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Social therapy: developments in the psychosis department of the Dr S. van Mesdagkliniek

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ABSTRACT This article aims to present an attempt to define the role of the social therapist working in the psychosis department of a forensic psychiatric clinic for detainees under hospital orders (TBS)¹ and mentally ill prisoners. The emphasis is laid upon the co-ordinating task of the social therapist with regard to the total hospital care in this kind of clinic.

The relationship between the therapist, the patient's continuous companion and the various other social therapists, is also touched upon. It is the head of department who ultimately assumes the role of care co-ordinator.

The Van Mesdag Hospital is a forensic psychiatric state institution. The Ministry of Justice is ultimately responsible for granting leave or parole to the 90 detainees (under TBS hospital orders) and mentally ill prisoners (mostly with a history of violent aggressive and/or sexual behaviour). The Van Mesdag Hospital is working to develop residential psychotherapeutic and sociotherapeutic care within a psychoanalytic frame of reference.

The staff, nearly 300 strong, includes 135 sociotherapists, 13 psychotherapists (psychiatrists and psychologists), 4 nurses, a prison doctor and 28 (non-)verbal therapists (1 music therapist, 3 creative therapists, 9 occupational therapists, 1 psychomotor therapist, 3 teachers, 3 gymnasts, 5 social workers and 3 spiritual counsellors) and 44 members of the security staff. In addition there are middle management personnel and support services staff. The criteria for admission to the hospital are that the patient is seriously at risk of reoffending or of attempting escape and/or in need of intensive individualized treatment. The hospital comprises 5 intensive care wards, each with 12 places, 3 wards providing very intensive care, each with 4 places, a ward for 10 psychotic patients (usually schizophrenics, manic-depressives, and serious psychotic borderline patients)

and a resocialization ward (for rehabilitation and return to the community) with 8 places. Therapeutic activities such as psychotherapy are not conducted in the wards but elsewhere in the hospital. Van Marle (1988a, 1988b) has described the psychotherapeutic climate of this hospital.

Social therapy in psychiatry has been studied for several decades (Jongerius, 1963). In this article the sociotherapeutic management of psychotic patients will be examined along with the issue of how to care for the patients' individual needs while aiming at diminishing the risk of reoffending.

Social therapy in the Van Mesdag Hospital is based on the concept of the 'holding environment' (Winnicott, 1960) which is formed by a combination of control, care and genuine empathy. It is important that such an environment reflects society at large, so that it constitutes a school for social behaviour. The main aim of this environment is to create the conditions in which personality change may take place and to show that it is possible to solve problems without resorting to violence.

The ward team of sociotherapists tries to find for each patient a continuous companion (CC), a member of staff who will establish a more longstanding relationship with the patient than the other members of the team. In that dyadic relationship between CC and patient early mother-child interactions can be enacted more easily, because of the very existence of the holding environment.

DIFFERENT CONCEPTS

The term 'enterprising' implies an active approach towards a particular goal, whilst the term 'co-operation' points to a collaborative relationship which is not primarily aimed at innovation.

It is for these reasons that the term *sociotherapeutic enterprise* has been chosen to define sociotherapeutic work carried out in the department caring for psychotic patients. This 'engagement' is characterized by a *co-ordinating* view of the task aimed at the *initiation*, *maintenance* and *continuation* of the care plan adapted to the personal make-up of the patient. The aim is to keep the threat of delinquency, in the medium term (4 or 5 years), at a controllable level. Our sociotherapeutic colleague (SC) is thus, in principle, a case manager.

Co-ordination of the caring tasks which may have a positive influence on the patient's psychic condition is, therefore, an important and guiding principle in the way in which the social therapist works.

Inherent in initiation is enabling the patient to feel that he² can make a 'nest' in the department – feel 'at home', as it were. He must be given all the necessary information about the department's rules and regulations, norms and values. Achieving a working relationship is the primary aim of *care co-ordinationship* (Willems, 1989). The care co-ordinator (CAC) (a better term than case manager perhaps) is the social therapist, who on the one hand knows enough about the

patient's background, but on the other hand does not directly embark on a transference/countertransference process with the patient (as in the relationship between CC and patient). In reality, it is the head of the department who acts as the main care co-ordinator for all the patients; in practice, he regularly delegates his co-ordinating role to one of his sociotherapeutic colleagues, who then acts as CAC for a particular patient for a given length of time. This person is thus the third aspect of the normal CC/patient/CAC triangle known as the *care trio*. This trio is responsible for (1) *the care*, (2) *the treatment* and (3) *the safety aspects* of the here and now.

As far as patient care is concerned, the trio must work according to a daily plan. For instance, at what time will the patient get up? What has to be done if the patient cannot or will not get out of bed? What interventions are necessary to ensure that the daily care plan can be realized? These combined interventions – as distinct from the general outlines of the treatment itself, i.e. the medication and/or psychotherapy – constitute the working area which concentrates on the patient's treatment. Social therapy is, therefore, an enterprise in which care and treatment must converge in a working partnership with the patient himself.

Treatment does not depend on a momentary assessment of whether or not the patient's behaviour is safe or unsafe. What this means in fact is that the social therapist by means of his regular contact with the patient is able to judge what the patient is experiencing at any given moment. Is the patient at ease or is he tense? Can what is going on at a particular moment explain the patient's psychomotor condition? What action should be taken, for instance, to prevent an escalation of a threatening situation, or to stimulate some kind of initiative?

THE TREATMENT PROGRAMME

The relationship between the patient's questions and what the social therapist has to offer

In broad terms, and seen from the point of view of the patient committed to the clinic by the courts, the following occurs.

- 1 The patient is aware that a problem exists (e.g. difficulty in sleeping).
- 2 He lacks something as a result of this problem and wishes that something be done about it. (There is a personal need.)
- 3 He acknowledges that he alone cannot remedy the situation – he is in need of care. (He wants something from somebody.)
- 4 He seeks help (from a fellow patient or the social therapist). (He is enterprising.)
- 5 He then poses a question to this person (directly or indirectly). ('I can't sleep; somebody is disturbing my rest; please help me to sleep; please come with me.')

- 6 At the request of the counsellor, he explains the 'please talk to me' statement in more detail (concentrating on 'needs' and 'possibilities').
- 7 On the basis of this information and the counsellor's judgement, the patient may or may not receive access to what is available. (His question may, or may not, be answered or acknowledged.) (He needs food, the counsellor may suggest.)
- 8 The acceptance of the question may, or may not, be translated into an offer of help. (He gets some milk.)
- 9 The help offered may, or may not, be forthcoming. (Milk does or does not help.)
- 10 He endeavours to ensure that the help offered is sustained. (He 'guards' the offer). (After a while the counsellor checks if the patient is asleep.)
- 11 He assesses the help offered according to its immediate effect. (Does the help actually help, or has it helped in the past?) (The milk has helped.)

In short, the patient embarks on a series of steps based on a supply and demand continuum:

- 1 He acknowledges that the problem deprives him of something.
- 2 He needs care.
- 3 He experiences the need for help.
- 4 He seeks help and/or support.
- 5 He formulates a request for care.
- 6 He finds a source of help.
- 7 He receives that help.
- 8 That help is maintained.
- 9 The effect of that help is assessed.

In everyday practice, the steps outlined might seem too sharply defined or even exaggerated. The patient, on the other hand, will often find himself stuck at certain phases during the course of this process of recognition, acknowledgement and communication. In addition, it is necessary to co-ordinate the need with the giving of help. For instance: you have neglected or realized too late that you have a problem or that as a result of it something is missing; help was available, you have insufficient information, the wrong kind of help was offered and you see that it is not effective.

This process involves being constantly engaged in taking decisions and acknowledging situations. Under normal conditions, most people co-ordinate their own care needs. But in the circumstances prevailing in the type of department we are talking about, patients always have to rely on help emanating from the process of supply and demand which has been mobilized.

The supply and demand continuum, viewed from the standpoint of social therapy

The social therapist sometimes yearns for the ideal patient, the kind of patient

who asks only questions which fit in with what he, the social therapist, is able to offer. This also enables him to do what he really wants to do – give help.

It is easy in practice to accept that staff in clinics should pay more attention to the real needs of the patient. However, in extreme cases, this can lead to a form of nihilism. A butcher cannot earn a living from customers who want to buy bread from him. It is important, therefore, that the social therapist makes a careful assessment of whether or not the questions he receives correspond with what he has available. Apart from ensuring that the question actually reaches him, he can also trace its source by contacting the patient.

Which steps are needed in this instance?

- 1 He identifies the question which fits what he has to offer.
- 2 He clarifies the question by discussing it further so that more information can be gathered.
- 3 He selects the question. (Which question can be answered by myself and which not?)
- 4 He may or may not grant access to what is available.
- 5 He defines the offer.
- 6 He grants actual access to what is available.
- 7 He delivers the help offered (or ensures that it is delivered).
- 8 He protects the help offered and makes alterations if necessary.
- 9 He evaluates the help offered.
- 10 He brings the help to a close.

Once again, we see a list of steps already well known to us. When things go wrong, however, they can cause misunderstandings, irritations, dysfunctioning – in short a large number of problems. Examples include: a wrong question (the patient or the counsellor is asking something which he doesn't mean), insufficient discussion, incorrect selection (the counsellor is selecting only from a small part of the questions of the patient); wrong or imprecisely defined help, or the help offered is not actually delivered. What is valid for the patient is also valid for the carer: he also needs someone from time to time to help him work through all the phases in sequence.

Complex situations involving patients lead not uncommonly to complex situations for the carer, and vice versa. A request for help becomes more complicated as identification of what kind of help is available becomes more difficult. It is, for instance, easier to work with a patient who gets up at a set time each day, rather than with a patient for whom it is impossible to predict at what time of the day he will rise from his bed. And the greater the number of helpers who are involved in the care of the patient, the more complicated the situation becomes!

The importance of decisions in streamlining contact between the patient and the social therapist

In both continua, there are always times at which decisions have to be made, both

by the patient and the social therapist. They can be divided into formal and informal decisions.

In the case of *informal decisions*, we are concerned with decisions made on the basis of a *judgement* of what is preferable in a particular situation. This judgement has a strong subjective element and depends to a large extent on the person actually making the judgement.

Formal decisions are characterized by an objective assessment of the situation. On the basis of predetermined criteria, a decision is reached as to whether or not a patient is eligible for a certain kind of help. Access to the supply of help is granted and a claim can be made for it. It is not always clear whether the help will actually be granted. Here are a few examples of decision moments for the patient:

- Which problem do I, as patient, want to present and which do I *not* wish to present? (There does not *have* to be a solution to every problem.)
- Which questions do I, or do I *not*, ask?
- From whom do I, or do I *not*, seek help?
- Which information do I, or do I *not*, give?
- Do I accept that I have no, or insufficient, access to help?
- Do I accept that I receive less than I am entitled to?
- Do I accept the wrong type of help, and also accept help that does not meet my expectations?

The social therapist also encounters important moments of decision:

- Which questions do I, or do I *not*, respond to? (Question selection)
- In what areas do I need to have further information?
- How do I get it?
- Do I, or do I *not*, grant access to the supply of help?
- What help do I actually undertake to provide?
- Do I actually deliver that help?
- Do I, if necessary, adjust the help?
- When and how do I bring the help to a close?

The CAC has an important role to play in these decisions, from the point of view of both the patient and the CC. He acts as an intermediary between the patient and the CC and between the patient and other social therapists. (In these cases, the department head may take over the role of acting care co-ordinator of the identified patient, if that is necessary, e.g. in case of absence of the regular CAC.) He also supports, whenever necessary, the position of the help-claimant in relation to the help-provider. In other words he helps the patient/claimant in reaching the best decisions. In this way, he also of course influences the decisions reached by both help-providers and social therapists, although this occurs indirectly, via the patient.

A few tasks appropriate to the care co-ordinator

The CAC's task is to

- 1 reach a correct assessment of the care needs of the patient and clearly formulate claims for care
- 2 prepare a care plan
- 3 bring cohesion into the care plan
- 4 ensure that the care plan is carried out correctly
- 5 evaluate the care plan.

A careful analysis of what the patient needs is a very important task. This implies that the CAC has an understanding of the diagnosis, the psychopathology and the patient's constitution. Is the patient acutely psychotic or is he just agitated? This means, in concrete terms, that the CAC acts as an intermediary between the patient and the consultant psychiatrist.

The claims for care need to be formulated in the context of, and in close co-operation between, the therapist³ and the patient. This linkage is expressed ultimately in the care plan itself and it embraces an integrated system of supply and demand, a relationship between the needs of the patient and the possibilities available to the therapist. This care plan, therefore, is a collaborative agreement between the patient and the therapist and both must satisfy its demands. Safeguarding it is the task of the CAC and hopefully its final evaluation follows its successful execution.

The treatment programme in practice

Wolf suggested in 1990 that the most important moments of such a programme are

- 1 an action-directed starting procedure
- 2 a network approach
- 3 balanced treatment
- 4 continuity of care
- 5 continuity of communication.

Working in an action-directed manner means that our aim is to influence a patient's ability to function in such a way that his control of the conditions he places on his own existence (his reason for living) is broadened, his quality of life increased and his autonomy strengthened. In the process of taking action and trying, accompanied by life's usual 'ups and downs', the patient and the social therapist should together be able to reach an agreement on the definition of the situation. The intensive process of searching with the patient is well worth both the time and the effort. The usual result is that the patient's self-esteem increases, simply because his needs are taken seriously and his voice is heard in deciding

what can be offered, an element which lies at the very core of the counselling concept.

The negotiations must produce goals that are both concrete and realistic, goals which the patient can fully understand and which enable him to know exactly what he is saying 'yes' to. A flexible adaptation of the supply of care to changes in the patient's actual situation is important. It is the numerous shifting problems and needs of the patient that ultimately determine the kind of help offered, where it is offered and in what context. Negotiations between the patient and the CAC are partly there to determine the tempo, the sequence and the manner in which they will work together in developing and expanding the skills the patient will need in looking after himself in daily life. These might be, for instance: preparing meals, cleaning the house, personal hygiene, contact with others, structuring his timetable and controlling his finances – tasks in which the CAC is the patient's model.

Interventions aimed at stabilizing or improving a patient's psychological and physical condition are essential to being able to work towards improving the quality of his existence. The patient in the psychosis department is not normally part of the kind of social network we find in daily employment or club membership, and most patients usually have difficult relationships with their family and friends. A thorough analysis of the extent of their social networks, and the quality of their interrelationships is therefore essential (Oei, 1987). What are the demands made on the patient from outside, and from his family, which affect his ability to function? It is very common to find that these people have become completely disillusioned because their attempts to relate to the patient have so often been frustrated in the past.

It is for this reason that the contacts between CAC and social worker are so important, because tuning in to information passing from the department to the family and vice versa must occur as smoothly as possible.

'Psycho-education' (Tabeling, 1992) can be a very effective instrument in the hands of the CAC, enabling the patient's family to be kept fully aware of what is happening. It is in this area that attention is paid to the patient's treatment, to effective channels of communication and, most importantly, to responding seriously to his requests for help. On the other hand, specific questions about the illness itself, the medication and the psychotherapy, fall under the jurisdiction of the medical staff (the consultant psychiatrist or physician). Patients can find themselves caught in the cross-fire, as it were, of the pressures put on them from their home and the department, and they can react to it, in consequence, with an upsurge of symptoms or the development of new ones. Where there is no social network, it is worthwhile trying to develop and sustain a substitute network, because without such back-up the patient is completely dependent on the one or two people in his immediate environment – namely his CC and the CAC. The choice of a network approach demands that great care is taken to deal adequately with the often conflicting interests of the patient, his family and his carers. If the

CAC reaches a point where he has no more techniques available to deal with the situation, then the matter must obviously be placed before a departmental multidisciplinary meeting. A balanced treatment of the patient does not necessarily demand frequent contact with him. The quality of the care is probably more dependent on the quality of the relationship, and the degree of communication, between the patient and the CAC.

The CAC can oversee what is taking place between the patient and his CC. He observes more often than he intervenes. He encourages, when the relationship between the patient and his CC reaches an impasse. He analyses behaviour rather than reflecting on its unconscious motives. He paves the way for mutual feedback in the interaction between the patient and his CC. In short, the CAC is his colleague's closest guardian, from whom support is fundamental. It is too easily assumed that psychotics are unmotivated, difficult, or 'therapy resistant'. What do we need to win this person's trust and stimulate his commitment to improving his own situation? Apart from patience, we need to realize that an offer of help gives a patient a perspective and is a response to his needs and hopes. The combined efforts of both the patient and the carers must be harnessed again and again to reach a common definition of the problem.

What stance do you take if the patient does not wish to communicate? Can you, uninvited, pop your head round the door of his room from time to time just to see how he is getting on? Do you just wait? Or do you take some kind of concrete action? The carer must approach the patient in the same way that medicine is administered – in doses, bit by bit. And so long as the patient needs it, the carer must continue to do everything possible to find ways of dealing fully with the patient's fears and uncertainties. This usually results in the patient making his requests clearer, so that the carer can also satisfy his own need to help. This does not mean, however, that the helper must always be active. Sometimes 'just being there' is all that is required to answer the call for help. Care continuity is, therefore, a question of teamwork.

It is not always necessary to take the one-to-one relationship as our model for treating the psychotic patient, although in cases where serious aggression threatens, the team approach is the only option. What is important here is that sustaining a carer's offer of help can only be guaranteed within the framework of a coherent, consistent and, in particular, cohesive treatment team.

The team members form a strong chain of treatment services which can be offered to the patient in a predictable manner within the 24-hour service of the clinic.

It is also necessary to realize that because the psychotic population is heterogeneous, a particular treatment might prove to be effective for one patient and non-effective for another. It is the communication and information feedback in respect of each individual patient which determines the treatment plan. This treatment must be based on a constant relationship between the various treatment disciplines, weighed against the patient's needs and the possibilities for

therapy. In the absence of sufficient, correct and up-to-date information, it is impossible to relate the types of help emanating from the various therapists and to co-ordinate them. Careless use of information puts pressure on the network, which has been constructed with such painstaking effort, and can create frustrations for both the patient and the helpers. Finally, it should also be remembered that the CAC cannot possibly perform all the tasks himself, but the onus is on him to ensure that they *are* fulfilled. Care must also be taken to ensure that the various tasks and methods do not become blurred or tailed off. The CAC is ultimately responsible to the department head, whose co-ordinating task is to ensure that everything in the department is carried out according to the tasks competencies and responsibilities assigned to each member of team – for the benefit of the patient.

CONCLUDING REMARKS

In a forensic psychiatric hospital, based on psychoanalytic treatment principles, the sociotherapeutic approach is valuable, especially in the psychosis department. Most important is the management of the detainee, who should get help which accords with his personal needs.

Case management principles in social therapy mean that there is a *care trio*, comprising *care co-ordinator* (a social therapist to whom this task is delegated by the acting head of department), *continuous companion* (a social therapist who takes the role of patient's friend) and the *patient* himself. This care trio should create an adequate supply of care for the patient. The methods used to reach this goal have been described. Focus has been directed on the special role of the care co-ordinator in the process of bargaining between needs and treatment possibilities (i.e. between CC and patient).

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NOTES

- 1 TBS: *terbeschikkingstelling*, an order made by a criminal court – placement at the disposal of the government.
- 2 In this paper 'he' stands also for 'she' throughout.
- 3 Therapist in the fullest sense: psychiatrist, psychologist, psychotherapist, music therapist, non-verbal therapist, etc.

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