group support for the families of the mentally ill*

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Phone calls to the doctor from anxious relatives, tense encounters on a ward between patient and parent, and tearful family therapy sessions are familiar indicators to mental health clinicians of the strains that schizophrenia places upon families. Although the impact of psychiatric illness on close relatives has long been recognized, it has not been until recent years that research has documented just how stressful psychosis is for families.

According to a number of studies, schizophrenic symptomatology and maladjustment adversely affect multiple aspects of family life (Brown et al. 1966; Creer and Wing 1974; Davis, Dinitz, and Pasamanick 1974; Doll 1976; Grad and Sainsbury 1968; Hoenig and Hamilton 1969; Kint 1977; Hatfield 1978; Wing 1966). These studies and the results of clinical experiments with the home-based treatment of mental illness have led proponents of community mental health to regard the expansion of services for families as essential to the process of successful deinstitutionalization (Davis, Dinitz, and Pasamanick 1974; Greenblatt et al. 1963; Rice, Ekdahl, and Miller 1971; Weiner, Becker, and Friedman 1967).

Among the useful services for the families of the mentally ill is supportive group counseling. This form of intervention has received comparatively little attention in the literature on community mental health. The concept of groups as a source of support and guidance for the relatives of handicapped and stigmatized populations is not new. However, the usefulness of these groups as components of community-based psychiatric care appears not to have been fully realized.

The efficacy of group approaches to the problems of families is reflected in the extensive literature on professionally led groups for the relatives of the physically handicapped and the mentally retarded (Cantoni 1975; Huberty 1974; Mandelbaum and Wheeler 1960; Milman 1952; Murphy, Pueschel, and Schneider 1973; Olshansky 1962; Pollak 1975; Yates and Lederer 1961) and in the proliferation of self-help groups for the members of families affected by divorce, widowhood, alcoholism, child battering, and sudden infant death (Killilea 1976).

This paper focuses on a model for a short-term group for the relatives of mentally ill adults who are clients at NEWW Center, Inc., a rehabilitation program located in a suburb of Boston. Although professionally led, this group shares many features with those organizations designated as self-help groups.

A Model for a Short-term Family Group

NEWW Center is an affiliate of a community mental health center (the name NEWW Center compresses the initials of Newton, Needham, Wellesley, and Weston). It is a day program with an average census of about 20 clients, most of whom are in their twenties and thirties and diagnosed as chronic schizophrenics.

When NEWW Center was first established in 1974, there was no formal liaison with families, although the need for their involvement was recognized almost from the beginning. Some of the relatives of clients had sought out staff members to ask questions, and the staff had the impression that the relatives benefited from

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these contacts. The staff sensed that cooperation from families might facilitate the program's work with the clients. These dual elements—the families' expressed need for assistance and the staff's felt need for families to support the program—led to a decision to develop a mechanism to promote these respective interests.

It was decided that this mechanism would be a group. Groups are the standard treatment modality in psychiatric day care, and this form of intervention seemed the most familiar to the Center's staff. From a practical standpoint, a group was regarded as the most cost-effective way to reach a comparatively large number of family members. This was an important consideration, since NEWW Center operates on a part-time schedule with a very limited budget.

The authors, in their capacity as staff social worker and consulting supervisor, assumed the task of developing a pilot group for family members. Since the establishment of the first, experimental family group, NEWW Center has sponsored several time-limited, supportive groups for the relatives of clients, all of which have followed the same basic model. The theoretical framework, structure, and therapeutic mechanisms used in these groups form the subject of this paper.

Theoretical Framework

The model used at NEWW Center derives conceptual and methodological elements from the fields of social psychiatry, social group work, and group psychotherapy.

The literature on support systems and mutual help organizations, much of which originated at the Harvard Laboratory of Community Psychiatry, identifies the following as characteristic features of self-help groups (Caplan 1974; Caplan and Killilea 1976; Hansell 1976):

- They focus on a specific problem area common to all the members.
- Their main mechanism for meeting affective and cognitive needs is interaction among peers, rather than influence from professionals.
- They bring people together who empathize with each other because they are going through the same or similar experiences.
- They help the individual to mobilize his psychological resources and master his emotional burdens.
- They offer information about practical ways of dealing with day-to-day and long-term problems.
- They provide feedback about an individual's behavior that fosters improved performance.

Our major task in building a model of group intervention was to facilitate the emergence of the various self-help elements suggested by this outline. While a group therapy model emphasizes patienthood, a self-help model emphasizes a common problem. The self-help model avoids a dignity-diminishing presumption of defect and presumes, instead, a normal motivation for problem solving. Mutual help organizations are not interpersonal groups and do not focus on "here and now" relationships within a group (Ablon 1974). Rather, the members focus almost exclusively on predicaments and dilemmas originating outside of the group.

Experience in social group work offers guidance about leadership methods (Auerbach 1968; Frey 1962; Konopka 1963; Northen 1976; Pollak 1975; Radin 1974). This field of social work emphasizes establishing a contract with the group's membership so that the members know why they are there and what they can anticipate from their participation. This contract is designed to focus the process on commonly agreed upon goals and to reduce anxiety-provoking ambiguity. The techniques of social group work are generally aimed at suppressing anxiety and bolstering the ego, although the leader recognizes what is happening at preconscious and unconscious levels. The normative leadership style is enabling and compatible with an emphasis upon self-help. The social group worker "always tries to increase the interactions and mutual help among members" (Konopka 1963, p. 127).

The literature on brief psychotherapy suggests a rationale for short-term intervention. When therapy is time-limited, problem solving

is stimulated and dropout rates are reduced (Barten 1971; Barten and Barten 1973). Although our model is not psychotherapy per se, the families are particularly vulnerable and the potential for resistance is high. Studies of groups in community mental health settings show that if a group is presented as time-limited, prospective members who might otherwise reject treatment tend to remain in therapy and to focus on the tasks at hand (Weinberger 1971). Fathers of psychiatric patients, in particular, are less likely to leave treatment precipitously if they know that a termination date is in sight (Donner and Gamson 1971).

Groups may be closed and time-limited or open and ongoing. The relatives of the mentally ill tend to feel socially isolated (Albert 1960; Beels 1975; Kreisman and Joy 1974; Raymond, Slaby, and Lieb 1975). A closed model fosters a group cohesiveness that decreases feelings of isolation (Frank 1974; Yalom 1970). The concept of the "therapeutic envelope" (Day 1963) suggests a need for maintaining a stable membership, if possible, and for attending to the specifics of structure. Cohesiveness tends to develop when the members operate on a commitment to the integrity of the group as a group and this commitment is made concrete by an emphasis on norms of attendance, confidentiality, and consistency in the time, place, and duration of the meetings. "Close attention to the externals of the envelope, and to the effect of every infringement on this concept" shows the members that the leader "really cares for the group and will protect them" (Day 1964).

In a discussion of structure, the degree of leader activity is a critical issue. While the self-help model seems to favor passivity on the part of the leader, a short-term, problem-oriented focus suggests that directiveness is needed. The approach we favor is "selective activity toward specific goals" (Auerbach 1968):

> Activity and passivity are not important in themselves but only in relation to what they are being used for . . . . Sometimes the group learning process calls for a leader to be active . . . to help the group move ahead. At other times, it calls for him to be passive, in the sense that he may not be talking; but even then he is actively involved, listening, observing the course of the discussion and the behavior of the parents, and letting the group function "on its own" as long as it progresses well and does not need his intervention. [p. 166]

There is a scattering of articles in the mental health literature about groups for the relatives of late adolescent and adult psychiatric patients (Adler 1968; Dincin 1975; Grinspoon, Courtney, and Bergen 1961; Lurie and Ron 1970; Tarver and Turner 1974). Two articles address significant issues related to process and focus.

A paper written about a group for the parents of patients hospitalized at Massachusetts Mental Health Center is notable for its sensitivity to the affective elements of the group process (Grinspoon, Courtney, and Bergen 1961). The authors describe the guilt, pain, and sadness of the parents as "exquisite." Providing a safe atmosphere for the expression of these feelings and permitting enough time for their expression are crucial considerations.

An article on psychiatric rehabilitation, containing a section on relatives' groups, makes an important connection between work with clients and work with families. Dincin (1975), in his description of the program at Thresholds in Chicago, explains that his agency takes the stand that "it is usually best for adult emotionally disturbed persons to live apart from their parents" (p. 142). In keeping with this position, clients participate in a curriculum about the psychological implications of moving away from home. As a necessary adjunct to this curriculum, the agency conducts supportive groups for parents which engage the parents as allies in a gradual process of separation between them and their adult children. The model used at Thresholds suggests a substantive focus for intervention that is compatible with research findings indicating that social distance between the schizophrenic family member and his relatives is conducive to community tenure (Brown et al. 1962; Brown, Birley, and Wing 1972; Vaughn and Leff 1976).

Structure of the Group

The model of intervention used at NEWW Center was designed to attend to the needs both of the clients and of the family members. Although these were not seen as necessarily in conflict, care had to be taken that the responses to each were kept in balance.

Preparation for the Group

Early in the process of planning, several decisions were made: the group would be exclusively for relatives and would not include the clients; the group would be a discussion group dealing with a problem common to all its members—mental illness in a relative; the group would be closed and time-limited.

The staff was concerned that the formation of a group exclusively for relatives would threaten the clients. The families might reveal personal material that the clients would prefer be kept secret. The clients might perceive their families as invading a private space by becoming involved in a day program that was the clients' personal domain. To allay these fears and to give the clients a sense of control in the formation of a group so intimately related to their own program, it was decided to discuss the proposed group with the clients and to ask them if they were willing to have their families participate. The leader presented the prospect of the group in terms that were ego-syntonic for the clients ("Maybe your parents will get some new ideas from the group that will help them to understand what some of your needs might be"). The clients were encouraged to ask questions, to air their fantasies, and to express their reservations. They were given the opportunity to request that their families not be invited; only one used this option.

Presenting the group to the families raised other issues. The invitation to join had to elicit the families' interest without betraying the clients by implying that the group would focus on them as problems. The invitation also had to avoid any veiled criticism of the relatives by hinting that they needed corrective psychological counseling. A letter was sent to all of the families at NEWW Center telling them that a new service had been added to the program, one that was "designed specifically for relatives." The letter invited the families to participate in an evening discussion group in which the relatives would have a chance to "share experiences, concerns, and ideas with others who are the family members of NEWW Center clients."

This letter served as an official introduction to the group. The leader followed up the letter with phone calls to prospective members. Six couples—12 parents, all of whom were in their fifties and sixties—indicated a willingness to consider participating.[1] The leader interviewed each of the six couples separately before the group met as a whole. These preliminary interviews helped to form an alliance between the leader and the individual group members, enhanced their sense of commitment to the group, and gave the parents an opportunity to discuss material that they wanted the leader to know and might be reluctant to reveal to the group as a whole. These interviews were also used for contract-setting, as follows:

- The purpose of the group was to bring about interpersonal communication among a group of people sharing a common problem: how to understand and cope with the mental illness of their family member and its effect on the family unit.
- The topics covered at the meetings would be determined by the interests and needs of the relatives themselves. The leader's role would be to help focus and facilitate

[1]The family groups at NEWW Center have been primarily for parents because most of the clients are unmarried and typically live with their families of origin. However, relatives' groups may be mixed, to include spouses, siblings, and unrelated significant others, as well as parents. In fact, according to a survey of relatives' groups sponsored by day treatment programs in Massachusetts, a mixed group is the norm. Some programs sponsor two groups—one for parents and one for spouses. About a third of the adult psychiatric day centers in Massachusetts conduct groups for relatives (Atwood and Williams 1977).

the discussion and, on occasion, to provide factual information.

- Only that material which the members themselves cared to discuss would be brought to the meetings.
- The leader would not report on the progress of any individual clients at NEWW Center during the course of the meetings, although the NEWW Center program in general would be discussed.
- The sessions would be confidential.
- The meetings would be held regularly at a preestablished place and time and would last 1½ hours.
- The group would terminate after eight sessions.
- Regular attendance was expected. Those unable to attend were to give the group or the leader advance notice.

Process of the Group

The initial sessions of the group were devoted almost entirely to the ventilation of frustration, disappointment, and resentment. All of the parents experienced a chronic sorrow that their children were not normal. They spoke openly of feeling devastated by the illness of their offspring, angry at the failure of various treatments to bring about the longed-for cure, and guilty about allegations that they might have contributed to the mental illness of their family member. They complained repeatedly about their children's seeming lack of motivation and difficulties in interpersonal relationships. It was a relief, they said, to talk with other people who were not judgmental and who understood what it was like to live with a mentally ill person.

Gradually, as they commiserated with each other and some of their affective needs were met, they were able to focus on those aspects of their situation that were positive and on those that could be modified. Cognitive components gained in significance. They began to speak more often about their children's strengths, to appreciate the small but sure steps that they were taking toward rehabilitation, and to offer empathic explanations for why their children acted the way they did. They were interested in learning about any and all community resources that might provide help. Accounts were shared of successfully handling a delicate situation or a difficult encounter. The leader reinforced these coping efforts by highlighting or summarizing suggested approaches for dealing with common problems.

The parents recognized that they tended to be "emotionally involved" with their adult children. They frequently wondered when they should intervene and when they should let their children fend for themselves, regardless of the consequences. They spoke of trying to hold themselves back from being too protective, but at the same time they felt responsible for their offspring's inappropriate behavior. Peer support and leader reinforcement followed any evidence that the family members were encouraging constructive individuation between them and their children. Gradually, a norm developed in the group which favored encouraging more autonomous functioning on the part of the adult children and more emotional detachment on the part of the parents.

Some behavioral changes occurred which seemed to be at least partially attributable to the influence of the group: a mother learned to restrain herself from awakening her son for job interviews and found that he was capable of setting his own alarm clock; a father stopped banking his son's Social Security check in the father's account and encouraged his son to open up one for himself; two group members reported that their adult children had applied for admission to halfway houses; a couple turned over the total responsibility for the taking of medication to their 35-year-old son; the mother of a 22-year-old refused to give her son money for a bicycle, and eventually he bought one for himself with the money he saved from his job in a sheltered workshop; and a couple who had not taken a vacation in several years made plans to spend 2 weeks in California.

About three quarters of the membership attended most sessions, and there were no withdrawals from the group. Subsequent, short-term family groups conducted at NEWW Center have also had a low dropout rate. Fathers have attended as regularly as mothers. The clients

themselves have come to favor their relatives belonging to the group and sometimes speak with pride about their family's participation.

Therapeutic Mechanisms

The separation of the relatives from the patients is a key distinction between relatives' groups and family therapy or multiple family therapy. The opportunity to modify the interactions among family members as they occur in vivo and to influence several family members simultaneously are among the benefits of family therapy. However, intervention with family members in groups by themselves has advantages of its own.

In family therapy, the relatives may feel inhibited and anxious, because they realize that any open expression of negative feelings is potentially harmful to the patient (Anderson 1977). The relatives may also be sensitive to any staff overidentification with the patient and feel that they are being scapegoated (Park with Shapiro 1976). The patient, during family therapy sessions, may sense the distress that his illness arouses in his family, and feel isolated and unique as the one "abnormal" person among normal people (Handlon and Parloff 1962). Under these conditions, neither the family nor the patient is adequately supported. When family therapy is skillfully handled, these problems are dealt with and constructive change ultimately occurs (Haley and Hoffman 1967), but the process itself is anxiety-producing in its potential for conflict. The tenor of relatives' groups, however, is more relaxed than family therapy, and the opportunity for abreaction is among their most therapeutic features.

Catharsis serves as a vehicle for countering depressive tendencies. The accepting atmosphere of the group gives permission to ventilate resentment without fear of being criticized as a "bad parent" or an "unsympathetic wife." The separation from the ill family member provides a chance to grieve for the loss of their child or spouse as he once was and for expectations that have not been fulfilled. Mourning requires a cathartic process of reviewing memories of what has been lost (Grayson 1970; Lindemann 1944). Initial sessions of relatives' groups include descriptions of what the family member was like before he became ill. There is sometimes a poignant exchange of pictures. In one NEWW Center group, for example, a mother showed a worn snapshot of her son in a sailor's uniform. His first breakdown occurred in the Navy.

When relatives are gathered together in a group, a process of identification takes place which helps to assuage guilt. Guilt is a key issue in all forms of treatment which deal with disability, whatever its origin. Freud (1930) describes guilt as the inevitable concomitant of misfortune. "When misfortune befalls man, he searches his soul, acknowledges his sinfulness, heightens the demands of his conscience, imposes abstinences on himself and punishes himself with penances" (p. 73). Freud attributes these tendencies for self-blame to the equating of misfortune with the loss of parental love. "Threatened by such a loss of love, man bows to the parental representative in his super ego" (pp. 73–74). In the group the relatives feel less inadequate because they discover that mental illness occurs in "nice" families. Grinspoon, Courtney, and Bergen (1961) describe the parents who come to the first group meeting as "ten guilty people" (p. 245):

> All of them, to a greater or lesser extent, saw themselves and the others as responsible for the misfortune that befell their children. As they became acquainted with other members and began to see them as "normal" respectable people, they could, through identification with the other members, then begin to see themselves in a less self-condemnatory light. [p. 245]

The identification of the members with each other contributes to the creation of a small interpersonal community which helps to satisfy the social hunger of its members. This is the "we-are-not-alone" phenomenon—the sense of universality—which figures prominently in all mutual help organizations. Freud wrote of misfortune as threatening a loss of love. Through the group, love in an attenuated form is regained, and the power of "emotional ties" holds the group together (Freud 1921). In a research study on the curative factors in groups for the

parents of disturbed children, the majority of the parent-respondents said that the gaining of support from other parents was the chief function of the group (Hausman 1974).

The attitudes of mental health professionals toward families have been influenced by research from the 1950s and 1960s indicating that schizophrenia is etiologically linked to distorted family relationships (Bateson et al. 1956; Bowen 1960; Jackson and Weakland 1961; Lidz, Fleck, and Cornelison 1965; Wynne et al. 1958). Sometimes clinicians overlook family strengths (Appleton 1974; Creer 1975; Finn 1967; Park with Shapiro 1976). There is research evidence to suggest that the majority of families are capable of relating in positive ways to a psychiatrically ill member. In a study (Deykin, Klerman, and Armor 1966) of approximately 400 relatives of acutely ill, hospitalized schizophrenics, the relatives' potential for emotional resourcefulness was assessed on the basis of 11 traits, which included aspects of ego strength and facets of interpersonal functioning. Seventy-five percent of the total cohort was perceived as having "mild to marked potential for resourcefulness" in providing "help, support, and stability to the patient" (p. 526). The morale-building effect of a relatives' group tends to elicit and capitalize upon these strengths.

At the same time that the group confirms a sense of family unity, the separation of parents from their adult children stimulates an age-appropriate individuation between generations. The parents of the handicapped sometimes feel that their responsibilities never end. While other parents, when they reach middle age, enjoy "new found freedoms" (Deutscher 1975, p. 264), the parents of adult schizophrenics frequently worry about what will happen to their son or daughter after they themselves die. According to Dincin (1975), these parental feelings of burden should serve as the motivation for the parents to encourage their adult children to live more independently, thus freeing parents from a sense of excessive obligation. Families receive permission from the group to take their own needs into account: to have a social life, to use the public system for financial support, and to get relief for themselves by exploiting all existing mental health resources for their relative. In Dincin's words " . . . we have asserted the rights of parents to live their own lives" (p. 143).

Closely linked to the assertion that families have rights of their own is the reassurance that the community has the resources, or can create them, to meet the needs of patients. As the leader and the group members share information about social clubs, cooperative apartments, and vocational training,the family members see their handicapped relative in a new and more optimistic light—as somebody who is entitled to services and potentially able to benefit from them. While cure may not be possible, social recovery is. For families for whom a sense of futility has become a way of life, this imparting of hope is tremendously significant.

Clearly, the group supports the relatives, but how does it help the patients? Group counseling for relatives seems to have attitudinal and behavioral ramifications that are positive for the patients, as well as for the family members. Why this is so is suggested by psychodynamic theory (Alexander 1948; Levy 1970; Nichols and Zax 1977) and by the nature of supportive treatment as a therapeutic instrument (Selby 1956): (1) The ventilation of negative emotions tends to free psychic energy that might otherwise be channeled into harmful interactions with the patient. (2) Grief work helps to shift the family's emotional investment away from what has been lost to what can be gained through building upon the handicapped person's remaining assets. (3) Reducing guilt diminishes some of the psychological pressure to overprotect and infantilize. (4) The supportiveness of the group helps to meet the needs of the members for dependency. Because the members feel accepted themselves, they are more likely to accept the handicapped person and to communicate this attitude of acceptance to him. (5) The sense of safety that the family members experience in the group reduces their defensiveness. They tend to become receptive to ideas about what changes they might make in how they think and act.

Thus, support acts as an antidote to destructive tendencies and as a precondition to change.

Through the group's "context of social comparison," participants see that other people do not all feel the same way or do things the same way (Grunebaum 1970; Lieberman 1975). The members are exposed to a variety of possible attitudes and behaviors and adapt those that are most compatible with their particular personality organization and circumstances. This process has been called "education by alternatives" (Ablon 1974; Arnold, Rowe, and Tolbert 1978).

Learning from each other includes giving and receiving feedback. Often the feedback is positive; occasionally it is not. Lidz (1973), in discussing groups for parents at the Yale Psychiatric Institute, remarks that family members may be able to accept "blunt comments" about their behavior from others that they "would deeply resent and consider biased if made by a staff member" (p. 121). The group experience, if properly led, provides both support and stimulation to change, or, to paraphrase, both "pleasure and pressure" (Lowy 1976, p. 125).

The groups appear to foster a rapport between the family members and the staff that is reflected in how the family as a whole, including the patient, responds to the patient's treatment program. It has been suggested that the formation of a relatives' group is among the factors associated with high levels of patient attendance in a partial hospitalization program (Pildis 1977). Our experience at NEWW Center indicates that those who belong to relatives' groups generally have positive attitudes toward the program, tend to encourage their family members to use related mental health resources, and are more likely to call upon the staff for additional help than are those relatives who have little or no contact with the facility. Credit for the creation of this type of trust should go only partially to the professional personnel who lead the groups. The true facilitator is the group process itself. The families associate the agency with support, and some of their previous tendencies to isolate themselves are reversed.

Summary

A model is presented for a professionally led, short-term supportive group for the relatives of adult schizophrenic clients. Studies documenting the stressful impact of schizophrenia upon families are cited as indicating the need for supportive intervention. The model, used with families in a day treatment center, draws conceptual and methodological components from the fields of social psychiatry (particularly the literature on self-help groups), from social group work, and from group psychotherapy. The process of the group includes the expression of affect, growth in cognitive understanding, and the reporting of behavioral change. Among the therapeutic elements are catharsis, identification with others, the creation of an interpersonal community, the stimulation of pride in existing strengths and assets, and the recognition of the legitimacy of personal needs and of helping resources outside of the family. The support and guidance that the relatives gain through the group benefit the handicapped family member by fostering an accepting attitude toward him and his program of rehabilitation and by facilitating both a felt sense of family unity and a discrete individuation between the family and its schizophrenic member.

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dean research award

The 16th annual Stanley R. Dean Research Award was presented recently to Dr. Solomon H. Snyder. The award of $2,500 was established by the Fund for the Behavioral Sciences and is granted each year, jointly with the American College of Psychiatrists, in recognition of "basic research accomplishment in the behavioral sciences contributing to our understanding of schizophrenia."

Dr. Snyder is Professor of Pharmacology and Psychiatry, The John Hopkins University School of Medicine, Baltimore, Md. Dr. Snyder succeeds Professor John Wing, winner of the 1976 award.