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"WHOSE GROUPS ARE THESE ANYWAY?" ON STAFF AND PATIENTS' NEEDS AND THEIR IMPACT ON THE MILIEU

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SUMMARY

The psychiatric ward is a complex organization. It contains two main groups: the patients and the staff. The different needs of each group influence the encounters between patients, the consumers, and staff, the suppliers. We shall discuss those needs and analyze the ways they interfere with or complement the therapeutic group work. For example: staff members need specific therapeutic group work for their professional development, and the patients need the group in order to maintain some form of interpersonal contact and to keep themselves active. The staff holds therapeutic groups in order to monitor the activity on the ward, while the patients seek a space where they can express their concerns about their treatment. Some vignettes will be presented which demonstrate these different needs, of staff and patients, and the way they were explored in the staff's group supervision meetings.

Key words: *group therapy - ward staff – patients - psychiatric ward*

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Introduction

Group psychotherapy is a very useful intervention in the treatment of psychiatric patients. Very often inwards therapeutic work is based on the participation of patients in social activities which are organized by the staff. These activities take the nature of therapy groups. The purpose of our paper is to discuss the issue of group work in a psychiatric ward, in terms of both the patients' and the staff's needs.

Method

A literature review about of group work in a psychiatric ward, in terms of both the patients' and the staff's needs is carried out, and the results of the author's supervision sessions with ward staff are examined.

Results and Discussion

The question we are asking: What are the inpatients' needs in group therapy and what are the needs of the staff's members? This question became apparent during supervision of the staff members who conduct the groups.

Why are the concepts of needs so important? There are a few answers:

All of us human beings strive for the same basic things. It is important to understand both, our needs and our patient's, because if we understand the needs, we will find it easier to realize what motivates us and them. The moment we identify a need we are more able to direct our acts to meet that need, and we can think to what extent we are able to provide the need.

What are our psychological needs?

Deci & Ryan (1991) defined 3 essential needs:

1. The need to feel competence in what one does.
2. The need to feel autonomous.
3. The need to feel close to some important others, relatedness.

Very similar outcomes came out in Sheldon and his friends' research on satisfying events. They found that when people are asked to think about an event that made them feel fulfilled they think about experiences in which they felt they had autonomy, competence, meaningful attachment to significant others and they found also the need for self esteem. The importance of this research was the contradiction of the common assumption of the importance of popularity and money; these needs were found to be even harmful to well-being.

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These outcomes correspond to Kohut's theory about self object needs.

According to Kohut (1971, 1977, 1984), the development of a cohesive self takes place along three axes: (a) the grandiosity axis which can be equivalent to competence and self esteem, (b) the idealization axis refers to the development of a person's ability to form and maintain a stable system of goal-setting ideals, what we can consider as belonging to autonomy, and (c) the alter ego–connectedness axis which can be equivalent to relatedness.

The psychotic patient's needs

What are the psychotic patient's needs? Under what conditions will he achieve development? Though there is some reference to this question in the literature the question remains unresolved. Do we really know what the schizophrenic patient's needs are? It seems that our ability to identify the patient's needs is limited, as is the patient's cognitive and emotional ability to articulate his needs. This condition leads us to empathic endeavor as well as failures and frustration.

Referring to group work in psychiatric unit, we can offer the same groups for all the patients, but in practice only part of the patients participate. Sometimes we hear resistance to group activity among the patients as one of our patients uttered: "I don't care what groups you have in this ward, I don't want anything from you and it does not interest me what is going on in these groups and why you are doing them".

The answer might be that despite the universality of human needs there are people whose ability to reach basic needs fulfillment is blocked and as a result they are detached and regressed. The psychotic patients are in this category.

What is the particular uniqueness that contributes to this barrier?

The comprehension of the psychotic condition can give us some answers.

The psychotic patient has difficulty in his relations to his surrounding specifically the others with whom he has interactions. Freud (1914) was convinced that schizophrenia was characterized by decathexis of objects. Freud used the concept of withdrawal of object cathexis to explain his observation that in comparison to neurotic patients schizophrenic patients were incapable of forming transference. This difficulty is natured by loss of cathexis of the ego boundary, with its attendant loss of a sense of personal identity (Federn 1952). The disturbance of the development and maintenance of adequate ego boundaries brings an uncertainty as to his own existence. The schizophrenic patient loses a sense of himself as a distinct entity, separate from the external world. He can confuse himself and parts of his body with others or with objects in the immediate environment. There may be a vague un-clarity as to whether an experience pertains to him or to someone else.

Grotstein (1977) vied a constitutionally based hypersensitivity to perceptual stimuli as the central defect of the schizophrenic patient. The inability to screen out various stimuli and to focus on one piece of data at a time is a central difficulty for most schizophrenic patients as a result of this defective stimulus barrier the unmodulated release of primitive destructive impulses resulted in a state of psychological emergency. To deal with these impulses a schizophrenic person resorts early in life to massive defensive operations such as splitting and projective identification.

Ogden (1980) suggested that the schizophrenic patient is torn between wishes to maintain a psychological state in which meaning can exist and wishes to destroy meaning and thought and the capacity to create experience and to think. According to this conceptualization the patient attacks unconsciously his own mental contents including his perceptions, feelings and thoughts because they threaten the patient with overwhelming pain and unmanageable conflict. The outcome is a state of shutdown of psychological limitation that approximates non-experience. There is a persistent conflict over maintaining this state versus allowing some absorption of thoughts, feelings and perceptions of the outside world that might lead to psychological growth.

Resnik (1995), in his vivid paper about group work with chronically ill schizophrenics he conducted in Paris "the space of madness" indicates some of the difficulties in reaching the psychotic patient:

> "Becoming ill, becoming psychotic has to do with overwhelming crisis, a catastrophic experience in which everything that was contained and built up internally explodes…The psychotic patient is usually an extremist and polar, the experience of time is blocked, in chronic states of madness inner time is paralyzed, there is an autistic

> protection, a state of being and living in a space far removed from ordinary time and space. The psychotic patient feels discontinuity, disintegration and fragmentation; he has his different language and different ideologies which the psychiatrists call delusions."

Resnik's dynamic work with chronic schizophrenics emphasized the birth of transference as the main goal in the group where patients were autistic and detached, whereas less chronic patients may show more need for interpersonal and expressive moments as they are more connected to reality.

Some authors like Kibel (1981), Beeber (1991), and others, described psychotherapeutic work for hospitalized schizophrenics in a different way. Kibel recommends the system approach and object relation approach, the main aim for him in the work with hospitalized psychotic patients is to understand the patient's experience in the ward. Others recommend approaches emphasizing supportive, structured and focusing interventions. (Green & Cole (1991) Kanas (1986).

Leszcz and his friends (1985), found also that there is a difference between lower and higher functioning patients. Higher functioning patients were dissatisfied with the overly structured groups. They valued the groups where more interpersonal learning was found. Gonzalez de Chavez and his friends in (2000), in their trial research found further validation of the hypothesized associations between levels of psychopathology and social structure. They suggest that the group contexts per se with their inherent demands for some sacrifice of personal identity for the sake of group cohesion are generally counter therapeutic for those with strong psychotic leanings.

These recommendations make us think that in terms of needs, the concept of hierarchy used by Maslow is relevant. The sick person's needs are much more for safety. It means structured repetition of rites and formalities which brings internalization of security. We also found that using the principles of dynamic group work with patients in the ward is very relevant and productive. This work helps to internalize structure and the experience of care, concern, interest and love, as has been noted by Rycroft (1985) "psychoanalytic treatment is not so much a matter of making the unconscious conscious, or of widening and strengthening the ego, as of providing a setting in which healing can occur and connections with previously repressed, split off and lost aspects of the self can be re-established, and the ability of the analyst to provide such a setting depends not only on skill of making correct interpretations but also on his capacity to maintain a sustained interest in and relationship with his patients"

To summarize all that have been said so far: some of the patients can feel self esteem, attachment, competence and autonomy in a well constructed defined and predictable setting. Others can enjoy a more explorative emotional open setting. How can we identify who are the former and who are the latter? Is the patient's organization level criterion always relevant?

Very often we meet patients whose reality testing is very poor and who insist on participating in the verbal unstructured groups whereas others whose verbal ability and reality testing is relatively good avoid open explorative setting.

The group conductors' needs

From what has been said so far the group conductors' needs are the same common needs for self esteem, competence, autonomy and relatedness.

Bacal and Thompson (1996) say: "When for whatever reason the therapist's needs are not met, he may experience the painful and even visceral sensations of disrupted self-states that can undermine his therapeutic function.

During supervision meetings the staff needs were expressed in the following way;

In this ward it is customary, almost mandatory, that each staff member participates in group work. This together with participating in group supervision enables learning and enhances feelings of affiliation to the staff. Groups which are popular among patients are not necessarily attractive to the staff. It is not rare that there will be tension between the needs of the ward for enlisting staff members to some group and the need of staff members to choose the group they prefer. It is sometimes not easy to enlist conductors to groups such as psycho education about medication and 'the actuality group' which deals with recent news in the newspaper. Staff members say: "I thought about an expressive group" or "a more dynamic group". These are also expressions of staff members' needs for autonomy. It is difficult to do therapeutic work that you don't identify with.

Notwithstanding, It is important to encourage the staff to experience new possibilities which they otherwise wouldn't have. Working with a co therapist with whom they feel close to and who enjoys conducting that specific group serves as a compensatory mechanism. Frequently, group conductors express their feeling that a group session was not deep enough. It is difficult to understand what the exact meaning behind these feelings is. My assumption is that feeling superficial expresses a failure in comprehending the group's process. What is damaged in this context is the feeling of competence. Repeatedly we face silent groups, restless groups, psychotic incoherent groups and we ask ourselves: what is going on? Group psychotherapy is a very qualified assignment, however less formally taught, or exercised. Staff members are assigned to conduct groups. They use their understanding and past experience but they lack basic knowledge about group theory and practice. This frustrates their need to feel competent. On the other hand, remembering my first example, one of the leaders in the group was a student, and in a way in this phase she was too much connected to theories and manuals and too little connected to her creativity. The feeling of superficiality may also reflect a need for emotional expressiveness. Group conductors expect patients to reveal emotions in a way they may be felt: to move out of the freeze. Virtually, lack of deepness means emotional detachment. The problem is that the staff wants patients to give them the very thing they are unable to give. This is the disappointment in the treatment of schizophrenics. The intricacy in therapeutic work with schizophrenics is not their delusions and hallucinations but their emotional inadequacy, which prevents them from giving the therapist recognition and gratitude. Therapists without sufficient support tend to protect themselves by counter detachment. Group therapists need to feel achievement. Group participants and the group as a whole become self objects to the therapist's therapeutic self. We can assert that our basic needs for relatedness, competence and self esteem are frustrated by work with schizophrenics. The distressed psychotic patient with his experience of worthlessness becomes an assault on the therapist's sense of significance. Often the therapist offers an interpretation to a group situation and the group responds in apathy, disinterest or worse; the group insults the conductor by ironical offense. This is a threatening experience. The personal and professional self is in danger. Frequently, it is complicated to find the correct time for interpretative intervention. Can we be sure that group members are ready to use their therapists understanding and are able to use it as a meaningful connecting resource? Does a group go through a developmental process where the turn-over is rapid and the groups are mostly open? The work which is an effort to build relations and contact is endless if not Sisyphean in such groups. It has to be done over and over again. Frustration about discontinuity is huge. Substantially we act in a setting which reactivates the patient's pathology in creating attachments and affiliation. This is enhanced by the temporality of some of the staff. Interns, students and volunteers work for limited periods of time, and sometimes they leave in the middle of the patient's recovering process. Some of the group conductors express a need to relate more closely to madness, to penetrate the world of madness. Others still communicate a fear of madness and a need to keep their distance. There is some mystery in madness. Chaos can be attractive in a way. This attraction may be in opposition to the need to construct the patient's world or to perform activities that deal with the chaos. There can be a contradiction between rehabilitating and expressive explorative task.

Clinical examples

Our first example is from an ADL group whose aim was to improve the patients' daily self care functioning. This group was conducted by the ward's nurse and the nurse assistant. The main goal of the group was to direct the patients in fixing their beds, their rooms, and their hygiene: teeth brushing, bathing, washing etc... This group was built for patients with difficulties in every day functioning. The conductors invited certain patients to participate who were identified as disabled in these domains.

Surprisingly enough other patients who certainly did not have such difficulties asked to take part in that group. In some cases, you wouldn't have believed that they can benefit from such activities. It seems that there are some projections in the manner the staff assume about patients' needs. Suddenly we have evidence regarding patients' needs. Higher functioning patients came and were happy to be active in this group. The conductors described partnership amongst the group members; there was a lot of mutual help and advice. During the group supervision hour, some of the supervisees reacted emotionally. For them,

dealing in a group with patient's self care seemed like infringment into the patients' privacy, and much too judgmental. Who are we to educate patients about their mode of dressing? Do we shift therapy into education? Step by step through the discussion in the supervision hour staff members expressed personal aspects of self neglectfulness existing in all of us. Do we have a person we are ready to consult with according to these issues? Who will it be? Are the patients' problems similar to ours? Are we close enough to say such intimate things to one another?

The second example is from a drama therapy group. It was a weekly meeting group conducted by a drama therapist and an occupational therapist. During the group supervision hour, the therapists described a meeting where the patients had a lot of fun; they collaborated agreeably in dramatic play. When the therapist directed the group to share and to introspect, the group became paralyzed. The supervision aimed at understanding the enjoyable part and its meaning in terms of play. We emphasized the therapeutic value of play for schizophrenic patients whose anhedonic characteristics are so inherent. The effect was that the therapists were able to stay for a longer time with the playful period without aspiring too early for introspection in the following group meetings.

The space of the large group encounters us with the similarity between patients' and staff's needs and in this sense it may soften the contradiction between the staff's and patients' needs. This is a weekly group conducted by the head of the ward. The participants are all the patients as well as all of the staff members, who participate in a non conducting role. This group's aim is to deal with milieu issues. The conductor invites patients to express their feelings about being treated in this unit and on the other hand, he invites therapists to relate to their experience of being a therapist in this ward. The experience of a large group itself evokes complex feelings both in the patients and in the staff members. In this context patients and staff members may feel uncomfortable and ambivalent at the same time. Things that have been projected on to the patients may be seen differently when viewed by the therapist as a participant. Therapists speak about the difficulty of speaking in large groups and they utter doubts about what is the correct thing to say in this group. They worry about the issue of boundaries which is blurred in this situation.

On the other hand, this is an opportunity for the staff to express their subjective stance, sometimes the frustration, and at other times pride and satisfaction, in being a therapist in the ward. When a staff member communicates his subjective feelings, the patients react in interest and gratitude. The emotional experience in this group can become very unique and powerful, for both sides; patients and therapists.

In one of our supervision hours of the closed ward's staff, two therapists who conduct together the biblio-therapy group presented a group session. This group aimed to help patients to express their feelings in reaction to a literary text. The participants were very attentive to a legend about a father who demands his sons' loyalty and obedience. One of his sons disobeyed him and wandered far away to seek his fortune. On his way he had all kinds of troubles and dangers. He scarcely stayed alive and decided to return home and not to stand against his father any more. But the way home was not safe and his father's forgiveness was not promised. At this point, the therapists stopped the story telling and suggested that the participants tell their own end of the story. One of the participants became very restless and asked the conductor to tell him a happy end. The conductors tried to calm him down and suggested that he choose whatever end he desired, but he became more agitated and forcedly demanded a happy end. He started crying and yelling: "I told you I need a happy end" "I told you I can't stand it" then he left the room aggressively. This patient usually participates willingly and enthusiastically in this group and thus his reaction extremely surprised the leaders and caused them to feel guilty and concerned. During the following week they tried to approach the patient in order to discuss his reaction with him, but to no avail since his antagonism remained unresolved.

Following this incident, we had to deal with the therapists' feelings of frustration and disappointment during the supervision hour. This couple has worked successfully together for a long period of time and their group is considered among the most desired ones in the ward. It is; therefore, appropriate to ask why their most committed patient would suddenly destroy the setting. We then devoted the supervision to a discussion about the patient's needs in this episode. The patient expressed an archaic idealized self-object need. He had a need for a mighty self object that can build a protected and peaceful world for him. The moment the leaders did not effectively provide this need, he became desperate and regressed. Thus, at this point, a more flexible way of coping with his need

could be to provide the patient with a "happy end" and then ask if he likes this end or would have liked it in any other way.

Interestingly enough, the issue of demanding a "happy end" did not come to an end. Various members of the group kept asking for stories with "happy ends". Some of them even place their hands on their ears and called out: "stop stop I want a happy end"

The contrasting needs expressed in this example exhibits the complexity of what we have said. The conductors were very busy in leading the group towards the prticipants' emotional expression. They expected them to identify with the hero and recall similar experiences in their life events. The participants, expressed mainly by one of them, needed an archaic omnipotent self object which will tranquillise their anxieties. This led to disappointment on both sides.

Conclusion

In conclusion: The psychotherapeutic group work for inpatients arouses a contradiction between the staff's and the patients' needs. This contradiction demands a space to work it through.

The group supervision can be such a space. The supervision goals are:

- To find a therapeutic work that meets the patient's real needs.
- To moderate therapists' expectations by emphasizing the schizophrenic patient's psychodynamic and its emotional characteristics.
- To allow the recognition from each professional sector of the importance of group work with patients, as well as the difficulty of performing it. Recognition about the value of group work should be given during supervision, particularly when participants seem frustrated and in despair.
- To facilitate good co-therapy in contrast with working alone or working in problematic co-therapy.
- To stimulate the creation of a variety of groups enabling the patients to participate according to their free will but with encouragement and support.

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