The International Journal of Psychosocial Rehabilitation
Volume 19, Number 2
July 2014– June 2015

Group Intervention in a Therapeutic Community for Persons with Chronic Mental Illness

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Citation:
Ramaprasad D & Kalyanasundaram S (2015) Group Intervention in a Therapeutic Community for Persons with Chronic Mental Illness. International Journal of Psychosocial Rehabilitation. Vol 19(2) 12-20

Abstract

Psychosocial rehabilitation aims at helping people with chronic mental illness to reduce disabilities and improve capabilities to the maximum extent possible so as to integrate them into the family and the community. Therapeutic community (TC) approach is one of the approaches to rehabilitation. This approach refers to milieu therapy that focuses on creating a supportive environment which by itself is therapeutic. Psychosocial rehabilitation programs following a TC approach are comprehensive programs which offer various therapeutic services and activities. One such intervention is group therapy. The present paper attempts to focus on the role of group therapy in a half way home following the TC approach. Following archival research paradigm, all the documented group therapy sessions from 2008 to 2014 were analysed for their themes and techniques. The results have been discussed in view of the themes and content and techniques and the process. The analysis suggests Theme Centred Interactional approach has been followed. Themes that were frequently focused on are: living skills, social skills and personal issues followed by psycho-education about mental and medical illnesses and family relationships. Techniques include role plays, 'go round', group discussions, small group activities, group games and sharing and narrating experiences. All of them promoted group interaction and communication. Overall improvement was reported as assessed on a standardized progress checklist.

Key Words: Group therapy, Therapeutic community, Psycho-social rehabilitation, Half-way home.

Introduction:

Treatment of chronic mental illness, especially schizophrenia, has remained a challenge for mental health professionals. The treatment process has been described as occurring in two phases: 1) a stabilization phase, wherein the focus is on reducing symptoms, especially the positive symptoms and maintaining the patients free of symptoms to the extent possible; 2) a rehabilitation phase, wherein the emphasis is on reducing disability,

improving skills of daily living, personal care, social skills and social adjustment, interpersonal relationship, and vocational skills (Breier and Strauss, 1984). Improvement in these areas takes place much more slowly and these are open to influences of multiple factors in the environment. As a consequence they are difficult to assess (Stone, 1998). Rehabilitation can occur in the hospital settings, at home or in rehabilitation centres, either residential or day care. Importance of psychosocial intervention in the treatment of schizophrenia is well recognized and established.

Psychosocial rehabilitation interventions aim at helping people with chronic mental illness to learn or relearn skills, improve their abilities, and reduce their disabilities. Ultimate goal of such intervention is to achieve the maximum level of functioning as is possible. In the rehabilitation phase long-term interventions including individual and group interventions can play a significant role. Rehabilitation in a residential care facility is also influenced by the approach followed in the set up.

One of the approaches that has been tried to achieve rehabilitation is the Therapeutic Community (TC) approach. Therapeutic communities are small cohesive communities based on ideas of collective responsibility, citizenship and empowerment. They are structured to encourage personal responsibility and avoid unhelpful dependency on professionals. (Campling, 2001). In a TC, the day-to-day experience of living and working together is as important as formal therapy, and the community is structured in such a way as to maximize opportunities for "the living–learning experience" (Campling, 2001). TC is an extension of milieu therapy which focuses on change and recovery in the context of living in a community. The environment following the principles of 'democratization', 'permissiveness', 'communalism', and 'reality confrontation' is in itself therapeutic. The community by itself has a therapeutic influence on every member. Elly Jansen, credited for introducing therapeutic community approach to patient care at Richmond Fellowship Society, in the United Kingdom (UK), concurs that the essence of a therapeutic community is the deliberate creation of a group that influences the social group interactions. The Community consists of a consciously contrived group of people who share all aspects of their daily life i.e. chores and leisure activities, problems and triumphs, distress and happiness. In the process, relationships are formed in a spontaneous way. These become therapeutic i.e., healing, supportive and life-enhancing (Jansen, 1985)

Use of group intervention in the treatment of schizophrenia has a long history. Lazell (1921) was first to report the advantage of group therapy for schizophrenia patients. Payn (1965, 1974) reported the advantages of group therapy in providing socializing experiences for patients that diminish anxiety, improve reality testing, increase self-esteem, and reduce necessity for hospitalization. O'Brien et al (1972) reported that group treatment improves medication compliance. Improvement in social functioning has been reported by many authors (Masnik et al., 1971, Donlon et al, 1973). There are reports of comparisons of the efficacy of group and individual treatments, and out-patient and inpatient group treatments. Compared to individual treatment group treatment have been found to be effective in reducing re-hospitalization (Prince et al; 1973), and in improving interpersonal relationships (Claghorn et al, 1974).). In a therapeutic community certain things are a basic necessity for the community to survive through the cooperation of its members. Having a structure to the day to day functioning, having a specific routine, a time to meet at a table, a time to meet during the week to address various issues of the community and even personal concerns, are few of them. (Jansen E, 1980)

Approaches to group treatment vary from therapist to therapist in terms of their theoretical orientation and the set up in which therapy is conducted.
Kanas(1999) mentions three fundamental approaches: Educative, Psychodynamic, and Interpersonal. He is of the opinion that group therapy is the primary socializing experience for persons with chronic mental illness. According to him insight-oriented techniques should be avoided as many of them may be harmed by too much uncovering and self-disclosure. He suggests the group therapist or facilitator to be active and directive in keeping group members focused on the topic; clear, consistent and concrete with interventions; supportive and diplomatic with comments; open and willing to give opinions appropriate to discussion; here-and-now focused;

encouraging of patient-to-patient interactions. Kanas (1998) also contends that groups are useful in improving psychosocial functioning, increasing school and work productivity, and reducing the number of days of future hospitalization among bipolar patients.

In recent years a long-term group therapy called Multimodal Integrative Cognitive Stimulating Group Therapy (MICST) has been suggested. This modal is based on the theory that views schizophrenia as a condition characterized by deficits in information processing and memory deficits which interfere with communication and interpersonal relations. The therapy combines elements of social skills, relaxation exercise, cognitive retraining, and traditional psychotherapy (Ahmed 2003). Roder et al (2011) in their meta-analytic update report positive outcome of Integrated Psychological Therapy (IPT). They put forth empirical evidence indicating that IPT is an effective rehabilitation approach for patients with schizophrenia. IPT is a group therapy program that combines neurocognitive and social cognitive interventions with social skills and problem solving approaches.

Psycho-educational Multiple-Family Group treatment among patients with schizophrenia has shown reduced rate of psychiatric hospitalization (Dyck, 2002). According to Stone (1998) "Research findings of psychotherapy of schizophrenia have not been robust, and as a result, research efforts in this area have nearly vanished. This has occurred in part because of the hypothesized lack of effectiveness of psychotherapy when compared with medications. The difficulties are magnified when it comes to research on group treatment."

Though there are reports of group therapy in inpatient settings and outpatient settings (Kanas 1985, 1986), short term and long term group intervention (Kanas, 1991; Kibel 1981, 1984), less is reported on group interventions in rehabilitation phase especially as a component of psychosocial rehabilitation program in a residential set up. One would hardly find any report on the effectiveness of group interventions by Indian researchers. Hence, the present attempt at understanding group intervention in a residential rehabilitation setting.

Aim:

The present paper attempts to understand the role of group intervention in a Therapeutic Community (TC) for persons with chronic mental illness.

Methodology:

This is an Archival Research. Documents pertaining to Group Interventions in a Half-way-home, ASHA, run by the Richmond Fellowship Society, in Bangalore, India, for chronically mentally ill persons formed the source of data.

The "Asha" halfway home is a residential facility for both men and women, and can accommodate 21 adults with SMI (mostly schizophrenia and affective disorders. Members (referred to as residents) play a significant role in decision-making and running the programs. Residents, depending on their ability, interest and stage of recovery, actively involve themselves in responsibilities and duties around the house and contribute in various capacities in managing the day-to-day affairs of the facility. In addition to following the principles of therapeutic community (TC), the center offers other therapeutic activities i.e. group interventions, individual counseling, art and movement activities, vocational training, cognitive retraining and family intervention. The center incorporates various features of a TC. It is run on the understanding that there is 1) Free communication, 2) Sharing of responsibilities, 3) Decision making by consensus, 4) Analysis of events, 5) Provision for living –

learning opportunities, 6) Examining roles and role relationships, and 7) Flattening of the authority pyramid (Kalyanasundaram and Murthy, 2000).

A thematic analysis of the documented group intervention from the year 2008 to 2014 was carried out (7 years). The records were analyzed in terms of:

- Number of sessions and duration of sessions
- Number of participants
- Themes of group intervention
- Techniques employed
- Perceived benefit and documented progress

Results:

A total of 267 sessions were recorded indicating approximately 38 sessions per year (about 3 sessions a month). Number of participants varied from 10 to 16, both men and women. The diagnostic categories were Schizophrenia, Bipolar Affective Disorder, and Major Depression. Length of each session varied from 75 to 90 minutes. The records were analyzed for the themes they addressed. The themes could be categorized into the following 6 major categories with some overlap:

	Themes	Number of Sessions
1.	Living Skills	71
2.	Social Skills	75
3.	Family relationship	15
4.	Personal issues	73
5.	Mental Health	16
6.	Medical health	17

Being a part of a residential rehabilitation center the groups were open groups wherein new members replaced those who were leaving after having completed their stay and launching out. The Group had set rules and norms which were followed. Reminding the members of these norms from time to time was found to be necessary. The preparation for the intervention session followed a specific procedure of A) Pre-session discussion among the staff team, wherein the main facilitator and co-facilitator were identified, the theme was decided based on the felt need and participants' views. In addition suitable techniques to be used were discussed and decided upon; B) Group therapy session as per the pre-session discussion; C) Post-session briefing among the staff team.

Group session:

The session can be explained in the following steps: 1) Members greeting each other and the facilitators; 2) a brief period of silence when the members were encouraged to orient themselves to the present and also reflect upon the previous session. If any member wished to bring in specific issues, they were addressed; 3) introduction of the theme/topic to the group by the facilitators and eliciting members' views; 4) use of different techniques depending on the theme so as to initiate the process; 5) feedback from each member about the session, their experience and learning from the session; 6) summarization of the session by the facilitators. Emphasis was placed on practicing the skills and implementing the learning in real situations.

The therapeutic techniques that were used were as follows:

- Group discussion
- Small group activity and sharing

- Role plays
- Modeling and demonstration
- Group games with specific purpose
- Narration of experience
- 'Go around': This is a method to get people to communicate. The therapist asks each member to give his/her opinion on a particular subject. The subject may be something that has occurred in the session, in the community, or something that is related to the personal life.

Impact of the sessions was assessed on a progress checklist, staff observation of the day-to-day behavior and as reported by the participants. As a routine practice the residents were assessed on IDEAS at the entry point. Once in a month each of the residents was assessed on a standardized progress checklist (Chowdur, 2011). The check list includes 10 specific areas i.e. Self-care, Following routine, Interpersonal relations, Participation in leisure activities, Communication, Vocational activities, Family relationship, General behavior, Money management, and Moving around. Specific positive impact was seen in the following areas:

- Improved health related behavior, especially medication compliance
- Improved general behavior (interpersonal relationship) within the community
- Better social skills (interpersonal interaction and communication)
- Improved personal skills (engaging in leisure activities, living skills, vocational activities)
- Improved relationship with family members as reported by the family members
- Participants also shared personal issues related to the themes which they had not shared earlier. These were then addressed in the individual sessions.

Overall impact of psychosocial rehabilitation program at the half-way-home on the recovery of the residents has been reported elsewhere (Chowdur et al, 2011)
Discussion: Psychosocial rehabilitation programs are designed to facilitate over-all recovery of the clients. In a residential setting, which integrates different modes of therapies, one cannot separate the impact of specific therapy on the recovery. At the 'ASHA' half-way-home, in addition to following a TC approach, other therapeutic inputs come from individual therapy sessions, art work, dance and movement activity, vocational training and Group therapy. Considering the comprehensive program it may not be appropriate to attribute the change and progress in recovery to any one therapeutic mode, to group therapy in the present context. However, therapist report and clients specific and personal feedback bring to focus the importance and benefit of group intervention for the residents.

Theme and Content:

Selection of themes was based on staff team's observed and perceived needs of the residents in addition to the residents' expressed need. Maximum number of sessions focused on Social Skills (75), Personal issues (73) and Life Skills (71). Social skills included communications skills, behavior in public places, cooperation, assertiveness skills, conflict management etc. Personal issues included personal goal setting, self-esteem, self-confidence, sharing personal stories, experiences and concerns, self-awareness, understanding one's own needs, empathy, problems and concerns, attitudes etc. Life skills were to do with skills like managing time, problem solving skills, stress and coping with stress, self-care, managing/regulating emotions, taking responsibility, leisure time engagement, personal hygiene, health care, motivation etc. Another significant theme that was covered was psycho-education about both medical and mental illnesses. Important medical health concerns were those of general health, obesity and diabetes. Mental health concerns related to illnesses like anxiety, depression, schizophrenia and bipolar affective disorder. The theme 'family' overlapped with two other themes i.e. social skills (interpersonal relations/interaction) and personal issues (attitudes) as they involved common issues of interpersonal skills and attitude. Moreover, family issues are addressed in family sessions which form an integral part of the Psychosocial Rehabilitation (PSR) program. Few themes related to social re-

sponsibility were also taken up like following traffic rules, law and legislation, use and abuse of tobacco, social obligations, etc. Coursey et al (1993) in a study found that when chronically ill patients in a rehabilitation setting rated therapy topics, out of 40 therapeutic topics, the highest rated items clustered in a category described as "illness-intensified life issues" which encompassed independence, developing self-esteem, relationships, and feelings. Other categories that were rated as important include adverse secondary consequences of illness, self-management of the disorder and coming to terms with the disability. In the present study it was noted that residents were not inclined to discuss personal/private issues of self-esteem, perceived stigma, and some relationship issues in the group. However, they had the opportunity and preferred to address these issues in individual therapy sessions. Long (1996) also suggests that positive results are more likely when group therapy focuses on real life plans, problems, and relationships; on social and work roles and interaction; on some practical recreational or work activity. Discussion on cooperation with drug therapy and its side effects is also advantageous. Supportive group therapy can be especially helpful in decreasing social isolation and increasing reality testing.

Techniques and Process:

Group therapy focused on both content and the process depending on the theme. Most often they occurred simultaneously. The themes or content lent themselves to promote a living-learning experience, sharing and social interaction in a non-threatening and nonjudgmental environment, and helped to engage in reality based conversation. The techniques used in the sessions facilitated the same. Group discussion helped an adult to adult verbal interaction in a socially appropriate and acceptable way on the part of the therapist / facilitator and listening and respecting others view on the part of other participants. Members made an attempt to understand the issues from different perspectives and from other's point of view. This provided an opportunity to learn from the experiences of others and also learning from their coping skills. This also facilitated better understanding among the members. Person to person interaction is proved to be of great value for members of the community. 'Go around' stimulated interaction among group members, especially those who were less communicative, reluctant to interact or withdrawn. This encouraged group members to comment or express their views on each other's comments or views. 'Go around' also lent a structure to the sessions. This technique was found to facilitate sharing of feelings and promoted ventilation for some of the members. Role playing technique used for behavioral training, helped to learn and practice social skills. Role reversal enabled them to view situations from other's point of view. Group activities, including small group activities helped in creating cohesion in the group by promoting cooperation and coordination among its members as they had to work together to achieve a common goal. This was also reflected in the day to day behavior of the members. Modeling and demonstration involved therapist in an educator's role. O'Brien (1975) suggests similar methods to facilitate groups. He suggests verbal and nonverbal interactions; go around; structured dialogue; role playing; and group activities to be of advantage. The routine activities including going out for purchases, going to a restaurant and taking care of one self, etc. provide for practicing the learnt skills in the real life situations.

Yalom (1970) suggests 12 factors in play in a group therapy especially in psychodynamic approach. The 12 factors are Interpersonal learning, Catharsis, Group cohesiveness, Self-understanding, Development of socialising techniques, Existential factors, Universality, Instillation of hope, Altruism, Corrective family re-enactment, Guidance, and Identification/imitative behaviour. The present study suggests some similar factors coming into play for the benefit of the members. These are interpersonal learning, catharsis, group cohesiveness, developing socializing techniques, instillation of hope, and guidance. However, not all the members experienced the same benefits and to the same degree. Shaffer and Galinsky (1989) synthesized the most frequently cited factors into five categories: Observation of self and others; identifying and practicing new behaviours; recasting problems and developing strengths; group support; and therapist's observations. These were also observed in the group therapy process.

The analysis indicates that the group intervention followed in the therapeutic community is similar to the

Theme Centered Interactional (Cohn, 1969) or the Theme-Oriented Group Therapy (Opalic, 1988) approach. Though attending the group sessions is mandatory for all in a therapeutic community, some of the residents missed a session or two. Some degree of flexibility was allowed in this area of attendance. Roback (1984) used the term Disease Management Groups to refer to groups specifically created for patients having the same illness. He describes the functions of a facilitator or leader of such a group as "information disseminator", "catalyst", "orchestrator", and "model for learning"

Staff team role and responsibility: Group intervention sessions gave an opportunity to the staff team to observe residents behavior, and interpersonal interaction in a different setting which could not be seen in individual sessions. Group intervention sessions also provided a platform to express and discuss differences and conflicts between members by the residents as well as the staff team. The group provided a safe environment to reflect on these issues and resolve them.

The staff team who were also facilitators for the group required to be supportive, and empathic. They were expected to be active and directive in their approach. Patience on their part had a significant impact. And being tactical, supportive and diplomatic with their comments was found important. They had to be clear and consistent with interventions, here-and-now focused, guiding and encouraging.

Challenges:

Getting some of the residents to attend as well as participate in the session was a difficult task. Schizophrenia, with its negative symptoms of low motivation, disengagement, and apathy, particularly presented a therapeutic challenge. Similarly, the fluctuating mood of persons with bipolar affective disorder had a significant impact on their attending and participating in the group session. Lack of insight or partial insight into the illness which contributed to the resident's difficulties in engaging in therapeutic activities could have been another barrier, undeniably for the new entrants of the community. The size of the group was larger than the ideal and suggested size of 8-12 persons (O'Brien, 1975). Group of 10 to 16 members can present its own challenges like time, number of interactions, more number of issues being brought in. It was felt that the normal time of 45-60 minutes per session was inadequate for this group (10-16) as more number of issues brought in by this larger number had to be dealt with. A longer duration i.e. 75-90 minutes per session was found to be adequate. Being open groups the changing group membership affected both, the cohesion and the stability of the group. Preparing new members and helping them to become integrated with the already existing group was an challenge.

Limitation:

This paper is based on archival research. Since, the source of data are the previously recorded documents, the researchers had to go by what has been recorded. Problem of inadequate documentation, missing data are its limitations. Since group therapy was a component of the rehabilitation plan the overall improvement and progress of the residents cannot be attributed solely to group therapy.

Conclusion:

Despite limitations the paper has been able to delineate the importance of group intervention in a rehabilitation phase of chronic mental illness in a residential set up. Opportunity for vicarious learning, skills learning and practicing, group cohesiveness, group pressure, group support, understanding and acceptance, positive regard, and safe space for ventilation were the most significant aspects of the group that benefitted the members. It brings to light the significance of including a well-planned group intervention in the rehabilitation program for people with chronic mental illness. Group therapy can contribute significantly in the recovery process. As O'Brien (1975) opines "Group therapy blends well in an overall rehabilitation program with pharmacotherapy, individual psychotherapy, family therapy, and a day hospital program'. This is true of a community based res-

idential rehabilitation program too.

Acknowledgements:

The authors are grateful to Dr. Lata Hemchand for her comments on the initial manuscript. We also acknowledge the contribution of the professional staff at the half-way-home who have conducted and facilitated the group intervention and documented it for the period under discussion.

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