Group dimensions in an Adult Mental Health Inpatient Unit

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Abstract

Human beings are immersed in group settings of one kind or another all life long and even when individual mental suffering exacerbates to the point of needing hospitalization, people find themselves sharing space, time and emotions with others. A mental health crisis breaks the individual and family balance and expresses itself with acute and extreme thoughts, emotions and behaviors. Psychiatric hospitalization, although traumatic, gives the patient and his/her relatives an opportunity of living all the alterations in a protected environment also offering them an explanation for these alterations. Clinicians aim to intervene as soon as possible after the onset of a crisis in order to enable the individual to overcome it and to return to normal functioning, reclaiming his or her life in the community. This paper explores the therapeutic application of group therapy on an acute inpatient ward (SPDC) in the Sandro Pertini Hospital in Rome, Italy.

Keywords: group, SPDC, hospitalization, crisis, evening meeting, group psychotherapy, emotions

The Italian Mental Health Act (1978) abolishes asylums and allows people with a mental disorder to be admitted to general hospitals in specialized wards so that such kinds of disorders are no longer considered a disease to segregate. To ensure proper continuity of care over time and to support or treat people with mental health difficulties, the law has provided for the opening of Community mental health services (CSM).

The Pertini acute inpatient ward (SPDC)

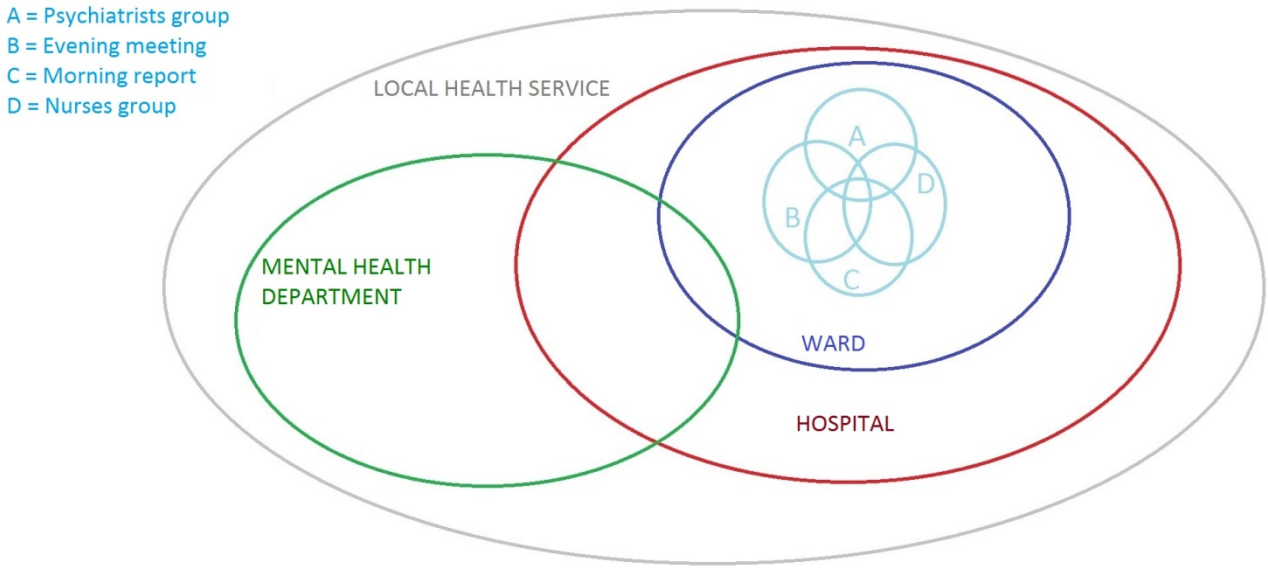
Pertini's SPDC is a 15 bed inpatient secure unit that began to function in 1990 as a locked ward. After a short running phase, the network of relationships and exchanges created by psychiatric professionals within the hospital, now allows patients to freely leave the ward and attend the meeting places inside the hospital; they can ask for a daily pass too. The ward is staffed by a multidisciplinary team of 10 psychiatrists, 3 psychologists, 21 nurses, 2 fixed auxiliaries per shift and at certain times, 2 trainee psychologists. The average stay is of ten days. Clinical activity is developed in a series of structured and structuring events: from the morning greeting in the patients' room by all the staff to the morning report, from the change of shift meeting to the *evening meeting* with patients. Every Monday a team meeting is held to focus on cases which may require particular attention and once a month the team is joined by an external supervisor. A group session of multifamily psychoanalysis takes place once a week.

The crisis, the person and the caring group

The SPDC is specialized in caring for adults in an acute psychiatric crisis. The term crisis derives from the Greek word «krisis» which means decision or turning point. In order to realize an opportunity for changing, to promote a reasonable therapeutic alliance and to enhance patients and family adherence to treatment in a short hospitalization, the clinicians need to know the patient's life story, to discover family dynamics and above all, to evaluate the severity of the crisis and what triggered it. Furthermore, it is necessary to contact the community mental health staff to create or restore a care network. Often in the early days of hospitalization, some patients are very withdrawn while others are so agitated and aggressive that it is necessary to use restraints and involuntary medication. Each patient is assigned to a therapeutic couple (psychologist and psychiatrist) who set up and conduct the intervention until the patient's discharge. During the morning clinical meeting they inform other members of staff in order to compare, modify and integrate observations, reflections and actions. In such a manner, the group as a whole takes care of the patient and at the same time provides the important function of carrying out the directives of a single operator. The individual mind is contained within the group mind.

The group dynamic makes learning possible and creates a mutual internal representation emerge with those operating characteristics adopted by the group when tackling a task. Characteristics such as mutual recognitions, looks, a network of giving and taking roles. We could talk about task interaction and network of bonds within the group that pertain to the group project or task. The shape, a conceptual and operational framework, is open and dynamic and despite being subjected to many changes, keeps its structural stability. As the group develops and its structure consolidates what Anzieu (1979) calls the group psychic skin appears, that which defines the group boundaries (space, places, temporality of the group, the rhythm of the meetings). This frontier, at the same time real and imaginary, allows a distance between the inside and the outside. The containment function carried out by the large group allows its members to differentiate between group identity and what does not belong to it. Kaes (1999) theorizes a "Group Psychic Apparatus for thinking, an area of illusion, a place for cultural experience, an arrangement which may possibly create relations between the inside and the outside groups". Foulkes (1964) introduced the notion of matrix such as "the hypothetical web of communication and relationship in a given group. It is the common shared ground which ultimately determines the meaning and significance of all events and upon which all communications and interpretations, verbal and non-verbal rest" (Foulkes, 1964, p. 292). The matrix has its own structure and functional autonomy that somehow transcends individuals, even though it is globally established and shared by them. It is also capable of conditioning thought, language and behavior. Bion (1961) speaks explicitly of group mind and introduces, among other things, the concepts of proto mental, of basic assumptions and workgroup. Correale (1991) believes that the institutional group has a self-referential function described as "... the ability to get in touch with and, to some extent, to represent as deeply as possible the conceptual and emotional overall state in which the institutional group is situated." The large ward work group is nested in larger institutional groups (Local Health Service, Mental Health Department,

Hospital) and contains small groups whose members are constantly in multilevel interdependence. One of these is the *evening meeting*.



The *evening meeting* and Local Health Services' organizational interconnections

Evening meeting

The SPDC is the place where the pathway for recovery from mental problems starts; the path has to be "... customized to the characteristics of the patient and proposes and integrates a variety of interventions: pharmacological, psychological and psycho educational interventions and interventions on the family. Social and work context are also taken into consideration because, often, these people develop a crisis in relation to their work environment" (Ducci, 2014, p. 7).

The ward *evening meeting*, planned on a regular basis and conducted from the beginning by a psychologist, is configured as a psychotherapeutic event available for every inpatient. It lasts 60 minutes and takes place before dinner with open doors in a large room that communicates with the garden on one side and with the ward on the other. While the meeting is going on, other activities are suspended and patients are rarely called out from the group. All the staff on duty support the activity from outside. The focus of such meetings is to give people a chance to speak about themselves as human beings and not as patients and make it possible to recognize that they differ one from the other despite living through the same experience of illness. Over time the evening meeting has undergone several adjustments and changes in the method and in the setting so that it could be integrated with the work of other clinicians and become a significant resource for the entire system. The facilitator is transparent and personal, active and directive but tolerant in order to provide maximum stability possible. He/she promotes and coordinates verbal interactions to improve communication skills and interacts openly with group members. Due to the rapid patient turnover, the variety of mental problems admitted and the weak boundaries in such groups it is necessary to set *achievable and realistic goals* (Yalom, 2005) focusing on relationships and on what is happening at the present

time. The facilitator encourages patients to perceive the group as a safe place, supports them in emotion regulation, tackles social isolation and avoids confrontation and criticism. The three psychologists in the ward, in respecting their working styles, fully share the emphasis on the here and now having in mind the goal of "...helping patients spot interpersonal problems and reinforce interpersonal strengths, while encouraging them to attend aftercare therapy, where they can pursue and work through the interpersonal issues identified in the group" (Yalom, 2005, p. 493). To organize the *evening meeting*, we follow Yalom's basic protocol: *orientation and preparation, personal agenda setting, agenda filling* (2005, p. 499). After the session, the psychologist writes a report that is always available for the rest of the staff. Important issues raised during the session will be discussed at the morning report in order to integrate diagnosis, treatment planning and the patient's response to treatment. During the *evening meeting*, patients are free to speak and move and although the group becomes a kind of prism on which they can project their chaotic and disruptive inner struggles, the psychologist always takes care to scale down interventions which are too long or inappropriate. More vulnerable and anxious patients have to be actively protected and respected and one must be careful not to completely change the rules and goals of the group. Examples of what happens during the *evening meeting* are illustrated in the following two clinical clinical vignettes.

A. is a 54 years old widow who has suffered from severe mental illnesses for more than twenty years. Normally she seeks voluntary admission when realizes that her psychopathological conditions can seriously threaten to topple the fragile psychological balance of her young daughter, her only caregiver. She calls the ambulance to be taken to hospital where after the first assessment she is normally admitted to the ward. Once in, generally she takes medicine as prescribed, but stubbornly refuses many rules of social coexistence, such as washing herself regularly and public smoking restrictions. She observes everything that happens, checks, warns, orders, challenges nurses' behaviors, prescribes bizarre solutions and often sets herself up as a champion of other patients, but rarely is violent. Not always her comments are meaningless because she brings to consciousness and gives voice, even if in a strange manner, to those feelings and thoughts belonging to others that are rarely expressed. We could say that A. is capable in objectifying unconscious and extremely primitive, rebellious and destructive elements that few other patients are able to bring out in such a manner. Despite the stubborn obstinacy to subvert the rules of coexistence, A. knows well when it's time to give it a rest (a clinical emergency or a difficult admission). A.'s behavioral and emotional characteristics, although putting a strain on staff and patients, help to revitalize the ward with play and fun. This woman never joins the evening meeting, but in a recent admission she showed some detached interest. In fact, one night, mumbling something unintelligible, she crossed the group space with a lit cigarette in her mouth and seated herself by the window; pretending nothing was going on, she turned her back to the other members and continued to smoke. The conductor decided not to address

her behavior and after a while asked A. to face the group and join the meeting. She replied: "even if you begged me, I'm not going anywhere, I'm staying here!" and with an ironic tone to her voice added: "I suggest a game. If the number of people sitting there including you is odd, you win. If it is even, I win!" It is needless to say that the number was even! Meanwhile she finished her cigarette, turned to the group and laughing said to the conductor:"young man, you're too serious! You distress me!" The conductor, who is not a young man, confessed to be too serious sometimes and thanked A. for her contribution that relieved the anguish and the discomfort of that moment. A. replied:"too serious, too serious!", stayed still and silent in her place for several minutes and then got up and moving toward the exit declared loud and clear:"tonight I have done my job well!". Right away she caught the number of people, their emotional state and above all the intolerable anguish circulating in the group setting and in a proto-mental way did something that ended up to be good for the whole group. Maybe A. wanted to say that she recognized the existence and function of the group to which she could take part only marginally and that she felt the urgent need to dilute and defuse tension and anxiety that was trapping individuals and the group.

The above report conveys that divergent behaviors always have a meaning and if they are contained and well addressed in the group, can create healthy climate change and alleviate feelings of fear and distress. Even when a person is very confused, blurred and disorganized, if they can respect their own time and place in attending a therapeutic group, they will be able to communicate, give and receive something from others.

The *evening meeting* takes place with open doors which, although sometimes upsets concentration, allows some patients to gradually get closer to the group, to cross it, to join late, to go out easily, not to join it, to stay "around the corner" and even to "eavesdrop on the conversation". The group provides a space for a vital exchange with others and acts as a bridge between what is thinkable and communicable and what isn't yet capable of being thought and communicated.

F. is a retired 60 years old man who lives with his elderly and very sick mother. He has been suffering from paranoia for many years, he feels suspicious and his behavior is obsessive and controlling. He is hospitalized when his persecutory anxiety states become unbearable for the home environment. His recent acute psychotic episodes are triggered by the mother's severe physical conditions who require continual medical care and assistance from in-home care workers. Helplessness, loneliness, need for help and his mother's illness generate intolerable emotions and feelings. His stress peak and he stops taking his medication and becomes angry and very persecutory. He hires and fires continuously paid caregivers because not one of them suits his perfectionism and his intrusion is very hard to tolerate for them. The result is a general exasperation of the whole system. F. loses control of the situation, sleeps less, becomes hyperactive, irritable and verbally aggressive, constantly calls the police denouncing a plot against him. At this point hospitalization becomes necessary and most of the time it is involuntarily. Once

admitted to the ward, F. is less distressed, but still devalues, threatens, promises revenge and agrees to take medication only after having asked many times its color, active ingredients, benefits and side effects; at the end, although continuing to verbosely claim the full recognition of his delusional beliefs, he takes the medicine. During hospitalization F. takes notes, writes memoranda for future lawsuits, threatens retaliation, rejects meetings with his consultants and at the minimal personal affront calls his lawyer and sometimes refuses therapy and lunch or dinner. He isolates himself from relationships and doesn't attend the evening meetings although sometimes while the meeting is on, he walks up and down the corridor with a briefcase in his hand pretending to be ready to return to work. During his last hospitalization, he was standing by the door while the evening meeting was on and when the conductor invited him to join the circle, he kindly replied he would remain in that position so: "I can be sure nobody talks about me". F. remained to listen out of the room for a long period of time generating contrasting feelings and remarks by group participants. The next morning he paid his compliments to the group conductor and without any arrogance asked for help to deal with his mother's foreign caregiver. The psychologist answered his questions, gave some advice and invited him to attend the next evening meeting where he could have help from a large number of people. F. answered back: " believe me doctor, I would like to attend your group, but at the moment I'm not ready to discuss with other people without rancor. If you don't mind, I'd rather listen from the corridor."

In this case, the patient made personal use of the group setting according to his own time and conduct and probably took something from the group. Certainly he could verify that there nobody was plotting against him, and gain a small amount of trust in another human being, even if just for a short while. F was able to reduce his feeling of intense distrust and suspiciousness and allowed an operator to help him on a very important issue.

Therapeutic factors and goals of the *evening meeting*

Often we wonder whether to use the *evening group* psychotherapy or not, seeing that it is a particular therapeutic tool, a sort of transitional and short-term group intervention on acute inpatients who only attend it 4 - 5 times during their stay. It is a temporary therapeutic tool, partial but intense and its continuity stays in the minds of operators and in its daily repetition even with a high turnover of patients. "The mental and time reference is in each session, but the group is attended by a core group of people who, for a number of meetings live according to the rules of the ward and are able to transmit group environment and norms to new patients" (Stòccoro, 2006, p. 94). Nevertheless, we think that the elements responsible for positive change in psychotherapy operate even in this kind of setting. Elements that Yalom (2005) calls "therapeutic factors": *instillation of hope, universality, imparting information, altruism, the corrective recapitulation of the primary family group, development of socializing techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis, existential factors.* The goals of the group are limited, achievable and tailored to the capacity and potential of group members who are

encouraged to concentrate on current experiences with the aid of tasks. In conducting the *evening meeting,* we constantly bear in mind the six realistic and achievable goals listed by Yalom (2005, p. 485):

- *Engaging the patient in the therapeutic process.*
- *Demonstrating that talking helps.*
- *Problem spotting.*
- *Decreasing isolation.*
- *Being helpful to others.*
- *Alleviating hospital-related anxiety.*

Conclusions

We have described a psychological group approach in a psychiatric ward and how it is possible to articulate an individual and collective thinking process. The ward group structure and its milieu is functional and protective for the single operator, offers patients and their relatives a good chance to experience communication, emotion sharing and social relationships often neglected in many other health contexts. Each day patients can experience the whole ward as a therapeutic environment where every operator is able to answer questions and give advice if required because he is an informed and involved part of an extremely active and evolving set. This *safe spac*e, where individuals and their care actions are connected one to another, doesn't remove professional boundaries and individual specificity for the benefit of standardization and lack of responsibility. It allows the achievement of caring goals avoiding or reducing feelings of loneliness and helplessness often experienced by mental health professionals. The known patients and especially those hospitalized for the first time quickly learn to respect the space, norms and timing of the various clinical meetings and often we hear one patient saying to another: "we must not disturb when a meeting is on, because, they are working for us." The *evening meeting* is a place where it is possible to organize and make sense of the fragmented, unclear and disorganized communications that very often characterize interactions in an acute mental health unit. Continuity of this work is guaranteed by the group conductors who collect, organize and tie together a patient's clinical and social information and share it with other care team members in order to improve services and treatments. In listening to the patient's despair and anguish, group conductors strive to free them from the "background noise" of their symptoms and try to make them understandable, communicable and acceptable in order to promote interaction between human beings and not between patients.

References

Anzieu, D. *The group and the unconscious*. Routledge Library Editions, 2014.
Badaracco, J. G. *Psicoanalisi multifamiliare*. Torino: Boringhieri, 2004.
Bion, W. (1961). *Experiences in Groups.* Routledge Library Editions, 1998.
Correale, A. *Il campo istituzionale*. Roma: Borla, 1991.

Ducci, A., Marzano, A. *The group activities in the Diagnosis and Treatment of Psychiatric Services*. In www.funzionegamma.it, n. 31, 2013.
Ferruta, A. (2013). *Come lavora il pensiero gruppale in differenti situazioni cliniche*. In Gabbriellini G. (a cura di). *Il pensiero gruppale nel lavoro con il paziente, nelle supervisioni, nei servizi*. Pisa: Felici, 2013.
Foulkes, S.H. (1964). *Therapeutic Group-analysis*. London: Maresfield Library.
Foulkes, S.H. (1975). *Group Analytic Psychotherapy, Method and Principles*. London and New York: Karnac 1986.
Kaës, R. (2014), *Les théories psychanalytiques du groupe*. Paris: PUF. It.Tr. *Le teorie psicoanalitiche del gruppo.* Roma: Borla, 1999.
Kaës, R. *Lezioni romane.* In www.funzionegamma.it, 1999.
Michelini, S., Gasseau M. *Psicoterapia di gruppo nel servizio psichiatrico di diagnosi e cura*. Roma: Franco Angeli, 2003.
Mosher, L. Smith S. *Psychosocial treatment: individual, group, family and community support approaches*. Schizophrenia Bulletin. Vol. 6, 10-41, 1980
Neri, C. (1995-2005), *Gruppo.* Roma: Borla. *Group*, London: Jessica Kingsley Publisher 1998.
Yalom, I. D., Leszcz M. *The Theory and Practice of Group Psychotherapy* (5th edition). New York: Basic Books, 2005.
Yalom, I. D. *Inpatient group psychotherapy*. Basic books, 1983.
Stòccoro, C. *Il fuoco si spegne col fuoco*. In Carnevali R., Pratelli A. *Pensare il gruppo*. Milano: ARPANet, 2006.

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