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Randomized Comparative Trial of a Ward Discussion Group

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Summary: A randomized controlled study of 38 catchment unit psychiatric in-patients in a discussion group showed no significant additional benefit compared with 36 in-patients in an activity group. Symptom change scored by three rating groups agreed closely, average $r = +0.64$. Patients treated with ECT showed 2.6 times as much reduction in morbidity as those not so treated, but there was still no appreciable difference between discussion and activity groups when this was allowed for. Other treatment factors and the Hawthorne effect appeared to obscure any effect due to group therapy.

Advertisements for nursing staff for psychiatric hospitals have shown photographs of nurses involved in a patient discussion group. Student psychiatric nurses arrive on the wards believing psychiatric treatment consists mainly of psychotherapy. Recently there has been criticism of physical treatments in psychiatry with an implied bias towards the various psychotherapies. Physical treatments in psychiatry, including electroconvulsive therapy (ECT) have been subjected to double blind controlled trials (West, 1981) and shown to be effective. Controlled trials of the various psychotherapies have been reviewed by Bergin and Garfield (1978) and Smith *et al* (1981) and reverse previous evidence which seemed to show that the various psychotherapies were ineffective. However, the trials reviewed by these authors vary from counselling college students to lay psychotherapists working with schizophrenic in-patients. Smith *et al* (p. 89) (1981) review 17 varieties of psychotherapy, the majority of studies dealing with neurotics. Some psychiatrists working in catchment services include in group psychotherapy all acute in-patient psychiatric admissions of all varieties of illness and of varying severity. It seemed to us appropriate to test this particular model by a randomized controlled trial comparing a ward discussion group with an activity group.

Methods

Patients admitted to the Sutton psychiatric unit were used in this study. This unit caters for the psychiatric admissions (770 in 1980) from the London Borough of Sutton, population 170,000. Only patients admitted under one of the two consultants sharing the intake of the under 75's were studied. On admission all patients were assigned from a list of random numbers either to a discussion group or to an activity group as a control. It was decided that the study should fit into the existing treatment regime, and all other treatments were not randomized. The ward consultant (psychiatrist A) was not made aware of the random allocation to group or control. This consultant (psychiatrist A) rated the patients weekly on a visual analogue scale (VAS) of presenting symptoms without knowledge to which of the two groups the patients had been assigned. Two ward nurses not involved in either of the groups rated the patients in both groups weekly on a 6-point scale of global improvements (GS). The discussion group patients were rated weekly by a second psychiatrist (psychiatrist B) together with a charge nurse (B) on the same scale (GS), although this rating, unlike the others, was discussed with the discussion group patients, and the score agreed between the therapists and the patients. There was, therefore, a patient self-rating component in these scores.

The discussion group

Allocation to the group was publicized on the ward notice board. The group was held weekly at the same time in the quiet room on the ward. The therapists were an experienced charge nurse (B) who had just attended a 10-week group work course, and psychiatrist (B) who had more than two years' experience of running therapy groups mainly in a day hospital. A student nurse also participated actively in the discussion group. Because patients had been chosen at random, people of all diagnoses and of varying severity were included.

At the beginning of each group the patients seemed

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unsure as to why they had all been gathered together, and almost every week the question of what should be discussed came up. Invariably the patients found a topic of conversation for themselves with very little guidance from the staff. When numbers were low, and the few patients present were fairly severely ill, the staff had to play a more active part in starting the discussion. The most frequent topics talked about were people's illnesses, being in hospital, weekend leave and anxieties about going home. Sometimes complaints arose about the running of the ward, arrangements for meals, and having to wait to see the doctor. If patients wished to leave the group they were encouraged to stay and discuss their feelings, but were not prevented from leaving. Sometimes they would wish to come back into the group later on. One schizophrenic patient repeatedly left the group, and one depressed female left early as did one alcoholic patient.

The patients' reaction to the group varied. Some appreciated the chance to talk about themselves and others seemed to find the group situation fairly difficult and were quite angry at being asked to participate; in fact on some occasions, especially on sunny days, they expressed jealousy of other patients in the activity group who were going out into the sunshine. Overall, despite patients of varying diagnoses and varying verbal capabilities, it was found that patients did talk about themselves and were able to react to each other in a group situation. It was found that the staff had to be more active in running the group than they would have been in an outpatient group where the patients chose to have group therapy. The patients were constantly changing and only attended for a few weeks so that the group was constantly re-forming and tended to be dependent on its therapists for leadership. Interpretations were kept within the limits of the patients' understanding, but an effort was made to explore and analyse the patients' reactions to their illness with the aim of helping them to minimize dependency reactions.

The activity group

The activity group consisted of the random assigned patients and two to three members of the nursing staff. The patients were encouraged to decide on an activity that the majority would find most enjoyable. At first the patients regarded the group with suspicion, but after a few weeks these feelings diminished and they admitted to enjoying the group and suggestions were forthcoming. The activity found to be most enjoyable was a walk across the Downs with a specific task in mind—to collect flowers for pressing, to fly a kite or to appreciate the surroundings. Several factors had to be taken into consideration, the physical fitness and age of the patients and their current mental state. When the group was very large it was split in two, the younger patients taking a longer and brisker walk than the elderly and physically impeded patients who took a slow and relaxing stroll. On cold or wet days the group stayed on the ward and activities consisted mainly of art work, making collages and pressed flower pictures.

Discussion was not actively encouraged by nursing staff, but was not discouraged. In this way most of the conversation that took place was natural and forthcoming, whereas if patients had been made to feel that they had to contribute, their conversation would most likely have been artificial and the object of the activity group would have been defeated.

Results

Table I shows the age, sex and diagnoses of the patients in both groups. The difference between the initial (baseline) score and the final score for each rater is shown in Table II. The final score was used as this score represented the outcome of treatment at the time of the patients' discharge from the unit. Table II shows that patients in both groups improved on average very significantly, but there were no important differences between the discussion and the activity group.

Table III shows product-moment correlation coefficients between the raters with similar levels of agreement. The average correlation coefficient for all raters calculated via the z transformation was $r = +0.64$. In view of the close agreements between the raters, a composite mean score which would be expected to conform more closely to a normal distribution was calculated from the scores of each rater for each patient individually. These composite scores were used to examine the rate of change from the initial through to the intermediate and to the final scores between the two groups by an analysis of variance model for two independent groups observed over the same time intervals. The highly significant reduction of morbidity for both groups was confirmed with no significant differences in the magnitude of this reduction between the two groups, and with no significant difference in the rate of reduction in scores ($F_{3,222} = 1.0$; P = n.s.). Analysis of variance of the composite scores for the two groups taken separately confirmed the significant reduction of morbidity shown by the paired t test in Table II: for the discussion group ($F_{3,111} = 18.7$; $P = 0.001$) and the activity group ($F_{3,105} = 17.8$; $P = 0.001$). Ratio of t values 5.6/5.4 for the composite scores in Table II 1.04, for the F values 18.7/17.8, 1.05 showing close agreement between paired t tests and the analysis of variance.

Electroconvulsive therapy (ECT) was one of the

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treatments given to the patients in both groups according to accepted indications. The decision to give ECT was taken independently of which group the patients were in. Eleven patients (29 per cent) were given ECT in the discussion group and fifteen (42 per cent) in the activity group ($\chi^2 = 0.8$; P = n.s.). All raters' scores showed that ECT caused the biggest reduction in morbidity of any treatment given. If the composite scores of all raters are taken together, ECT was associated with 2.95 times as much reduction of morbidity as that seen in the non-ECT treated patients in the discussion group, with 2.5 times as much reduction in the activity group.

This large and rapid reduction of morbidity due to

TABLE I

Age, sex and diagnoses of patients in both groups

		Discussion group n = 38	Activity group n = 36
Males	Mean age	43.4 years	38.2
	±S.D.	16.2	13.8
		n = 12	n = 10
Females	Mean age	45.9	46.7
	±S.D.	11.0	15.7
		n = 26	n = 26
Diagnoses	Affective illness	22 (58%)	16 (44%)
	Schizophrenia	8 (21%)	12 (33%)
	Personality disorder	4 (11%)	4 (11%)
	Alcoholism	2 (5%)	4 (11%)
	Obsessional neurosis	1 (3%)	0
	Anorexia nervosa	1 (3%)	0

There are no significant differences between the items in the two groups.

TABLE II

Initial and final ratings for the two groups of patients

	Means							
	Baseline	Final	Mean difference	±SE	% change in means	t*	d.f.	P <
Discussion group (n = 38) as rated by:								
(A) Independent psychiatrist (VAS)	52.50	32.30	20.20	5.06	−38.5	3.9	37	0.001
(B) Discussion group psychiatrist and nurse (GS)—Includes patient self-rating	3.50	2.16	1.34	0.19	−38.3	5.2	37	0.001
(C) Independent ward nurses (GS)	3.00	1.92	1.08	0.23	−36.0	4.7	37	0.001
Composite scores (A, B, C)†	3.17	1.94	1.23	0.22	−38.8	5.6	37	0.001
Activity group (n = 36) as rated by:								
(A) Independent psychiatrist (VAS)	44.17	26.48	17.69	2.59	−40.0	6.7	35	0.001
(D) Activity group nurses (GS)	2.60	1.60	1.00	0.18	−36.3	5.5	35	0.001
(C) Independent ward nurses (GS)	2.58	1.64	0.94	0.21	−39.0	4.6	35	0.001
Composite scores (A, D, C)†	2.60	1.65	0.95	0.18	−36.5	5.4	35	0.001

VAS = Visual analogue scale rating; GS = global scale rating.

* Method of paired comparisons.

† Scores of A transformed to 6-point scale.

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TABLE III

*Agreement between raters**

Raters	Discussion group n = 38	P	Activity group n = 36	P
Psychiatrist (A) vs Psychiatrist (B) and Charge nurse (B)	r = +0.56	0.0005		
Psychiatrist (B) and Charge nurse (B) vs Nurse (C)	r = +0.52	0.0005		
Psychiatrist (A) vs Nurse (C)	r = +0.65	0.0005	r = +0.42	0.01
Psychiatrist (A) vs Nurses (D)			r = +0.54	0.0005
Nurse (C) vs Nurses (D)			r = +0.68	0.0005

* Paired differences between baseline and final scores for each patient (product-moment correlation coefficients).

ECT was thought likely to swamp the smaller expected effects of group discussion. It seemed reasonable to look for the effects of group discussion in the non-ECT treated patients by correlating the reduction in their morbidity scores with the number of times they actually attended the group. If help was being given in unravelling of problems, presumably benefit would be both proportional to exposure to the group and also cumulative. Patients did not always attend their group on every occasion due either to phases of their illness or to their own reluctance. The possible attendances for the discussion group were a mean of 4.50 with actual attendances of 3.2, and for the activity group 4.55, actual 4.0; (t = 1.2; P = n.s.) for the differences between the actual attendances. The correlation coefficient for reduction in the composite scores with actual attendances in the 27 non-ECT treated patients in the discussion group was r = 0.18 and for the 21 non-ECT treated patients in the activity group was very similar, r = 0.23. This result suggests that there was a general improvement influence not related to the particular activity in either group, possibly resulting from a variety of general milieu and other treatment factors. Both the psychiatrist and the nurse leading the discussion and activity groups were asked which patients they would have selected for inclusion with the prospect of most benefit had there not been a randomized input. For the discussion group 22 (58 per cent) of the 38 would have been selected. The mean reduction in the composite scores of the 'selected' 22 was 1.25 (S.E. ± 0.27) and of the remainder, mean difference 1.22 (S.E. ± 0.37) t = 0.07; P = n.s. For the activity group, 26 (72 per cent) would have been selected, their mean composite score reduction was 0.95 (S.E. ± 0.23). Ten would not have been selected; their mean composite score reduction was 0.74 (S.E. ± 0.23); t = 0.9; P = n.s. Hence selection would have only very marginally improved the results, this marginal improvement applying to both groups. Ward medical and nursing staff noticed a general improvement in both patient and staff morale resulting from the extra attention and involvement caused by the research process, the Hawthorne effect (Mayo, 1933).

Discussion

It might be said that our study is based on an inappropriate model. However, several of our former patients, although none in our present study, had been in units or hospitals run on therapeutic community lines where they were automatically included in a ward discussion group. Hence our study reflects the current practice of some psychiatrists. It might be suggested that improvement would have been detectable had the discussion group been held more frequently or gone on longer. We were, however, looking at what could be achieved within the usual length of stay of our patients, bearing in mind that prolongation of stay is likely to increase dependency. Although no structured discussion was planned in the activity group, nevertheless patients did discuss problems with staff and other patients in this group which might have narrowed differences in outcome in both groups.

A possible objection to our study could be that we did not expect any benefit from a discussion group and therefore influenced the patients' responses. This does not apply to our study since both therapists (B) were convinced from previous training that group therapy is worthwhile, although their ratings (Table II) of what was actually achieved in the discussion group did not differ importantly from the ratings of the uninvolved observers. The skill and experience of our two discussion group therapists might also be thought to be an important factor although several research studies, including that of Strupp and Hadley (1979),

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have shown that highly experienced professional psychotherapists achieved no better results than did untrained therapists in time-limited psychotherapy. Also Smith *et al* (1981) chapter 5, Table V–X show that therapist experience showed a zero correlation with outcome in 1,637 studies. Our group therapists reported that those patients who participated most in discussions appeared to benefit most, and have now proceeded to a ward group selected as a result of this experience. Broad outcome studies which measure symptoms may be criticized, but patients expect to be relieved of their symptoms. In a study of groups, Taylor (1961) used symptoms as an index of change.

It is possible that the only benefit from a ward discussion group is within the Hawthorne effect (Mayo, 1933).

As the controlled comparison of ward discussion groups of the type we describe has not been included in recent reviews, we feel it justifiable to have carried out a broad outcome study, but realize that a more detailed analysis needs to be undertaken to detect the subgroup of patients who do benefit in the particular setting we describe.

'A walk is as good as a talk' may be an over-simplification of our conclusions.

References

BERGIN, E. A. & GARFIELD, S. L. (EDS.) (1978) *Handbook of Psychotherapy and Behaviour Change*. Chapter 5, 2nd Edition. London: John Wiley.

MAYO, E. (1933) *The Human Problems in an Industrial Civilisation*. Chapters III and IV. Boston: Harvard University Press.

SMITH, M. L., GLASS, G. V. & MILLER, T. I. (1981) *The Benefit of Psychotherapy*. Chapters 2 and 5. Baltimore and London: John Hopkins University Press.

STRUPP, H. H. & HADLEY, S. W. (1979) Specific vs non-specific factors in psychotherapy: A controlled study of outcome. *Archives of General Psychiatry*, **36**, 1125–36.

TAYLOR, F. K. (1961) *The Analysis of Therapeutic Groups*. Chapter V. London: Oxford University Press.

WEST, E. D. (1981) Electroconvulsive therapy in depression: A double blind controlled trial. *British Medical Journal*, **282**, 355–7.

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