

A structured problem-solving group for psychiatric inpatients

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Abstract: *The problem-solving group was used on an 18-bedded male acute inpatient ward. The aim was to provide a therapeutic activity to all patients which would teach them basic problem-solving skills as well as providing stimulation and social contact, and helping improve concentration and reasoning. Preparation was of great importance, both in terms of the materials used and encouragement of patients to attend. Each session lasted 30 minutes and followed the same format. Patients were given a written problem scenario and asked to first identify the problem, then generate possible solutions, and then discuss the advantages and disadvantages of the solutions. Two group facilitators were necessary to help keep to the format, encourage participation and deal with any problems that arose. The group was accepted well by patients and attendance varied with up to eight patients at any one session.*

Keywords: *problem solving; groupwork; problem scenarios; schizophrenia; inpatients*

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Introduction

Providing psychological therapy for psychiatric inpatients is not easy. Since most patients can be adequately looked after in the community, inpatient treatment is only used for those with the most acute or intractable problems. On the average ward, patients with any combination of complex problems are likely to be found, including schizophrenia, bipolar disorder, personality problems, forensic issues, drug dependency or alcohol problems, and a substantial proportion of individuals will be in the acute phase of illness. Furthermore, wards are likely to be locked at most times, with many patients confined to the ward and left with little more than the television and fellow-patients for company.

These factors make it difficult to provide accessible therapy options to all patients regardless of diagnosis. The Problem-Solving Group is one example of a group activity that can be offered to almost all patients, if facilitated by an experienced staff member. This paper describes how the group was used on an acute male ward, and offers guidance on some of the common difficulties encountered.

Rationale

The social difficulties experienced by people with a diagnosis of schizophrenia are well-documented. For example, Bellack et al (1994) describe deficits in all aspects of social problem-solving skills. These include being less assertive and less persistent, less able to negotiate conflicts, less able to construct clear arguments, less fluent, less skilled at using non-verbal communication, and finally, having diminished affect and interest. There are a number of possible reasons for these deficits. People with schizophrenia commonly experience repeated episodes of loss of control over their thoughts, social isolation and social failure. This is likely to lead to a gradual erosion of cognitive and behavioural abilities, diminished expectations and disinclination to persist with complex social situations. Other research suggests that people with schizophrenia have frontal and hippocampal dysfunction which may cause poor processing of complex tasks. Also, poor perceptual skills may cause errors in judgement of negative affect in others, leading to difficulties in responding to feedback from others.

The impact of the illness across perceptual, cognitive, emotional and behavioural domains requires a multimodal approach, comprising medication for the psychobiological aspects; training in social problem-solving to strengthen protection against stress and case management to compensate for residual symptoms and deficits (Kopelowicz et al, 2003). Group approaches have been used for various psychological treatments for outpatients with psychosis, including skills-training and CBT (Randall and Walker, 2000; Cwikel and Oron, 1991; Mason, 2000; Phillips and Corcoran, 2000). Some of these have been shown to have some beneficial effects (eg Wykes et al, 2005; Barrowclough et al, 2006; Kern et al, 2005; Combs et al, 2007) Unfortunately, however, there is a paucity of research on the use of these approaches with acute inpatients.

There have been a number of studies using problem-solving training for patients with serious mental illness, many of which are based loosely on D'Zurilla and Goldfried's (1971) early model of social problem-solving. The present project used a simplified version of the classic model, emphasizing just three steps, namely, identifying the problem, thinking of solutions, and evaluating the solutions.

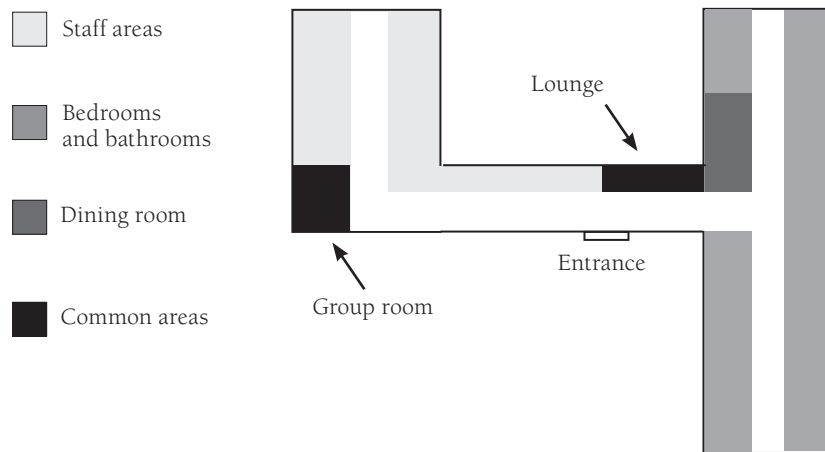
Aims of the group

The major aim was to encourage the development of problem-solving skills in inpatients, but participation in the group was expected to have some additional general benefits, such as facilitating collaborative working, encouraging analytical skills, encouraging awareness of other people's point of view, and improving concentration.

Setting

The setting was an 18 bedded acute admission ward for men living in Southwark, an inner London borough with a mixture of both socially-deprived and well-off communities. Over the two years the group has been running, patients have had a variety of problems, predominantly psychosis or bipolar disorder, but also including drug or alcohol dependence, personality problems, affective disorders or any

Ward layout



combination of these. The layout of the ward is shown above.

The figure shows that the group room is located at the end of a central corridor in sight of the entrance to the ward and the patients' lounge. Two of the staff areas in this corridor are the medication room and the nurses' station. The staff areas at the top left of the figure are mainly private offices. The central corridor also has a few chairs where patients sometimes sit and watch people coming and going on the ward.

The layout means that the central corridor is a focal point for general activity and any preparations for organised events in the group room are very visible to everyone on the ward. Interestingly, the ward on the floor above in the same building has a similar layout, except the group room is located at the far end of one of the wings, out of sight of the entrance and the main lounge. Audits of the group activities upstairs have shown that attendance is relatively poor in the group room that is remote from the central corridor, unless loud music is used to attract participants.

Format of the group sessions

An important aspect of the group was that it was intended to teach a general methodology for problem-solving, but not to solve any individual's current problem. For this reason we worked on a hypothetical problem scenario in each session. These scenarios were prepared in advance and described problems relevant to the patients on the ward. The group sessions run for 30 minutes and the format includes ground rules, introductions, explanation, reading the problem scenario, identifying the problem, generating possible solutions and evaluating the solutions. However, we also found it essential to spend at least 20 minutes preparing for every session.

Preparation

This is probably the most important and most easily neglected part of the group process, as most patients need encouragement to attend. We advertised the group sessions in advance, using notice boards and listings of ward activities and ensuring that the shift coordinators were aware of the day and time of the group. The group was timetabled for 3.30 in the afternoon, towards the end of visiting time, when patients can sometimes feel bored if they have no other appointments with staff and are not permitted to leave the ward. The group would always be led by a psychologist, together with an additional staff member to help facilitate discussion. We always arrived on the ward about half an hour before the group was due to start and used this time to tidy the room, remove dirty crockery, papers etc., arrange the chairs in a semi-circle, and switch off the TV and noisy vending machine. A few basic items of equipment were needed, namely about eight copies of a written problem scenario (which we selected at random from a set of 30 prepared in advance), a felt-tipped pen, three sheets of flip-chart paper, a notice board and drawing pins. The sheets of paper were pinned side by side on the notice board, with the heading 'Problems' on the first and 'Solutions' on the second. Setting up the room was often a useful way of generating interest among any patients who may have been loitering nearby. About 15 minutes before the start, we visited all communal areas and knocked on bedroom doors to let everyone know the duration and

the start time of the group. There would usually be a few patients in bed at this point, but a few words of encouragement might be enough for them to decide to come along. Occasionally another patient would take it on themselves to go round the ward asking others to join in.

Running the group

Group attendance was variable, with anything from one to eight people present. Before beginning everyone was asked to introduce themselves just by giving their name. Ground rules and explanations were given every session, regardless of whether patients had attended before or not, as this helped establish the procedure clearly. Patients were reminded to take it in turns to speak, to respect one another's opinions, and to stay for the whole 30 minutes if possible. We explained the purpose of the group, which was to learn a method of solving problems in three steps, first by defining the problems, then thinking of solutions and finally choosing the best solution. Finally, we gave out copies of the written problem scenario and asked someone to read it out loud.

Step 1 Identify the problem

We asked participants to identify the main problem, which the facilitator then wrote on the first sheet of paper. If more than one problem was identified they were included as long as they were relevant, we tried not to have more than three or four problems on the list. If anyone jumped ahead to suggest solutions, we would say 'ok, that might be a solution, but first we need to be clear what the problem is'.

Step 2 Finding solutions

We asked the group to think of as many possible solutions as they could. We wrote all suggestions on the board, regardless of whether they were practical or not and explained that we do not make judgements about the solutions at this stage. If one person dominated, we would try to quickly paraphrase their suggestions and ask others for ideas. Two sheets of paper were usually needed for this list.

Step 3 Identify best solutions

We then asked the group to look at the list of solutions and think about whether any were particularly good and whether they could see any disadvantages to any of them. We encouraged discussion of the reasons why some solutions might be particularly good or problematic, and where possible discussed the difference between suggestions that got to the nub of the problem and those that might be generally good things to do without being specific to the problem. Finally we summarised which solutions were agreed to be most useful and put a tick by those on the list.

The scenarios described a variety of problem situations experienced by patients during a hospital admission or after discharge to the community. Two examples are shown below, together with the problem lists and solution lists generated in the sessions. For the Scenario 2 solution list, the comments made during the evaluation discussion are also shown.

Scenario 1

Ron is an inpatient on a section of the Mental Health Act. He has been given leave to go to the shops accompanied by nursing staff. He needs to buy some batteries. Every afternoon, when he asks the nurses to go out, they tell him that other patients have already requested to go out and he will need to wait for them to come back. This upsets Ron and causes him to become angry. He shouts and kicks at the exit doors. Then nursing staff say that he is too aggressive and angry to use his pass. So Ron doesn't get to go to the shops.

What are the problems Ron is facing?

What can Ron do to solve his problems?

Scenario 1: Problems

He can't go to the shop

He can't buy his batteries

Staff might sedate him because of his angry behaviour

He is upset/angry/frustrated

He might have lost his trust in the staff

He's got mental health problems

He's got no friends

Scenario 1: Solutions

He needs to learn how to be patient

He could attend an anger management group

He could talk to staff about his feelings

He could ask staff to go to the shops for him

He could fix a time with staff to go out tomorrow

He could get a Bosch-breaker with a 2/10 transformer and an angle grinder and could dig his way out.

Scenario 2

Ben was discharged from a ward like DB2 a while ago. He is living in his own flat in the community. He is often having mates round and they usually listen to music and use cannabis and crack. Ben is obtaining his drugs from a local dealer. He is on benefits and using quite a lot of money for buying his drugs. He is not always able to pay the dealer and has built up debts with him. He also has trouble paying all his bills and his rent. The dealer has recently been on his back about the money and is threatening him that something will happen to him if he doesn't pay it back soon. Ben is feeling very pressurised and anxious about these financial problems

What are the problems Ben is facing?

What can Ben do to solve his problems?

Scenario 2: Problems

Drug addiction

Paying his bills

May be in danger from the dealer

May lose his property

His health

He is anxious

Scenario 2: Solutions:

Call the police and shop the dealer (the dealer might get angry and seek revenge)

Switch from crack to cannabis

Admit himself to hospital (might not be possible, if not unwell)

He could ask someone for money (eg parents)

Contact the housing department and communicate a plan for paying back his arrears

He could get help for his addiction

Go to Picadilly and be a rent boy (causes new problems)

He could get financial advice (from his care-coordinator, the community agencies)

He could talk to friends/relatives

He could stay with friends/relatives and sort out the problem from a safe environment

Kill himself (loses everything)

Negotiate a deadline for paying back the money to the dealer

Take out a contract on the dealer (might end up in prison)

Run away and hide (would have to give everything up and might end up as a vagrant)

Change friends (might be difficult to do, but maybe a good longer term solution)

How patients responded

There were a number of common issues arising from each step. For Scenario 1, Step 1, the most pertinent problems identified were 'he can't go to the shop', 'he can't buy his batteries', and 'he's angry and frustrated'. Other suggestions were really explanations for the problem ('he's lost his trust in staff'), possible consequences of the problem ('staff might sedate him'), non-specific ('he's got mental health problems'), or not included in the scenario ('he's got no friends'). Highly speculative ideas or problems not actually shown in the scenario were excluded from the problem list, but other ideas were included if they were at all relevant, in order to encourage participation. It was usually helpful to move the discussion along as soon as the most relevant problem had been identified, since too many items on the problem list can be confusing for the next step.

When generating solutions in Step 2, there were usually one or two patients who could make some relevant suggestions, but a number of common errors required guidance to remind the participants of what sort of solutions to look for. Several issues were important to emphasise, as follows.

First, thinking of what the character in the scenario could do, rather than what other people could do. For example, in Scenario 1, if someone suggested that 'the nurses should be better organised' or 'his friend should help him' these suggestions would be acknowledged

briefly, but the patient would be prompted to think of things Ron could do himself to make that happen - such as 'he could raise the issue at a ward community meeting' or 'he could contact his friends and ask them to bring him some batteries'. Second, encouraging patients to focus on the problem described on the sheet, not on their own problems. So if a patient said 'Someone stole my CD player' or 'I've got problems - I don't like my medication', this would be acknowledged briefly as an annoying experience, and the facilitator would remind the patient to think about what someone in Ron's position could do to get his batteries. A third issue was the importance of seeing the problem from the point of view of the person in the scenario. Derogatory remarks like 'he's a loser', 'he's mental' could be difficult to deal with as patients who made such remarks usually were reluctant to put themselves in the position of the person in the scenario. In these cases it was often helpful to have a brief discussion of how everyone has different problems and what seems easy to solve for some people might be hard to solve by others. Once patients accepted the general idea of trying to be helpful to the person in the scenario, rather than condemning them, discussion of solutions could usually proceed. Finally, the strategy for dealing with unrealistic or unusual solutions (eg 'he should get a Bosch-breaker etc.') was usually to include them on the list but to discuss their possible disadvantages later in the evaluation phase. Extreme solutions were suggested from time to time, such as those in Scenario 2, eg. 'take out a contract on the dealer', 'go to Picadilly and be a rent boy'. Writing these on the list sometimes caused hilarity but were useful to illustrate the principle of not censoring solutions during the brainstorming stage. Taking these suggestions seriously was also a useful way of drawing in and disarming those patients who made jokes and might otherwise have disrupted the discussion.

After producing a list of solutions the group then discusses their advantages and disadvantages. The easiest way to do this was usually to ask people which solutions they think are the best and which may not work so well. This discussion could result in a simple conclusion that one or two good solutions might be suitable, or could evolve into a more detailed discussion of the relative strengths of each solution, the difference between short term and long term solutions, and the difference between solutions that were highly relevant to the problem and those that might be good things to do without actually dealing

with the nub of the problem. During these discussions the favoured solutions were marked as either definitely helpful or possibly helpful. The Scenario 2 solution list shows some of the comments made during this discussion.

Other issues

Overall the format and purpose of the group seemed acceptable to the patients and many were intrigued by the scenarios, especially as they were realistic examples of the kind of problems they faced themselves. The group was open to all patients, regardless of mental state, so their contributions to discussion were variable, depending in part on how well they were. For example, one patient often left the room after a few minutes and returned later, possibly because he found it too stimulating to remain in the room for more than five or ten minutes at a time. Some patients remained silent throughout the group and were unable to think of anything to say despite being asked. Other patients grasped the point of the task immediately and were able to make helpful suggestions and encourage others to participate. Patients who found it difficult to participate at the beginning of their stay in hospital often became more responsive later on as their mental state improved. Having a mixture of patients did cause some problems, but might have been helpful to those patients who were too unwell to contribute meaningfully, but who might benefit from hearing others' suggestions or having some social contact. Among newly-admitted patients, those with alcohol problems or depression tended to find it easier to stay focused and make relevant points than those with a diagnosis of schizophrenia.

We generally encouraged all contributions, selectively reinforcing elements that were relevant to the task, giving lots of eye contact and trying to ensure that everyone had at least one of their contributions included on the board. If one person was doing most of the talking we would usually thank him for his contributions and ask him to wait while we asked others to contribute. Sometimes patients did not contribute even if prompted, and this may have been because of hearing voices or difficulty controlling thoughts. In these cases we did not put further pressure on them, but included them by making eye contact and checking that they understood the discussion. It was often helpful

to have a second facilitator sitting in the group and contributing to the discussion, this could provide prompts and examples of how to think of imaginative solutions. This also provided some extra assistance in encouraging patients to stay focused on the task and avoid dominance by any individual.

Future options

There are a number of possibilities for running this group in other settings. For example, it could be offered to discharged patients, or it could take place in the Occupational Therapy Centre and include participants from other wards. However, this would not be suitable for the original target group, the most acutely ill and most restricted patients. Within the existing setting there may be possibilities for some improvements, for example by using errorless learning. This approach is used with neuropsychological problems and assumes that learning in the absence of errors is more durable. It begins with simple tasks with a greater likelihood of success and uses overlearning of successful practice. The method has been piloted in an outpatient population of people with a diagnosis of schizophrenia (Kern et al, 2005) with a very systematic course of training over a period of several group sessions. For our standalone ward-based group it might be helpful to use simpler scenarios with a more easily identifiable main problem and to give more explicit coaching in the solution generation stage. However, the commitment remains to provide, within the ward environment, structure, stimulation and support which are accessible by all patients regardless of diagnosis.

Conclusions

The problem solving group described in this paper offers a simple method for groupwork in an acute inpatient setting, that has high face validity for patients. The scenarios utilised in the groups are all derived from clinical experience with patients from this ward. Groupworkers require skills to keep such groups focused and to deal with the unpredictable mix of patients attending each session. This is mainly

achieved by the setting of clear ground rules, using a very structured format and actively reinforcing all relevant contributions to the problem-solving process. Further work would be needed to evaluate the clinical effectiveness of these problem solving groups.

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