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Inpatient Group Psychotherapy In Chinese Patients

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ABSTRACT

Objective: Inpatient group psychotherapy in acute psychiatric units has been a much maligned treatment modality with doubts cast upon its therapeutic value. However, local Chinese patients value and benefit from its inclusion in the therapeutic package after some adjustments to its structure and content.

Design: Groups of 8 inpatients met weekly with a regular therapist and co-therapist. Feedback forms were filled by consenting patients at the end of each session to rate the value of each treatment modality in the ward package and to ascertain if therapeutic factors had been achieved.

Setting and Patients: All were voluntary patients on an acute psychiatric ward based in a general hospital, who had consented to attend group therapy and were able to sit through a 45-minute session. Excluded were those with dementia, organic brain syndrome or those who were too disturbed. Thirty-nine patients completed the questionnaire legibly.

Results: In order of preference, patients rated individual attention from doctors first, followed by medication, relaxation therapy, then group therapy. Among the therapeutic factors, the ones achieved most were acceptance, altruism and self-awareness. Patients wanted instruction and advice on mental health. Twenty-eight of thirty-nine patients wanted to continue attending group therapy.

Conclusion: In this study, group therapy ranked 4th in the therapy package on an inpatient unit. Patients were able to experience some therapeutic factors but they valued factors which were different from those described in Western literature. Increased educational input from therapists was the preferred agenda.

Keywords: therapeutic milieu, group psychotherapy, therapeutic factors acute inpatient psychiatric patients

INTRODUCTION

Inpatient group psychotherapy in acute units is a commonly offered treatment modality in most general psychiatric settings. This kind of therapy uses the principles of classical group therapy described by Bion[1] and Foulkes[2], in 1941 who experimented with this method in treating neuroses in Northfield Military Hospital. Classical group therapy is typically conducted in a "closed" setting of 8 to 10 regular group members. Membership to the group is usually "closed" after it is initiated as opposed to "open" groups where members join and leave the group at will. Stable closed groups meet every week for 90 minutes, facilitated by 1 or 2 regular group therapists over a period of 1-2 years. Within these boundaries, the group therapists strive to create a feeling of safety for the group. They are concerned about containing affect and using the groups' internal milieu to achieve certain "therapeutic factors". A "therapeutic factor" was defined by Bloch[3], as a process that occurs in group therapy through the actions of the therapist, the patient, or the other members of the group that contributes to the improvement of the patient's condition. These factors were originally described in the 1950s by Corsini and Rosenberg. The therapists concentrate on day-to-day relationship problems brought up by group members and look at how they are reflected between and among current group members "here and now". The past, or "then and there" problem are discussed only in so far as they help to explain current problems.

These principles have been introduced for use in acute inpatients of psychiatric wards in many countries. Yalom et al[4,5] have advised that although some modifications may be necessary, this therapeutic modality has been found useful in inpatient management. Not much has been written on this topic in the West and even less in the Asia Pacific Region. In Western literature, the general consensus seems to be that while group therapy is a useful adjunct to the other forms of therapy held on an inpatient unit, it has little therapeutic value on its own[6]. Many authorities have even cast doubt on its role in the care of inpatients of acute psychiatric units because these patients are often acutely ill and thus unlikely to benefit from such participation-dependent therapy[7]. Patient surveys done elsewhere have actually found it very much valued as a component in the treatment package[8]. The constraints of practising "classical" group therapy on an acute inpatient psychiatric unit are obvious. Patients on these units stay for a very short while and may in fact show "revolving door" type multiple admissions. Group membership in these circumstances is very changeable. The average length of stay is about 2 weeks. Most patients are exposed to group therapy only a few times. Acute units also have very varied diagnoses - neurotics live alongside paranoid schizophrenics[9,10] and the demented. Symptomatology is accordingly very varied as well. Actively hallucinating and deluded patients may be in the group alongside with stressed-out executives or suicidally depressed elderly. Most patients are not highly educated or psychologically minded[11]. Most are ethnic Chinese who value privacy in confiding problems to their doctors, have a strong sense of shame about psychiatric problems and are inhibited in talking openly about their problems. On the other hand, in Chinese people where social norms emphasise conformity in groups, we were curious to find out if group therapy had a therapeutic role[12]. The aims of the therapist in these groups were:

(1) To achieve the therapeutic factors described by Yalom.
(2) To increase the desire for more groups among patients attending.
(3) To measure the extent of (1) and (2).

PATIENTS AND METHODOLOGY

This paper describes the experience of conducting group therapy once a week in an acute inpatient setting in the psychiatric ward of a general hospital in Singapore. The ward consists of 28 beds and the male/female ratio is about

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1:1. Patients accepted for admission must be above 11 years of age. Diagnostic categories accepted for inpatient care run the gamut from the mildly neurotic to the severely disturbed psychotic patient, but all are voluntary admissions. The patients live and interact in a "therapeutic milieu" consisting of a large airy dining hall, a TV room, and a large landscaped garden with benches and garden furniture. All patients are involved in an occupational therapy group with art therapy, assembly work, crafts, games and exercises. Weekly community meetings to discuss ward management are held by nursing staff. There are weekly karaoke sessions in the studio area. Twice a week, a clinical psychologist does a stress management session in which relaxation techniques are taught as well as sleep hygiene and the benefits of exercise and nutrition. Social activities include occasional tours to places of interest eg. Botanic Gardens, Crocodile farm, etc. Ninety percent of the patients are Chinese but therapy can be conducted either in English or Mandarin with fellow patients acting as translators for those who are not familiar with the language.

The group therapy sessions were held in a private room behind closed doors. They were conducted at the same time, on the same day, every week by the same therapist. Meetings were held in a closed room with no windows and patients were seated in a circle in full view of one another. The patients were pre-selected that morning to include as many members as possible up to a maximum of 10 individuals including the therapist and a co-therapist (often a nurse or junior resident). Those patients that were included were only those who were deemed capable of sitting through the entire session lasting 45 minutes. They received pre-group preparation by the author to prime them in their role. They were told that while their main doctor would help them with their illness, they also needed help in their relationships with others. Group therapy was for them to focus on their relationships with others on the unit and this would be mutually beneficial for self learning. Patients who had dementia or were too drowsy or too disturbed to sit in the group were excluded. No patient was forced to participate in the group. The technique used is adapted from Yalom with concentration on the "here and now" interactions among group members and their encounters in the milieu of the ward environment. As advised by Yalom, the therapist is highly active in the group to promote the group process in each session.

The session is opened by the therapist with an introduction about the purpose of group therapy and limits are set about confidentiality. The emphasis is on relationships, communication and personal problems that are brought into the group discussion. At times the therapist may go round the group to elicit responses. The therapist would discourage group members from "then and there" type of interactions (when group members recount in detail their life histories and problems in the past) and especially from trying to solve other's problems by giving advice. Wherever possible, the therapist encourages each patient to discover and clarify an area of conflict or difficulty on which further work needs to be done in the future. The therapist is also concerned about creating a feeling of safety within the group and must act to contain any anxious or angry outburst that might wreck the group. At the end of 45 minutes, the therapist goes around the group again to allow them to have a last word. At the end of each session, a summary is made either by the therapist or one of the patients and presented as a "take home" gift to all who attended that meeting.

In such an acute inpatient care facility, most patients attend 1-2 sessions only and are new to the experience of group psychotherapy. Feedback was sought at the end of each session to explore the patient's perceptions of group therapy and how they rated the various therapeutic modalities in the ward treatment programme. Inpatient care on the unit included individual patient/doctor sessions, individual patient/nurse sessions, behaviour therapy group, occupational and psychotherapy community meetings as well as physical treatment like ECT and drugs. Patients were asked to arrange these in order of preference. The effect, if any, of therapeutic factors was also measured subjectively in these patients (n=39) by asking them to rank the therapeutic factors of Yalom. Acceptance, altruism, self awareness, self responsibility, universality, hope, learning and catharsis were reworded into lay language and patients were asked if they had experienced these during the meeting.

RESULTS

Seventy-two feedback forms were received but the majority were incomplete or illegible and had to be excluded, leaving 39.

Thirty-two of the 39 had attended at least one previous meeting. Twenty-nine of 30 were coaxed to attend by ward staff while only 5 out of 30 were self motivated to attend.

When asked to rank ward activities offered by the unit, patients preferred individual sessions with their own doctors, with medical treatment coming second. Relaxation therapy was rated third and group psychotherapy fourth, ahead of occupational therapy, individual sessions with nurse or other patients. Community meetings ranked lowest.

In ranking the therapeutic factors, acceptance, altruism and self awareness were the three most valued, while hope, learning and catharsis were the least valued.

The preferred agenda for group psychotherapy appeared to be some form of didactic teaching or health education. Twenty-two of 39 requested talks on "Depression". Twenty of 39 wanted talks on "Stress Management" and 14 of 39 preferred talks on "Anxiety" rather than group therapy.

However, an encouraging 28 of 39 patients wanted to attend another group while 10 of 39 said "maybe" and only one patient had no desire to attend any further groups.

DISCUSSION

This is a general survey of patients' attitudes to inpatient group psychotherapy in psychiatric patients.

In conducting inpatient group psychotherapy, Yalom has described that techniques used are different from closed groups that meet regularly for long periods.

These are essentially "open" groups and patients are unused to group work. Patients only attend 1 to 2 sessions and membership changes each week. More structure is given by the therapist with a clear introduction and clear definition of boundaries. The therapist should be active and constantly alert for material that can be "grist for the mill". A theme for each meeting must be sought and found early (within 20 minutes) in order that this can be developed strongly before the session ends. The therapeutic ward milieu is rich in material for use in "here and now" interactions since patients spend hours in each others' company even before they join the group.

In developing the "theme" for each group meeting, the therapist hopes to achieve as many therapeutic factors as possible. Often though, it is only days or weeks after the group meeting that patients gain some insight. Therefore, this method of rating immediately after a group meeting has its weakness.

The patients included in this study are not homogenous. As such, no conclusions can be made about the efficacy of group therapy for any particular diagnostic category. However, almost every acute inpatient unit would have this mixture of neurotic and psychotic patients. Group composition in these settings would also reflect this

population mix. Thus the findings in this survey that inpatients value group therapy can be used to design therapeutic interventions in these kinds of units.

It would have been helpful if some form of control group could have been established to compare the therapeutic values achieved. Unfortunately, the nature of group therapy is such that it is very difficult to identify a valid control group and even more difficult to conduct such a group in a similar fashion to an inpatient psychiatric group. Medical and surgical patients have altogether, different concerns and stressors from psychiatric patients. The treatment modalities of medical and surgical patients have much less to do with the ward milieu and group therapy than surgical operations and medication.

In Western cohorts, a meta-analysis of 5 studies[8], (Maxman 73, Schaffer 82, Marcovite 83, Leszcz 85[13] and Kahn 86) showed that the top 3 therapeutic factors experienced by patients attending a group, were self responsibility, self awareness and hope. This contrasts with our local study in which acceptance, altruism and self awareness were most important. This may reflect the group's Asian roots where conformity and acceptance are much valued and self interests are commonly submerged in the interest of the group as a whole. Catharsis is ranked last in our study and this may be a measure of the "shame" factor. This appears to be an important concern of Asian culture and can colour psychotherapy practices in these societies. It is notable that selfless altruism is seen to be a virtue and valued above catharsis. Catharsis may be considered a more selfish way to use the psychotherapy group.

Ward activities with greater instructional value were preferred. Preferred ward activities were rated by these patients to be those with greater instructional value. Sessions alone with their doctor were highly regarded, as doctors are considered more powerful authority figures than nursing staff. Activities organised by nursing and occupational therapy staff were less valued. Private sessions are also less threatening than group therapy where strangers were party to their problems, again related to the concept of "shame" and "losing face".

Medication and electro-convulsive therapy were also more valued than group therapy. Perhaps, this reflects Asian values of respect for authority figures and receiving "gifts" or "lessons" from these figures. Community meetings were rated lowest. These sessions were often used to complain bitterly about hospital food, ward rules and cleanliness of the toilets. Although it is considered healthy to ventilate displeasure/discontentment in Western culture, Asians may not feel comfortable making complaints against authority figures who have made provisions for their comfort.

Further evidence of this desire for "gifts of instruction" from authority figures is noted in patients' preference for lectures on depression, stress and anxiety. There is a focus of trying to learn from caregivers rather than on self discovery.

CONCLUSIONS

The information generated in this study has been used by the author to modify the treatment of patients. There is now more emphasis on teaching patients and educating them on their illness. Doctors have also "lent" their authority to other paramedical staff to increase their stature in the eyes of the patients and increase the acceptability of their interventions in the ward treatment package. Doctors' instructions to patients that they have much to learn from each other in their interactions can prime them to use other patients' experiences for vicarious learning as an acceptable method.

Group therapists who are interested or already using group psychotherapy in Asian patients may not be able to adopt Yalom's methods wholesale. From my work, it does appear that some degree of modification is needed to maximise the potential for group psychotherapy in this part of the world. The findings of this study confirm that inpatients do value and benefit from group therapy. Plans are now underway for the establishment of more acute psychiatric units in general hospitals utilising the principles of milieu therapy. It is hoped that aspiring group therapists will be encouraged by the present findings and will continue to conduct groups with warm enthusiasm, which is perhaps the most important therapeutic tool of all.

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