PROBLEM ANALYSIS:
AN INSTRUMENT IN THE REHABILITATION
OF CHRONIC PSYCHIATRIC PATIENTS IN THE COMMUNITY

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SUMMARY
In the light of governmental policy in European countries to enhance and reinforce community psychiatric services, the need to introduce a more systematic approach in the treatment of chronic psychiatric patients by the community psychiatric services is currently being stressed. In this paper the problem analysis (P.A.) is described. It is a practical, treatment-oriented instrument which methodically compiles information on chronic patients and their systems. The systematic acquisition and examination of such information provide clues to a rational rehabilitation plan, one that can be carried out by a multidisciplinary community psychiatric service. Such an approach has the added advantage of making education and research in the field feasible.

INTRODUCTION
Inadequate care of psychiatric patients discharged into the community, a lack of direction in formulating psychiatric rehabilitation policy are critical comments at both Government level (House of Commons Social Services Committee, 1985) and by workers in the field (Dingwall, 1987). Despite this criticism reduction of psychiatric in-patient facilities coupled with a further development of community psychiatric services is still a main Governmental policy in European countries. (Dutch Dept. of Science, Public Health and Culture 1984). What such a community service should embody is still a source of dispute.

In community psychiatry, a systematic, methodological treatment model for chronic patients is not yet available. The literature on this subject deals either with epidemiological surveys of prevalence, incidence, and the course of certain psychiatric illnesses (Brown & Harris, 1978; Strauss & Carpenter, 1977), or with the desirable structure and organization of community psychiatric services for the chronic patient (Bachrach, 1983).

Considerably less attention is paid to actual treatment, although certain aspects have, indeed, been examined and reported on (Test & Stein, 1978; Leff et al., 1982). Some conceptual frameworks of the chronic mentally ill were elaborated on in Great Britain by Wing & Morris (1981) and in the U.S.A. by Adler (1984). Both frameworks, however, though carefully thought out, lack a practical protocol.

Up until now, a systematic and practical inventory, assessing the main problem areas of the chronic patient, has not been available. Consequently, knowledge of this group of patients has been limited and rather inaccessible to education and research. The Department of Social
Psychiatry of the State University of Limburg, in cooperation with the community psychiatric services of Maastricht, the Netherlands, has designed such a systematic inventory which is usable in the management of the chronic psychiatric patient living in the community.

**Problem Analysis (P.A.)**

In order to systematically gather information and explore the problems of chronic psychiatric patients living in the community, the authors created a semi-structured inventory covering 3 main aspects:

1. the psychiatric history of the patient,
2. 4 levels of functioning of the patient, and
3. the competence of the patient.

The P.A. has been designed as a practical, treatment-oriented instrument, with manageability by all workers in a multi-disciplinary community psychiatric team as one of its major goals. Information can be contributed from anyone the therapist thinks fit, ranging from referring hospital, family members and neighbours to the local policemen on the beat. The P.A. does not function as a research instrument or a rating scale; rather it is an inventory with open-ended questions, which can be completed within 3 months of regular patient care. In this paper we will elaborate on the 3 above-identified components and present sample questions.

1. The psychiatric history

The foremost reason for obtaining information about a patient’s psychiatric history should be to enable the therapist to learn from the experience of that history and thus to develop a new strategy which is more likely to succeed than previously. With chronic patients in particular, it is important to obtain a clear insight into those factors which have contributed to the process of chronicity. Patient-specific traits (i.e. primary handicaps due to the actual illness process), therapy-specific traits, and traits concerning the interaction between patient and therapist are among the relevant factors.

To illustrate this with an example: in reviewing long psychiatric histories, the main trait of many subsequent treatments can be described as ‘more of the same’. The patient only switches from one therapist to another, while time and again the same strategy is employed, leading to the same problems found in the previous treatment efforts. Additional literature on ‘staff burn-out’ (Intagliata & Baker, 1983) emphasizes the importance of long-term case management traits.

2. 4 Levels of functioning.

The authors chose a systematic approach, similar to that of von Bertalanffy (1950) to the description of the problems of the patient and his system. This approach was used as an explanatory principle but also as an organizational principle. This theory organizes systems in order of complexity and comprehensiveness. Starting at the level of atoms and moving through cells, organs, individuals to family, subculture and finally society (Engel, 1980). Each system affects and is influenced by other systems in a hierarchical manner.

Our model based on this theory is cybernetic and operates in one of two ways: either by providing negative feedback between the various systems in a stable structure or by providing
positive feedback which can amplify minor dysfunctions and cause instability and the possible development of a new structure.

Engel elaborated on systems theory in a different setting and described a case history by means of this theory (Engel, 1980).

In community psychiatric practice, Romme et al. (1981) described 4 levels of functioning within this systematic framework which are used in the current version of the P.A. These are the somatic level, individual level, microsocial level, and the mesosocial level.

![Figure 1](image-url)

At each level of functioning, a certain explanatory principle was arbitrarily chosen. The principles chosen were those most often applied by our team of community psychiatric workers and researchers. They also allowed space for the description of individual philosophies or views at every level of functioning. This was done in order to have the P.A. correspond with the views and philosophies of those working with it. A therapist might, for instance, not work with Erickson's developmental model (2nd level) but rather with a behavioural developmental model. The P.A. offers such alternatives.

The accumulation of information per level of functioning is as follows:
Level 1: The somatic level
At the somatic level, physical complaints and illnesses are the focus of attention. The therapist is asked to describe these complaints and illnesses and, at the same time, determine their origin. If this is not clear, the therapist is then asked to note what steps he is planning to take in order to clarify the cause of dysfunction at this level. (This often involves an affirmation or exclusion of physical dysfunctions.) Such steps may involve obtaining information directly from the patient or consulting with the patient’s G.P. or specialist.

Questions at the somatic level include:
- If symptoms are of an organic nature, is there any reason to pay attention to them in your therapy?
- If a functional disorder has been diagnosed, do you intend to treat this disorder on the somatic level (e.g. with relaxation training, psychotropic drugs)?

Level 2: The individual level
At the individual level, our focus shifted to a systematic description of psychopathology on the one hand, and to the detection of possible developmental disturbances on the other. The most important and obvious justification for this choice is the frequency of psychopathology and developmental disturbances found in our patient group.

In the definition of psychopathology, a classification according to the diagnostic criteria from DSM III (American Psychiatric Association, 1980) Axis I and II was chosen. The therapist is first asked to describe psychopathology, psychiatric syndromes, and a personality disorder, if present. Approximately 20% of our chronic community psychiatric patients prove to be mentally handicapped, and the P.A. must also take this assessment of mental handicap into consideration.

The second part of the description at the individual level refers to possible developmental disorders. It is accompanied by a guideline for taking a biographic history by means of a short description of the developmental stages described by Erickson (1963).

Level 3: The microsocial level
At the microsocial level, the primary issue is the identification of problems in the interaction between the patient and his social network. Here, the problem analysis focuses on 3 elements:

1. A factual description of the family in the broadest sense of the word. Most often this will involve the traditional family; however, in the case of single persons living in boarding houses, fellow occupants might form the actual “family”.
2. A description of the most prominent interaction patterns within the involved family.
3. A description of the social network of the patient i.e. those who have an important role in the maintenance of the patient’s social equilibrium or the fulfilment of certain needs of the patient. People falling into this category may range from the G.P. to the policeman on the beat.

Family description
Gathering information on major role models for the patient is necessary because these people
may play an important role in many community psychiatric strategies. Giving direct support in times of crisis, providing shelter, and securing a job for a patient are examples of community psychiatric strategies.

**Interaction patterns**

Here we use the concepts used in communication theories and family therapy. The therapist is asked to give a description of the family in interactional terms. An explanation of the P.A. is given in the form of an observation scheme, as proposed by Cleghorn & Levin (1973) and Boeckhorst (1980). A modified scheme allows the therapist to come to some conclusions as to the structure of the patient’s system, relationships within that system, main themes and dogmas of the family, delineation, and conflict regulation of a system. It is not our intention to initiate family therapy. Our intention is, however, to help the therapist focus on families of the chronic patient. One might, for instance, attempt to detect stereotype, and rigid interactions or a high level of “Expressed Emotion” (EE) (Leff et al., 1982), which might suggest a possible treatment plan. A question typically asked is:

— What is the hierarchical position of the various members within the particular system? Who, for instance, is the leader of the system, and what is the patient’s relationship to this person?

**Social network**

Because the social network surrounding many chronic patients often becomes diminished and is taken over by therapists and their services (Speck & Atteave, 1973), an exact analysis of the social networks of our patients is vital. Therefore network strategies play an important role in community psychiatry.

We use the classification in sectors by Erickson (1975) for a systematic description of these networks. The classification includes a kinship sector, a friendship sector and a service and caregiving sector. We take this classification a step further by dividing the functions which people in each sector fulfill into affective needs, identification needs, material needs, and social obligations. This part of the P.A. includes a short explanation of each of the above-mentioned classifications. Two illustrative questions from this section are:

— Which of the patient’s relatives keeps in contact with him? What is the significance of these contacts for the patient? Have there been any changes in this sector?
— Which of the following figures representing authority does the patient interact with: his employer, the local police officer, his physician? Have there been any changes in this sector?

**Level 4: The Mesosocial Level**

The degree to which a patient is able to function in his community depends not only on the social problems he has but also on his particular position.

Social changes and traumas principally influence the patient’s mental health in a subjective way and have consequences that are significant on the somatic, individual, and microsocial levels. This leads to P.A. questions such as:

— Which important events have occurred in the life of this patient?
— What were the psychological consequences of these events for the patient (e.g.
pathological mourning, paranoid reaction)?

— What were the social consequences of these events for the patient (e.g. social isolation, budgetary problems)?

The authors' impression is that the relationship between the moment the above-mentioned events occurred and the beginning of the help-seeking behaviour is very important, particularly since the consequences of social problems are only felt in the long run. Therefore, the next P.A.—question to be asked is:

— Do the events described earlier and their consequences have any relationship to the onset of the help-seeking behaviour? If so, describe this relationship and note if you are in agreement with your patient.

This part of the P.A. ends with the question:

— Which consequences do you want to act upon and how?

Special attention is focussed here on the possibility of compensating for losses suffered (often the loss of work and the loss of structure and meaning in one's life) and on the possibility of promoting the social interests of the patient.

3. The competence of the patient.

We define competence as the ability to act when confronted with stimulus. In the P.A., a distinction is made between role competence, coping competence, and competence in the 'sense of control'. Role competence is defined as the ability to adequately fulfil a social role; coping as a form of competence which refers to the way in which people handle problems. Competence, in the sense of control, is defined by the possibility of feeling able to control a given situation, parallel to the internal/external locus of control theory (Rotter, 1966).

Some of the findings of our problem descriptions on the 4 levels involve a form of competence (e.g. the level of intelligence, the presence of a handicap). The following are examples of questions related to the above-defined forms of competence:

— In what important role does the patient exhibit a dysfunction?
— Is there a fixed pattern evident in the handling of problems, or is there a flexible style of handling problems?
— Does the patient show a sense of competence in, and mastery of, his life, well-being in his environment, and concern with the overall outcome of his life?

P.A. intake notes

Once the P.A. is completed and discussed in the team a working hypothesis is formulated consisting of considerations as to the main problems and the mechanisms causing lasting instability. A treatment programme with goals in both short and longer term is thereafter designed.

An example of such a final formulation and treatment plan is given in figure 2.

Four Years of experience with the P.A.

A criticism which can be levelled at P.A. is that it is a method of assessment already in use by many in—and out patient services and not more useful than standard psychiatric, social and
functional assessments. The general notion of a multi-level descriptive schema and a treatment oriented record has been thought of as already integrated in daily practice.

What, in effect, is new in this approach? Four years of experience with the instrument in

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**Figure 2**

<table>
<thead>
<tr>
<th>P.A. intake note</th>
<th>Patient number: 87-32-206</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: Mrs. J. Brown</td>
<td>Therapist: Harris</td>
</tr>
<tr>
<td>D.O.B.: 17-2-50</td>
<td>Date of intake: 23-2-87</td>
</tr>
<tr>
<td>Marital Status: divorced</td>
<td>Date: 15-4-87</td>
</tr>
<tr>
<td>Referring agent: local Psychiatric Hospital, acute admission ward.</td>
<td></td>
</tr>
<tr>
<td>G.P.: Dr. Engel.</td>
<td></td>
</tr>
<tr>
<td><strong>Reason for referral:</strong> frequent compulsory admissions; non attendance O.P. Clinic; non-compliance with medication.</td>
<td></td>
</tr>
<tr>
<td><strong>Reason for client to seek help:</strong> wants rehousing; wants to be discharged from hospital.</td>
<td></td>
</tr>
<tr>
<td><strong>Short summary of psychiatric history:</strong> 5 admissions during last 3 year with a recurrent acute psychosis, accompanied by drifting- and sexually disinhibited behaviour.</td>
<td></td>
</tr>
<tr>
<td><strong>Therapies:</strong> compulsory admission with antipsychotic medication, rapid remissions 1 year ago individual contacts for 6/12 with social worker.</td>
<td></td>
</tr>
<tr>
<td><strong>Main dysfunctions on levels of functioning:</strong></td>
<td></td>
</tr>
<tr>
<td>Somatic level</td>
<td></td>
</tr>
<tr>
<td>Hypertension regulated by medication as prescribed by G.P.</td>
<td></td>
</tr>
<tr>
<td>Tension headaches: approx.: twice weekly.</td>
<td></td>
</tr>
<tr>
<td>Individual level</td>
<td></td>
</tr>
<tr>
<td>Only child; uneventful upbringing; difficulty in maintaining lasting intimate relationships except with her only child, a son of 18 y. old.</td>
<td></td>
</tr>
<tr>
<td>DSM III: Axis I a typical psychosis</td>
<td></td>
</tr>
<tr>
<td>Axis II none</td>
<td></td>
</tr>
<tr>
<td>Microsocial level</td>
<td></td>
</tr>
<tr>
<td>living with son in a small terraced council house. No family contacts; contact with a former female colleague. Confides in son as if a partner. Negative contacts only with neighbours.</td>
<td></td>
</tr>
<tr>
<td>Mesosocial level</td>
<td></td>
</tr>
<tr>
<td>living on social benefit: 1st episode of illness occurred following the break up of a relationship of 1 year standing with a former employer. Employed as a receptionist till the 2nd. episode of illness.</td>
<td></td>
</tr>
<tr>
<td>Good relationship with G.P.</td>
<td></td>
</tr>
<tr>
<td>Formulation:</td>
<td></td>
</tr>
<tr>
<td>A 37 year old divorcee, living on social benefit with her 18 y. old son. She has a 3 year history of recurrent psychotic episodes, leading to a rapid decline of her social network, expulsion from the neighbourhood and unemployment.</td>
<td></td>
</tr>
<tr>
<td>Unability to maintain lasting and trusting relationships, diminishing compliance with treatment.</td>
<td></td>
</tr>
<tr>
<td>Treatment goals and means:</td>
<td></td>
</tr>
<tr>
<td><strong>a. short term</strong></td>
<td></td>
</tr>
<tr>
<td>working on a therapeutic relationship with both patient and son. Increase of compliance by offering depot neuroleptmedication via G.P. (consultation by co-therapist).</td>
<td></td>
</tr>
<tr>
<td>Help with rehousing and day activity.</td>
<td></td>
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<tr>
<td><strong>b. longer term</strong></td>
<td></td>
</tr>
<tr>
<td>prolonging periods of none psychotic state</td>
<td></td>
</tr>
<tr>
<td>restoring social network and employment</td>
<td></td>
</tr>
<tr>
<td>facilitation of a normal leaving home process of her son.</td>
<td></td>
</tr>
<tr>
<td>Co-therapist (if necessary): Dr. Adler</td>
<td></td>
</tr>
</tbody>
</table>
routine rehabilitation care was obtained. The implementation of the P.A. in the community psychiatric service of Maastricht resulted in

- creating order for the therapist in the chaos of problems the patient and his system presents.
- focussing therapists on life domains and problem areas of the patient which were until then not recognised or given attention.
- a systematic recording of, and communication on, often very complex rehabilitation problems.
- the formulation of a well founded rehabilitation programme.

On the other hand the P.A.

- is time and energy consuming (2 to 4 hours spread over a 3 month period).
- sometimes evokes feelings of insecurity, especially when levels of functioning of patients are assessed on which the therapist involved assumes lack of factual as well as professional background.
- reduces the possibility of a free and personal overall formulation of the rehabilitation problems the patient presents.

As far as training and research purposes are concerned the P.A. proved to be very useful. Trainees in the rehabilitation of chronic psychiatric patients irrespective of professional background, experienced the P.A. as a useful and systematic tool in their assessment of patients.

The P.A. also resulted in 4 research projects and publications involving somatic, social network, sociological as well as psychopathological aspects in the rehabilitation of chronic psychiatric patients.

REFERENCES

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