The Detroit Group Social Activity for Convalescing Mental Patients

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CONVALESCING mental patients require transitional treatment facilities as they return to community life. Social activity groups provide needed social experiences in a protected environment geared to the individual needs of these patients.

In Metropolitan Detroit a social activity group for convalescing mental patients met under professional leadership from October 1954 to December 1957. This demonstration project was sponsored by United Community Services, the local health and welfare agency council, and the McGregor Fund, a private foundation. The uses of such a transitional treatment facility in aiding in the social reintegration of patients into community life were studied, and an evaluative study of the project was made. Results of groups such as that reported in this study have been described by Greenblatt (*1*) as follows:

> *The ex-patient club.* Patients and ex-patients have shown they are able to band together successfully in their own interest. Inpatient self-government is a gratifying actuality in many hospitals, and ex-patient clubs are increasing in number and variety throughout the country. In ex-patient clubs, former patients have an opportunity to participate in many group activities and in this way gain assurance and confidence in social situations. Club membership may be a steppingstone to developing more secure community roots and thus may play an important role in prevention of relapse.

Greenblatt summarized succinctly some of the general purposes assumed to be served by social group activities for convalescing mental patients. Adequate aftercare programs for hospital and clinic patients have been shown under specified circumstances to correlate with lowered relapse rates, greater economic productivity, and better social adjustment generally. Schwartz has prepared an excellent summary dealing with the spectrum of services most helpful in the rehabilitation of mental patients and the purposes they are purported to serve (*2*).

Aim and Method

The study undertook to evaluate the outcome of participation of 96 members in a social activity group on the basis of the experience of a sample of the 33 members attending sessions of the Detroit group during the third and last year it met. Thirty-two of these members were interviewed; one had disappeared and could not be located. The records of the entire group of 96 members were used to study behavioral responses to group activity. The values which the members, their relatives and close associates, and the referral sources attributed to the activity and service given by the group were elicited.

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The study was implemented under Public Health Service Mental Health Project Grant OM–96 and was completed in September 1959.

Data were obtained through interviews with members, relatives, and close associates and through questionnaires sent to referral sources. These data were used to determine whether these values coincided with the members' expectations, the understanding and purpose of the referral sources in referring patients to the group, and the value of the group as a transitional treatment facility in aiding in reintegration of the members into community life. Recommendations were made for the future use and organization of similar groups.

Four schedules were set up for interviewing the members, their relatives or close associates, and the referral sources. The interviewers were all professional psychiatric social workers. Ratings were based on meeting protocols and individual observation sheets kept on each of the 96 group members for each meeting he attended. The evaluations of these experiences by the members and their relatives were compared. The ratings of the protocols and observation sheets attempted to evaluate the intensity and quality of social contacts, the attitudes and interest shown by the members, and their social adjustment in the group. Indices of adjustment were clinical diagnoses, subjective evaluations of the members, relatives, and referral sources, and ratings by the interviewers. Data on clinical diagnoses and other vital statistics on all members were used for statistical analysis. Recommendations for future planning were based on these findings.

Limitations of the Study

The study investigated the responses of group members only, since no outside group was available for use as a paired control. The vast array of variables could not all be eliminated, identified, or studied individually. There were no criteria by which to measure changes in the patients resulting from attending group sessions. Other forms of treatment were in progress for most group members. The research design was post hoc rather than ante hoc. Hence, the evaluation was retrospective and could only make use of data already recorded and of the memories and opinions of a sample of the members.

Scientific measurement was involved only insofar as the methods of observing, recording, and rating individual members and the group's responses can be considered to be standardized procedures.

Hypotheses and Assumptions

• The self-confidence of the members in their social relationships is related to their use of activity group experiences. Activity group therapy contacts give members an opportunity to test their capacity to relate socially and to share feelings about their inadequacies.

This hypothesis was supported by the patients, their relatives, and the referral sources who responded to the interviews and questionnaires used in the study.

• Members of a social activity group increasingly accept their illness and their need for treatment. Bierer's therapeutic social groups in England reported that such groups serve "to break the cycle of inferiority, failure, and solitude of patients; to restore as far as possible capacity for interpersonal relations with others of both sexes; and to restore patient's relationship to the group as a whole" (*3*).

The study data contributed only indirect evidence that this hypothesis was supported; for example, insofar as the group assisted members in living more comfortably with their illness in their social interrelationships.

• It is inappropriate to mix patients needing and able to use the uncovering type of group therapy and those needing and able to use mainly social and psychological supports and inspirational suppressive measures in their social adjustment. One or the other group will predominate according to the way the group and its program are structured.

The composition of the Detroit group supports the finding that members attending and remaining with the group do so for ego support and strengthening. These patients predominated, whether by selection of patients sent by referral sources or by the choice of the members themselves.

• The modus operandi par excellence for convalescing mental patients is activity rather than the interview type of group therapy.

Activity was the predominant purpose for which referral sources sent patients to the social

activity group. The fact that the majority of the members chose more social activities in larger groups instead of more solitary activities in small groups supported this hypothesis.

Findings

The patients ranged in age from 19 to more than 60 years. Their distribution by sex, race, marital status, education, religion, employment, referral source, and diagnosis is shown in table 1.

Participation in Meetings

Fifty-four patients, more than half the members of the social activity group, attended only one to five weekly meetings. Guzie believed that the relatively short period of participation of ex-patients in group meetings is due to the chronic nature of their illness and the accompanying lack of insight and hope (*4*). Also, since these patients have devoted considerable time and resources to their recovery, they often need to consider themselves cured and therefore they are not willing to become involved in long-term treatment programs. Furthermore, patients may not be able to see what they gain by participation in the group's activities. Depressed and guilty patients especially may feel that they do not have a right to use the therapist's time. Another factor in the small number of meetings attended may be the lack of followup by the referral sources. These included five large public hospitals where followup services were not readily available.

The attendance record of the entire study group is presented below.

Number of meetings	*Attendance (number of patients)*
1	25
2	8
3	10
4	2
5	9
6–10	16
11–30	18
36–55	8

The following findings are based on interviews with 32 of the 33 members who joined the group in the last year of the study, with their relatives and close associates, and the sources of their referral to the group.

The reason stated most frequently by both group members and their relatives for the pa-

Table 1. Distribution of 96 members of a social activity group of convalescing mental patients, Detroit, Mich., October 1954–December 1957

	Number	Percent		Number	Percent
Sex:			Employment:		
Male	43	45	Homemaker	2	3
Female	53	55	Unemployed	37	39
Race:			Unskilled labor	6	6
White	86	90	Skilled labor	6	6
Negro	10	10	Unskilled officework	8	8
Marital status:			Skilled officework	8	8
Single	53	55	Commercial establishment	7	7
Married	23	24	Professional work	3	3
Divorced	10	10	Unknown	19	20
Separated	9	9	Referral source:		
Unknown	1	2	Public psychiatric hospital	80	83
Education:			Private psychiatric hospital	3	3
8 grades or fewer	9	9	Public mental health clinic	2	2
9–11 grades	15	16	Social or health agency	2	2
12 grades	42	44	Private physician	7	8
1–2 years college	15	16	Self	2	2
College graduate	6	6	Diagnosis:		
Unknown	9	9	Psychosis	78	82
Religion:			Neurosis	11	11
Protestant	52	54	Emotional instability	2	2
Roman Catholic	28	29	Alcoholism	3	3
Jewish	5	5	Unknown	2	2
Other	2	3			
Unknown	9	9			

tient's attendance at group sessions was the desire for social contacts for the patient. Other reasons given, in order of frequency, were:

Patient's reason	*Relatives' reason*
Psychotherapy	Lack of social activity elsewhere
Curiosity about group	Desire for psychotherapy
Recommended by a professional person	Lack of self-confidence
Something to do	Curiosity about group
Urging by relatives	Search for a new religion
Desire to help others	Search for a new experience

The most predominant reason given for absence from group sessions was that the members felt uncomfortable in the group because of their illness and their feelings about the composition of the group, its community auspices, leadership activities, and so on. The reasons given for absence are as follows:

	Number giving reason[1]
Felt uncomfortable in group	16
Did not feel like attending	7
Financial	5
Not feeling well	4
Had other recreational activities to attend	4
Sessions not beneficial	4
Had to work	2
Family responsibilities	2
Transportation difficulties	1
No response	2

[1] Some patients gave more than one reason.

A major reason given for discontinuing attendance at meetings was the disbanding of the group. This was expected, however, since the members interviewed were active in the last year of the study. The reasons given for discontinuing attendance at group sessions are shown in table 2.

Preferred Activities

The activities preferred by group members were divided into "more social," those requiring participation by more than three persons, and "more solitary," or all other activities. Supper parties, discussions, picnics, holiday parties, and square dances were designated as "more social," and Ping-pong, shuffleboard, quiet games such as bingo and dominoes, active games, and trips as "more solitary." The patients ranked their activities on a scale of 1 to 10, according to their preferences. Twenty-two of the 32 members interviewed preferred more social activities or had no preference, 7 preferred more solitary activities, and 3 refused to answer the questions. Twenty-six members preferred meetings with more than 10 persons present; only 2 preferred smaller group sessions; and 4 members did not respond. Most members wanted more social activities and more social contacts and preferred larger groups.

Table 2. Reasons given by 32 patients[1] and their relatives for discontinuing attendance at sessions of the Detroit Social Activity Group

Reason	Patient	Relative
Disbanding of group	6	7
Sessions not beneficial	7	2
Uncomfortable in group	5	3
Illness	5	3
Finances	4	1
Had to work	2	2
Lack of transportation	0	3
Other recreational activities	1	0
Miscellaneous	2	1
No response	3	10

[1] Some patients gave more than one reason.

Results Reported

In response to open-ended questions, the members stated most frequently that they were helped in their feeling of ease in their social relationships and in self-confidence, or feeling of inner security. The greatest number stated that they received most help from both the leader and other members of the group. The kinds and sources of help are shown in table 3.

To discover whether there had been changes in the behavior of the patients as a result of their attending the social activity group, several areas were explored. The majority of the members and their relatives did not report any change in the number of groups attended. Their statements were not consistent enough to determine whether their reports of attendance at meetings were meaningful or even reliable. In reply to the questionnaire, relatives most frequently reported that there had been no change in the social adjustment of the patients as a result of their attendance at the social activity group meetings; next, they made no reply to the question; then reported that the

attitude of the patient was better after meetings in relation to family, friends, and employers, better with family and employers before attending meetings, and finally, better with family and friends during attendance at meetings but not after attendance had been discontinued. Statements of relatives about changes in the patient's health were equally inconclusive. Relatives of 13 patients reported no change, relatives of another 13 reported that the patients were better either before or after attendance at meetings, and relatives of 6 made no reports.

For all members attending five or more meetings, at least three of them in succession, an analysis was attempted of the extensive records of group activities and of individual observation sheets. Fifty members were rated on several categories, as follows: intensity of social contacts in the group; quality of social contacts—withdrawn, average mingling, or very active; attitudes—passive, submissive, aggressive, competitive; interest—verbal participation, motor activity, and affect; and social acceptability.

According to these criteria, 5 members improved and 45 remained the same. One member was not included in the analysis because three of the five meetings attended were not successive. The most frequent improvement was in interest; improvement in attitudes was next. Improvements were evident to both the leader and members of the group. Social acceptability of the patients was not a discriminating variable.

Table 3. Help and sources of help received from group sessions of the Detroit Social Activity Group by 32 members interviewed

Help received and source of help	Number	Percent
Help received:[1]		
Confidence in social activities	10	----------
Self-confidence	8	----------
Relationships with friends	5	----------
Relationships with relatives	4	----------
Carrying on social responsibilities	4	----------
None	8	----------
No response	4	----------
Source of help:		
Leader and other group members	15	47
Leader only	7	22
Other group members only	2	6
None	5	16
No response	3	9

[1] Some patients gave more than one response.

Replies to the questionnaires sent to referral sources were too inconsistent to be easily interpreted. The majority of referring physicians had learned of the Detroit group from members of the advisory committee. The modal number of referred patients varied from one to five. The patients were mainly referred to the social activity group to provide opportunity for group experiences. This was especially true of patients newly discharged from mental hospitals who were attempting to adjust to life in the community. Most of the patients were considered by the referral sources to be unable to adapt to less protected group situations. The social activity group also provided a group experience away from the source of treatment. When patients needed a group experience related to their source of treatment, they were referred elsewhere.

Most referral sources reported improvement in the patient's ability to establish social contacts and greater ego strength. The referral sources thought they could refer many more patients to the social activity group and that similar groups should be available throughout the community to avoid transportation problems for the patients.

Conclusions

The main conclusions drawn from the analysis of the study findings were:

1. The principal reason given for attending the Detroit group sessions was the desire for social contacts.

2. Larger groups were preferred to smaller ones, and activities which required more social intermingling were rated higher than those in which participation was limited and more solitary.

3. The main reason for absence from meetings was a feeling of discomfort in the group. The major reason for dropping out of the group was that it was disbanding.

4. The principal benefit derived from the meetings was a gain in self-confidence.

5. The evidence was inconclusive as to whether there was a change in the health of the members; on the basis of the measurements made, there was not.

6. There was no evidence of changes in psychological factors related to the psychosocial adjustment of the members.

7. Professional persons who served as referral sources agree that there is need for meetings such as the Detroit Social Activity Group.

Recommendations

Recommendations for the organization of social activity groups for convalescing mental patients follow:

1. Staff services on a consistent basis for continuous service and followup and individual contacts with the members.

2. A drop-in center with a great variety of social activities, life-space or marginal interviewing, and referral services.

3. Administrative services to provide adequate interpretative activities with referral sources, members, and their families.

4. Enlistment of a great variety of volunteers working with the professional leaders to enrich the services offered to the members.

5. An individualized approach to fit the situation and the needs of the members, although most members of the study group appeared to prefer large rather than small groups.

6. Organization of services on a community-wide, independent basis under community agency auspices.

7. Groups available in areas accessible to members who may lack transportation facilities. Many patients are deprived of their driver's license for varying periods of time.

8. Understanding and support of the purposes of the group on the part of referral sources, who need to give active encouragement until their patients have related to the group.

9. Evaluative procedures built into the design for such services. Preferably, control groups should be set up to test the significance of studies of the efficiency of these procedures.

10. Strong lay board support to inaugurate and support such services. Use of public and private sources of financial support, of referral sources, and of services for the members, including all the rehabilitation services available in the community.

11. Adequate followup of members from referral through termination of contact to conserve the members' proper and sufficient use of the group experience.

12. Referred members who are in a sufficient state of remission at the time of referral to desire social contacts and to be able to use supportive measures to encourage their participation in social activities.

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