TECHNICAL NOTE

Social Problem Solving Therapy provision with a Deaf patient group in a secure hospital environment

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ABSTRACT
This paper describes the adaptation and use of a Social Problem Solving therapy (Stop and Think) for pre-lingually Deaf men in a secure hospital. It highlights the potential links between deficits in problem solving skills, emotional and behavioural problems and the over-representation of deaf people in forensic settings.

KEYWORDS
Deaf, Forensic, Cognitive Behavioural therapy (CBT), Social Problem Solving (SPS), mentally disordered offenders, British Sign Language (BSL).

Background

Ninety percent of deaf children are born to hearing families¹ and this can delay the development of language, which can then impact upon psychological, emotional, social and educational development¹. Due to frequent communication difficulties, d/Deaf people may have ‘… a much poorer fund of worldly information’ and it is reported that staff in mental health services often are often required to teach patients the difference between thoughts, feelings and behaviour².

Poor problem-solving skills are associated with a range of psychological and behavioural difficulties including anxiety, depression, substance abuse and aggression³. Deficits in the ability to problem solve may therefore be an important reason why Deaf people are over represented in secure mental health settings⁴,⁵.

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Social problem solving (SPS) therapies have been found to be an effective intervention for diverse patient groups, including forensic personality disorder and deaf adolescents. Good problem-solving skills consist of the “ability to recognise problems when they arise, define the problem clearly, set goals for change, produce a diversity of possible solutions, anticipate outcomes, devise effective action plans that have stepwise stages, and carry out those action plans to solve problems effectively.”

An intervention designed to build these skills and improve social functioning is ‘Stop and Think’ (SAT). SAT is based upon six steps to consider when solving a problem:

1. ‘Bad Feelings?’
2. ‘What’s my problem?’
3. ‘What do I want?’
4. ‘What are my options?’
5. ‘What is my plan?’
6. ‘How am I doing?’

The treatment manual for SAT allows for adaptations to the length and content of sessions while still using the six-step structure. SAT assumes prior knowledge and understanding of a variety of terms which may not be very familiar to Deaf patients. Thus, while SAT may be useful for Deaf people with mental health problems, in its standard form it likely also presents challenges in terms of its accessibility, assumed background knowledge and reliance on abstract concepts. Although there is evidence that SAT therapy is beneficial for hearing patients with personality disorder detained in a secure unit, it may be a difficult programme to provide to Deaf people due to its abstract concepts and minimal emphasis on emotions.

ODearn and Pollard stated that their (successful) adaptation of Dialectical Behaviour Therapy (DBT) for Deaf service users required changes to both materials and treatment methods. Glickman also suggests a more skill-based approach – not dissimilar to that of SPS approaches like SAT.

Aim

The aim of this work was to successfully adapt and deliver a (modified) Stop and Think therapy in British Sign Language (BSL) to a small number of pre-lingually deaf men within a secure hospital.

Method

Ethical approval

The intervention was carried out as part of each patient’s routine clinical care (as recommended by their multidisciplinary team following approval of the intervention from the appropriate local clinical governance forum). Outcome data was anonymised and collected as part of routine service evaluation.

Setting

The program was adapted and delivered within a specialist medium secure in-patient hospital service for Deaf men in the United Kingdom (UK).

Participants

The intervention was delivered to 3 pre-lingually deaf patients who all used British Sign Language (BSL) as their first language. The age of the participants ranged between 25 and 45 years old and all had a primary diagnosis of schizophrenia complicated by disocial personality disorder and were of normal intelligence.

Measurement of Outcome

The Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM12) was used to assess outcome. The CORE-OM is a self-report questionnaire that covers four domains: 1) Well-being; 2) Problems; 3) Functioning; and 4) Risk. The CORE-OM is ‘problem-scored’ in that lower scores on all domains indicate better outcome. It is important to note that, like many assessment instruments, the CORE-OM has not yet been validated for use with Deaf people.

Materials

Due to the poor understanding that the patient group were likely to have regarding the difference between thoughts, feelings and behaviour, prior to the actual delivery of the adapted Stop and Think (SAT) group patients underwent a pre-treatment phase in order to increase their understanding of these concepts. Both parts of the programme adopted a Cognitive Behavioural Therapy (CBT) approach. The programme was examined for its conceptual, linguistic and cultural applicability by clinicians (consisting of a mixture of hearing and Deaf professionals working in the service from a number of disciplines including psychiatric, communication support, nursing, social work and psychology).
Based on recommendations in Suarez each adapted problems using a six-step problem-solving process. This was based on, and adapted from the Stop and Think (SAT) programme, described by McMurran, which had also been successfully delivered with numerous hearing populations within the same hospital. The aim was to build knowledge of the terms ‘thought’, ‘feeling’ and ‘behaviour’ and the differences between them. This stage focussed on recognising these concepts and labelling them appropriately. This involved nine one-hour group sessions delivered twice weekly by a clinician working with the aid of a qualified BSL interpreter.

The Dealing with Emotion (DWE) was an adapted form of the ‘Dealing with a Feeling’ programme that had already been successfully implemented with many of the hearing patients within the hospital (including patients with Learning Disability and Autistic Spectrum Disorder). The aim was to build knowledge of the terms ‘thought’, ‘feeling’ and ‘behaviour’ and the differences between them. This stage focussed on recognising these concepts and labelling them appropriately. This involved nine one-hour group sessions delivered twice weekly by a clinician working with the aid of a qualified BSL interpreter.

This was based on, and adapted from the Stop and Think (SAT) programme, described by McMurran, which had also been successfully delivered with numerous hearing populations within the same hospital. The main focus was problem-solving (circumstantial, social, interpersonal), and building skills to effectively and independently manage problems using a six-step problem-solving process.

Based on recommendations in Suarez each adapted SAT session mainly consisted of the following:

1. Introduction to step/concept. First, the focus of the particular session was posted on the board in pictorial and written format together with a set of questions related to the learning goal. Next, a group and/or individual task were conducted to aid understanding and consolidation. We then used discussion of the step/concept using examples from patients or the facilitators to promote generalisation. Throughout, we used ‘table-based’ exercises and found these helpful in maintaining focus, aiding learning, generating discussions and overall participation with the group. This strategy also provided a more collaborative and less didactic environment.

2. Role play. Interpersonal situations were role played by the facilitators to aid understanding. Patients then used role play to practice new skills or to demonstrate examples of their own experience.

3. Discussion. Discussions was used to ensure that patients were aware of the learning points regarding each concept/step. It was also used to facilitate generalisation of knowledge and skills.

4. Generalisation. Between each formal session, an informal session was held with other staff members. This encouraged the group members to use the skills outside of the session, and to discuss the use of skills in other circumstances.

SAT was delivered in one hour sessions once weekly over fifteen weeks (the usual length with hearing patients is twelve weeks). Most of the sessions focussed on generating discussions and group tasks based around a table. Visual representations were used extensively. The six steps of SAT were transferred onto separate cards with pictorial representations. These cards were useful to refer to during each session as they helped to identify particular steps in the SAT process.

Each session included two facilitators and a qualified BSL interpreter (for both DWE and SAT). The BSL interpreter was experienced in working with Deaf mental health patients in secure settings and was also familiar with the general Cognitive Behaviour Therapy (CBT) approach. Consistent with recommendations, the interpreter had also seen the materials prior to the commencement of each session to enable smooth delivery. When working with an interpreter it is important to be aware of the added elements that this may bring to the therapy (e.g. subjectivity). It was important to work in parallel with the interpreter to provide a clear understanding of the message being delivered.

While not always possible, using the same interpreter was found to be of great benefit. This aided in consistency of the types of signs used, the interpreters level of understanding of the session materials and knowledge of previous sessions work.
Further, this also helped build a stable environment in which the patients felt comfortable in acquiring and utilising their new skills.

Supervision and reflection

The use of supervision helped to avoid ‘drift’ from programme content and the opportunity to discuss any difficulties with the materials or delivery of the programme. The need for continuous reflection on the material to be presented and the process of learning was important as this allowed for changes to be made when challenges to successful implementation occurred.

Results

Attendance was good with 100% attendance for all patients. No major problems were experienced when delivering the group and no adverse outcomes occurred. When asked their opinion of the group evaluating the group, two out of the three patients stated that the group had been beneficial to them.

There was a decline in overall problems and difficulties regarding functioning and an overall improvement in well-being following completion of both groups (Figure 1).

Discussion

This was a small scale evaluation of an adapted intervention to meet the needs of a Deaf patient group. There were only three participants and the main outcome measure used has not been validated on a Deaf population. Despite these limitations our data support a general decrease in reported problems and increased wellbeing. Most group members reported a positive experience of the sessions.

In the authors opinion, our opinion, the two stage process (delivering adapted DWE prior to adapted SAT) was beneficial in ensuring sufficient knowledge of concepts to allow the patients to understand the concepts required in SAT. In order to build upon this work we plan to refine and deliver this therapy again with further evaluation in order expand the evidence base for the use of CBT based approaches within this patient group.

Declaration of interest

None.

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