and skills
	Participation in and opportunities for recreation / leisure activities
	Physical environment (pollution / noise / traffic / climate)
	Transport

*3. The **Clinical Global Impression (CGI) Scale** (Guy 2000) is an assessment tool that allows the clinician to rate the severity of illness. This subscale assesses the clinician's impression of the patient's current illness state. Scores on the Severity of Illness subscale range from 1 not ill at all to 7 among the most extremely ill.*

4. All patients evaluated group therapy by answering the question: "Do you think that group therapy had influenced your life? On a scale from 1 to 3, where 1 is no important influence, 2 is medium important influence, and 3 is important influence.

5. The treating psychiatrist answered the question: "How well did the patient participate in group therapy?" on a scale from 1 to 3. Where 1 is for poor participation, 2 is for satisfactory participation and 3 is for very productive participation with insight.

SPSS version 17.0 was used for data analysis (SPSS, 2008).

Results

The results describe demographic characteristics and evaluation of group therapy influence on patients' lives. Further tables present frequencies for evaluation of participation in group therapy by the group therapist, evaluation of CGI area of severity by the treating psychiatrist and correlation between WHOQOL-Brèf domain scores and Participation in group, CGI Severity, group therapy influence and time spend in group therapy.

Table 2. Demographic characteristics of the participants

	Category	Number (N=32)	(%)
Gender	Male	21	66
	Female	11	34
Age	Mean ± sd	40.01±11.46	
Age in years	21 – 35 years	10	31
	36 – 50 years	16	50
	51 – 65 years	6	19
Marital status	Single	13	41
	Relationship	6	19
	Married	10	31
	Divorced/Separated	3	9
Number of children	None	20	63
	One	6	19
	Two	6	19
Education	Vocational High School	5	16
	Senior High School	14	44
	Student at present	7	22
	University degree	6	19
Current occupation	Unemployed	13	41
	Employed	10	31
	Part time retired	2	6
	Retired (psychosis)	7	22
Duration of group therapy in years and months	from 0 to 2;11	16	50
	from 3 to 5;11	11	34
	From 6 to 10	5	16

Our sample consists of 21 (66%) male and 11 (34%) female patients. There were originally 47 patients included in group therapy, 24 (51%) females and 23 (49%) males. On average male patients stayed in group therapy for 5,6 years and female patients for 2,5 years. Exactly half of the patients were between 36 and 50 years old. Most of the patients marital status was single (41%), they did not have children (63%), finished senior high school (44%), were unemployed (41%) and attended group therapy for les than 3 years.

Table 3. Frequency table for evaluation of participation in group therapy by the group therapist

Participation in group therapy	N	%
Poor participation	6	19
Satisfactory participation	14	44
Very productive participation	12	38

Most of the patients' participation in group therapy was rated as satisfactory or very productive by their group therapist.

Table 4. Frequency table for evaluation of CGI area of severity by the treating psychiatrist

CGI - Severity	N	%
Normal, not at all ill	13	41
Borderline ill	8	25
Mildly ill	9	28
Moderately ill	2	6

Table 4 shows that most of the patients (41%) were regarded normal and only 6% moderately ill by the treating psychiatrist at the time of assessment.

Table 5. Frequency table for patients' evaluation of group therapy influence on their life.

Group therapy influence	N	%
No influence	3	9
Medium important influence	11	35
Important influence	18	56

More than half of our patients rated the group therapy's influence on their life as important; only three of them noticed no importance of the group on their life.

Table 6. Correlations between WHOQOL-Brèf domain scores and Participation in group, CGI Severity, group therapy influence and time spend in group therapy

WHOQOL–Brèf	Participation in group	CGI Severity	Group therapy - Influence	Time spend in group therapy
Physical health	-0.057	-0.316*	-0.514**	-0.193[a]
Psychological	0.019	-0.284	-0.228	-0.262[a]
Social relationships	-0.052	-0.312*	-0.073	-0.301*[a]
Environment	-0.079	-0.132	0.009	0.054[a]
DAI-10	0.154	-0.349*	-0.092	-0.018[a]

Note: * < 0.01; ** < 0.05; All the correlations were Spearman type, except for the ones marked with [a].

A statistically significant negative correlation was found between the present severity of the psychotic illness rated on the CGI severity scale and the WHOQOL–Brèf physical health domain.

A statistically significant negative correlation between the health domain and the patients' influence of the group rating was found. This may mean that the group was more important to the more severely ill patients in our sample.

No statistically significant correlations were found between the psychological domain of the WHOQOL–Brèf and participation in group, time spent in group therapy, group influence on the patients' life or CGI severity.

We have clinically observed the best outcome for patients who attended the group for three to five years. Some patients who stayed in groups for more than six years were unable to separate from the group and move on to social settings outside the group. The group represents the only social interaction outside the immediate family for some patients that stayed in the group for more than six years.

As expected there was a negative correlation between the social relationships domain and the CGI severity.

We have also found a negative correlation between the social relationships domain and time spent in group therapy.

No statistically significant correlation was found between the environment domain of the WHOQOL–Brèf and participation in group, time spent in group therapy, group influence on the patients' life or CGI severity, which is an expected finding.

A statistically significant negative correlation was found between the drug attitude and the CGI severity, which is not surprising.

Discussion

Our finding of the negative correlation between the social interaction domain and the time spent in group therapy suggests that there may be an optimum time at which the patient should leave the group. Our clinical observation is that the patients that stayed in the group for longer than six years had less social interaction outside the group or immediate family.

The physical health domain in our sample covers the areas that can be significantly impaired by the psychotic illness, like daily living activities, dependence on medical services and medication, energy and fatigue, sleep and rest and work capacity. The score on this

domain can be interpreted as closely related to the severity of psychotic illness. The insight that these areas are impaired is better in patients that are less severely ill, which is in accordance with our results.

There were no severely ill patients in our sample. All of them live in the community, many are employed, and some of them are students. The finding that the group was more important to the more severely ill patients in our sample means that the recovered patients don't need group therapy as much as the patients with some degree of illness or disability.

Conclusion

Long term group work has important short and long term effects on quality of life, attitude towards medication, social functioning and stigma reduction. Patients should be intrinsically motivated and well prepared for group work.

They should be encouraged to stay in group therapy for long enough to gain insight into the nature of their illness, reduce the stigma, become more confident in social situations and more independent. The right time to leave the group should also be noted and they should be encouraged to do so and supported in the period after group therapy.

Further research into the specific therapeutic factors is needed.

The sample may be too small to show a statistically significant correlation between participation in the group and time spent in group therapy and attitude towards medication.

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