Nurses' management of a clubhouse model-based self-help group for people with depression

Original Article

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Abstract

This study aimed to elucidate, through mutual action research, the transformation process occurring in a newly launched clubhouse model-based self-help group (SHG), operated collaboratively between the staff (7 nurses) and members (9 people with depression), in its efforts to realize positive group operation. To understand the transformation process of the group, we accumulated data through semi-structured interviews and participant-observer study of actual practice and talks by the staff and members. Using the data, we reviewed the effective SHG management methods.

We performed qualitative descriptive analysis of data from the staff in phases 1, 2, and 3 and of data concerning the staff and members in phase 5. Data were coded and categorized for phase 4 when members started joining in SHG operation, phase 6 when the SHG was operated cooperatively by the staff and members, and SHG operation was performed mainly by members.

As a result, the following six phases were identified to constitute the transformation process: *Expression of the wish to establish an SHG for people with depression* (Phase 1); *Examination of ideal group operation* (Phase 2); *Determination of concrete methods for group operation* (Phase 3); *Stabilization of clubhouse model-based group operation* (Phase 4); *Shift to member-centered operation* (Phase 5); and *Clarification of issues via member-centered activities* (Phase 6). The results indicate that in the management of SHGs for people with depression, the use of the clubhouse model is effective for promoting members' autonomy via role assignment and for ensuring voluntary participation leads to continuous participation. The study further suggests that in order to operate effective SHGs, it is important for the staff to provide support at the members' pace, respect the space in which members can engage in dialogue among themselves, work to foster leadership and self-help abilities among members, and understand the cognitive characteristics of people with depression and support their behavioral vitality via group operation.

Key words

Major depressive disorder, Bipolar disorders, Self-help group,
Clubhouse model, Mutual action research

Introduction

In a growing number of people with depression, the relationships between depressive symptoms, suicide, and other factors have become a serious social problem in Japan, with national measures being undertaken[1]. Often people with depression are hospitalized for suicidal ideations and are subsequently discharged even though other symptoms have not resolved[2]. Further, compared to other psychiatric disorders, people with depression often attempt to return to work after brief inpatient treatment. However, given the fact that nearly half of community-dwelling people

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with depression experience suicidal ideation[3] and less than half of them can remain symptom-free for 2 years post-remission[4], depression is often a recurrent disorder requiring ongoing treatment and support. Yet Japan has an insufficient support system for people with depression: there have been widespread community-based self-help group activities for many chronic diseases and other psychiatric disorders, but few self-help groups for depression (SHGs).

Self-help group activities have evolved primarily in North America since the 1950's[5]. In Japan, they have been reported in the fields of medicine, social work, and psychology since the 1980's[6]. In the field of psychiatry, nursing professionals have taken part in the management of self-help groups for cancer[7] and chronic diseases[8], as well as for alcohol dependence[9] and drug dependence[10]. Certain self-help groups have established operational methods, with documented support contents and roles. In North America, SHGs (i.e. those specifically for people with depression) started from the late 1980's and are now incorporated in community-based care systems for depression[11]. The peer support these SHGs provide has been found to alleviate depressive symptoms among persons with mood disorders[12]. In Japan, reports on SHGs emerged in the 2000's, documenting the efficacy of sharing personal experiences[6] and reporting that when family members of persons with mood disorders participate in family groups, it leads to improved family relationships and stabilization of symptoms[11]. These reports, however, describe the effectiveness of SHG activities as perceived by the experts providing support for such groups–they are not based on the analysis of the viewpoints of the SHG participants suffering from depression. Previous research in Japan on support groups for vocational rehabilitation reported that support from peers, professionals, and the whole group influences the members' ability to return to work[13]. Further, a study on the experiences of SHG participants[14] reported that although SHGs contribute to symptom stabilization among members, they are often faced with operational challenges. It has also been reported that the positive operation of SHGs for people with psychiatric disabilities requires the involvement of professionals[15]. It would appear then that collaboration between the members and professionals is regarded as essential in operating an effective and sustainable SHG.

Research to date has not elucidated the operational methods or the transformation process that SHGs undergo to realize effective operation and there remains great variability in the group activities conducted as well as in the degree to which professionals are involved. The clubhouse model has been introduced to provide effective support for community-dwelling persons with psychiatric disability. With a goal of providing mutual support and employment support primarily for persons with schizophrenia, clubhouses operate at over 400 locations in 30 countries around the world and at 5 locations in Japan[16]. The clubhouse model has been widely researched overseas: clubhouses were found to provide meaningful opportunities for members to connect with others living with similar illnesses[17] and participation in a clubhouse has been found to be effective in increasing employment[18,19]. Research conducted in Japan includes an investigation into the staff-member relationship at a clubhouse[20] and a study examining the significance of clubhouses via analysis of the clubhouse unit activities[21].

Because the clubhouse model is based on member-centered operation and activities undertaken through collaboration of the members with professionals, we hypothesized that the model would maximize the efficacy of an SHG and lead to its positive operation. Therefore, we established an SHG based on the clubhouse model and in this study aimed to elucidate, through the use of mutual action research (MAR), the process of transformation in SHG operations over time in order to determine the characteristics of positive group operation.

Operational Definition

People with depression are an individual who have been diagnosed with major depressive disorder or bipolar disorders, or who have been treated for depressive symptoms.

The SHG in this study refers to a self-help group only for people with depression and is distinguished from groups for people with other background characteristics.

Methods

1. Study design

This study aimed to elucidate the transformation process of a clubhouse model-based SHG using the methods of MAR[22] (Figure 1), a process model that places a high value on the mutual interdependence between members and the staff. This approach was developed based on Margaret Newman's unitary-transformative paradigm[23]; that is, the perspective that "a human being is a unified whole that cannot be divided into parts or separated from his/her environment and that transforms suddenly when a change occurs to a phenomenon." This study viewed the transformation process as one where the members and the staff aimed to operate an ideal SHG while maintaining their mutual relationships within the space of the group.

2. Study participants

Study participants were 9 members (people with depression) (Table 1) who continuously attended the SHG and 7 staff (nurses) (Table 2) who acted as staff members on the SHG operating team.

3. Outline of the SHG

Launched in November 2010, the SHG, which was operated collaboratively by the members and the staff, had continuously met twice monthly in 2-hour sessions. Although the core activity of the SHG was group discussion, study groups on medical care and pharmacological treatment had been held irregularly. In 2010, there were 5 members and 22 trial members; in 2011, there were 12 members and 7 trial members; in 2012, there were 7 members and 8 trial members (as of the end of September).

4. Data collection period

Data were collected between November 2010, when the SHG was first established, and September 2012.

5. Data collection methods

1) Participant observation.

Participants' verbal and nonverbal behaviors during the SHG activities were observed. When questions arose during observation, informal interviews were conducted to better understand the meaning of the participants' verbal and nonverbal behaviors. Information obtained during participant observation was recorded in field notes, to be treated as study data. The SHG activities involved numerous verbal and nonverbal behaviors that were critical for understanding the study participants'
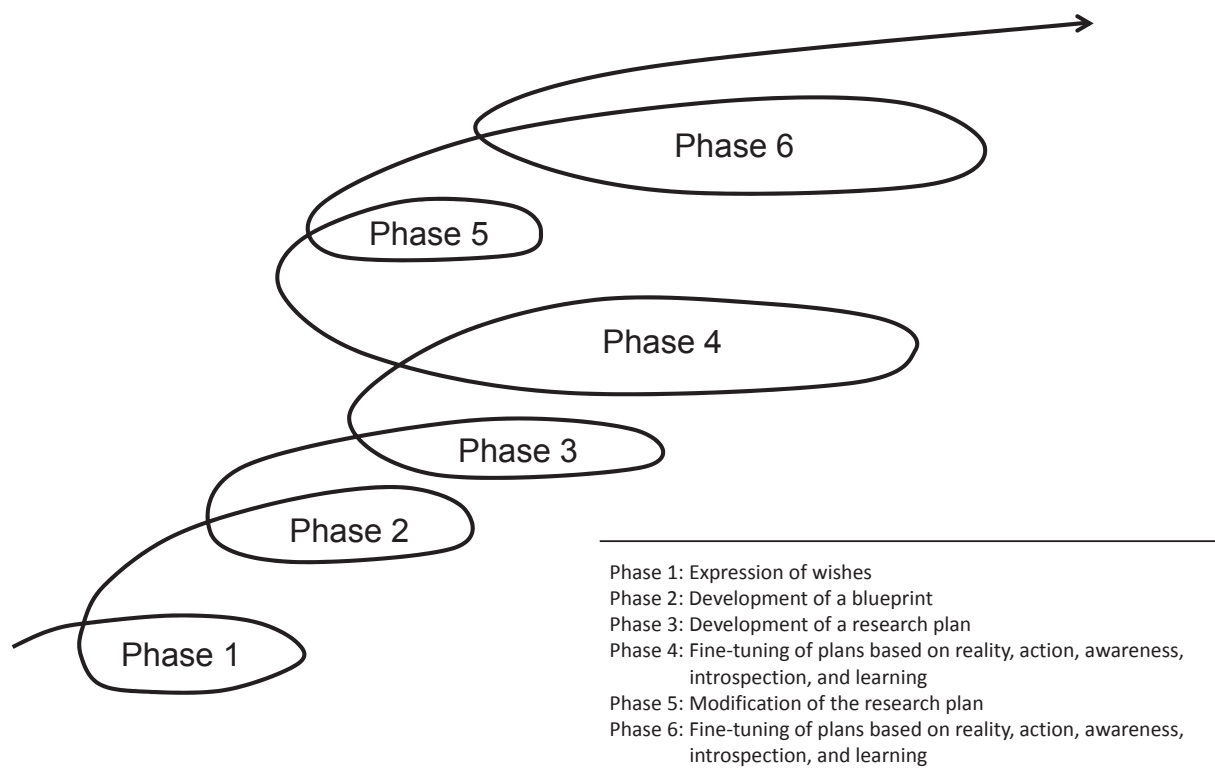

Phase 1: Expression of wishes
Phase 2: Development of a blueprint
Phase 3: Development of a research plan
Phase 4: Fine-tuning of plans based on reality, action, awareness, introspection, and learning
Phase 5: Modification of the research plan
Phase 6: Fine-tuning of plans based on reality, action, awareness, introspection, and learning

Figure1. The process of MAR (Endo, et al., 2001)

Table 1.　Characteristics of members at the start of the study

Participants	Sex	Age	Diagnosis	Duration of illness	Duration of group participation	Interview
A	Male	40s	Bipolar disorders	5	1 year and 2 months	○
B	Female	20s	Bipolar disorders	3	1 year and 2 months	○
C	Female	30s	Major depressive disorder	3	1 year and 8 months	○
D	Male	40s	Bipolar disorders	3	1year	○
E	Female	50s	Major depressive disorder	10	1 year and 8 months	×
F	Male	50s	Major depressive disorder	5	1 year and 6 months	×
G	Female	50s	Major depressive disorder	3	1 year and 8 months	×
H	Female	40s	Major depressive disorder	6	1year	×
I	Male	60s	Major depressive disorder	3	1 year and 5 months	×

Table 2. Characteristics of the staff at the start of the study

Staff	Job category	Years of clinical experience	Years of nursing experience
J	Nurse, Graduate	9	10
K	Researcher, Graduate	4	5
L	Nurse, Graduate	3	4
M	Nurse, Graduate	8	12
N	Researcher	26	44
O	Researcher	10	30
P	Researcher	2	15

experiences. Further, some of the participants gave consent to study participation, but not to a personal interview. Participant observation was chosen as a data collection method for this study, in order to take into consideration the psychological state of study participants.

2) Semi-structured interview.

Using an interview guide, a semi-structured interview was conducted once or twice with each participant who consented to it. The interview guide covered participants' opinions about the operation and activities of the SHG, as well as their experiences with the SHG. The interviews were tape-recorded and later transcribed verbatim, to be treated as study data.

6. Data analysis

The data were meticulously reviewed to extract, qualitative descriptive analysis the contents considered to be clearly an opinion regarding SHG operation, the degree of participation in the SHG, and so forth. The following 6 phases have been suggested for the process of MAR: Expression of wishes (Phase 1); Development of a blueprint (Phase 2); Development of a research plan (Phase 3); Fine-tuning of plans based on reality, action, awareness, introspection, and learning (Phase 4); Modification

of the research plan (Phase 5); and again, Fine-tuning of plans based on reality, action, awareness, introspection, and learning (Phase 6)[22]. In accordance with the process of MAR and paying close attention to the transformation process of the present SHG, we performed qualitative analysis of data from the staff in phases 1, 2, and 3 and of data concerning the staff and members in phase 5. Data were coded and categorized for phase 4 when members started joining in SHG operation, phase 6 when the SHG was operated cooperatively by members and the staff, and SHG operation was performed mainly by members. Then, each of the phases was named after examining the meaning of the perceptual and behavioral changes found to be associated with it. Further, the MAR-based group transformation process in this study was summarized in a schematized diagram. In general, hermeneutic analysis is performed in MAR[22]. However, during the 2-year operation of the SHG by members and the staff, we accumulated sufficiently detailed data on the actual transformation process of the SHG's operations and members' stories, without relying on hermeneutic analysis. We therefore decided that it would be possible using a qualitative descriptive analysis method to obtain data that reflect the study results accurately and to present the reality of the process of operating the SHG.

The analytical content was shown to the study participants for the purpose of confirmation and supplementation. In order to ensure reliability and validity of the study, data analysis was conducted under close supervision by a researcher who had over 20 years of clinical experience in psychiatric wards and who specialized in education and qualitative research in psychiatric nursing. In addition, several

psychiatric nursing experts and nurses at the interview site were consulted and discussions were held among them to verify the results.

7. Ethical considerations

The study was conducted with the approval of the Medical Ethics Committee of Kanazawa University (Approval number: 327). Participants were informed that study participation was voluntary and refusing to participate would not result in any disadvantages or impact their SHG participation. Before their consent was obtained, study participants received further explanation, both orally and in writing, that, for example, the data would be anonymized, stored securely, and destroyed immediately upon conclusion of the study to protect participant privacy and that the study results were to be published.

Results

The following six phases were identified to constitute the MAR process in the present study: *Expression of the wish to establish an SHG for patients with depression* (Phase 1); *Examination of ideal group operation* (Phase 2); *Determination of concrete methods for group operation* (Phase 3); *Stabilization of clubhouse model-based group operation* (Phase 4); *Shift to member-centered operation* (Phase 5); and *Clarification of issues via member-centered activities* (Phase 6). Each of the phases will be described below. With regard to Phases 1, 2, 3, and 5, details of the examination will be noted. As for Phases 4 and 6, the categories for which practice contents were ascertained will be noted as [ ].

1. Phase 1: *Expression of the wish to establish an SHG for patients with depression* (preparation phase for establishing the SHG: November 2010).

Although SHGs were regarded as an effective approach to helping people with depression, there were only a few SHGs in Japan and they varied in terms of operational methods, activities, the involvement of professionals, and so forth. Moreover, the nature of the activities practiced remained unclear. Here the staff decided to develop an SHG that could, via member-centered group operation, contribute to recovery and symptom stabilization in people with depression. To realize this goal, an operating

team was established, consisting of researchers and graduate students in the field of psychiatric nursing.

2. Phase 2: *Examination of ideal group operation* (preparation phase for establishing the SHG: November 2010).

Previous research[14,15] has found that group operation spearheaded by professionals did not foster autonomy among people with depression and couldn't take advantage of the assets of the SHG, and conversely that an SHG operated solely by people with depression was ineffective due to the vagueness of their understanding of the illness or SHG operation and because it was difficult to sustain due to the burden of group operation. For these reasons, collaboration with professionals, who understood the vulnerabilities of people with depression and assumed a supportive role, was considered critical to establish effective SHG operation. The MAR in this study, therefore, attempted to operate an SHG based on the clubhouse model—a psychiatric rehabilitation program that has been effectively practiced in many countries around the world. The goal was effective SHG operation through collaboration between the staff and members, with a strong focus on member autonomy.

3. Phase 3: *Determination of concrete methods for group operation* (preparation phase for establishing the SHG: November 2010).

To implement SHG operation based on the blueprint developed in Phase 2, the ways to practice clubhouse model-based activities were explored. The International Standards for Clubhouse Programs (ISCP) were examined: 23 of the 36 Standards (excluding items on employment, transitional employment, frequency of meeting, etc.) were judged to be applicable, and modified bylaws were developed for the SHG (Table 3). Further, the staff examined program contents and operating rules for the SHG (Table 4) and drafted an operating plan. In terms of the staff's basic involvement in the SHG, an agreement was reached within the operating team, based on Hasegawa's findings[20] to (1) promote self-determination, (2) promote equal relationships, (3) increase motivation for participation, (4) place a high value on roles, (5) strengthen camaraderie, and (6) support practical activities.

Table3. International Standards for Clubhouse Programs vs. the Bylaws of our SHG

Clubhouse	Our SHG
Membership ・All members have equal access to every Clubhouse opportunity with no differentiation based on diagnosis or level of functioning. ・Members have a right to immediate re-entry into the Clubhouse community after any length of absence, unless their return poses a threat to the Clubhouse community. Relationships ・All Clubhouse meetings are open to both members and staff. There are no formal member only meetings or formal staff only meetings where program decisions and member issues are discussed. Work-ordered day ・The Clubhouse is open at least five days a week. The work-ordered day parallels typical working hours.	Membership ・Members have a right to immediate re-entry into the Group after any length of absence. Relationships ・All Clubhouse meetings are open to both members and staff. There are no formal member only meetings or formal staff only meetings where program decisions and member issues are discussed. ・Group activities are run by staff and members. Management staff and members will cooperate with each other. Management ・The Clubhouse is open twice a month (Saturday).

<div align="right">Japan Clubhouse Coaltion24), Rules of our SHG</div>

Table 4. Operating rules of our SHG

Flow of activities	Relationship between staff and members
① Recent report, Self-introductions ② Deciding the theme ③ Group discussion (or lecture)	・Cooperation in management roles ・Staff support the burden on members ・Considering the maturity of the group, management is transferred gradually from staff to the group's principal members

Table 5. Categories identified in Phase 4

Categories	Sub-categories	Discourses
Unable to autonomously participate in the operation of the group due to unstable physical condition	・Symptoms affect the activities ・Understanding of symptoms of depression requires effort	*A: I'm not sure if I'm allowed to come to the group when manic.*
Unable to figure out how to run the SHG	・Can't figure out how to run the group independently ・Can't help but rely on the staff or other members ・Can't welcome new members ・Growing bored with the activities	*A: I think it'd be a huge burden to fill the staff's roles. So I think I can kind of understand when the staff says, "Let's make sure that each member is clear about⋯." But then, it'd probably be difficult to actually do it.*
Desire to foster the group as a venue to guide recovery	・It's been established as a place for open dialogues ・Would like to link group operation with confidence for symptom stabilization and recovery	*C: It makes me feel that I'm not alone. That feeling alone gives me such a relief⋯when I realize that others are struggling, too, coping with the illness. It's not absolute like A was caused by B, it's that I'm not alone⋯how can I describe it, well, I can't explain it well, but it's really significant.* *E: It's like, the more you do it, the better at it you become. Gradually⋯ not like a role or anything, but again, it will be nice if, like that, I could gradually step toward community integration .*

4. Phase 4: *Stabilization of clubhouse model-based group operation* (Sessions 1–48: November 2010–February 2012) (Table 5).

Based on the research plan developed in Phase 3, the staff and members opened the SHG. Although group membership had been gradually stabilizing, many members discontinued SHG participation. During this time, SHG activities were unstable and varied according to which members participated; the staff-centered group operation was inevitable.

In Phase 4, the best that members could do was to continue attending the SHG and deepen their understanding of depressive symptoms; they were [*unable to autonomously participate in the operation of the group due to unstable physical condition*]. Operated by trial and error, meanwhile, the SHG gradually established itself as a place where the members could freely exchange opinions. The members were able to increase their understanding of depressive symptoms and use the knowledge in their recovery. As for the initial goal of member-centered operation, however, the members were [*unable to figure out how to run the SHG*] due to their poor understanding of the operational methods as well as their expectations for or dependency on other members or on the staff. On the other hand, with the

stabilization of group activities and membership, the members gradually came to address their concerns for being unable to include new members in some activities and growing bored with the activities. In addition, during this phase, a few members demonstrated their leadership role by participating in the activities regularly and actively sharing their opinions about SHG operation. However, despite their [*desire to foster the group as a venue to guide recovery*], they remained unclear about how to actually run the activities and unable to operate them positively.

5. Phase 5: *Shift to member-centered operation* (Sessions 49 and 50: March 2012).

In Phase 4, how to actually develop the activities remained unclear, although the staff and members understood principles of the clubhouse model. As a result, using clubhouse unit activities as a guide, each of the members was assigned a role for SHG operation (Table 6). Further, as membership became further stabilized, the staff and members mutually agreed that the operating base should be shifted to the members, with the staff taking a more supportive role, in order to actualize member-centered activities. Furthermore, in order to improve their skills for SHG operation, the members learned more about SHG

via interactions with other groups and the staff and members planned and implemented several study groups (Table 7) to better understand the symptoms of depression.

6. Phase 6: *Clarification of issues via member-centered activities* (Sessions 51–59: April-September 2012).(Table 8)

Group operation was re-launched based on the research plan modified in Phase 5. As the members continued to perform the role assigned using the clubhouse unit activities as a guide, the members came to express, for example, that "it feels more like we're running the activities ourselves," "The assignment role has increased my motivation to participate in the activities," and they became [*able to participate in the SHG autonomously because of role assignment*]. Further, an increasing number of members came to want an equal relationship with the staff and mutual support among the members, and they felt that there was [*an equal relationship between the members and the staff*]. Some members, however, felt burdened mentally by the role assigned to them and were [*worried about being able to perform the assigned role*]. Further, many members were [*worried about running the activities on our own*], questioning the gap among the members in the

Table 6. Examples of clubhouse unit activities vs. role assignment in the SHG

Clubhouse	Our SHG
[Kitchen unit] Preparation and lunch, Accounting of food, Tea room, Laundry [Office unit] Newsletters issue, Managing attendance record of members, Accounting office operating costs, Blog updates [Unit receptionist] Reception , Telephone answering [Free unit] Members spend according to their physical condition	[MC] Receive others, check the roster, collect dues, act as moderator [Refreshments] Purchase tea and sweets, accounting for refreshments [Accounting] Accounting [Create schedule] Create activity schedule on paper [Blog update] Update the blog [Recording] Create activity log [Free] Devoted support of other roles

Clubhouse activities were created with reference to the homepage peer station in Yu[25]

Table 7. Topics for study groups

Topic	Instructor	Content
Dealing with depression	Staff	Symptoms of depression, How to deal with symptoms
Cognitive behavioral therapy	Staff	Concept of cognitive behavioral therapy
SHG for depression	A leader of SHG	Introduction to methods of operation of the group and challenges
Medicine	Pharmacist	The medicine used in psychiatry

Table 8. Categories identified in Phase 6

Categories	Sub-categories	Discourses
Able to participate autonomously because of role assignment	・Working on performing the assigned role ・Role assignment has enabled me to participate in activities autonomously	*D：I thought it would be a challenge for those not doing well. But while some people are having bad symptoms, there are others in remission, so it can work if people doing well can cover for them.*
Worried about being able to perform the assigned role	・It's not easy to do even if the role is assigned ・Worried that participation in the activities might exacerbate my symptoms	*A：It could just be me, but I feel the pressure to do a perfect job even when I'm assigned a simple task.*
An equal relationship between the members and the staff	・An equal relationship is forming between the members and the staff ・Want mutual support among the members	*D：When someone presents a problem in the group, we first want to help alleviate their suffering. Then, as the person gradually becomes familiar with the group, they can start assuming a role and help to grow this group…I think that's the goal.*
Worried about running the activities on our own	・Still depend on the staff for difficult tasks. ・Members vary in their degree of autonomy ・Still not confident about running the activities on our own ・Don't know how to develop group operation in the future	*B: Some members are just…not like a wall, but I sense that they always expect the staff to do things for them because they're nurses .* *D：There is a growing sense of unity among us, like, "Let's do it together"; but I think the reality is, if told to manage the operation of the group by ourselves, we'd hesitate and go, "What?"*
Hope for group operation	・Would like to continue appreciating the principles of the clubhouse model ・Need to make the activities known	*F：One of the points is that I want others who are suffering to also understand. I think that's why we're facing stumbling blocks on the issue of making announcements. Something's got to be done…I think that is one of the issues to be addressed.*

degree of participation in SHG operation, recognizing that members had no choice but to depend on the staff to some degree, or feeling apprehensive about the members' ability to independently guide the operation of the group. By this time, however, the group had been established as an indispensable venue

of hope for recovery. Despite an absence of clear and concrete guidelines, the members continue to operate the group, carrying a [*hope for group operation*], namely, the desire for the group to grow by gaining new members and appreciating the principles of the clubhouse model.
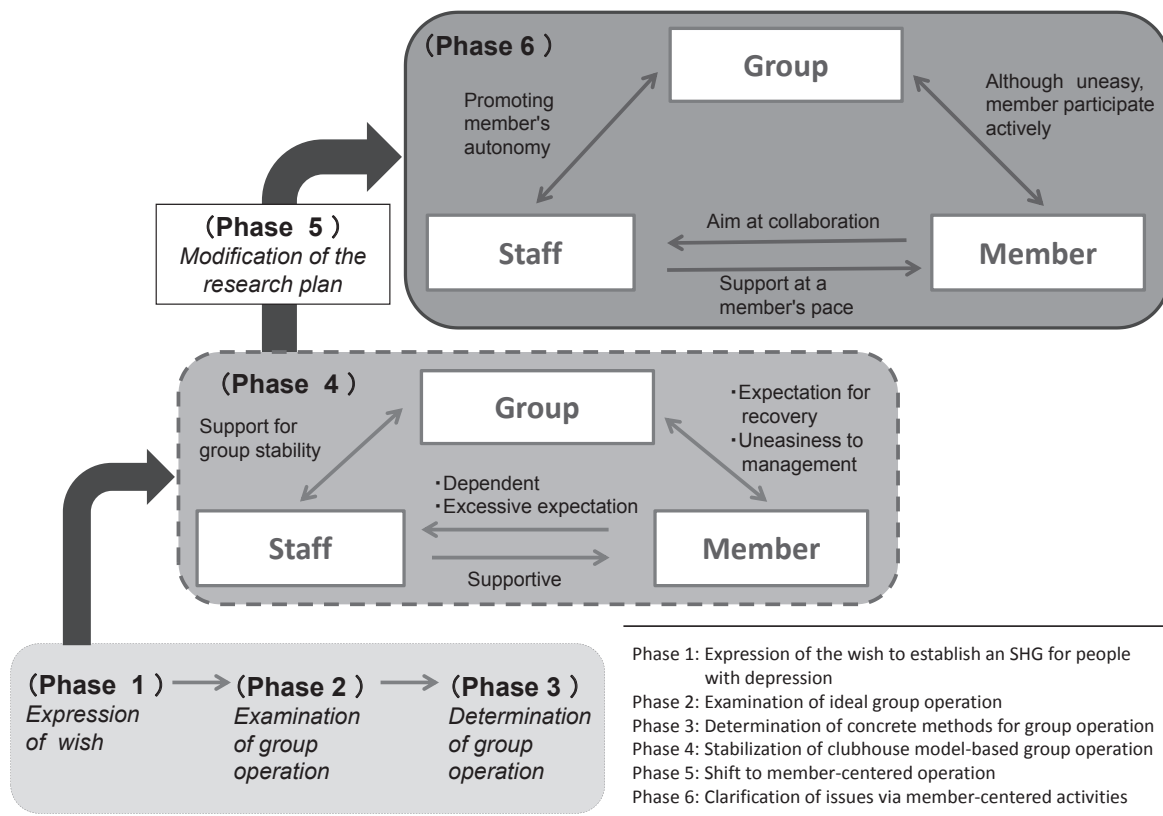

Figure 2. The process of MAR in this study

Discussion

This study is unique in its focus on people with depression and on a clubhouse model-based SHG operated through collaboration between the staff and members. The transformation process the SHG went through will now be discussed in detail.

1. Efficacy of clubhouse-based SHG operation

The goal of the clubhouse model is to provide mutual support and employment support[16]. The SHG in this study, however, did not offer programs for direct employment support because many of the working-age members had already returned to work or had been doing job searches on their own at the point of achieving a certain degree of recovery. The status of the members of the SHG suggested that people with depression have the capacity for community reintegration once a normal physical condition is regained. In addition, some of the members were housewives or were retired and did not necessarily have the desire to return to work. Therefore, the activities of the SHG in this study were focused on member-centered mutual support. As a result, each of the members felt that sharing his/her personal experiences was helpful to others' recovery and had come to regard the SHG as a place where he/she belonged because of the role he/she was assigned to help operate the group. The assignment of concrete roles derived from clubhouse unit activities (during Phase 5) was especially helpful to elicit autonomy in the members. People with depression often are "absolutely dependent on the object of dependency" and have "a strong sense of duty" [26]. During phase 4 in which the roles were not clearly specified, the members had high levels of expectations for or dependency on the staff and were not capable of member-centered operation. However, program stabilization and role assignment brought out their "strong sense of duty" and enabled many members to actively participate in the SHG operation (phase 5 to phase 6). These observations suggest that stabilization of a clubhouse model-based program, where members and the staff can work collaboratively, and role assignment are effective for making the most of the assets of those with depression and promoting their autonomy. On the other hand, the members continued to feel [*worried about being able to perform the assigned role*] and [*worried about running the activities on our own*] even when they actually were performing their role, indicating that it is important for the staff to understand the characteristics of such members and provide continuous support to them.

According to previous research, conscious use of positive self-appraisal is effective in recovering from low self-esteem[27], and having someone who is understanding and supportive leads to a sense of purpose in life[28]. It is surmised that when the members, regardless of task difficulty, feel that they are fulfilling the duties of their clearly-defined role, their positive self-appraisal is increased, while mutual support elicits a sense of purpose in life. Further, collaborating with the staff and fulfilling their role, the members did in fact operate the SHG autonomously. This is consistent with the assertion by Hamada et al.[29] that members need to experience the feelings of being helpful to others in the community and possess the strength to actually do so, while health care professionals must trust their strength to help others in the community and provide support.

In accordance with the ISCP, the SHG members also agreed that they "could return to the group any time, regardless of how long they had been absent": this allowed some members to return to the SHG after an absence due to returning to work or because of exacerbated physical health problems. This assurance appeared to be effective for the members' continuous participation, for people with depression often go through cycles of symptom exacerbation and remission, obtaining a job and resigning or being reinstated and leaving.

Although incorporating the clubhouse model produced the aforementioned benefits, SHG operation in the present study was a fragmented application of the clubhouse model; therefore, it must be distinguished from clubhouse activities that are practiced internationally at present. Future efforts are needed to ascertain the Standards of the ISCP that are applicable to groups for people with depression; the findings should assist with the standardization of SHGs for depression.

2. Indication for effective SHG operation

In the present study, SHG activities spend for many hours at phase 4 and membership became stabilized

because people with depression characteristically have "a strong sense of duty" and are "over-conscientious" and "absolutely dependent on the object of dependency" [26]. Demanding member-centered group operation before the SHG had achieved a certain degree of stabilization would have resulted in imposing a burden to participate in the group out of "a strong sense of duty" and "over-conscientiousness." Further, it was also expected that continuing to run the SHG with the goal of mutual collaboration between the staff and members—while experiencing such a burden—would instead result in "absolute dependence on the object of dependency" (i.e., the staff), leading to decreased member autonomy as well as SHG effectiveness. Indeed, some members in the present study reported being [*unable to autonomously participate in the operation of the group due to unstable physical condition*] or [*unable to figure out how to run the SHG*] during Phase 4. Because of this, it was necessary for the staff and members to hold extensive discussions to determine the timing for initiating the MAR process and for transitioning to the next phase. It has previously been reported that for an SHG to become a place where an individual with psychiatric disability belongs, "others in the place acknowledge his presence, and although he initially was unable to perceive it as a place of belonging, he never hesitated going there or felt uncomfortable being there" [29]; therefore, special efforts were made for member-centered group operation not to burden individual members, which is likely to have allowed smooth transitions between the phases as well as a stepwise transition into member-centered SHG operation. In this study, however, the members continued to report being [*worried about being able to perform the assigned role*] in Phase 6, when the SHG had been in operation for some time; therefore, the staff must be aware that members experience chronic anxiety throughout the process of group maturation. According to Newman [30], "the client and the environment follow a pattern of evolving as a unified whole; the role of the nurse is to facilitate, via caring, the client's awareness of this pattern and health is a process of transformation into more comprehensive consciousness." In the present study, the staff facilitated the transformation

into an autonomous SHG operation by providing support at the members' pace. This suggests that it is critical that nurses who have a good understanding of the characteristics of people with depression (i.e., tendencies to be anxious or dependent) provide support at the members' pace.

The members' endorsement of being [*unable to autonomously participate in the operation of the group due to unstable physical condition*] during Phase 4 reflects the fact that the instability of depressive symptoms underlies their anxiety. In the clubhouse model, member contact is often made by professional social workers. In the present study, however, nurses—who are health care professionals—answered the members' questions about symptoms to increase their understanding of depressive symptoms and provided advice on the need for medication, anxiety about recurrence, and so forth from a medical/health point of view. The study demonstrates that in the operation of an SHG, nurses can effectively reduce anxiety among the members with depression by providing continuous support.

The purpose of the SHG in this study was not to provide vocational rehabilitation (such as that offered at day care, etc.) [31] or training aimed at community reintegration [11] described in previous research; it instead focused on activities in which the members could feel free to participate and have open dialogues. It has been reported that individuals who have recovered from depression often have someone or an environment that acts as the "receiver" when they give vent to their true feelings [32]; there is a high likelihood that the SHG in this study offered such a space. Unlike SHGs aimed at providing day care or training (which are often short-term and limited to the transition period between treatment and community integration), SHGs that allow the members to participate at any time, regardless of their condition—even when symptoms are exacerbated or after community integration has been achieved—would prove to be a significant place of belonging. Furthermore, it was surmised that the interactions between members who have recovered and those in recovery promote hands-on learning and hope for recovery, eliciting the [*desire to foster the group as a venue to guide recovery*] in Phase 4 and eventually

improving the efficacy of the group.

As addressed in Phase 6, however, positive operation of the SHG requires overcoming the issues that make the members [*worried about running the activities on our own*] (e.g., how to increase autonomous participation among members, how to recruit new members); the group must also endeavor to realize the [*hope for group operation*] (e.g., further integration of the clubhouse model, recruitment of new members). The SHG was faced with these issues at the time of study completion and has yet to resolve problems associated with irregular participation among new members and diminished opportunities for participation for some core members due to community integration. Usual clubhouses offer activities every weekday to foster leadership among members and gradually build a foundation for mutual support. In the present SHG, core members who came to assume a central role by participating in the group activities over a long period of time often ended up disengaging themselves from the group because of recovery, employment, and other factors. Development of new leaders is a challenge because the activities are not as frequent as clubhouses; in such instances, the staff act as substitute leaders while focusing on the process to foster leadership among the members and promote stabilization of participation among new members. A previous study[14] reported that leadership by a member with stabilized depressive symptoms is essential to SHG operation aimed at membership stabilization, and that efforts should be made to improve, among the members, self-help abilities leading to symptom stabilization. As a specific measure to realize such efforts, the SHG implemented several study groups during Phase 5; these study groups proved to be highly meaningful and enabled a smooth transition to Phase 6.

Cognitive therapy is currently attracting much attention as a therapeutic approach to supporting people with depression. Although its core focus is on cognition, cognitive therapy also has behavioral components. On the cognitive side, a pattern of "cognitive distortions" are explored from various points of view to broaden one's way of thinking and make it more balanced; the use of the behavioral approach brings a synergistic effect[33]. The use

of cognitive therapy not only by doctors and psychologists, but also by nurses has been reported[33]. Identified in the transformation process of the SHG in the present study were cognitive characteristics of persons experiencing depression; during Phase 4, for example, the members reported being [*unable to figure out how to run the SHG*] due to their expectations for or dependency on the staff or on other members. In dealing with this cognition, the members sought out various opinions from others via continuous participation in the SHG, broadened their way of thinking, and gradually transformed it into a more balanced one. Further, despite their anxieties about their physical condition and apprehension about continuing their participation in the group, members were able to increase self-confidence gradually by coming back to the group. Consequently in Phase 6, they reached a point where they reported having [*an equal relationship between the members and the staff*] and being [*able to participate in the SHG autonomously because of role assignment*], while continuing to experience lack of confidence in member autonomy or in their own ability to perform assigned roles. This may suggest that the process of SHG operation itself has demonstrated a therapeutic effect seen in cognitive therapy. Based upon the foregoing, continued collaborative efforts between the staff and members to identify the issues and explore effective SHG operation could bring therapeutic effects for people with depression and contribute to their recovery or symptom stabilization.

Conclusions

1. The study established a clubhouse model-based SHG in an attempt to elucidate, using the methods of MAR, the transformation process of an SHG launched and operated collaboratively between the staff and members. As a result, the following six phases were identified to constitute the transformation process: *Expression of the wish to establish an SHG for patients with depression* (Phase 1); *Examination of ideal group operation* (Phase 2); *Determination of concrete methods for group operation* (Phase 3); *Stabilization of clubhouse model-based group operation* (Phase 4); *Shift to member-centered operation* (Phase 5); and *Clarification of issues via*

member-centered activities (Phase 6).

2. The study demonstrated that integration of the clubhouse model brings the following benefits to SHG operation: member autonomy can be increased via role assignment, and ensuring voluntary participation to accommodate the members' physical conditions effectively increases continuous participation. Future efforts need to ascertain the Standards of the ISCP that are applicable to groups for people with depression in order to standardize SHG operation.

3. For effective SHG operation, it is critical that nurses who have a good understanding of the characteristics of people with depression provide support at the members' pace.

4. In order to realize positive SHG operation, it is important for the staff to respect the space in which members can engage in dialogue amongst themselves and to endeavor to foster leadership and self-help abilities among the members.

Study Limitations and Future Directions

This study analyzed data that were collected within a restricted field (i.e., a group); it is important, therefore, to consider the possibility of bias in the sample as well as the analytical content. Further, the SHG was operated based on the protocol developed by the researchers, which limits the generalizability of results. In addition, maturity of the group may have impacted the results, as the data were collected during the 1st through 3rd years after the SHG was launched. Future research needs to employ a longitudinal study design and improve the quality of data collected in order to identify the foundations of group operation and investigate their effects.

Acknowledgement

References

1) Ministry of Health, Labour, and Welfare: Outlines for comprehensive measures to prevent suicide and depression. http://www.mhlw.go.jp/bunya/shougaihoken/jisatsu/torimatome.html (downloaded April 28, 2012)

2) Suzuki Y., Kobayashi C.,Yamakechi J.: Depression nursing based on nursing research, kokorono kangogaku, 4(1):69-76, 2003 (in Japanese)

3) Koyama, T., Tajima, M., Igarashi, Y., et al.: Suicide ideation in patients with mood disorder and consultation to psychiatrists. Rinsyo Seishin Igaku, 36(10), 1311-1314, 2007 (in Japanese)

4) Fujita A., Eguchi M., Nakano Y., et al: Long-term course of depression, Rinsyo Seishin Igaku, 34(5):669-675, 2005 (in Japanese)

5) Katz A. H: Self Help in America, Kubo H. translator, Iwasakigakujyutsushuppan. pp42-44, 1997(in Japanese)

6) Kubo Y.: Actual conditions of self-help groups for depression, Rinsho Kango 34(5):761-766, 2008 (in Japanese)

7) Terasaki A., Mase Y., Tsuji K.: Relationship between factors support from self-help groups and ways of coping with stress in laryngectomees, Jpn J Nurs Sci, 26(4):37-45, 2006 (in Japanese)

8) Omote S, Sugimori F., Saeki K., et al.: Meaning that participants are found in patients with rheumatoid meeting; An interview of rheumatoid difficult to walk, Tsuruma Health Sci Soc Kanazawa Univ, 29(1):77-83, 2005 (in Japanese)

9) Katamaru M., Kageyama S.: Difficulty in the recovering process of female alcoholics and the experience among female members, J Jpn Acd Psychi Ment Health Nurs, 17(1):82-92, 2008 (in Japanese)

10) Nishikawa K.: A study on support group for families with drug problems; Aims of support and examination of group participators' situation, J Alcohol Stud Drug Depend, 43(5):720-735, 2008(in Japanese)

11) Yamaguchi R.: MDA-JAPAN as social support, Rinsyo Kango, 31(1):29-34, 2005 (in Japanese)

12) Pfeiffer P.N., Heisler M., Piette J.D., et al.: Efficacy of peer support interventions for depression a meta-analysis. Gen Hosp Psychi, 33(1): 29-36, 2010

13) Harada Y., Kageyama S.: Influences of a support group on women with depression aiming at reinstatement into the workplace; From experiences of women with depression in a support group, Jpn J Nurs Sci, 29(4):98-108,2009 (in Japanese)

14) Oe M., Hasegawa M.: The experience of depression patients participating in self help group, J Jpn Acad Psychi Ment Health Nurs, 21(2):11-20, 2012 (in Japanese)

15) Tanimoto C., Hasegawa M.: Requirements for successful self-help groups in mental health, Tsuruma Health Sci Soc Kanazawa Univ, 32(2): 1-10, 2009

16) Kato D.: Clubhouse model promoting participation and collaboration; Possibilities for open community and open communication, J Hum Well-Being, 5(1):85-93, 2005 (in Japanese)

17) Carolan M., Onaga E., Pernice-Duca F., Jimenez T.: A place to be; The role of clubhouses in facilitating social support. Psychi Rehabili J, 35 (2): 125-132, 2011

18) Schonebaum A, Boyd J: Work-orderd day as a catalyst of competitive employment success. Psychi Rehabili J, 35(5): 391-395, 2012

19) Tsang AW, Ng RM, Yip KC: A six-month prospective case-controlled study of the clubhouse rehabilitation model on Chinese patients with chronic schizophrenia. East Asian Arch Psychi, 20(1): 23-30, 2010

20) Hasegawa M.: Staff characteristics for support of people with mental disorders at the clubhouse, J Jpn Acad Psychi Ment Health Nurs, 11(1):10-18, 2002 (in Japanese)

21) Kato D.: Significance of clubhouse model, Jpn Soc Psychi Rehabi, 10(2):161-127, 2006 (in Japanese)

22) Endo E., Nitta N.: Action Research in Nursing: Theory of mutual action research, Kango kenkyu, 34(6)17-22, 2001 (in Japanese)

23) Newman M.A.: Health as Expanding Consciousness, 2nd Ed., Teshima M., translator.
pp69-81, Igakushoin, 1995 (in Japanese)

24) Japan Clubhouse: Clubhouse international standard, http://www.clubhouse.or.jp/cat2/. (downloaded January 26, 2013) (in Japanese) http://www.mhlw.go.jp/bunya/shougaihoken/jisatsu/torimatome.htm

25) Peer Station Yu: Unit activity, http://web1.kcn.jp/narayui/yu-index.htm. (downloaded January 26, 2013) (in Japanese)

26) Okada Y.: The relationship between cognitive characteristics and symptoms in female patients with depression, Jpn J Nurs Sci, 26(4):93-101, 2006 (in Japanese)

27) Kunikata H.: Structure of mind, body and behavior in persons with psychiatric illness with low self-esteem, Jpn J Nurs Sci, 30(4):36-45, 2010 (in Japanese)

28) Sakai I., Mizuno E.: Purpose of life of people with mental illness living in the community, Jpn J Nurs Sci, 31(3):32-41, 2011 (in Japanese)

29) Hamada K., Tsutsumi Y.: Actual condition of creating a place to belong (ibasho) and subsequent gaining of self-motivation in the mentally challenged, J Jpn Acad Psychi Ment Health Nurs, 19(2):22-32, 2010 (in Japanese)

30) Newman M.A.: Transforming presence; The difference that nursing makes. Endo E., Kubo S., Takagi M., Minegishi H., Morota N., translators. Igakushoin, pp11-23, 2009 (in Japanese)

31) Oki Y., Igarashi Y.: Outcomes of a rework program to help people with depression return to work, Depress Front, 10(2):79-85, 2012 (in Japanese)

32) Chikada M.: The transition in "the way of living" among people recovered from depression; From "Situierung" point of view, J Jpn Acad Psychi Ment Health Nurs, 18(1):94-103, 2009 (in Japanese)

33) Okada Y.: A literature review of nursing research on effects of cognitive therapy written in English, J Jpn Acad Psychi Ment Health Nurs, 11(1):1-9, 2002 (in Japanese)

看護師によるクラブハウスモデルを基盤としたうつ病者の当事者グループ運営

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要　　旨

　うつ病者と看護師の協働により運営するクラブハウスモデルを基盤とした当事者グループの変容過程を明らかにすることを目的とし、ミューチュアルアクションリサーチを行った。SHG に参加するスタッフ (看護師 7 名) とメンバー (うつ病者 9 名) の実践や語りを参加観察と半構造化面接により収集したものをデータとし、グループの変容過程を明らかにした。そして、その結果から有効な SHG 運営の方法について検討した。

　局面 1、2 および 3 はスタッフが検討した結果について、局面 5 はスタッフとメンバーが検討した内容のデータを質的記述的に分析した。メンバーが SHG への参加を開始し、メンバーとスタッフの協働による SHG 運営の実践段階に移行した局面 4 と、スタッフとメンバーとの協働により、メンバー中心の SHG 運営を実践した局面 6 は、データをコード化、カテゴリー化した。

　その結果、【局面 1】うつ病者の当事者グループ設立への願いの表明、【局面 2】理想のグループ運営の在り方の検討、【局面 3】具体的なグループ運営方法の決定、【局面 4】クラブハウスモデルを基盤としたグループ運営の固定化、【局面 5】メンバー主体の運営への移行、【局面 6】メンバー主体の活動による課題の明確化の 6 局面の変容過程が明らかとなった。

　本研究から、うつ病者を対象としたグループ運営を効果的に実践するためには、クラブハウスモデルを用いることで、メンバーが役割を担うことによる主体性を引き出すこと、自由な参加の保障が参加継続につながることが示唆された。さらに、効果的なグループ運営には、スタッフがメンバーのペースに寄り添ったサポートを行うことが重要であること、当事者同士が語り合える場所としての意義を尊重すること、リーダーの育成やセルフヘルプ能力向上に向けた取り組みを行うこと、うつ病者の認知の特徴を理解し、グループの運営を通して行動面へのアプローチを支えていくことが求められることが示唆された。