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Social efficacy in the reintegration of the self: A groupwork model in schizophrenia care with older adults

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Abstract: *Freud discounted that persons living with schizophrenia could benefit from psychoanalysis because they were incapable of attaining insight. Departing from classical Freudian psychodynamic theory, Heinz Kohut formulated a theory of self psychology to give a prominent place to the development of the self in an interactional field. Using the interactional field, Harry Stack Sullivan applied relational theory in his work with schizophrenics. Now, drawing on Kohut's theory and Sullivan's pioneering work, the author retrospectively analyzes the interactional fields and processes observed in her groupwork with older adults with schizophrenia residing in long-term care. Data on psychosocial interventions for older adults with schizophrenia are lacking. This article underscores the need for addressing this gap in the research.*

Key words: *schizophrenia; selfobject; groupwork*

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Introduction

Social work practice in long-term care homes with older adults with schizophrenia is often guided by the practitioner's intuition of what *should* and *ought* to be done to alleviate resident-related problems. This 'seat of the pants' approach tends to be atheoretical, leaving social workers without a theory base for systematically explaining why they do what they do, how they achieve desired outcomes, and how they demonstrate practice effectiveness. The groupwork model of practice discussed here is informed by theory, grounded in social work ethics, and circumscribed by U.S. federal law. Like all models, it has a beginning, middle, and end, each with its goals, practice content, and processes. For the purpose of this discussion, however, the author focuses on the middle phase—that is, the change process—and explicates the theoretical basis for the behavioural changes that result in increased social efficacy as a measure of personal growth and quality of life. Social efficacy, also known as collective efficacy (Bandura, 1995), is the self-directed, purposive behaviour occurring in groups towards a stated objective that empowers the group and its members.

The groupwork model with older adults diagnosed with schizophrenia proposes that self psychology, formulated by Heinz Kohut for unraveling the developing self forming in childhood, offers a conceptual framework for understanding the fragmentation of the self that occurs in schizophrenia and a compelling need for reintegration to achieve a renewed sense of self. The principles of self psychology further give clinical researchers some direction for explicating the process by which the fragmented self of older adults with schizophrenia becomes reintegrated. In this way, the author offers a provocative model for theory-based social work practice with older persons living with schizophrenia as an alternative to 'gut-level' practice.

Although a developing evidence base suggests the efficacy of geriatric mental health interventions, data on psychosocial interventions for older adults with schizophrenia are lacking. While psychotropic medications remain effective, the extant literature on the effectiveness of psychosocial treatments in geriatric schizophrenia is limited (Bartels, Dums, Oxman, Schneider, Arean, Alexopoulos, et al., 2002). Much can be done with non-pharmacologic interventions (Karim and Byrne, 2005). Social workers are, thus, compelled to demonstrate the

effectiveness of residential treatment approaches. The groupwork model in schizophrenia care with older adults offers one resident-centred approach.

Self Psychology

An early supporter of Freud's drive and libido theories, Kohut gradually became disenchanted with these notions, believing that they did not go far enough in explaining the foundation of human behaviour. In the 1940s and 1950s, Kohut began to formulate a theory that proposed the development of a *self*, even before a person's behaviour might be said to be 'driven.' Like Harry Stack Sullivan, Kohut supported an interpersonal view of human behaviour and sought to *de*-stigmatize and *de*-pathologise all behaviour. For Kohut, adaptive and maladaptive behaviours in children are determined by the extent to which the child, in the process of the unfolding self, experiences *empathic failure* with the selfobject (i.e., primary caregiver). A selfobject reflects one's own internal thoughts, feelings, experiences, and perceptions in relation to an external object which may be another person, thing, or symbolic representation. Kohut (1987) writes that the self develops through the *mirror transference* and *idealizing transference* with selfobjects, usually parents or others on whom children depend for the satisfaction of their physical needs as well as empathic care-giving for the satisfaction of their emotional needs. The mirror transference occurs when the parental response reflects back to the child a sense of self-worth and value, thereby creating internal self-respect (Baker & Baker, 1987). Kohut described the idealizing requirement in 'our need to merge with, or to be close to, someone who we believe will make us safe, comfortable, or calm' (Baker & Baker, 1987). The child *transmutes*, or internalizes, the functions of the selfobjects into her own developing self structure which, as it matures, comes to rely increasingly less on selfobjects for the regulation of the maturing person's inner states (e.g., anxiety). Elson (1986) writes that the psyche structure of a cohesive nuclear self comes into being through the transmuting internalization by which selfobject functions are gradually withdrawn and replaced by self-functions. According to Kohut, these self-functions become the enduring components of personality.

Kohut describes three types of selfobjects as

1. the *mirroring* selfobject, responding to and confirming the child's greatness and perfection as a reflection of the parent (e.g., expressed by 'look at Mommy's / Daddy's good girl');
2. the *idealized* selfobject with whose calmness, infallibility, and omnipotence the child can merge; and
3. the *twinship*, or alter ego, selfobject through whom the child is confirmed as a member of and a partner in a community of others. The process through which transmuting internalization occurs is called *optimal frustration* by which Kohut means that the selfobject performs a function up to a point, withdrawing in just sufficient amounts to allow the child to perform a given function, or part of a function, in her own unique way (Elson, 1986). A healthy functioning self is not a replica of a selfobject, but a unique self.

Selfobjects (including vocation, occupation, religious and cultural experiences, ideas, symbols, and significant others) are continuously evolving; they are needed for the creation, consolidation, and sustenance of the self throughout the lifespan. The *nuclear self* is an autonomous centre of initiative and perception that is inextricably linked to symbolic and human selfobjects. Like Sullivan, Kohut sees the formation of the self taking shape in a field of interpersonal relations in which sufficiently empathic selfobjects confirm, accept, affirm, validate, and mirror images of the self.

The central organizing principle in self psychology is *narcissism*. Kohut (1987) discusses its centrality in the Kohut Seminars. He explains that selfobjects are nothing more than narcissistic objects that perform needed self-functions in the young child. All objects serve a narcissistic dimension 'in the sense of being agents for self-confirmation, for self approval.' Kohut discusses the narcissistic balances and relationships that maintain the child's narcissistic equilibrium, or well-being. Narcissistic rage results from prolonged disequilibrium. In short, in a very young child, nothing is recognized as apart from the child's 'narcissistic grandiose self.' The mature self, on the other hand, is an integrated, cohesive set of psychic self-functions.

From this theoretical framework, the author deduces that the incomplete or fragmented formation of self-functions in schizophrenia

is explained, in part, by disruptions in the interactional field where the emerging self of the child and the selfobject converge, the child's unresolved narcissistic rage resulting from prolonged (narcissistic) disequilibrium, and the absence of empathic validation of the emerging self.

The Ageing Self

The integrity of the self may well be threatened by the vicissitudes of life (Knight, 2004; Morales & Sheafor, 2002). This is particularly true for older adults whose sense of self has been fragmented through experiences involving multiple lost selfobjects (e.g., separation, divorce, death, family relocation, and so on). A period of grieving is normative at any age; however; at the end of the lifespan, recovering lost selfobjects becomes increasingly remote and sets the stage for hopelessness. Yet, clinical experience with older women (e.g., Browne, 1995) suggests that social efficacy is an important tool for the reintegration of the self.

The self of older persons with schizophrenia continues to experience fragmentation owing to empathic failure with primary selfobjects. Social losses and cognitive decline that come with age may further exact a toll on autonomous self-functions, particularly when older adults reside in long-term care where each day is regimented, choices are few, and freedom of movement is somewhat restricted.

Before the reintegration of the self can occur within a long-term care setting, older persons with schizophrenia must have the opportunity to learn what they *can* do, where they might go, and how they might experience empathic responding. This supportive can-do approach begins upon admission to long-term care (e.g., assisted care facility or residential home). The process of learning what persons with schizophrenia can do requires an empathic, facilitative environment with sufficiently empathic personnel to *re*-create early confirming, accepting, affirming, and validating selfobjects. In the days when people with schizophrenia were institutionalized for long periods, this approach was referred to as milieu therapy because every aspect of the inpatient psychiatric ward was intended to be therapeutic.

Older adults with schizophrenia tend to be more accommodating than their younger counterparts—perhaps owing to institutionalized

behaviour acquired through early, recurrent inpatient admissions and late-life cognitive decline. A study by Auslander, Lindamer, Delapena, Harless, Polichar, Patterson, et al. (2001), comparing older outpatients living independently with those in assisted-care facilities, found that assisted-care status was associated with an earlier age of onset of illness, longer illness duration, lower probability of ever having been married, more severe negative symptoms, worse cognitive impairment, and a poorer health-related quality of well-being. Cognitive status was measured by scores on the Mattis Dementia Rating Scale (DRS). Similarly, Gupta, Steinmeyer, Frank, Lockwood, Lentz, and Schultz (2003) note that scores on the Mini-Mental State Exam (MMSE) may be used to determine the nature of dwelling that a patient should have following hospital discharge. Health care status, ability to self-care, and cognitive status are the best predictors of admission to residential care homes for older adults with schizophrenia (Gupta, et al., 2003).

The author's groupwork model for older adults with schizophrenia proposes that learning what older residents *can* do is key to their *re*-acquisition of selfobjects toward the *re*-integration of self. This model is decidedly proactive because it anticipates resident adjustments when transitioning to long-term care as illustrated in Figure 1.

Fig. 1. Groupwork model for older adults with schizophrenia

Schizophrenia groupwork model

The groupwork model in schizophrenia care derives from the author's early formulation of a transitional model of clinical social work practice for older adults with mild-dementia. The model, shown at Figure 1, proposes that a facilitative environment predisposes newly admitted residents to long-term residential care, to a change process in which they acquire new selfobject representations, new roles, and new behaviors resulting in successful transition as evidenced by documented desired behavioral outcomes. The process demands the following, all of which form 'twinship' (alter ego) selfobject representations.:

- a membership orientation (Falck, 1984), collegiality and collaborative relationships among the clinical staff, exemplified by mutual recognition of each person's 'me' (i.e., Kohut's 'self-functions') and appreciation of the contributions they bring to the clinical process;
- mutual trust and the freedom to express emotions;
- mutual understanding as demonstrated by sensitivity to feelings, thoughts, and actions of members of the clinical team;
- mutual concern; fairness and impartiality; choice; and
- mutual respect and privacy

All of these dimensions (i.e., healthy self-functioning, staff collegiality, a membership orientation, as well as family involvement) conspire to promote an environment that facilitates resident (and family) transitions to long-term care. The environment is both a physical location and a selfobject representation. The location is a safe, orderly and manageable setting in which food, clothing, and shelter can be counted on. As selfobject, the environment provides protection from ambiguity and difficult problems. Thus, the facilitative environment in this model takes on the characteristics of a therapeutic milieu (Artiss, 1962; Cumming, 1990) which can be engineered in such a way as to reduce isolation and promote personal and social efficacy thought to be essential for the reintegration of the self. Drawing on the model's theoretical orientation, the author created opportunities for older adults with schizophrenia to view themselves in a new way through the groupwork process.

Consenting participants in two public residential (nursing) homes

in Washington, DC, met once a week for eight weeks with a licensed clinical social worker, for structured group interaction to reduce isolation while promoting personal and social efficacy and reality orientation. The participants' progress in groupwork was noted in their medical records following each session. Seven case narratives follow:

Case 1

On initial meeting, *Ms. H., a* 65-y/o African American single (never married) female, is tall and slightly above her ideal body weight, walks with a shuffle, and presents with flat affect. Her primary diagnosis is paranoid schizophrenia. She wears glasses for nearsightedness, is alert to self, others, generally to time, and verbally responsive, and tends to be very isolative. She can usually be found sitting alone by a window reading, either in her room or in the solarium. Observation and corroborative information provided by the nursing staff reveals that Ms. H. does not participate in activities on the nursing unit nor in other nursing home events.

The social worker (SW) established a therapeutic relationship with Ms. H., visiting with her weekly. On the third visit, when asked if she recalled the SW's name, Ms. H. replied, 'Miss Jessica?' At that point, the SW believed that a connection had been made between the two women. These weekly visits centred on Ms. H.'s perceived health status, her experience of internal stimuli (if any) in the previous week, and her general comfort in long-term care. The nursing home psychiatrist assessed Ms. H.'s mental status quarterly and adjusted her psychotropic medication as needed although she seemed to be very stable by all accounts. Documentation in the daily or weekly progress notes and quarterly evaluations, for all clinical disciplines, provided corroborative data.

During one visit, Ms. H. informed the SW that her brother visited on weekends and brought new library books. [The nursing staff was sceptical as to whether Ms. H. actually read the books.] The SW asked Ms. H what she was currently reading and if she would give a synopsis. Ms. H. summarized her book (which the SW had also read), and all doubt was removed. Thus, Ms. H. seemed like a very suitable candidate for groupwork aimed at reducing social isolation

and promoting personal and social efficacy, given her intelligence, level of cognitive functioning, and capacity to articulate beyond one-word responses.

Ms. H. attended group sessions as scheduled. The SW accompanied her to the first two meetings; thereafter, she arrived accompanied by a nursing assistant. At the sessions, Ms. H. sat at the conference room table, attentive but averting eye contact. Her affect remained flat throughout each session. She responded when spoken to directly, but only initiated questions for the other participants with the SW's prompting (e.g., 'Ms. H., ask Mr. W. how he's feeling today'; or 'What do you think about what Ms. So=and=So said'). Although Ms. H. did not recall the name of one of the participants who almost always sat next to her, she visibly registered concern on hearing that he had died in the week since the last group session. 'That's too bad,' Ms. H. offered,' without prompting.

Since arriving at the home, Ms. H. had seldom left the nursing unit except for annual home visits at Christmas. She responded positively to the SW, an 'agent for [the residents] self confirmation and self-approval.' Groupwork with Ms. H. helped to reduce isolative behaviour and promoted greater personal and social efficacy, as evidenced by increased participation at off-unit events.

Case 2

Ms. C. is a 72-y/o divorced, Caucasian female, who propels herself in her wheelchair despite having suffered a mild stroke, which has left her partially paralyzed on one side of her body. Her diagnosis includes schizophrenia. Her mood is labile and she has frequent verbal outbursts, grounds for enforced isolation away from others. In a predominantly African American nursing home, Ms. C. has a penchant for calling the other residents 'nigger.' The SW meets with Ms. C., weekly to reinforce desirable behaviour. Ms. C. asks, 'What must I say?' The SW replies that 'Black people,' 'African Americans,' or 'people of color' are appropriate terms. Ms. C. verbally contracts with the SW to try using whichever term is more comfortable for her.

Ms C. was deemed appropriate for groupwork because of her ability to comprehend and communicate effectively and her willingness to change. In group sessions, when Ms. C. became agitated, the 'n' word slipped out once. However, the SW's glare from across the table prompted self-correction, so that Ms. C.'s utterance sounded like this: 'I don't think the ni___, I mean, people of color should. . . .' She remained in the group until a second, debilitating stroke confined her to bed.

Although Ms. C.'s participation in group was short-lived, she made some gains which can be attributed to individual work that was reinforced in the group context.

Case 3

Mr. W., a 68-y/o African American male, is diagnosed with paranoid schizophrenia. He shouts obscenities and spits at all who approach his room, behaviours that isolate him from the general population. Nursing staff suits up in biohazard nursing gowns, gloves, hats, and shoe coverings to bathe him three times a week. Dietary staff takes the same precaution. Mr. W. has no visitors and the medical record reveals no observed social interaction with any of the other residents. His behaviour precludes attendance at organized social events in the home. The SW accompanies the visiting psychiatrist for a review of Mr. W.'s medication(s). The psychiatrist asks Mr. W. if he had ever considered 'not spitting,' to which Mr. W. replied, 'F___ you.' The doctor responds, 'Okay, with your permission, I'm going to order something to help you spit less.' Mr. W. glared angrily at both of us, prompting us to leave his room lest we experience his sputum. The psychiatrist prescribed a medication that inhibits spitting by intentionally making the mouth dry. In three days, the nursing staff report a significant change: The nursing assistants are able to bathe Mr. W. without wearing biohazard gear. Gradually, the rate of obscenities would abate as well.

Mr. W. was invited to attend group sessions after a couple of weeks of one-on-one with the SW who praised his clean-shaven appearance and (non-spitting) behaviour. In group, Mr. W. communicated appropriately with prompting, turning to Ms. H. to introduce himself on cue.

With the medical and psychosocial interventions, Mr. W. was no longer avoided on the nursing unit, and could be frequently found with others eating his meals, watching the television, or sitting quietly in the unit solarium. On occasion, he also attended other off-unit social events. With the spitting behaviour interrupted, the SW (the mirroring or idealizing selfobject) began to approach Mr. W. as a valued member of the human family, and he participated in groupwork for 2-3 sessions before dying. At the request of the same administrator, the SW provided services on a contract basis to a second residential care (nursing) home,. Owing to the perceived success of groupwork with persons living with schizophrenia, the SW obtained permission to replicate her groupwork practice.

Case 4

Ms. C. is a 70-y/o African American divorced female. Her diagnoses include paranoid schizophrenia. She is tall, ambulatory, and above her ideal body weight. She has a friendly disposition with labile affect that alternates between laughter and tears in response to internal stimuli. She enjoys the support of her son on whom she dotes & looks forward to monthly home visits. Ms. C. attends nursing home events daily unless confined in bed for health reasons. She approaches the nursing desk to ask for candy or if it is time to take her medications. She appears to be well liked by the nurses.

On initial meeting with the SW, Ms. C. smiles and says, 'You're pretty.' In the following weeks, she looks forward to one-on-one with the SW, as evidenced by her frequent inquiries at the nursing station: 'Is Jessica coming today?' Given her social nature and apparent connection with the SW, Ms. C. was invited to participate in group, where week after week she responded appropriately to others or sat listening attentively. Sometimes she applauded spontaneously or drifted in and out of sleep, possibly due to the time of day (e.g., after lunch), medication effects, or both. Whenever possible, group sessions were held in late morning or before the evening meal.

As Ms. C. was usually very affable and eager to participate in the home's activities, particularly when food was served,

the extent to which the SW group intervention was effective cannot be determined. However, the SW affirmed, validated, and mirrored Ms. C's selfobject representations revealed during their one-on-one interactions. What remained clear was that Ms. C. was no worse off attending the group sessions.

Case 5

Mr. A. is a 68-y/o short, visually impaired African American male. He walks slowly, relying on his limited vision, and uses no assistive device. Nursing helps with bathing, dressing, and grooming. Mr. A. is verbally responsive. He stutters when speaking, but sings a particular tune ('Laura') from a bygone era in a melodious tenor voice, impeccably. His primary diagnosis is paranoid schizophrenia. He is isolative, preferring to listen to the radio in his room. Mr. A. seldom participates at nursing home events; he is generally seen with others only at meals in the unit dining room.

On initial assessment, Mr. A. was cooperative, but guarded. He asked, 'Where did you come from?' and later, 'What do you want?' The SW asked Mr. A. if he ever thought about being with other people other than at meal times. Mr. A. was surprised by the question. He explained that, if he was with others, they would laugh at him because he stutters.

Mr. A. warmed to the SW with regular weekly visits. Reluctantly, he accepted the invitation to attend one group session, then another. In group, he listened attentively and, with prompting, gave his opinion. On occasion, Ms. C. (introduced above) asked Mr. A. to sing; he would flawlessly render a tender version of 'Laura.'

In groupwork, Mr. A. found acceptance among his peers. His attendance in the group sessions helped to reduce the tendency for isolation and promoted his personal and social efficacy. In time, he regularly joined other residents in the TV room for the nightly news following the evening meal.

Case 6

Ms. B. is a 72-y/o blind African American female. Her primary diagnosis is paranoid schizophrenia. When not agitated and

shouting obscenities in response to the television or internal stimuli, she is able to converse coherently. She speaks of a son who visits about once a month. Ms. B. accepted the SW's invitation to come to a group session, where she listened attentively and responded appropriately with prompting. However, her participation was short-lived due to persistent verbal outbursts occurring on the nursing unit, for which she would be returned to her room. The SW recommended a psychiatric consult medication review.

Once stabilized, Ms. B. might again be a candidate for groupwork.

Case 7

Seated in her wheelchair near the nursing station, Ms. O., a 73-y/o heavy-set Caucasian female, frequently shouts obscenities at other residents, staff, and visitors. This behaviour lands her in her room where she remains, according to nursing staff, 'until she calms down.' The strategy apparently works, leading the SW to question the purpose served by the resident's outbursts. Further observation reveals that Ms. O. tends to become agitated by mid-morning and in mid-afternoon. The suggestion to return Ms. O. to her room for a mid-morning nap and similarly in mid-afternoon following lunch results in fewer resident outbursts and timeouts and happier staff.

Ms. O. has several medical problems and a diagnosis of schizophrenia. On initial assessment, she was guarded and eyed the SW with distrust. At the fourth one-on-one, visit with the resident, the SW invited Ms. O. to participate in groupwork; she agreed to attend the next scheduled late-afternoon session.

Ms. O. actively participated in group, where her behaviour and language were appropriate. She listened attentively and responded spontaneously or with prompting. She turned to others in the group to ask, 'How are you doing today?'; wish them 'Happy Birthday'; or to find something nice about a person and tell her/him. She particularly liked hearing Mr. A. sing ('Laura'), telling him as much without prompting.

Ms. O. participated at five of the eight group sessions. A

hospital visit explained one absence; she was sleeping at the time of two other afternoon sessions. She is memorable because her toxic behaviour was mediated by a simple environmental change (i.e., planned down time twice a day) combined with medication management. Once the change was implemented, she became a candidate for groupwork, an affirming and validating experience.

The foregoing case narratives represent the author's best recollection of the nursing home residents, their personalities and characteristics, diagnoses, and progress in group. Each participant had a long history of institutionalization for schizophrenia and long-term use of psychotropic medications. With one exception, they all exhibited isolative behaviours and shunned social events. Each came to groupwork through individual work with the SW (idealizing selfobject). They faced their fears about being with others (optimal frustration) and received validation from their peers. Following individual and group sessions, the SW noted each resident's verbal content, affect, social interaction, and behavior. The medical record, thus, provides evidence of personal and social efficacy for each group participant. It is noteworthy that, as the SW anticipated terminating the groups and leaving the residential care settings, she asked each participant what they would miss. Ms. H. (in Case 1), replied, 'Nothing.' At the second home, most participants indicated that they would miss coming to group each week. [No one said anything about missing the SW.]

Discussion

The number and proportion of adults with schizophrenia will increase in the coming decade as the population ages (Palmer, Heaton, & Jeste, 1999). We have much to learn about schizophrenia in older adults and its treatment. Because little research has been done on late-life schizophrenia (Karim & Byrne, 2004), social workers and other health professionals are challenged to demonstrate the effectiveness of non-medical treatments, particularly psychosocial interventions. A study by Depla, deGraaf and Heeren (2005), comparing the quality of life and mental stability of older adults with chronic mental disorders,

concluded that supportive living in residential homes for older adults does not automatically guarantee a better quality of life although this is certainly an attractive alternative to inpatient care. Palmer et al. (1999) recommend establishing a consortium for the study of late-life schizophrenia; conducting multicenter studies of treatment effectiveness; and forming interdisciplinary collaborations among researchers, clinicians, government and industry representatives, and patient advocacy groups.

This retrospective analysis with case summaries illustrates the importance of using a theoretical perspective for guiding groupwork in late-life schizophrenia. Freud discounted that persons living with schizophrenia could benefit from a therapeutic intervention aimed at attaining insight. Perhaps there is less need for insight than converging with mirroring selfobjects in an interactional field that holds out the promise for optimal reintegration of the self in schizophrenia. Kohut's formulation of self psychology, while incomplete, is a good place to begin as this theoretical framework is consistent with social work principles that recognize inherent human dignity and worth and with our mission to help restore individuals, families, and groups to their optimal level of psychosocial functioning. Data on psychosocial interventions for older adults with schizophrenia are lacking. This article underscores the need for addressing this gap in the research.

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