The onset of schizophrenia has a profound impact on an individual’s self-concept (Estroff, 1989; Gunter & Bedell, 1983). Therapeutic modalities are required to help individuals work out a positive self-concept in the context of this illness.

The group setting can provide individuals with schizophrenia an opportunity to construct a positive self-concept through interacting with others, exploring the meaning of their illness, developing an acceptable understanding of the illness, and developing diverse coping strategies.

Specifically, this article describes an outpatient coping group with young adults in the early phases of a psychotic illness. It was anticipated that the group would be an effective modality in which to address psychological issues related to self-concept, specifically, meaning of illness and engulfment.

**Theoretical and Conceptual Framework for the Group**

The theoretical concepts of “meaning of illness” and “engulfment” provided a conceptual framework for the group intervention. Given the negative public attitudes toward schizophrenia (Beiser, Waxler-Morrison, Iacono, Lin, Fleming, & Husted, 1987; Fink & Tasman, 1992), it is critical to assess the meaning that individuals ascribe to their illness experience. Kleinman’s (1988) explanatory model of illness addresses meaning of illness by providing a framework for directing a comprehensive perspective of the illness experience as it encompasses the personal, social, and cultural meanings of illness. Kleinman (1986) and Benner (1984) suggest that talking with patients about the actual experience of illness and helping to order and make sense of that experience has therapeutic value.

**Engulfment**

The term “engulfment,” adapted from the concept of role engulfment, has been used in relation to self-concept (Rosenberg, 1979) and in the context of response to illness (Lally, 1989; Miller, 1983). Schur (1971) derived the term role engulfment from labeling theory to describe the centrality that the deviant role may acquire in relation to the person’s self-concept. Engulfment in the context of this article refers to the degree to which individuals define themselves by their illness—schizophrenia.

Individuals engulfed by their illness.
become increasingly demoralized and lead progressively more restricted lives (Estroff, 1989; Lally, 1989; Townsend & Rakfeldt, 1985). In a recent study by McCoy (1994), high levels of engulfment in schizophrenia were associated with increased levels of hopelessness, depression, low self-esteem, a lack of self-efficacy, and decreased social adjustment.

Engulfment in McCoy’s study was measured by the Modified Engagement Scale (MES) (McCoy & Seeman, 1996). The MES is a 30-item Likert scale designed to measure the degree to which individuals define themselves by schizophrenia. The psychometric properties of the scale are available elsewhere (McCoy & Seeman, 1996). The group intervention described in this paper was aimed at helping individuals develop positive self-concepts in the context of schizophrenia or psychosis, thereby decreasing feelings of “engulfment.”

Group Therapy

Group therapy has been recognized as an effective psychosocial treatment modality for persons with schizophrenia (Kanas, 1986; Kanas, Deri, Ketter, & Fein, 1989; Kanas, Stewart, & Haney, 1988; Seeman, 1988; Wilson, Diamond, & Factor, 1990).

In a review of 40 controlled studies, group therapy with patients with schizophrenia was found more effective than no group therapy in 70% of inpatient studies and 80% of outpatient studies (Kanas, 1986). Interaction-oriented approaches were more useful than insight-oriented approaches that used uncovering techniques and self-disclosure (Kanas, 1986).

Recent work in group therapy with individuals with schizophrenia reflects this trend toward interaction-oriented groups. Groups are supportive and discussion oriented with a “here and now” focus, rather than focusing on past relationships and developmental issues (Kanas, 1986; Wilson et al., 1990). Current approaches also foster the development of coping strategies and provide a vehicle for emotional expression (Kanas, 1991; Kanas et al., 1988). Although current research supports the efficacy of these approaches, the meaning of the illness experience and the impact of illness on self-concept are areas that have been overlooked.

The group intervention described builds on the present knowledge base concerning group therapy by attending to the meaning of the illness experience within the group context and attempting to help individuals reconnect with non-illness dimensions of self-concept.

Group Goals and Intervention

Group goals (Figure) were developed from the literature, the theoretical framework, and the authors’ clinical experience. Group goals were shared with group members for feedback. The group members identified the goals as relevant and personally meaningful.

The intervention consisted of weekly group sessions for 6 weeks. The group was led by the first two authors who have experience with this patient population.

The group was held in a house next door to the hospital, which accommodates the hospital’s day center program. This was an attempt to buffer the stigma associated with the hospital setting. Furthermore, the group was conducted as a seminar, with handouts, tables, and refreshments, rather than as a “therapy” group per se. Because all but one of the participants were students, the authors felt this teaching format would add to the participants’ comfort.

Group membership

Participants for the pilot group were recruited from a First Episode Psychosis Clinic at a university psychiatric hospital. This clinic is directed toward the assessment, treatment, and management of individuals who may have a diagnosis of schizophrenia and is located within close proximity to a university campus. Participants for the group were diagnosed with one of the following Diagnostic and Statistical Manual of Mental Disorders, 4th Ed. (DSM-IV) categories: Schizophrenia, Schizophreniform Disorder, Schizoaffective Disorder, Brief Reactive Psychosis, or Psychotic Disorder Not Otherwise Specified. Participants had been ill for no more than 5 years and were able to read and comprehend English.

Six participants were recruited for the group. One participant attended the pre-group screening but did not actually attend the group, and a second participant decompensated and had to withdraw after the first group. Therefore, four participants formed the core group.

All group members were concurrently receiving follow-up care in the First Episode Psychosis Clinic that included medical and case management. The participants comprised a young (M=30), single, and fairly well-educated group, with low levels of symptomatology. There were equal numbers of males and females. All but one participant were attending university. The remaining participant was unemployed and also had experienced a later onset of illness, during her mid-40s.
Group content

The group sessions were guided by the group goals that stemmed from the conceptual framework. A focus for each session was developed ahead of time and included meaning of illness, coping strategies, and the development of meaningful goals. The description that follows illustrates the format and content of the group sessions. It should be noted that there was overlap in content from one group session to another. The group leaders were flexible, allowing participants to shape the discussion and share material they felt was relevant.

Eliciting Meaning of Illness

The first three sessions of the six-session group focused on eliciting the meaning of a first episode of psychosis (goal 1). During the earlier sessions, group members shared emotional responses to the psychotic episode. These included confusion, denial, anger, shame, and a sense of alienation from others. Most participants described a period of isolation and withdrawal following the psychotic episode.

Stigma, Labeling

Stigma was identified as a prevalent issue. To elicit further discussion of illness meanings, group members were asked to describe their illness and whether they had been able to share this understanding with anyone before.

All group members had difficulty labeling the illness as schizophrenia. Although one individual found it helpful to receive a diagnosis because it provided a framework for making sense of the illness experience, all group members expressed concern that labeling the illness or receiving a diagnosis like schizophrenia led to a “fear of permanence” and a profound loss of hope for the future.

Group members shared labels they felt were more acceptable to them. For example, “nervous breakdown” was described as an acceptable label because it implied a temporary situation perhaps related to external factors such as stress and internal factors such as “sensitivity.”

Group leaders facilitated the expression of this content, but did not offer alternative explanations related to understanding illness. This approach was taken to allow for the elaboration of group member perceptions rather than imposing the leaders’ perspectives. All group members had received education about their illness as part of the ongoing care they received in the First Episode Psychosis Clinic.

As group members described their illness, they also were asked to consider whether their illness interfered with things they liked to do or with their relationships with family or friends. Group members readily identified their concern that labeling led to a fear of being stigmatized, misunderstood, and rejected. Participants talked about the need to be cautious in sharing illness-related material with friends and family and agreed that sharing this information would evoke, in themselves and others, strong emotional responses.

Loss of Self-Esteem

It also was hoped that group members would be able to begin the work of establishing a positive identity through discussing the meaning of illness (goal 2). A loss of self-esteem was described in relation to stigma and rejection associated with the illness experience. Participants felt it important to move beyond the illness and get on with their lives, facilitated by “having hope” and pursuing goals. One participant described how persistent, residual symptoms interfered with this process. However, it was our impression that the remaining three members were regaining some sense of their former selves.

Coping Strategies

The fourth and fifth sessions in particular focused on the identification of specific problems that participants’ illnesses posed in everyday life and how these difficulties could be overcome. Group members were asked to identify situations in which they had become involved in settings, reflecting on how the situations were handled, and describe ways in which the situations may have been handled differently.

Participants were encouraged to examine the coping strategies they used in terms of the different styles of coping described by Endler and Parker (1994)—specifically, emotional versus task-oriented styles. Endler and Parker demonstrated that a task-oriented coping style is associated with lower levels of psychopathology and psychological distress in comparison with an emotional coping style. The exercise was designed to engage members in problem solving, encourage members to consider alternative coping styles, and accelerate the group process, given the 6-week timeframe. Again, the stigma associated with mental illness and psychiatric hospitalization, and the negative responses of others, were central to the situations presented in the group.

Coping was a prevalent theme throughout all group sessions. Some coping strategies that evolved follow.

Distancing oneself from the illness experience was a strategy facilitated by having some awareness or insight into the illness. Having this awareness led to taking medication for some of the partic-
participants and making temporary adjustments in expectations around social and occupational functioning.

**Monitoring thoughts** was described as a protective strategy to ensure one was thinking clearly. However, the need to do this was experienced as annoying, and for some, it implied a sense of loss of one’s former “normal” self. For example, one person commented, “normal people don’t have to do it.”

**Having hope and building confidence** were viewed as important, and were facilitated by “doing things that help you feel good” and “experiencing success.”

Knowing your strengths and potential and getting on with your life were strategies that helped one deal with the negative impact on one’s self-esteem.

A view of the illness as part of life and just another hurdle to overcome helped to normalize the illness experience. In addition, recognizing that others have limitations, too was helpful in this way.

Stigma was handled by fighting the negative responses of others, for example, by conveying a positive self-image. Group members also exercised discretion around self-disclosure; in other words, they had an awareness that “telling the wrong people can be hazardous” and lead to further rejection.

**Facing the Future**

The final session was devoted to recognizing future possibilities. Discussion of future goals was a major group focus throughout all the group sessions, and most participants indicated returning to school as a goal. It is of interest that two members wore university T-shirts to the group, perhaps reflecting their view of themselves as students.

Group members were asked to identify two of their social roles and how they might like to change these roles. In retrospect, the short-term nature of the group did not enable the content regarding social roles to be developed fully and did not elicit a future-oriented discussion. Instead, the exercise seemed to emphasize a sense of limitation and difficulty surrounding the change process.

The authors propose to modify the content for this session by asking group members to discuss future goals and ambitions and reinforce where appropriate the feasibility of these goals. The difficulties surrounding the last session also may have reflected sadness regarding termination.

As a component of the last session, members were asked to evaluate the group. Generally, the group felt that the 6-week time commitment was realistic, stating that commitment to a longer term shared their experiences regarding a recent relapse of symptoms. Most members had returned to the university and were finding the stress of dealing with course loads and social expectations quite challenging. There seemed to be an ongoing wish for contact with each other, yet also a desire for normal relationships away from formalized care settings.

As a follow up to the “booster” session, members decided to meet as an informal self-help group, with further meetings to be arranged by the group. As mentioned previously, all group members also received individual follow up in the First Episode Clinic by the group leaders. As such, they had opportunities to address issues further that had been raised in the group during individual sessions with their therapists.

**Implications**

The results of this pilot group support the relevance of the theoretical perspective to individuals with early psychotic illness. Working through and making sense of the illness experience were important to individuals recovering from a psychotic illness. The identification of content themes by the group leaders was helpful to participants, particularly because of the focus and structure they provided.

The stigma of mental illness was a pervasive theme throughout the group and, in fact, may have impeded the recruitment of subjects to the group. Group members identified their wish not to be associated with the formal psychiatric care system and wished to continue meeting informally.

The results of this pilot group emphasize the critical role of stigma for young adults attempting to deal with the early phases of a psychotic disorder. Although the nature of the illness is highly problematic, coping with the ongoing shame and stigma associated with mental illness appears to present the most significant and arduous challenge of all. The formal process of being diagnosed with mental illness, and being hospitalized.
because of it, are seen as highly stigmatizing events (Schur, 1971).

Conclusion

Stigma toward individuals and families suffering from mental illness remains a significant problem in society, resulting in delays in seeking treatment and profound feelings of isolation and shame (Fink & Tasman, 1992). For group members, "rejecting medical diagnoses" seemed to facilitate some preservation of self-esteem, and protection from the stigma and misconceptions associated with labels like "schizophrenia" and "psychosis."

It is clear that members of this group felt at great risk of being "engulfed" by their illness and by the mental health care system. They engaged in many strategies to reassure themselves, and to declare to others that they had not become irreversibly damaged psychiatric patients.

References


