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Open-ended and Open-door Treatment Groups for Young People with Mental Illness

RACHEL MILLER and

National Institute of Mental Health, Bethesda, MD, USA

SUSAN E. MASON

Wurzweiler School of Social Work, Yeshiva University, New York, NY, USA

Abstract

The concept of open-ended groups is expanded to include an open-door model (OEOD) wherein members with severe mental illnesses, including schizophrenia disorders and bi-polar, can join, leave, and re-enter groups as their life circumstances dictate their availability and willingness for treatment. This model is grounded on the work of Schopler and Galinsky's (1984/2006) and Galinsky and Schopler's (1989) theses on the value and processes of open-ended groups and includes perspectives on mutual aid and group development. Groupwork with the OEOD format is illustrated with examples taken from a group of 79 participants diagnosed with first-episode schizophrenia/schizoaffective disorders, 40 of who had co-occurring substance abuse. Of the 79 participants in the OEOD group program, 70 (89%) remained in treatment for the maximum of 3 years. The over-all value of group treatment for this population is reviewed along with the small number of available publications on open-ended and open-door-type groups.

Keywords

Groupwork; schizophrenia; open-ended; open-door; mental illness

Group treatment is generally framed as close-ended, wherein no new members can be added, or open-ended, a more flexible frame in which patients can be added over time. Open-ended groups have in fact been known to go on for many years, adding new members as old ones move out (Yalom, 1983, p. 277; Galinsky & Schopler, 1989; Schopler & Galinsky, 1984/2006). This article expands the open-ended group framework to discuss an open-ended and open-door (OEOD) approach to group treatment with 79 young people of diverse ethnicity experiencing schizophrenia or schizoaffective disorder and, in 40 cases, co-occurring current or past substance use disorders.

A flexible OEOD group model takes into account the unique problems of newly diagnosed severely ill young people, who in addition to a variety of symptoms related to schizophrenia, often struggle with problems of acceptance of illness, adherence to both medication and psychosocial treatments, substance abuse, failures of medication treatment leading to relapse, side effects of medications and numerous issues regarding the integrity of the self. Members may leave group for a variety of reasons, some positive, such as leaving to return to school or work. At least as often, however, people leave group because they are still very symptomatic, relapse or lack insight into the benefits of treatment. In many settings members who fail to attend their group treatment are discharged, an action that leads to

difficulties for all involved. For the clinician, group turnover can involve time-consuming paperwork and increase stress. For continuing group members, the permanent loss of a group member who is known to be exceptionally vulnerable may be frightening and add to feelings of helplessness and hopelessness. Most importantly, the patient who has left group, only to fail in the attempt at school, work, or being medication-free, requires a safe and familiar group to ease the transition back into group treatment.

In the real world of agencies, mental hospitals, and health clinics a substantial amount of groupwork takes place on an open-ended—and possibly open door—basis. This occurs for both economic and practical reasons; 1) agencies cannot afford to keep groups exclusive and 2) the reality of mental illnesses is that patients are often unavailable for scheduled treatment and yet still remain in the agency caseload. Many patients with serious mental illnesses, including but not only schizophrenia, require years of treatment and will often come and go as symptoms and life circumstances prevail. Given these realities, the OEOD model is likely to be in practice in many mental health facilities and skilled group workers have found ways to make it therapeutically successful.

This work hopes to begin conceptualization of an OEOD group framework and examine the unique benefits and limitations, structuring, and interventions of OEOD groups, particularly for patients with long-term mental illnesses. A review of the literature and case illustrations from our work with OEOD groups provide the basis for discussion.

Background

As Evans and colleagues (Evans, Hubbard, O'Reilly, & Overton, 2010) point out in their review of 108 inpatient psychotherapy groups, building a definitive evidence base for group treatment can be extremely difficult. Not surprisingly, there are few published descriptions of OEOD groups in psychiatric settings. In one recent study, group workers in the United Kingdom formed a group in an acute care hospital unit that was mostly comprised of people with the diagnosis of paranoid schizophrenia (Davidson, Hammond & Maguire, 2009). The “Living with Voices” group allowed participants to attend at will, which made it an open ended/open door group. There were 23 participants for the 7 session pilot study group and attendance ranged from 1 to 6 sessions with a mean of 2.2 participants each time. The sessions were planned so that each session could stand alone, therefore allowing for a variance in attendees. When patients were not in attendance they may have been involved in another hospital service. Members were welcomed back into the group after missing one or several sessions. The group workers concluded that this type of group could be successfully implemented in an acute care psychiatric setting and that patients benefited from participation. Although they did not conduct a formal study they were satisfied that aggression among participants was controlled, and that being in the group helped members form coping strategies. In another setting, rural Australia, an outpatient group intervention for people suffering from schizophrenia and substance abuse disorder was described as open-ended and allowed members to enter at any point. Although the authors (Bradley, Baker & Lewin, 2007) do not specifically state that members could leave and re-enter, they indicate that leaving and returning to the group during a single session was allowed. The purpose of these groups was to reduce symptoms and use of substances and groups were successful in both domains. Members who attended the most sessions showed the greatest improvement.

Research on typical open-ended groups is also limited. The challenges involved in working with open-ended groups are documented in observational reports. Schopler and Galinsky (1984/2006) note that open-ended groups are helpful in transitioning members at times of crisis. They underscore the prompt screening and almost immediate availability of many

open-ended groups as a crucial advantage for clients in crisis states. They further note that clients can stay in these groups as long as needed. Schopler and Galinsky (1984/2006) make reference to a report (Dupe, Mitchell & Bergman, 1980) in which clients were given the option to return after leaving, but where in 6 groups, only one client ever returned for continued treatment. Other reports on open-ended groups are typically based within inpatient units of psychiatric hospitals but they are also found in settings that serve people recovering from cancer, strokes, recent surgery and most other life-changing transitions. In one example of a series of in-patient psychotherapy groups, Beeber (1988) identified four stages: rebeginning, subgrouping, working, and termination. In each of these stages the primary task was described as perceptually creating boundaries between the group and the rest of hospital services. As members left, and new members entered, the leader helped the group redefine itself so that it did not feel as forever beginning. Open-ended groups in in-patient settings can place a great deal of pressure on the leader. Simon (1994) reported on leading a cognitive therapy group for severely disturbed, non-psychotic patients. She noted the stresses of not knowing from day- to- day, which would be joining or leaving the group and the lack of progress that group members made in their relatively short stays on the units. She discussed the additional pressure of the leader making a mistake and saying something to upset a member, potentially causing a violent episode. Ultimately, she found the group helpful for members in working on personal responsibility and problem solving.

Looking specifically at groups utilizing various models for first episode psychosis patients, the population we observed, there is considerable literature on the outcome of group treatment. A review of published articles with empirical data on the efficacy of group treatment when compared to other formats for early psychosis patients (Saksa, Cohen, Srihari & Woods, 2009) reported outcome results for five studies that used the cognitive behavioral therapy (CBT) model for people with early psychosis. Groups were found to be successful in reducing symptoms and enhancing quality of life when compared to controls, although not always individual treatment. Eack et al. (2009) provided data on the positive value of closed-ended groups using Cognitive Enhancement Therapy (CET) as opposed to individual treatment. In their work the participants in the CET groups showed more favorable outcomes in the areas of social cognition, cognitive style and social adjustment. They also did better than their individually treated cohorts in reduction of symptoms, especially negative symptoms. Studies involving closed-ended groups with carefully planned protocols include the EPIC studies that showed that group members with early psychosis did equally well when compared to individually treated people with far higher levels of pre-illness functioning (Albiston, Francey & Harrigan, 1998). In a controlled, close-ended group study in Canada, young adults with the diagnoses of schizophrenia/schizoaffective disorder showed lower scores on a disease engulfment scale, higher on a quality of life scale and fewer symptoms than their counterparts who were not assigned to the treatment groups (McCay et al., 2006). Miller and Mason's (2001) study of 65 early psychosis group members and 12 people with similar diagnoses being treated individually reported a strikingly higher rate of staying in treatment among the group members (85% vs. 33%). In this study, group treatment was eclectic, combining cognitive therapy, psychoeducation, social skills training, supportive counseling and strategies taken from psychodrama. Data on group treatment of people with schizophrenia disorders and co-occurring substance abuse disorders is also positive. A number of studies show encouraging results for participants in groups, although close-ended (Grawe, Hagen, Espeland & Mueser, 2007; James et al, 2004; Jerrell & Ridgeley, 1995).

The OEOD Group

The rationale for OEOD groups is that group treatment benefits people with severe mental illness (Albiston et al., 1998; Eack, 2009; Grawe et al., 2007; McCay et al., 2006; Miller &

Mason, 2001; Saksa et al., 2009) and that newly diagnosed young women and men who would benefit from groups often need time to accept and commit to treatment.

Mutual aid groups

Although the work discussed utilizes numerous features of cognitive behavioral therapy, psychoeducation, psychodrama, skills building, and numerous other group strategies the overarching model is that of the mutual aid group. This model offers a non-judgmental stance that treats severe mental illness as any other biological illness, thereby setting a tone appropriate for the serious mental illnesses of its members. Mutual aid is a concept first developed by William Schwartz (1961) and enlarged upon by numerous groupwork theorists (Gitterman, 1989; Gitterman & Shulman, 1994; Shulman, 2005). Essentially, mutual aid is described as a process whereby group members agree to help each other and by doing so, they help heal themselves. Implementing mutual aid groups with people with a severe mental illness requires a group leader with skills to help groups overcome feelings of isolation, inadequacy, and shame, all associated with having low self-esteem related to the illness (Miller & Mason, 2005). Reaching out with a helping suggestion to another group member entails a degree of confidence that the group leader needs to patiently encourage. It also assists group members to move from dysfunctional self-involvement/illness engulfment to empathy with others. By carefully moving the group toward mutual aid the group leader establishes the group as a healing vehicle and enhances the process of normalizing.

Group structure

The group may consist of between three to eight members of diverse cultural and demographic backgrounds. However, it is homogenous regarding the type of illness. All members must have been diagnosed with a severe mental illness, particularly schizophrenia, schizoaffective disorder, or bipolar disorder with psychotic symptoms. The group members may have varying abilities to communicate. Furthermore, it is recognized that motivation of group members will vary since newly diagnosed young people often require time to accept the need for treatment, one factor that may affect the stability of the group size,

Group members are seen individually for supportive therapy and preparation for group by the group leader approximately three times in order to develop a therapeutic relationship that can be carried into the group. This relationship is especially important to those recently diagnosed and treated for psychosis.

A primary feature of the OEO group is the creation of a core group membership from which to build a cohesive larger group with shared purpose and effort. The core group is the key to moving from a loosely knit group or "collectivity" (such as an AA group) to "groupness," so that members have multiple means for bonding together and a broad influence upon one another (Lang & Sulman, 1987, p.13). OEO allows for the natural movement in and out of treatment that is inherent for first-episode of schizophrenia (and bipolar) patients. It is a model where inconsistent attendees are strongly encouraged to become regular attendees, are made to feel welcome when they do attend, and group members understand the reasons for and expect changes of group composition.

In order to facilitate a smooth transition during these entries and exits Schopler and Galinsky (1984/2006) and Galinsky and Schopler (1989) suggest a focus on forming an alliance between the core group members, those who remained as stable members, and the group leader. The core members and the leader essentially work out the group tasks including the rituals of people leaving and staying. The method we utilized focused on building mutuality and empathy among members in order to encourage participation. We assumed group members would become regulars. It was clearly explained that the group members meet

weekly and that if someone was going to miss group it was very important to let the group leader know. If necessary the group processed what it is like if a member does not call but this was rarely needed. When a member did not return the group processed individual feelings and explored the reasons a member may have dropped out. The group leader would assure the group that the worker was following up and that the group member was welcome to rejoin the group. For members who were leaving to return to school, work or training, the group processed the event with their peer in a positive way and asked the member to drop-in when they were able. The group member leaving often requested that the leader keep the group updated on his or her progress.

Group development

For the mutual aid model to succeed with an open door requires that leaders and participants are adequately prepared and comfortable with the dynamic nature and development of the OEOD group. Group development theory for the closed-ended model assumes stages of group development, i.e. preaffiliation, power and control, intimacy, differentiation, and separation (Garland, Jones & Kolodny, 1965/76). However, in the case of the OEOD group we posit three stages of group development, the beginning, middle and end (Toseland & Rivas, 2005, p.27). Because the new first-episode of psychosis member is often extremely anxious, possibly paranoid, the beginning stage requires immediate engagement of the group members. During the middle, much longer phase, the group will continue to build cohesion, identify individual goals, learn about illness, and work on their individual and shared issues. If new members enter the group, they will be helped to join the group at its stage of development by the core group. The group leader will be more active in facilitating the group to engage the new member by sharing their experiences of entering the group. The frequency and extent of group membership changes can affect group coherence and development (Galinsky & Schopler, 1989); therefore, every change, entry and departure, must be handled with sensitivity and skill both by the core members and the leader.

The group is not expected to end but to continue indefinitely. However, individual group members may reach a point of autonomy and leave the group to return to work, school, or a training program. They are encouraged to consider their attempt an experiment so that if, as does sometimes occur, they find they cannot succeed at their endeavor they are able to return to group without a sense of failure. The same viewpoint is taken when members leave the group because of relapse for any reason, including poor medication adherence or drug use.

Guidelines for group leader

The work of the OEOD group leader is complex. It is essential to foster “groupness” in order to lessen the group members’ feelings of being alone and horribly different. At the same time the group leader helps the group to identify and work toward goals. Although more concrete in nature, the tasks of learning about their illness and developing a repertoire of tools for rebuilding their lives is essential to increase hopefulness and the sense of control. The following concepts serve as a guideline to keep in mind when creating and maintaining OEOD groups:

- Maintenance of core group cohesion, consistency, and purpose;
- Recognition by the leader of members’ varying stages of mental health and individual place in group development;
- Awareness by both leaders and group members that the group is its own entity that can help members who may only participate in a limited number of sessions;
- Culture of toleration and flexibility from the core members and group leader;

- Sessions are to build on the past sessions while also standing on their own with a beginning, middle and end; and
- Clearly developed set of group tasks so that group members view group attendance as beneficial.

Group tasks

Two levels of task are required for the OEOD group: 1) maintenance of the group cohesion, which involves a great deal of repetition as new members are introduced, others leave and former members return; and 2) work with core members to keep the group moving forward. This can be accomplished by creating a problem solving agenda that fits members' needs. In this way, leaders, along with core members, keep the group on track with its purpose and move it along from a beginning group to one with a history and potential legacy (Galinsky & Schopler, 1989; Schopler & Galinsky, 1984/2006).

Clinical Case Example

The OEOD outpatient groups described developed over a period of approximately six years of providing clinical care for first episode of psychosis patients who were part of a first episode medication study sponsored by the National Institute of Mental Health (NIMH). Participation was voluntary and each client was able to remain with the treatment team for up to three years. Group treatment offered to the clients included one ongoing open-ended day hospital group, and as needed, one to three daytime outpatient groups, and one evening group for patients. In addition there was a once a month group for families with patients and a three times a month family-only group. Over the period of six years, there were generally three groups: a morning, afternoon and evening group with a total of 79 people with the *DSM-IV* diagnosis of schizophrenia or schizoaffective disorder (American Psychiatric Association, 2000). The ages ranged from 16 to 38 and the average age at time of group entry was 23. There were 54 males and 25 females in the groups. The ethnic profile was diverse consisting of 38 Black/African American; 22 White; 9 Hispanic; 7 Asian; and 3 Other. The substance use profile consisted of 40 meeting *DSM-IV* criteria for substance abuse or dependence, with the primary drug of abuse being cannabis.

Purpose and Implementation

The over-riding group purpose was to provide a safe holding environment from which individuals could develop or restore a healthier sense of self, venture out, and return for refueling over extended periods of time. Its unique aspect was that the leader built group cohesion from a position of "not knowing" how the group would change with the addition of each new member or loss of old members. When a new member joined the group, the leader helped members to:

- welcome the new member;
- provide empathetic support for the new member;
- review their own growth and set new personal and group goals;
- use the process of returning to old issues as ways to reinforce their skills and help new members catch up;
- rework unresolved issues; and,
- increase autonomy.

The core group was also given the task to be sensitive to the plight of being a new or a returning member who was likely to be overwhelmed by the openness of the group

regarding their problems. When members left the group, because they moved away, dropped out of treatment, required another level of treatment, or if all went well, were able to return to work or school and could not meet at the scheduled time, the group needed to work through feelings of loss.

In keeping with the commitment to an open door policy the leader emphasized the right of group members to return to group during school breaks, vacations, or in times of need. Even when a member dropped out without telling the group, he or she would be welcomed back.

Examples of Group Process in OEOD Groups

New Member—The group is adding a new member and will be a group of 8, 3 female and 5 male (4 Black, 3 White, 1 Asian). They have all been hospitalized within the past year with psychotic disorders, all between ages 18-23. The new member to join the group was Beth, a 21 year old female, black, who first developed psychotic symptoms two years previously but was untreated until three weeks previously. She is extremely shy, makes almost no eye contact, and is wearing a baseball cap to hide her face. She has a history of cannabis use and refusing medication in past. For the past two years she has been staying in her families' house until a recent incident occurred with a neighbor. Beth became paranoid about the neighbor and went into her home and stole something minor.

Following the group warm up exercise of keeping a beach ball in the air, the group leader begins by saying that there is a new group member and asks others to introduce themselves. They each do so, some giving information about themselves. For example, John says, "My name is John. I was in the hospital last year with schizophrenia and I come to group since then." Len says, "I'm Len and I was in the hospital too for hearing voices and stuff." The leader says, "It's wonderful that you are all being so open with Beth, but how about telling her a little more about yourselves, like what you like to do now..." Liz introduces herself and says, "I was sick too but now I'm back in school and I have a little 2 year old daughter to take care of." The leader helps Beth: "How are you doing so far?" Beth mumbles, okay. "Beth, can you say a little bit about yourself?" "Okay, I'm Beth and I just came out of the hospital." Jim says, "Low 3?" [a hospital unit the group knew]. When Beth says yes, they all say they were there too. The group leader then asks the group members to recall how they felt the first time they were in the group, and asks if Beth would sit in the middle so the group members could "double her."

The doubling technique involves having the identified member sitting in the middle of the group and one person at a time stands behind her responding to questions asked by the leader. For example, the leader might ask, "how are you feeling now?" The standing or doubling member responds to the question. Then the leader asks the person being doubled, sitting in the middle, "is that how you are feeling?" This technique allows the doubled person to feel more comfortable describing feelings by not being asked directly. It also allows other group members to develop empathy while participating in the process of discovering how Beth feels.

In this example, the members take turns doubling Beth, each adding some of the fears they imagine she might be having coming into the new group. The leader encourages each member and asks Beth after each one if she agrees or has anything to add. Crystal says, "I don't want to be here and I don't want to take these medicines." John asks if Beth uses "weed" and she says yes. She asks if anyone else does and five members respond that they "used to." She says "Wow."

Two subjects are now open for further discussion as the group continues, adherence with medications and cannabis use. This allows members to share with Beth their experiences,

thereby strengthening their own motivation and understanding of the need for adherence and abstinence.

Dropping Out—Luke, who has been talking about the fact that he no longer needs medication and discontinued medication several weeks ago, stops coming to group. The leader helped group members understand that sometimes people try to stop their treatment, but usually they do return if problems begin to reemerge. When he is later rehospitalized, Luke asked the leader to let the members know so they can come visit him. The leader let the group know he is safe and would like visitors. They all signed a get well card and some people made plans to visit. Luke returned to the group some weeks later. The leader welcomed him back into the group and helped the group discuss what happened for Luke and the group.

Luke's return provided an opportunity to demonstrate the group's goodwill and the leader's non-judgmental stance. Since many young people with mental illness harbor wishes to leave treatment, this is also an excellent time to examine acceptance of feelings and also to provide appropriate psychoeducation about the course of treatment.

Moving On

John passes his GED exam and is now accepted into a training program for auto mechanics. He can only get out of classes once a month for group. Group is helped to support this move for John. Tanika gets a job during the day and moves into the evening group. The leader helps the group see this as a group they may go to if they need to have evening treatment, but after five weeks Tanika loses her job and returns to the daytime group. The group helps her work through her difficulties with that job and to begin to set new goals.

In this way group is seen as a means of enhancing the next step, and not as a substitute for "real life" accomplishments. The process of accepting "moving on" helps normalize the self perceptions of members. The open-door policy allows members to view group as a safety net and may, for some, encourage the risk taking of moving on.

Group Outcome and Limitations

There are many ways to measure group outcome for first episode of schizophrenia clients, including remission of psychiatric symptoms or decrease in substance abuse. However, it is equally important that patients find the group treatment helpful and remain in that treatment so that they are able to optimize their potential for recovery. Therefore, it was the overall goal of the described OEOD group modality to provide group treatment that would help patients to remain in treatment. Since patients, even extremely ill patients, often vote with their feet, one way to evaluate the OEOD group model used by this treatment program is to focus on the ability of the group to engage participants. Of the group, 9 (11%) of the 79 members dropped out of all treatment during the three years available for each study participant, substantially less than the reported dropout rates for first episode patients generally reported: 53.6% in a study of 56 by Novak-Grubic and Tavcar (2002); 56.5% (N=363) by Gaebel et al. (2002); and 34.4% in a study of 122 stabilized first episode patients (Linden et al., 2001). Of the 9 who dropped out in the groups described herein, there was no follow-up information to show if participants sought alternative treatment or if they simply stopped. Those who remained affiliated with the groups continued their treatment with the expected mixed results. Not all members remained affiliated with the group for the full length of time available to each member and there were comings and goings, as would be expected. Members who successfully returned to school or work continued to drop into group whenever possible, and at such times were extraordinarily helpful to members who were new to the group.

Discussion

Helping first episode of schizophrenia clients adhere to treatment recommendations, decrease substance abuse, and begin the long healing process requires intensive treatment from numerous members of the healthcare community. Here we discuss the OEOD framework, one part of the treatment protocol for this cohort, as it developed over several years. For a discussion of group goals and methods we refer the reader to Yalom (1983); Randall and Walker (2010); Manor (2010) and Radcliffe, Hajek, Carson and Manor (2010) as well as Miller and Mason (1998; 2001; 2004; 2005). We found that group treatment was extremely important in helping these young people move on with the recovery process and that there were multiple benefits to the OEOD model, including provision of continuity of care, peer support, and increased patient retention. Continuity of care has been shown to enhance treatment adherence for people with dual diagnoses (Ilgen, Unger Hu, Moos & McKellar, 2008; Lambert, 2002) and with schizophrenia (Ilgen et al., 2008; Adair et al., 2005). The OEOD model made it possible for participants to continue with their group even after withdrawing due to relapse, periods of poor adherence, difficulty with acceptance of illness, or struggles with drug use. The OEOD framework also made it possible for participants who left the group to return to school or work, or to begin a vocational program, or to return if needed. In these examples, members made use of the continued care offered to them to help them maximize recovery from the symptoms of a severe mental illness that was new and overwhelming. Many also benefited from the group's ongoing process to help to discontinue the use of substances, which frequently requires ongoing attention (Hellerstein, Rosenthal & Miner, 2001; Miller, Caponi, Sevy & Robinson, 2005).

Programs that use peer support as a primary treatment mode have become popular over the last several years due in part to the increase in acceptance of the recovery model (Davidson et al., 2006; Lucksted, McNulty, Brayboy & Forbes, 2009). The OEOD model discussed here integrates the idea of peer support into a more traditional treatment model to gain the best of both therapeutic constructs. The OEOD groups described offered peer support to create an emotional safety net from which members utilized what they learned about caring for themselves, discussed future goals, took on challenges, and worked with temporary setbacks. These groups offered a setting of peers that empathized and provided support while allowing members to move comfortably into the world of recovery. The mutual aid opportunities that the OEOD groups afforded members were viewed as a crucial group function. The support given to new members and to those leaving or returning was a group effort that each member participated in individually in the name of the group. It is difficult to measure mutual aid benefits, however, there are a number of observations asserting the importance of social cohesion, empowerment, development of coping behaviors, and empathy (Gitterman, 2005; Shulman, 2005; Steinberg, 2004). For now the best that can be said is that when groups appear to thrive measured by their continued work toward meeting their goals, then it is reasonable to think that members are deriving benefits.

Another potential advantage of the OEOD that we observed was its ability to keep people involved in psychosocial treatment. By doing so, group leaders were able to provide psychoeducation including information about the nature of their illness, treatment, medications, side effects, and diet, along with many problems that may be preventing progress such as drug use, loss of cognitive and social skills, dealing with feelings of shame or guilt, overwhelming anxiety or depression and coping with other positive and negative symptoms of schizophrenia (Miller and Mason, 2011). When appropriate the leaders were able to utilize cognitive behavioral therapy, motivational therapy, cognitive enhancement therapy and teach a wide range of coping skills.

Finally, by being an open-ended *and* open-door model participants were able to meet peers who were in the same frightening place—maybe a bit ahead or a bit behind—but clearly experiencing the same struggles. Within these groups each patient was helped to recognize he/she was not the only one and learn from each other's failures and successes. In the process of being empathic with each other they also learned to be kinder to themselves and begin to normalize their illness, to see themselves and their group members as good human beings with an awful illness for which there was help.

The OEOD model that we describe is built on and adds to the work of numerous group practitioners and researchers described including the pioneering concepts put forth by Galinsky and Schopler (Galinsky & Schopler, 1989; Schopler & Galinsky, 1984/2006) and Yalom (1983). There are other group models for treating people with first episode psychoses such as on-going closed groups, time-limited open-ended and closed groups and groups that emphasize specific treatments such as social skills, problem solving, family therapy and others. The efficacy of other models is beyond the purview of this article as we are reporting on our experiences and observations.

A significant limitation of the OEOD model of treatment is the ability to obtain a strong commitment from the agency in which the group takes place. It is also important to note that patients who attended the OEOD groups described were all part of a randomized control trial of medications for schizophrenia. As such patients required the same psychosocial treatments, thereby preventing the possibility of a control group or randomization to compare close-ended, open-ended and OEOD group treatment. As with all such treatment there are numerous other variables that may have affected our ability to maintain people in group, including group composition, group interventions and group-leader skills. Nevertheless, this was a fair sized, ethnically diverse group that appeared to be representative of the first episode of schizophrenia patients regarding substance abuse. Despite the numerous difficulties inherent to group research for this population, it may be useful for future research to compare closed, open and OEOD group models utilizing measurements of attendance, group member satisfaction, rehospitalization and relapse rates.

Conclusion

By reframing the way we thought of group members from being either “in or out” of group to being part of an open-door group we eliminated the stress of feeling a sense of failure—for both the patient and the clinician—if a member left group or needed to return. We found ourselves and the group members prepared for the ups and downs of first episode schizophrenia treatment, and in this way better able to assist patients to maintain treatment. Furthermore, by helping participants to stay in treatment we believe they were better able to process the numerous issues of first episode schizophrenia and gradually maximize recovery. That 70 of 79 members of this extremely difficult to treat population stayed in treatment for the full three year period is an indication that OEOD groups may have a place in group modalities, particularly newly diagnosed young people with psychosis.

Based upon our observation of the group treatment for first episode of psychosis clients described, we hope to open the door to the concept of OEOD groups. It is our belief that the open-ended group can be extended to the OEOD model of group treatment by making changes to the way we think of the group, our expectations of members, and our understanding of the group structure and development.

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References

- Adair CE, McDougall GM, Mitton CR, Joyce AS, Cameron W, Gordon A, Costigan N, Beckie A, et al. Continuity of care and health outcomes among persons with severe mental illness. *Psychiatric Services*. 2005; 56:1061–1069. [PubMed: 16148318]
- Albiston DJ, Francey SM, Harrigan SM. Group programmes for recovery from early psychosis. *British Journal of Psychiatry Supplement*, 48. 1998; 172(33):117–121.
- American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 4. Washington, DC: Author; 2000. Revised
- Beeber A. A systems model of short- term, open-ended group therapy. *Hospital and Community Psychiatry*. 1988; 39:537–542. [PubMed: 3378751]
- Bradley A, Baker A, Lewin TJ. Group intervention for co-existing psychosis and substance use disorders in rural Australia: Outcomes over 3 years. *Australian and New Zealand Journal of Psychiatry*. 2007; 41:501–508. [PubMed: 17508320]
- Davidson L, Hammond V, Maguire T. The implementation of a “Living with Voices” group in a psychiatric intensive care unit: A pilot study. *Journal of Psychiatric Intensive Care*. 2009; 5(2):89–94.
- Dube BD, Mitchell CA, Bergman LA. Uses of the self-run group in a child guidance setting. *International Journal of Group Psychotherapy*. 1980; 30:461–479. [PubMed: 7440031]
- Eack SM, Greenwald DP, Hogarty SS, Cooley SJ, DiBarry AL, Montrose DM, Keshavan MS. Cognitive enhancement therapy for early course schizophrenia: Effects of a two-year randomized control trial. *Psychiatric Services*. 2009; 60(11):1468–1467. [PubMed: 19880464]
- Evans, C.; Hubard, N.; O'Reilly, T.; Overton, E. *Groupwork: The evidence-base*. In: Radcliffe, J.; Hajek, K.; Carson, J.; Manor, O., editors. *Psychological groupwork with acute psychiatric inpatients*. London: Whiting. & Birch; 2010. p. 106-131.
- Gaebel W, Janner M, Frommana N, Pietzcker A, Kopcke W, Linden M, Muller P, Tegeler J, et al. First vs. multiple episode schizophrenia: Two-year outcome of intermittent and maintenance medication strategies. *Schizophrenia Research*. 2002; 53:145–159. [PubMed: 11728846]
- Galinsky M, Schopler J. Developmental patterns in open-ended groups. *Social Work with Groups*. 1989; 12(2):99–114.
- Garland, JA.; Jones, H.; Kolodny, RL. A model for stages of group development in social work groups. In: Bernstein, S., editor. *Explorations in group work*. Boston: Boston University, 1965. Republished by Charles River Press, Boston, 1976; 1965/76. p. 17-71.
- Gitterman A. Building mutual support in groups. *Social Work with Groups*. 1989; 12:91–106.
- Gitterman, A. *Mutual Aid Groups, vulnerable and resilient populations, and the life cycle*. New York: Columbia University Press; 2005.
- Gitterman, A.; Shulman, L. *Mutual aid groups, Vulnerable populations and the life cycle*. 3. New York: Columbia University Press; 1994.
- Grawe RW, Hagen R, Espeland B, Mueser K. The Better Life Program: Effects of group skills training for persons with severe mental illness and substance use disorders. *Journal of Mental Health*. 2007; 16(5):625–634.
- Hellerstein DJ, Rosenthal RN, Miner CR. Integrating services for schizophrenia and substance abuse. *Psychiatric Quarterly*. 2001; 72(4):291–30. [PubMed: 11525078]
- Ilgen MA, Unger Hu K, Moos RH, McKellar J. Continuing care after inpatient psychiatric treatment for patients with psychiatric and substance use disorders. *Psychiatric Services*. 2008; 59:982–988. [PubMed: 18757590]
- James W, Preston NJ, Koh G, Spenser C, Kiseley SR, Castle DJ. A Group intervention which assists patients with dual diagnosis reduce their drug use: A randomised controlled trial. *Psychological Medicine*. 2004; 34:983–990. [PubMed: 15554569]
- Jerrell JM, Ridgeley MS. Comparative effectiveness of three approaches to serving people with severe mental illness and substance abuse disorder. *Journal of Nervous and Mental Disease*. 1995; 183:566–576. [PubMed: 7561818]

- Lambert MT. Linking mental health and addiction services: A continuity-of-care team model. *Journal of Behavioral Health Services and Research*. 2002; 29(4):433–444. [PubMed: 12404937]
- Lang, N.; Sulman, J. *Collectivity in social work: concept and practice*. New York: Haworth Press; 1987.
- Linden M, Godemann F, Gaebel W, Kopke W, Muller P, Muller-Spahn F, Tegeler J, et al. A prospective study of factors influencing adherence to a continuous neuroleptic treatment program in schizophrenia patients during 2 years. *Schizophrenia Bulletin*. 2001; 27(4):585–596. [PubMed: 11824485]
- Lucksted, McNulty, Brayboy, Forbes. Initial evaluation of the peer to peer program. *Psychiatric Services*. 2009; 60:250–253. [PubMed: 19176421]
- Manor, O. Groupwork fit for purpose? An inclusive framework for mental health. In: Manor, O., editor. *Groupwork & mental health*. London: Whiting & Birch Ltd; 2010. p. 163-191.
- McCay E, Beanlands H, Leszcz M, Goering P, Seeman MV, Ryan K, Vishnevsky T, et al. A group intervention to promote healthy self concepts and guide recovery in first episode schizophrenia: A pilot study. *Psychiatric Rehabilitation Journal*. 2006; 30(2):105–111. [PubMed: 17076053]
- Miller R, Mason SE. Group work with first episode schizophrenia clients. *Social Work with Groups*. 1998; 21(1/2):19–33.
- Miller R, Mason SE. Using group therapy to enhance treatment compliance in first episode schizophrenia. *Social Work with Groups*. 2001; 24(1):38–51.
- Miller R, Mason SE. Cognitive enhancement therapy: A treatment strategy for first- episode patients. *Bulletin of the Menninger Clinic*. 2004; 68(3):213–230. [PubMed: 15342329]
- Miller R, Mason SE. Shame and guilt in first episode schizophrenia. *Journal of Contemporary Psychotherapy*. 2005; 35(2):211–221.
- Miller, R.; Mason, SE. *Diagnosis schizophrenia*. 2. New York: Columbia University Press; 2011.
- Miller R, Caponi J, Sevy S, Robinson D. The insight-adherence-abstinence triad: An integrated treatment focus for cannabis using first episode schizophrenia patients. *Bulletin of the Menninger Clinic*. 2005; 69(3):220–236. [PubMed: 16178711]
- Novak-Grubic V, Tavcar R. Predictors of noncompliance in males with first-episode schizophrenia, schizophreniform and schizoaffective disorder. *European Psychiatry*. 2002; 17(3):148–54. [PubMed: 12052575]
- Radcliffe, J.; Hajek, K.; Carson, J.; Manor, O., editors. *Psychological groupwork with acute psychiatric inpatients*. London: Whiting and Birch Ltd; 2010.
- Randall, L.; Walker, W. Supporting voices. Groupwork with people suffering from schizophrenia. In: Manor, O., editor. *Groupwork & Mental Health*. London: Whiting & Birch Ltd; 2010. p. 72-80.
- Saksa JR, Cohen SJ, Srihari VH, Woods SW. Cognitive behavioral therapy for early psychosis: A comprehensive review of individual vs. group treatment studies. *International Journal of Group Psychotherapy*. 2009; 59(3):357–383. [PubMed: 19548785]
- Schopler JH, Galinsky MJ. Meeting practice needs: Conceptualizing the open-ended group. *Social Work with Groups*. 1984/2006; 28(3):49–68. Republished in 2006 in a special issue of 25 years of selected classic articles from *Social Work with Groups*.
- Schwartz, W. The social worker in the group. In: Saunders, B., editor. *New perspectives on services to groups: Theory, organization, practice*. New York: National Association of Social Workers; 1961. p. 7-29.
- Shulman, L. *The skills of helping individuals, families, groups and communities*. 5. Belmont, CA: Brooks Cole; 2005.
- Simon KM. A rapid stabilization cognitive group therapy programme for psychiatric inpatients. *Clinical Psychology and Psychotherapy*. 1994; 1(5):286–297.
- Steinberg, DM. *The mutual aid approach to working with groups: Helping people help one another*. 2. Binghamton, NY: Hawthorn Press; 2004.
- Toseland, RW.; Rivas, RF. *An Introduction to Group Work Practice*. 5. Boston, MA: Allyn and Bacon; 2005.
- Yalom, ID. *Inpatient Group Psychotherapy*. New York: Basic Books; 1983.

Figure 1.
OEOD goal is to build a cohesive core group that is open to new members and returning members to share goals and effort.

Table 1

Stages of OEOG Group Development

Beginning Stage	Middle Stage	Ending Stage
Orienting	Trust	No set end point
Interpersonal empathy	Building group cohesion	Recognizes that individuals seek autonomy and may leave group before optimal time in group is completed.
Mutuality	Identifying, setting and working on goals	Flexible: Individuals may be ready for autonomy at varying points, in part dependent on nature of illness.
Group reinforces beginning stages of development whenever a new members joins group.	Psychoeducation	Individuals may return to group. This is seen as a continuation rather than failure.
	Problem solving	