Medication group therapy for patients presenting intellectual disability associated with psychiatric comorbidity: our experience

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Abstract
The goal of this article is to describe the functioning of a medication group therapy in both ambulatory and intra hospital settings, geared towards intellectually disabled patients with psychiatric comorbidity. First, we will briefly describe the care facility in the psychiatry units of mental development (UPDM). Next, we will discuss the objectives and setting of group, then conclude with our observations and queries.

Key words: intellectual disability, heterogeneous psychiatric morbidity, medication therapy group, therapy in homogeneous groups

A) Introduction

We want to focus on the concept of group therapy in its wider application for rehabilitation before engaging in the core of this article. This model, which was developed for general psychiatric population by R. Lieberman and H. D. Brenner as well as by others, is suitable for patients presenting a persistent psychic health problem associated with intellectual disability and/or physical handicaps. Its goal is to rehabilitate social and personal autonomy at various levels, such as personal hygiene, interpersonal and social interactions, etc...
In the current accepted model, the genesis of psychiatric afflictions results from the interaction between vulnerability (stress) factors and protective factors : here we will use the term of resilience. Vulnerability factors can be divided into two classes : psycho biological (genetic, biochemical and structural) and environmental (familial and social). Protective factors can be many, such as suitable social environment, the availability of optimised therapeutical programs, and drug intake.
On the basis of this model, we can hypothesis that when the so-called protective factors, including the rehabilitative approaches, are strengthened, the probability of improving the psychiatric outlook of the patient and his general functioning via a positive bio feed-back will be augmented. This is so, in spite of the vulnerability factors, such as the genetics ones, which we have little impact on. Among the many rehabilitative models, those involving medication have an essential role. The privileged personal patient-therapist relationship remains the main focus in the rehabilitative therapeutic approach. However, group therapy can complement it. It offers also various advantages. Indeed, via the social dimension, group therapy demonstrates to the patient that he is not alone in his reality and problems, and that others have often the same queries as he has.
Thus, the sharing of information constitutes per se a therapeutic dimension. Indeed, in addition to the considerations directly linked to the medication, group therapy allows

to develop other social abilities such as the ones related to the training or retraining of interpersonal relationships, thereby enhancing the others rehabilitative processes. It is therefore not surprising that group approach is increasingly used in therapeutic circles and, namely in psychiatry. It is also widely used for chemotherapy as exemplified by many references. Therefore, there is no valid reason to exclude it from the field of intellectual disability, even though it may need some technical adaptations.
In this context, it is worth mentioning that intellectually disabled patients show a comorbidity rate of 10 to 60%, depending on the case study and the applied methodology. Psychiatric diagnoses cover all those usually encountered in an adult psychiatric so-called « normal » population and include, without exception, the entire spectrum of the DSM IV and the CIM 10. Psycho tropic drugs are widely used in our population. However, one of the major problems encountered is linked to the lack of medicine intake compliance, as observed in the other domains of psychiatry. Nevertheless, it is not surprising that patients ignoring the basis of the affliction they suffer from, which is associated with misperception of their own body, have problems understanding the meaning of any medication. Additionally intellectual disability that is associated to cognitive problems prevents the patients from accessing the information they could obtain through other means than their therapist. A typical example is that of a patient who cannot read the explanatory note of his medication. A person with verbal communication problems will be in the same situation.
It is therefore understandable that medication group therapy is one of many available approaches. It goal is to improve the patient's ability to understand his medication and to provide him with the necessary means to his introspection ; and this is in a interactive manner.

B) Brief description of the care facility in the Psychiatry Units of Mental Development in Geneva.

The Psychiatry Units of Mental Development are specialised in the care of intellectually disabled adults presenting a psychiatry comorbidity. It provides care for either hospitalised or outside patients, aged 16 or more. There is no upper age limit. The UPDM are associated with the Psychiatry Department at Geneva University Hospitals. The setting comprises an ambulatory facility in the centre of town and a Day Hospital located within Belle Idée Psychiatric Hospital. The later registers patients in either ambulatory services (pre-crisis) or in the process of being released from hospital (post-crisis).
The intra hospital section consists of two units comprising 18 beds total and admits patients presenting severe psychiatric and behavioural problems which are beyond the intervention means of ambulatory unit. A so-called mobile unit is also available; this unit operates on crises sites (institution or domicile) and also assists the socio-educative teams in the often complex hospital procedure of releasing patients.

The entire care facility works in close interaction with socio-educative structures as well as with the patient's relatives and/or tutorial authority. It consists of medical doctors, nurses and various health professional such as psychologists, psychomotrists, logopedists, social assistants, physiotherapists, educators. The proposed care taking is both at the individual and group level.

C) Goals of the medication group therapy

n To give the participants the opportunity of a discussion group in order to express their living experience and questions about their medication.
n To teach patients how to handle their treatment according to their cognitive competency.
n To inform them on the possible side effects of medication ; how to cope with it.
n To improve their knowledge about medication ; to develop awareness of the beneficial effect of medication in improving the quality of life.
n To increase their sense of responsibility towards their treatment.
n To improve compliance.

We wish to stress that major goal is not to provide patients with clear information which is easy to remember, but mainly to render them autonomous and responsible towards their drug intake, effects and goals. We want also to lead patients to express their living experiences, internal representations, psychic disease, handicap and opinion on the quality of their life.And additional goal is to foster and enrich the interactions that patients may have with their psychiatrists prescribing the medication, in order to allows them to better discuss possible adjustment of the treatment and improve their compliance to the therapy.

The medication group in ambulatory

a) The Framework

The "medication group" in ambulatory is a closed group working on the basis of five sessions lasting one hour each. The patients could participate to two modules at most. The modules are repeated every two months. The groups are weekly, on Wednesdays at 5 p.m. Regular attendance of participants is requested.
The group is animated by a medical doctor and psychomotrist.
In a rehabilitative goal, it is psyco educative group leading to provide information but also to freely discuss several themes :
- disease, diagnostic, nature of psychic troubles as a whole, notions of physiology and anatomy.
- Psychotrophic drugs : prescription, how to read an explanatory notice, intake mode, scheduling, expected effects, side effects, interactions, etc.
- Whom to call in emergency.

The sharing of feelings and personal experiences is encouraged among the participants.
In the group certain rules apply, such as confidentiality and restitution, so that patients can feel safe and dare to relate outside experiences which are of general concern. The two co-therapists have distinct background, sensitivity and roles inside the group. They thus foster different types of investment by the participants.
The doctor is obviously the reference for the transmission of medical information, whether diagnostic, ethiological, scientific, pharmacological or else, whereas the psychomotrist focuses his/her intervention on the level of physical sensations, knowledge of body function and its associated fears. The psychomotrist can also function as a person who can help the patient to word certain questions or preoccupation about his experience, by playing the role of mediator between the patient and the doctor. In spite of this distinction, both therapists assume together the responsibility of the group organisation (spatial and temporal setting, internal cohesion) and both interact by communicating information and interest in the perception of the participants.
In summary, the medication group therapy is :

n Psycho educative with a rehabilitative goal.
n Closed group, weekly, modules of 5 groups
n Two therapists
n Groups of 1 hour with 15 minute of post-group
n 4-6 patients

b) The Participants
Each module consisted of 6 patients. Taking the absentee into account, the meetings took place with an average of 4 participants, all of which suffering from mild to medium intellectual disability and psychiatric comorbidity. In the experience described here, the patients were depressive and had severe borderline personality syndrome. One of them had also a severe and chronic alcohol dependence linked to a severe depressive state ; another was schizophrenic.
The group was mixed and geared towards patients with sufficient verbal skills, both expressive and comprehensive. The patients were autonomous, living in a flat, or lived with family or in socio-educational institutions. They all had a job, for instance in protected workshop, in small enterprises or in a city services. They all had psycho tropic therapy. For most of them, problems with therapeutic approaches appeared from having to take their medication, and these problems motivated their inclusion into the group. It is worth mentioning that the heterogeneity of the psychiatric afflictions was not limiting factor in the group dynamics. On the contrary it stimulated exchanges and questions among participants.

c) Descriptive of the Module

The module's content and structure were quite simple : didactic information and free discussion should alternate smoothly, depending on the needs and request of the patients.

Practically, the 5 sessions for each group were subdivided as follows :
The first consisted of welcoming and introducing the group's leaders and participants and stating the objectives. The framework of the group was also reminded (frequency, duration, location, regularity of attendance) as well as its rules (see above, point a : the framework). In order to open the debate broadly about drugs intake, spontaneous interactions were readily established in this session. This was so as to encourage patients to speak, express themselves and share their thoughts and personal experiences. Indeed we think these talks may have more impact on the group than our theoretical input. The lived and shared experience allowed members of the group to tackle their difficulties towards their medication, no longer feel isolated, realise that others have similar concerns and thus, speak more freely.
The 2nd, 3rd and 4th sessions were organised in the same fashion ; we started by discussing a subgroup of psychotherapeutic drugs : neuroleptics, benzodiazepines, antidepressants and mood stabilisers. We then described some principles of anatomy and physiology : we showed scheme of the brain, of neurones ; the way by which information is transmitted from the brain to the body, the relations between thoughts and psychological states. We also discussed modes of absorption and diffusion of drugs, their possible side effects, i.e. shaking, dryness of the mouth, sexual dysfunction, etc. Most of these subjects were introduced at the patients requests. As often as possible we let the group's dynamics drive the discussion. Widely discussed subject matters were also: diseases, of whether somatic or psychic origins, their mode of transmission (for instance;: can one become depressive by contagion, does one die from X?;), diagnosis and aetiology.
The 5th session was devoted to the informal discussion of certain subjects, in more depth. Also the satisfaction criteria, or lack thereof, about the content. The farewell ends the group to permit a quiet termination of the meeting.
Practically, as we went along, our didactic input was reduced in favor of the thoughtful questions and comments of the patients. The field of discussion was broad: from philosophical questions about life and death to more germane ones about how to ingest a pill: with a fruit juice? As a delay pill? What about injections?

d) Clinical Examples
In order to illustrate what was described above in a more concrete fashion, we propose to show examples of a session in the form of a dialogue.
- Leader: we will talk today about a kind of drugs, the neuroleptics, which some of you take on a regular basis. Here we have some commercial names.

The next minutes were used to describe briefly the modes of action of the drug, the way o take it and its possible side effects. Slide of a human brain attracted the immediate attention of the group who appeared fascinated by something they had not seen or imagined beforehand.
- Patient 1: How does it work?
A long discussion ensued, mainly in the shape of the interactive dialogue among patients and leaders, about the function and complexity of the brain. We were puzzled by the interest of the patients, their meaningful questions about a subject we had considered basic and well know. For this reason, we wondered whether if would be worth to diverge from the original subject, the neuroleptics and introduce some comments on human physiology.
- Leader: do you know how a pill does, once swallowed, to reach the brain?
- Patients...
- Leaders: we will explain it to you.
We then uses a paper board to draw a mouth, a digestive tract, some blood vessels and their way to the brain.
- Leader: do you know what a blood vessel is? A vein? I will show it to you.
Everyone was invited to take his pulse with our help, when necessary.
- Here you go: it is exactly in this kind of tube which beats in rhythm with the heart, that drugs are able to circulate in the whole body.
- Patient 2: So, drugs go in the whole body and have effects everywhere?
- Leader: exactly
- The ensuing discussion on drugs' side effects clarified certain points in the mind of the patients.
- Patient 3: what about injections?
We repeated the same type of explanations by stressing the concept of deposit.

e) Thoughts and commentary
· This group surprised us by its resourcefulness and diversity
· The meetings allowed mentioning mental diseases and behavioural troubles but not intellectual disability. Indeed, our prescriptions treat psychiatric troubles and not the intellectual disability itself. It is important to distinguish clearly these two concepts.
· The term of handicap was however mentioned in the context of limiting the intellectual comprehension or the autonomy of the patient, in understanding his medication.
· The pleasurable aspect of getting together and the self-discovery of physical autonomy helped the patient to discuss about their difficulties.
· In this setting, the participant appreciated to be listened about their treatments, without the feeling to loose control, or to be ignorant and entirely dependent on the doctors' knowledge. They in fact regain possession of their treatment.

· The atmosphere of the group remained relaxed and pleasant even though some of the tropics raised might have been painful, anxiogenic and even disorienting at times.
· The members of the group tended to show empathy and support for one another.
· Albeit its short duration and novelty of this group in our ambulatory services, the utility and resources of the experience described here, as well as the patients' satisfaction were evident.
· As it the case for the general psychiatric patient, medication was frequently evaluated for the social handicap it produces, for instance by preventing alcohol intake, lowering the libido or the sexual performances.
· Also, many patients wanted to have their treatment and prescription re-evaluated or even interrupted.
Indeed, when the crisis or post-crisis period were overcome, the improvement and stabilisation of the psychic status led to a justified wish to further improve one's life quality by discontinuing the therapy.
· The discussion of this topic and the ensuing information may play an important role in the participation in-and compliance with the treatment.

f) Additional remarks
· Some of the material could be simplified, for instance the scheme of the neurones. One patient spontaneously brought documentation to complete our own, the encyclopaedia of the human body. The discussion enhanced the patient's ability to listen, understand and introspect their bodily function, which are often misunderstood.
· To bring prescription drugs and their explanatory notices to the meetings was an efficient mean to materialise the information.
· A difficult point was to convince the patient to attend the sessions regularity. The scheduling was also complicated by our and the patients own work commitment.
· Questions about additional tests which were taken, such as ECG or blood test, widened the debate. In fact we noticed that although our topic was initially focussed on drug therapy, there was a real need for information on the human body and its function.
· Two of our patients subscribed to an additional group session in order to study these points in more depth. We can thus assume their need for reassurance.
· Shall the number of sessions within a group be increased or not? It seemed that 5 sessions match the needs and availability of our patients. We leave to the persons interested in leading such groups the care to evaluated this point for themselves.

2) The medication group therapy in the intra-and day hospital setting

a) The framework
Patients in day hospital together with those hospitalised in the Intra hospital Units constituted the group. The outside patients manage their medication more or less by

themselves. Obviously, the situation is different for the hospitalised patients. Their medication is prescribed by a psychiatrist and administered by nurses. In contrasts to the situation in the Consultation, where it was difficult to obtain regular attendance from the patients, this problem did not occur with this group. Almost all patients attended each session. As described above, the group was psycho educative with a rehabilitative goal, with the difference that it operated in the "slow open" mode. During the whole year, news patients could join the group or leave the group, according to their needs or progress, but with a slow rhythm.
The group was based on verbal exchanges, with the corollary that patients had sufficient comprehensive and communicative skills. Its duration was 30' with an additional 15' discussion period for the medical team. It merits mention that although the leader of the group was obviously the medical doctor, the presence of other caretakers as co-therapists (nurses, teachers, etc..) was relevant to insure a securing and respectful atmosphere. The rules and regulations were frequently reminded: respect of others, correct behaviour, remaining sited throughout the session, listening to others with no interrupting, confidentiality.
The goals of this group were similar to the ones described above, see

In summary, the drug therapy in the intra-and day hospital setting is:
· Psycho educational with a rehabilitative goal
· Operative in "slow-open" during the whole year
· Supervised by a medical doctor and several co-therapists on the style of inn-patients group (caretakers with various backgrounds).
· On a weekly basis, 30' duration plus a 15' discussion post-group
· Constituted by 5-8 patients

b) Clinical illustration of the sessions
First session: as mentioned above, the group was constituted on average by 5-8 patients. Initially, we used individually therapy files. Each patient had a board with his different drugs in front of him. Each pill, including its name and time of intake, was taped on the board. This procedure was to allow the patient to obtain a visual conception of his treatment from the colour and shape of the pills. In practice, this approach showed some limitations due to the high number of pills prescribed to each patient, which frightened some of them. Also, the patient had difficulties in associating a pill with its timetable. Hence, one of our patients saw on his board 12 pills, 7 of which were prescribed on a daily basis, plus five as a reserve. He got scared at the idea that he had to ingest so many chemicals and quitted "a group that told lies".
Some patients were quick to understand the nature of their treatment. However, forgetfulness became quickly an obstacle. For this reason it was necessary to go through reiterations which were adapted to the patients' limited capacity to take it so much information at once. We also noticed that we should not allow to much

speaking time to a given patient. The group leader had to be very active in conducting the debate, in order to keep the anxiety level, generated by each one's emotional stress, under control.
Following sessions: we decided to use a large board to note our explanatory comments. We drew schemes of intestinal blood absorption, blood exchange, pathways to brain and the drug's way to take effects at this level. The patients responded with an enthusiastic interest, immediately started to interact and ask multiple questions. Some of them even wanted to got to the board to prove they had understood everything, which was indeed the case for most of them.
We then decided to limit each session to the presentation of one type of drug (neuroleptics, sleeping pills, etc..).
Concerning the sleeping pills, it became obvious in the course of the discussion that most patients did not know when to take theirs. Here follows an illustrative sampling of a conversation :
Mrs. C. has been prescribed a sleeping pill for reserve use if insomnia.
« I take my sleeping pill every evening between 5 and 6 p.m. I then fell tired and go to sleep. The problem I do not understand why I wake up at 3 a.m." She said.
In this case, the problem was twofold : the patient misunderstanding was about the pill's intake timing and its use on a necessary basis only. The first point was easy to solve. We explain to Mrs C. that if she took her pill at 5 p.m. she would obviously wake up at 3 a.m., given the inherent kinetics of the drug. So she had to take her drug later. She had much more problems in understanding the concept of pills on reserve, for necessity use only. The comments of this patient are worth of mention. Indeed, she said in a following session :

« Now, doctor, I no longer take my sleeping pill every evening and try to go to bed a little later. However, I wake up at midnight so I can take my sleeping pill ! »
To summarise this case, we have made two mistake : the patient understood that she woke up at 3 a.m. above all because she was taking the pill at 5p.m.and not because she went to bed too early. Also, she did not integrate the concept of pill for reserve use at all, and she felt compelled to take her medicine at midnight. This case exemplifies the difficulties patients have in grasping concepts and forces us to word our comments very carefully, so that they are adjusted to the patient's cognitive ability.
We want to mention yet another case. In the course of a discussion on neuroleptics we happened to stress the relevance of a healthy life style during a long term treatment. We thus learned that one patient used to drink coffee and smoke a cigarette before going to bed and did not understand why she had problems with falling asleep; thus she had to take a sleeping pill every night! This generates a lot of explaining.
Also, discussions about alcohol interactions provided their share of surprises.

A patient who listened attentively our explanation about dangerous interactions between alcohol and drugs interrupted his treatment during the New Year holidays. Questioned about this, he answered, quite logically:
« You stressed the fact that drug and alcohol do not mix. I wanted to drink some champagne during the holidays. That is why I discontinued my treatment with neuroleptic".

c) Remarks
We noticed that the group discussion expanded to a wide range of topics, although its initial goal was to focus on problems linked to medication. This was also the case for ambulatory group and furthermore provided the opportunity to stress the importance of a healthy life style during the treatment. We have also been able to explain to the patients the symptoms they sometimes feel and do not understand.
As the sessions progressed, the patients got increasingly interested, opened to others and interactive. Thus a group dynamic took shape, creating a relaxed, even playful spirit. The group leader, who was initially invested in a rather professorial role, could later works in the group in a less formal fashion, thus permitting more meaningful interactions.
For the patients, the meetings became a privileged moment, impatiently looked upon and sorrowfully regretted when finished. Indeed the patients were keen on getting informed about their disease and medication. For them, the group provided them with the opportunity to finally express their needs and queries, and with the awareness of being listened to.
Intellectual disability and cognitive difficulties in our group sampling did not represent a limiting factor. These were far from preventing patients to become invested into a group and greatly benefit from it.

Conclusions

This article summarises the Geneva experience of a medication therapy group, which was geared towards a population with light to moderate intellectual disability associated with heterogeneous psychiatric morbidity. Although we lack some elements regarding the catamnesis of the participants, the above-described experience appears very positive and meaningful. The patients in the different groups have clearly showed their interest, their enthusiasm even, for this type of approach. They have participated actively in the sessions and displayed their activity in getting information they were never able to get beforehand.
It became soon obvious that we needed to broaden our original scope of discussing medication by introducing simplified notions on the human body, its functioning and general diseases. The debate even reached topics such as AIDS and death. This confirmed the interest of patients even though the intellectual disability prevented them from dealing with their own health.

In any case, the setting of a medicine group therapy proved an essential tool for multi-disciplinary patient car intellectual disability and heterogeneity in the psychiatric comorbidity were never a problem. On the contrary they were a source of enrichment and fulfilment. We shall conclude our observation by stating that this type of group is well suited for the intellectually disabled persons and should be developed within both ambulatory and hospital settings.

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