Skills Training Groups on a Psychiatric Intensive Care Unit: A Guide for Group Leaders

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This paper outlines a structured group intervention for use in a locked acute psychiatric intensive care environment. This intervention, described in manualized form, draws upon the empirically validated psychosocial skills training approach for the rehabilitation of individuals with chronic mental illness (cf. Liberman et al., 1993). The first section discusses general principles for conducting skills training groups in the acute psychiatric population, including practical strategies for encouraging patients to attend group, group structure, rules, and process. The second part of the paper outlines seven specific skills training modules that provide concrete, step-by-step instructions for conducting groups on such topics as anger management, communication skills, coping with mental illness, and relapse prevention. The reader is invited to critically evaluate, modify, and expand upon the materials presented in order to better serve this challenging population.

DRAMATIC CHANGES in health care over the past 10 years have effected equally dramatic changes in the delivery of psychiatric services. A person with schizophrenia can no longer routinely receive inpatient treatment for 3 to 6 months from the same team of providers and participate in long-term group and individual therapy. This is particularly true in the psychiatric intensive care environment. With an average length of stay on our unit being approximately 10 days, the focus is necessarily on getting patients stabilized on medications and moved to an open ward or directly back into the community as quickly as possible.

What role, then, can a psychologist or other mental health professional play in such an environment? Conducting psychosocial skills training groups such as those described in this paper can be one particularly rewarding role. This program bears resemblance to more intensive, empirically validated social skills training interventions (see Benton & Schroeder, 1990; Liberman, Vaccaro, & Corrigan, 1995; Liberman et al., 1998). It utilizes many of the same core behavioral techniques that define social skills training (cf. Benton & Schroeder) including problem or skills specification, didactic instruction, modeling, role playing, coaching, and verbal reinforcement. However, due to a short length of stay and high levels of acuity in the psychiatric intensive care environment, the structure and content of the present program depart significantly from more traditional skills training programs.

Because social skills training does not typically result in the reduction of psychotic symptoms, even when delivered in a long-term, intensive modality (e.g., Liberman et al., 1998), it would be naive to expect the present program to accomplish that goal. Similarly, it would be unrealistic to expect a skills training intervention delivered in the acute psychiatric setting to result in generalized, long-term improvement in social functioning. What goals then might we realistically expect such a program to accomplish? In our experience, implementing this program can result in a significant improvement in the therapeutic milieu. Many patients enjoy participating in these groups and express enthusiasm about attending them. Thus, these groups can be an important source of validation and respect for patients, providing them with a rare opportunity for social interaction while on the ward. Nursing staffs support these groups because topics such as anger management and communication skills directly address some of the more common behavioral problems on the ward. Social workers are typically supportive of these groups because they encourage patients to take active steps to plan for discharge and to prevent readmission. Finally, as members of a psychology staff, we have found these groups rewarding because they allow us to apply our knowledge of cognitive-behavioral interventions in a real-world setting with a population that is sorely in need of help. We firmly believe that any intervention that provides incremental gains in understanding of an illness and its management will ultimately benefit the patient.

A Word About This Population

This population is a difficult one to work with. The majority of patients are chronically mentally ill with very serious disorders such as chronic paranoid schizophrenia, schizoaffective disorder, and bipolar affective disor-

Cognitive and Behavioral Practice 7, 385–394, 2000
1077-7229/00/385–394$1.00/0
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der. Furthermore, many of the patients have comorbid Axis II diagnoses as well as significant histories of alcohol and drug abuse and dependence. Finally, psychiatric intensive care patients are typically on involuntary civil commitment for dangerousness or grave disability. Many patients are at high risk for suicide or assault, and many are quite disorganized and have difficulty providing for their own basic needs.

There is an upside, however. Many chronically mentally ill individuals have been in and out of mental institutions for most of their adult lives, and a unique part of their culture is that they have attended many group therapy sessions. Once stabilized on medications, patients typically know what groups are and how they are expected to behave in group. Some actually enjoy group interactions, and come to look forward to daily meetings as a place to learn new skills and discuss their problems. Even patients who are still decompensated can often behave appropriately in group and participate to some extent.

> Groups can be an important source of validation and respect for patients, providing them with a rare opportunity for social interaction while on the ward.

That being said, it is important to remember that in our milieu, these skills training groups are completely voluntary. While patients are often encouraged to sample groups, they are never forced to attend and are free to leave once the group begins. Some patients may even be encouraged to leave group if they are not able to follow the rules, respect other patients and staff, and participate without compromising the safety of the group environment.

General Principles

Getting Patients to Come to Group

This is one of the most important, underappreciated roles of a group leader in this environment. In our experience, it is most effective to "advertise" the group at every opportunity, to both staff and patients. Here are some of the strategies that have proven useful:

1. *Invite individual patients to attend groups.* During rounds, tell patients the group's topic for that day and how they would benefit from it. For patients who respond that they already know all about the topic, encourage them to come and help teach the other patients what they know. For patients who are not seen in rounds that day, introduce yourself, tell them that you run groups on the unit, and that you'd like them to come to the next one, letting them know when and where the group meets.

2. *Post the group schedule for the month on the bulletin board in a public space.* Introduce yourself to new patients and point out which group topics might be of interest to them on the board.

3. *Inform nursing and psychiatry staff about the group.* Engage their help in encouraging patients to attend.

4. *Take advantage of meetings that occur before group.* If a community meeting ends early, don't let the patients wander off. Instead, encourage them to walk with you immediately to the group room and begin group right away.

5. *Don't be afraid to wake patients up!* Stand by their bed and invite them by name. Tell them that you're having a group on topic X and that you would really like them to join the group. Although some might be rude and uncooperative, other patients really seem to appreciate the personal invitation.

6. *Try, try again!* If someone doesn't come to group one day, that doesn't mean that they will never be interested in attending. As patients become more stabilized, they may be thinking more clearly and decide to take you up on your offer.

7. *Call the group topic something that sounds interesting and relevant.* For example, we don't ask patients to come to a group on "Relapse Prevention," we invite them to a group on "How to Stay Out of the Hospital." We've given some suggestions for marketable names for each topic in the skill modules section of this manual.

Importance of Continuity and Patient Expectations

Most patients on the psychiatric intensive care unit lack structure in their lives. Part of creating a therapeutic environment on the ward is helping them to impose some structure on their chaotic experiences. While crises and "putting out fires" are typically the rule in this environment, we strongly encourage you to make every effort to hold group at the same time each day. On our unit, we hold group at 11:00 every day, immediately after rounds. Different members of the staff serve as group leader, depending on their availability. Regardless of who leads the group, however, it is always held at the same time and place. Thus, we can tell new patients that "we have group every day at 11:00." Before long, certain patients will begin asking you each morning what the group topic will be for that day.

Group Structure

Along similar lines, for reasons of continuity, it is important that groups always have the same structure. Review the group structure at the start of each meeting so that new patients know what to expect and a group cul-

ture is established. We typically start groups with the following:

> "Welcome to our group. We do three things in each group. First we introduce ourselves so that we all know each others' names. Next we go through the five group rules so that we all know how we are expected to behave. The third thing we do is talk about the topic for today. Today's topic is _____."

Introductions

> "I'll get started with the introductions. My name is Ken Weingardt, and I'm a psychology intern here. Let's go around the room and everyone should say the name that they would like us to call them."

Some patients will prefer that you call them by their last name, others by their first, still others by their nickname. Make an effort to remember each of their names and to address them by their preferred name throughout the group.

The Five Group Rules

"In this group, we always follow five group rules. Can someone get us started by remembering one of the rules?" If no one jumps in with one, we usually call on one of the patients who have been in group a number of times and ask him if he can remember one. As patients say the rules, we write them on the board so that we can refer to them if someone starts violating them. It's important to try to get patients to generate all of the rules themselves. If they get really stuck, help them out. You shouldn't spend more than 5 to 10 minutes on the introductions and rules. You've got a lot of ground to cover, and our group is typically only 30 minutes long.

After someone contributes a rule, we ask them why that is an important rule to follow. Here's a list of the rules and reasons why they are important.

1. *No cross talk. One person speaks at a time.* Reasons: so we can hear what someone is saying. Respect.
2. *No profanity, threats, or violence.* Reasons: safety, respect.
3. *Try to stay until the group is over.* Reasons: prevent disruption, disrespect.
4. *Confidentiality.* Reasons: safety.
5. *Stay on the topic.* Reason: so that we can get some work done. Here, we usually say that we may have to interrupt someone during the group. We make it clear that interrupting them doesn't mean that we disrespect them or are not interested in what they are saying. We're interrupting so that we can all stay on the topic. With this kind of explanation, patients get much less irritated when you have to interrupt them (which can be quite frequent!).

If someone violates one of the rules during group, always go back to the list of rules, point out which one was violated, and explain why it's important that everyone adhere to the rules. After introductions and reviewing the group rules, it's time to move on to the topic of the day. We've written a brief description of each of the seven group topics that have worked well with this population, as well as a list of the specific areas to cover in each of these groups and some helpful hints. Each skill area is described later in this paper. Before turning to the skills training modules, however, we turn our attention to the issue of group process in these types of groups.

> Review the group structure at the start of each meeting so that new patients know what to expect and a group culture is established.

Group Process

Skills Training Groups Are *Not* Process Groups

The reader may be familiar with the principles of the traditional process-oriented group psychotherapy. Suffice it to say that working in psychiatric intensive care, this type of process group simply does not work well. Our patients are typically too disorganized, impulsive, or psychotic to benefit from traditional group therapy. Furthermore, our groups are open, and our turnover is very high due to our extremely short length of stay, so it is unlikely that patients will form deep, insightful relationships with one another.

Instead, our skills training groups are much more like classes. In fact, many patients prefer to call group a class, and we see no reason to correct them. Calling it a class may be less stigmatizing to them, and to be honest, the concrete, specific, didactic nature of these groups makes them seem a lot closer to a traditional classroom than a traditional group therapy environment.

You Are the Group Leader, Not the "Facilitator"

In traditional group therapy, the group facilitator often sits back and observes interactions among clients, sharing observations on the process from time to time. From experience, we can say that taking this sort of passive stance with this patient population is a recipe for disaster! A much more effective role is to think of yourself as the group leader, or teacher, if you prefer. Remain standing throughout the session. Make liberal use of the whiteboard and markers to guide the discussion. Feel free to interrupt a patient and bring the session back on

topic when necessary. It's okay to be the authority figure, to maintain control of the conversation, to invite participation from some group members, and to ask other members to hold a thought or comment for a little while. This is not to say that you should be autocratic. It's also important to remember to use your therapy skills. Temper your directiveness with empathy. Allow patients to speak their piece, but only so long as they are addressing the topic at hand. The best way to describe this role is part therapist, part teacher, and part traffic cop.

For reasons of safety and support, we often have more than one staff member present during the group. However, each group has only one leader. The leader remains standing, while the other staff member sits in the circle with the group, makes contributions, and helps to redirect and manage the more difficult patients. This makes the group structure very concrete and unambiguous, which is helpful for the more disorganized patients. If a patient must be asked to leave the room because of difficulty following the group rules, the second staff member is available to escort the patient out of the group, briefly discuss the request to leave, and notify nursing staff.

Engaging Patients in the Process

Just as being too passive with this population can lead to trouble, being too didactic can cause problems as well. If you stand at the front of the room and lecture at the patients, you're in for trouble. Our patients' attention spans are too short, and they are simply too impulsive to just sit there and listen to you. You've got to find some way to engage them—and keep them engaged—for the whole session. Here are some suggestions:

Questions, questions, questions. While it may seem odd to think about using the Socratic method with psychiatric patients, a variant of the Socratic method can actually be remarkably effective. A good general strategy that you will see throughout the skills training modules is to ask patients to generate lists and then put those lists up on the board. Ask questions like, "What does it feel like to be angry?" "How do you know when you need to go see the doctor?" "What makes a relationship a good one?" "How do you avoid using drugs and alcohol?" "What does 'coping' mean?" Solicit input from the patients and write it down. Patients really like to see their contributions up on the board. It reinforces participation and validates their contributions.

Call on patients by name. Similar to getting patients to come to group, getting patients to participate is often much easier if you give them a personal invitation. Some patients may be too shy or too disorganized to initiate a contribution on their own, but will be happy to contribute if asked. Be prepared to repeat the question (often several times) until the patient responds. We've often found it useful to call on those patients whose attention is starting to drift, falling asleep, or staring at something else—calling them by name and asking them a question directly can get them to engage with the group topic once again. (Elementary school teachers seem to have discovered this technique a long time ago.)

Be concrete and specific. Do your best to avoid jargon and "50-cent words." Keep your vocabulary aimed at an audience that typically has less than a high school education. When talking about abstract concepts, always tie them back into concrete examples (preferably ones that the patients generate themselves). Many examples of how to be concrete and specific can be found throughout the descriptions of the skills training modules.

Enlist higher-functioning patients as allies. Although the majority of patients on a psychiatric intensive care unit have serious thought disorders, there are usually a few patients who are less disturbed and are motivated to come to group. It can be enormously helpful to identify these patients and let them know that you value their attendance and assistance. Higher functioning patients are often good at encouraging other patients to come to group, redirecting disruptive patients while in group, and providing good modeling of group behavior for other patients. In turn, these patients typically feel very validated by sharing their knowledge with others and knowing that you genuinely appreciate their help.

Get patients talking to each other. Patients struggle with similar stressors, challenges, and problems. They also often share similar goals: to live independently, to stay out of the hospital, to stay clean and sober. As patients in group typically have varying degrees of success in dealing with life problems and achieving goals, those who have had some degree of success can be encouraged to give advice to those who have not. Higher functioning patients are also typically much more receptive to feedback from other higher functioning patients.

Don't take yourself too seriously. Humor can be very engaging. Think back on your own experiences in seminars, workshops, or groups. You were probably more engaged by speakers who were dynamic and flexible, rather than rigid—those who could work with whatever material the group brought up—those who were able to laugh at themselves when they misspelled something or momentarily forgot what they were talking about. Keeping the energy level high and the mood of the group lighthearted ensures that your groups will be less threatening than traditional groups. This, in turn, ensures that patients will be open to participating actively in your groups and that they will look forward to coming back to group each day.

Dealing With "Difficult" Patients

Our discussion of group process would not be complete without acknowledging that some of our patients

can be very hard to work with in the group setting. We'll discuss three general classes of patients that can pose problems for you as the group leader and suggest some ways of dealing with them.

Floridly psychotic patients. Some patients on the unit will be floridly psychotic; they will be experiencing auditory hallucinations, delusions of grandeur or persecution, ideas of reference, and loose thought processes. When patients are particularly psychotic and disorganized, the best solution usually is to avoid inviting them to group. Sometimes, however, they will see the group beginning and want to join in. Our policy has typically been to let in any patient who wants to come. We make special efforts to review the group rules with the disorganized patient and try to make sure that they understand that if they fail to abide by them, they may be asked to leave the room. These disorganized patients may then either sit quietly and observe the group, mutter to themselves, try to contribute, or be loud and disruptive. If they try to contribute, we usually listen closely to hear if there is anything relevant to the group topic in what they are saying. Remarkably, there often is. If that is the case, we'll put their contribution on the board and move on. Fortunately, many disorganized psychotic patients who are disruptive tend to get up and leave the group. The best strategy then is to simply not let them back in the room. It may be a good idea to keep floridly psychotic patients out of the group until you feel somewhat comfortable leading these kinds of groups.

Acutely manic patients. Patients with bipolar affective disorder who are in an acute manic phase can be the most difficult patients for the group leader. They tend to dominate the discussion and can be difficult to interrupt or stop. They invariably are aware that the group is going on and want to be a part of it. They are often unable to sit still for the half-hour group. Like the disorganized patient with schizophrenia, we typically allow them into group, but take extra care to make sure that they are aware of the rules and the consequences for violating them. If they are disruptive, we address them by name, and impress upon them that other patients in the group need to have a chance to speak, and that we're willing to talk with them one-on-one after the group is over. Manic patients typically want to enter and exit the room repeatedly. Again, your best bet is to let them out and not return.

Hostile patients. Floridly psychotic or acutely manic patients can sometimes be quite hostile. Those patients who respond to your invitation to attend group in an openly hostile manner are probably best left alone. Those who previously manifested hostility in group are best spoken to in a soft, calm voice and reminded of the rule prohibiting threats, violence and profanity. Verbal escalation can be a precursor to physical assault and should be taken *very* seriously. Patients who are escalating can be reminded that these groups are entirely voluntary and that they are free to leave the group at any time. If you feel unsafe in the room with the patient, do not hesitate to leave the room and inform nursing staff about what is going on. Finally, make sure that you know where the panic button is in the room. You never know when you might need to use it.

Discussion

This paper outlines a novel group intervention for use in a locked, short-term psychiatric hospital setting. Based on empirically validated psychosocial skills training approaches, the interventions described can enhance patients' understanding of their illnesses, as well as their skills in managing them. Implementing these groups on our unit has contributed to our therapeutic milieu by providing patients with much needed social interaction, validation, and respect. This skills training curriculum has proven useful because it directly addresses many of the behavioral problems that are often exhibited in the acute psychiatric environment.

Because getting patients to attend group in this environment can be a challenge, we first described a number of different strategies that a group leader might use to ensure good attendance. We next emphasized the importance of continuity and patient expectations, as well as the importance of a consistent group structure within each session. We then turned to a discussion of group process, describing the difference between skills training groups and traditional process-oriented group psychotherapy, the role of group leader in this type of intervention, and strategies that have proven useful in helping patients to engage in these groups. We identified three categories of difficult patients that are encountered when running groups, and we discussed how to address the challenges that they present. Finally, we outlined seven different skills training modules, each of which is intended to provide the reader with concrete, specific instructions for conducting groups on topics such as anger management, communication skills, coping with mental illness, and relapse prevention.

We hope that by sharing our experiences of leading groups in this setting, we have given you some ideas about how you might comfortably and productively work with this population in the acute setting. If length of stay were longer, these groups would undoubtedly be more effective in teaching skills that might generalize to improving our patients' social functioning. Each of these topics could easily be expanded to fill weeks of group time (e.g., Liberman's group at UCLA holds outpatient skills training groups with schizophrenics 12 hours a week for 6 months). Our reality, however, is an average length of stay of about 10 days; the material described in these pages attempts to enhance the therapeutic milieu

SKILLS TRAINING MODULES

In each of these modules, tasks, statements, or questions intended for the group leader are printed in plain text. Items in italics represent responses that are likely to be obtained from group members.

Anger Management

"What to do when you get angry"

1. Introductions
2. Review group rules
3. Ask group members "What does it feel like when you're angry?" Put list up on the board. Likely responses include:

My heart beats faster
I breathe more quickly
I get sweaty
I feel like lashing out
I feel my gut tighten up
I feel my muscles tense up

4. Introduce exercise by telling group that there are different ways of handling anger; some are good because they lead to positive consequences, and some are bad because they lead to negative consequences.
5. Put two columns up on the board labeled "good" and "bad."
6. "What are some of the *bad* ways that you can handle anger?"

Yelling and screaming
Hitting
Killing
Fighting
Throwing things
Breaking things
Drinking alcohol/using drugs

"Why are these bad?" Because they lead to negative consequences.

"What are some negative consequences that might happen?"

Jail
Get hurt
End up back in hospital

7. "What are some good ways of handling anger?" Again, ask the patients to generate the list, and put their responses up on the board.

Exercise
  Walking
  Swimming
  Running
Talking about it
  With someone who understands
  With someone you trust
  With the person that you're angry at using "I feel" statements
  Praying

Some good ways to express anger on the ward are:

Tell staff that you're feeling angry
Take a PRN
Walk away from the situation
Spend some time by yourself to cool down

8. What are some good ways of preventing anger?

Have a sense of humor
Try to understand where the other person is coming from (empathy, walking a mile in their moccasins, etc.)
Try to take responsibility for your own emotions—don't let other people control them
Count to 10
Take deep breaths
Walk away

Goals

"How to reach your personal goals"

This group is designed to help patients learn how to identify the smaller steps required for them to achieve their personal goals. When inviting them to this group, tell them that you'll be talking about what goals they would like to accomplish once they get out of the hospital, and that the other patients will help them figure out how to do it.

1. Introductions
2. Review group rules
3. Ask each group member to identify a goal that he would like to achieve once he gets out of the hospital. Most patients will be able to come up with something concrete and specific to work with. Good examples include:

Independent living
Getting a job
Getting a driver's license
Visiting with family
Going back to school
Applying for social security

It's important that each goal come from the patient himself. You may need to do some probing to find one that's appropriate to work with.

4. For each patient, write his name on the board, and on the other side of the board, write the goal that he has given you. You'll end up with something like this:

Here (in Hospital)	Goal
Bob	Get an apartment
Max	Find a job
Robin	Go back to school
Dan	Start dating
Richard	File for Social Security

Then, for each patient, you can work backwards from his goal and identify all of the subgoals or small steps that he needs to accomplish to get from here (on the ward) to there (in an apartment, job, etc.).

This can be a great exercise for getting patients talking to each other. For example, you might ask patients "What steps does Bob need to take to get from here to living in his own apartment?" Group members might then volunteer that to get an apartment, one has to find out how much money one can spend per month, make sure that they have first and last month's rent and deposit, figure out what neighborhood they want to live in, get the classified ads, make telephone calls, and so on.

Group members usually make good contributions, which you can list sequentially on each person's "timeline" on the board. Try to pace the group so that you don't run out of time before you get a chance to work with each member's goal.

Communication

"How to get what you want from other people"

This module helps patients to identify the elements of effective communication. A good way to "market" this topic when inviting patients to group is to describe the group as "How to get what you want from other people" or something along those lines.

1. Introductions
2. Review group rules
3. Get things rolling by asking patients what communication means. Generate a list of relevant responses up on the white board. Responses might include:

   Talking
   Sending messages
   Listening
   Getting your point across
   Asking questions

4. Point out that communication has three parts: sender, receiver, and message.
5. What are the different ways of sending a message? Discuss verbal vs. nonverbal ("body language," eye contact, etc.).
6. When is communication effective?

   When we're listening to the other person
   When we don't get loud or hostile
   When we try to understand "where the other person is coming from"
   When our message is clear and direct
   When we are polite
   When we follow the group rules (one at a time, no profanity, threats or violence, stay on the topic)—point out that group rules are good rules to follow outside group

7. Use interaction with staff as an example of effective communication.
   - How to ask a nurse for something that you want or need
   - How *not* to ask a nurse for something
8. Consider role-playing if group interacts well.

Drugs and Alcohol

"Reasons to use and not to use"

Many psychiatric patients struggle with substance abuse. This group is intended to help patients focus on why it is important to remain clean and sober outside of the hospital and to give them some pragmatic suggestions that might help them.

1. Introductions
2. Review group rules
3. As a way of really getting patients engaged on the topic, consider beginning the group by asking patients what they like about using alcohol or drugs: What's good about them? Why do they use them? Typical responses might include:

   Makes me feel more relaxed
   Makes it easier for me to have sex
   Makes me feel powerful
   Makes my body feel good
   Makes me forget my problems

4. Now that you've got everyone's attention, ask them to list some of the bad things that have happened to them when they have been using alcohol or drugs. Typical responses are:

   I lost all of my money
   I ended up in jail
   I got addicted and couldn't stop
   I had to go back to the hospital
   I lost my apartment
   My girlfriend left me

5. The "Decisional Balance": typically the list of negative consequences of drinking or using is far longer than the list of positive effects. You can frame the pros and cons of continuing to use as a balance—while using has some attractive aspects, the negative consequences really make it a good idea to stay clean and sober.
6. How to stay clean and sober: Many patients will have had some substance abuse treatment experience, so it should be fairly easy to help the group generate a list of useful strategies. A typical list might be:

- *Avoid certain people:* e.g., the so-called friends who only seem to show up at the first of the month, when most of our patients get their disability checks.
- *Avoid certain places.* Everyone has their "slippery" places where they're most likely to use—could be a bar, a park, a downtown area, friend's house, etc.
- *Get help.* Emphasize that no one can really stay clean and sober on his or her own. Run through a list of resources that are available: self-help groups (AA, CA, NA), and treatment available through your facility and other facilities in the community.
- *A relapse isn't the end of the world.* Many people think that if they slip up and have a drink or smoke that they might as well just give up and keep on using. A slip is a mistake that you can learn from—don't give up on your sobriety because of it.

Relationships

"How to make new friends"

Patients often lack the basic knowledge and skills necessary to initiate and maintain social relationships. They often express interest in dating or making friends, but have little idea how to go about doing that. This module is intended to help them begin to overcome these deficits.

1. Introductions
2. Review group rules
3. Ask patients what "relationship" means to them. Most will come up with romantic relationships, but challenge them to think of other kinds of relationships that people can have. A typical list might also include:

Friendship
Teacher–student
Doctor–patient
Neighbor
Roommate

4. After making sure that all of the members understand what relationship means, in the broader sense, ask them to come up with a list of things that make relationships good. A typical list:

Communication
Trust
Understanding
Listening
Respect

5. Make it concrete by doing some more specific social skills training. For example, how to initiate a conversation:

Make eye contact
Maintain appropriate personal distance
Ask another person about themselves
Identify a common interest
Listen and respond

6. Consider modeling and/or role-playing if the group interacts well.

Coping With Mental Illness

The majority of patients on the psychiatric intensive care unit are chronically mentally ill. They have suffered a lifetime of terrifying symptoms, medication side effects, institutionalization and stigmatization. This group addresses techniques that can be used to help them cope with the difficult aspects of mental illness in a very direct and up-front manner.

1. Introductions
2. Review group rules
3. Ask patients what "mental illness" means to them.

Some might find this definitional exercise heavy-handed or insensitive. Others might think that it would meet with much resistance by patients who don't consider themselves to be "mentally ill." To the contrary, we have found patients' responses to this question remarkably insightful and powerful. Notice that this exercise does not require patients to label themselves as mentally ill, only to discuss what mental illness means to them. Here are some typical responses from our patients:

A different way of thinking
A chemical imbalance in the brain
Hearing things that other people can't hear
Feeling nervous
Feeling like everyone is out to get you
Can't sleep
People treat you differently
Needing to take medication

4. Ask patients to define "coping." Again, you'll often be surprised by the degree of insight that patients have into what coping means. Typical responses include:

Dealing with it
Adapting
Adjusting
Doing things differently

5. Finally, ask patients to generate a list of things that they can do to cope with their illness. Typical responses include:

Exercise
Taking medication
Going to school
Learning more about their illness and their medications
Educating others about their illness (family, society)
Avoiding alcohol and drugs
Asking for help when they need it (from doctors, family, friends)

In our experience, this exercise can take widely different paths. Some groups will focus on more superficial aspects of managing mental illness, while others will delve into heartfelt and poignant discussions of the pain of mental illness, touching upon the loneliness, stigma, and rejection that they have suffered.

Relapse Prevention

"How to stay out of the hospital"

This group is focused on helping clients to identify the early-warning signs of decompensation and useful strategies that they can employ to help prevent a full-blown relapse and consequent rehospitalization. When you invite patients to a class on things they can do to stay out of the hospital, you're almost guaranteed a good turnout.

1. Introductions
2. Review group rules
3. Ask patients how they know when things are starting to go wrong for them. What are the early-warning signs that they are headed back to the hospital? It's important to emphasize that each person's early-warning signs are different. Therefore, we encourage each patient to make a unique list of things to watch out for. Although it is best to make a list for each patient, if you have a big group, or are running out of time, you can make one big list. Here are some examples:

EARLY WARNING SIGNS

Roberto
Staying up all night
Not eating
Spending too much money
Using methamphetamine
Thinking that other people want to kill me

Max
Hearing voices
Sleeping too much
Feeling hopeless
Wife notices something wrong

Robin
Feeling really good
Stopping medication
Fighting with roommates
Not going to appointments

Next, ask patients to make a list of things that they can do the next time they find themselves experiencing these warning signs so that they might be able to prevent rehospitalization. Here's a list of popular relapse-prevention strategies:

- *Call your outpatient doctor.* Describe the symptoms you are experiencing, and ask for an appointment so that your medications can be reevaluated.
- *Talk to someone that you trust.* This could be someone different for each patient. It could be a case manager, a board and care operator, a spouse, a counselor, or the patient's parents. Encourage patients to listen to what they say; other people often have a different perspective on our problems that we are not able to see in ourselves.
- *Don't stop taking your medication.* Many patients start feeling so good that they think that they no longer need to take medication. Ask your group how many people this has happened to (many hands usually go up). Then ask them what happened—usually negative consequences: jail, rehospitalization, etc.
- *Take care of yourself.* Make sure that you eat right and get enough sleep.
- *Don't use drugs or alcohol.* Although drinking or using drugs may seem like a good thing to do when you're not feeling well, they typically lead to more negative consequences; it may work well in the short-term, but makes things worse in the long run.

Each group will come up with other, idiosyncratic relapse-prevention strategies that you will have to evaluate for their own merit. Patients who are delusional will often come up with some interesting ones. Ask other patients if they think that the more outlandish strategies will work—if not, ask them to give the delusional patient some suggestions about strategies that might work better.

and help patients learn all that they can within that time frame. Some patients (typically the higher functioning ones) have indicated that they have gotten a tremendous amount out of these groups. Other patients (typically the severely disturbed ones) probably retain very little of the information. However, in our experience, almost all of the patients who attend these groups get something extremely important out of them: a sense of validation and respect, something that is often lacking in the psychiatric intensive care environment.

One of us (KRW) initially drafted this manual while on internship at the VA Palo Alto Health Care System. Early drafts proved quite useful in orienting subsequent interns and other trainees in how to work with groups in the locked, acute psychiatric environment. As each new intern, trainee, or staff person has gained experience running these groups, he or she has typically seen the present curriculum as a starting point from which they have added new group topics and modified existing ones.

On a related note, we'd like to leave the reader with a

humble request. All too often, psychologists develop an intervention, a therapy, or a manualized treatment protocol that becomes a static entity with a life of its own. It is labeled with a catchy acronym, is empirically validated in clinical trials, and is vigorously defended against criticism. In contrast, the reader is invited to treat the present paper and the program it describes as a work in progress. We invite you to alter it and adapt it to your specific treatment setting. Develop skills training modules on different topics. Change the modules to fit your own preferences and needs. Think critically. Expand upon the material, modify it, or start over, if you prefer. So long as your focus is on improving the provision of psychological services to a population that is sorely in need of them, you do so with our blessing and encouragement. Finally, we invite you to share your experiences developing and running these types of groups with us either formally or informally so that we can continue to improve the quality of services that we provide to our own patients.

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Preparation of this manuscript was supported by the VA Health Services Research and Development Service and Office of Academic Affiliations.

The authors gratefully acknowledge the valuable contributions of Xavier Apodaca, Ph.D., in developing this program. We would also like to thank Robert P. Liberman, M.D., and his colleagues at the UCLA Clinical Research Center for Schizophrenia and Psychiatric Rehabilitation, whose social and independent living modules greatly influenced the content of the groups described in this manual.

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Received: January 25, 2000
Accepted: March 29, 2000

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