A Modular Work Group With Hospitalized Psychiatric Patients

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Theoretical Background and Beginning

The issues of the life task of work as they relate to psychiatric patients has traditionally been the province of occupational therapy. As a respected and important aspect of psychiatric care, occupational therapy has been involved in a wide range of activities from sensory motor assessment to actual job training. The psychiatric community, however, often makes a distinction between the augmentative use of occupational therapy (support service) and the "heart" of therapy, i.e., individual psychotherapy in conjunction with psychotropic medications. Recognizing this somewhat artificial separation, the writers noted that the vast majority of psychiatric patients reported tremendous anxiety and concern around the issues of work/job. It appeared that while individual psychodynamics made for interesting discussion, a major (if not the major) "here and now" patient concern was failure in the world of work.

Adler defined three primary life tasks that each individual must meet and resolve successfully in order to reach the longed for sense of belonging and fulfillment (Ansbacher and Ansbacher, 1964). The three life tasks include love or intimate relationships, social or community relationships and the life task of occupation or work. If one were to simplistically reduce the major effort of traditional psychiatric therapy (psychologic rather than psychotropic) it would undoubtedly be in the life tasks of intimate and community relationships.

Adler warned against artificially separating the three life tasks which should realistically be seen as interdependent and interwoven. While agreeing with this caution, Manaster (1977) has suggested that during different devel-

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opmental periods a particular life task is of greater concern to the individual. Athough the pre-teen child does not typically struggle with issues of occupation, the task of work is a paramount concern to the young adults seen in the psychiatric in-patient service. During these years the patient, the patient's important others and society in general expect the issues of constructive occupation to be addressed and resolved. Thus it is relevant and important to develop intervention focusing on the life task of work.

Designing the Experience

A group approach was chosen for a variety of reasons. Group work has long been an important aspect of the Adlerian approach beginning with the clinics in Vienna. Today a large body of literature exists to support the use of group therapy with psychiatric patients. Perhaps the primary factor for using the group method, however, is the quality and quantity of discussion that can be generated only through group interaction.

Although the group approach is hardly new, focusing on the issues of work is more novel. Certainly the hospital for which the present approach was designed already had on-going daily sessions of group therapy. The first problem to be encountered was convincing the staff that the "work group" would focus on important life issues, not simply how to fill out a resume. With this challenge successfully met, a good deal of flexibility and freedom was granted.

The population consisted of in-patients on the unlocked ward of a tax supported county general hospital. Patients were generally low income with problems ranging from acute psychosis to mild depression. Such a heterogenous group necessitated the development of criteria for group inclusion. Youcha (1976) provides a framework for such criteria by defining three broad patient types in an in-patient setting: (1) patients whose psychosis has overwhelmed all ego functions, (2) psychotic or acutely depressed patients who nevertheless have some intact ego functioning, (3) non-psychotic patients who are perhaps chemically dependent, suicidal, have somatic disturbances or are mildly depressed. It was decided that Type 1 patients could not benefit from the work group experience and were thus excluded (realizing they would probably enter Type 2 at some point and become included). Although Youcha suggests that distinctly different types of group therapy should be utilized with Type 2 and Type 3 patients, the authors decided to include both types in the work group in order to increase the number of possible group participants. The hospital staff felt that by including both types in the work group, Type 3 patients would place limits on Type 2's inappro-

priate behavior and both Type 2 and Type 3 patients would benefit from these higher expectations.

The reality of a constantly changing patient population is a relatively new phenomenon to the psychiatric ward with the advent of effective psychoactive medications. This particular psychiatric ward is defined as an acute care facility and rapid patient population change is further accelerated. These factors, along with an already tightly scheduled patient day, combined to offer additional problems. As ward composition changed almost daily, there would be difficulty in developing what Yalom (1975) saw as a primary curative factor in group therapy, i.e., group cohesiveness. Not only did ward composition change rapidly but schedule problems would allow only one morning a week to offer the work group. Thus, it was anticipated that in any given week 25-50% of the patients would be new to the group. These realities made three basic decisions necessary: (1) the group would be modular, i.e., able to stand alone at any given session without depending on past or future participation, (2) each modular group session would begin in a highly structured and essentially didactic manner and (3) an attempt would be made to help patients integrate the work group experience with their other on-going group therapy.

Dreikurs (1960) described four phases of uncovering therapy that he applied to the group approach. Along with the pragmatic realities of population and situation, these four phases proved a useful conceptual framework for structuring the work group. The four phases include (1) establishment and maintenance of the proper therapeutic relationship, (2) exploration of dynamics operating in the patient, (3) communicating to the patient an understanding of self (insight) and (4) reorientation. The first phase was seen as occurring as a direct result of the didactic approach. Since the group leader knows what the group is doing and where it is going group members will develop a sense of trust and "instant rapport" can be established (Corsini, 1977). The second phase was the specific exercise designed to be part of each modular group experience. The group leader was primarily involved in the first two phases. The third phase was ideally achieved through patient interaction and confrontation as the implications of the planned exercise were integrated. The fourth phase, reorientation, was recognized at the outset as the most difficult to achieve. Not only is this typically the case with "insight therapies," but the special constraints of limited time and a constantly changing population made this phase an elusive goal. It was hoped that this phase would be met by emphasizing the relationship between the work group experience and the ongoing ward group therapy.

The Work Groups

Each modular work group lasted for approximately 1½ hours. From a total ward population averaging 16, 8-10 patients attended each group session on a voluntary basis. Only one group rule was given to patients—no "crazy" behavior would be allowed. The following is an outline of each modular group session including the planned exercises.

Session I

Topic: Redefining the world of work, vocation, avocation, recreation.

Exercise: List each group member's work experience on board. Define each experience as pleasant/unpleasant.

Session Goals:

1. Broaden concept of "work" to include all aspects of life.
2. Demonstrate effect of ignoring particular aspects of "work" (avocation, recreation).
3. Provide encouragement by demonstrating all group members, to some extent, have a successful work history.
4. Information sharing among group members.

Session II

Topic: The ideal and the real—What I could be, what I am.

Exercise: Group members rate themselves on two scales. Scale one is the scale of the ideal career situation, in terms of success, prestige, money, etc. Scale is from 20 (highest success) to 1 (lowest success). After each group member rates on scale one, they are asked to rate themselves on scale two. Scale two is the scale of what is real for the group member now or how close they are to obtaining their career goals.

Session Goals:

1. Demonstrate effect of striving for perfection and high self-expectations on actual performance.
2. Demonstrate how fear of failure can keep one from finding out if they have potential.
3. Demonstrate relationship of assumed disability and purposive behavior.

4. Redefine unrealistic strivings for perfection in terms of "best I can do" without comparison with others.

Session III

Topic: Work and stress-analyze a job.

Exercise: A specific job is chosen (the job of a parent works well) and ask group members to list all the specific tasks that are required by that job. All tasks are listed on the board. Specific tasks are then defined as stress producing or non-stress producing.

Session Goals:

1. Awareness of typical stress symptoms.
2. Awareness of relationship of goal structure to individual stress symptoms.
3. Awareness of the purpose of individual stress symptoms.
4. Defining possible alternative and more constructive stress behavior for group members.

Session IV

Topic: What I'm best at.

Exercise: Each group member defines the one task/job they consider themselves to be "best" at. For members who are unable to provide a "best" it is suggested that they are best at their particular illness. After "bests" are generated on board, ask individual group members what it takes (a job performance description) to be best at their particular identified task/job. Ask at least one group member what it takes to be "best" at their particular illness.

Session Goals:

1. Awareness of need to feel competent in some area.
2. Possible use of illness for purpose of being "best worst."
3. Awareness of process of compensation for position of "felt inferiority."

Special Considerations

It must be emphasized that almost every patient seen in the work group was in much pain with dramatic feelings of alienation. It was encumbent on

the group leader to have a firm sense of each patient and how far they might be "pulled" at any given time. Although all patients should be involved to some degree, the leader must exercise judgment as to which patients can manage being the focus of the group at any particular point.

As in any group experience, the style of the leader is of great importance. Especially important to the work group model proposed here is a leader that provides not just good information, but also the "enthusiasm, fire and excitement" necessary to motivate a group composed of society's most discouraged individuals to a position of consideration for and participation in the group.

Although leader characteristics are important, it must be reemphasized that the most critical aspect of working with a group of hospitalized psychiatric patients is judgment. "It is the combination of good judgment, insight into others and ability to predict consequences of situation, which leads the good director to decisions of quality" (Corsini, 1977, p. 43).

Evaluation of the Experience

Considering the nature of the population, a systematic and empirically based evaluation was not possible. However, two primary evaluation procedures were used. The first was simply patient self report. Throughout the development and use of the work group model patient comments and feedback were solicited. This informal evaluation procedure revealed significant support and interest from the patient population. The patient consensus found the work group experience educational and most important, directly applicable to their lives.

The second and somewhat more objective evaluation procedure involved merely counting the number of available patients who actually attended the weekly group sessions. As the work group was the only optional group experience, the staff reportedly expected little attendance, since it was quite difficult to get patients to regular group therapy. The opposite phenomenon was experienced. Not only did almost every available patient attend work group sessions, but there typically was excited anticipation when "work group day" arrived. Newer patients were informed of the work group by previously attending patients and would willingly avail themselves of the group sessions. An interesting point relates to those few long term patients (4-5 months) that were on the ward. Although they had been through each designed group experience more than once (some actually enlisted to explain and lead exercises) they consistently returned, reporting they learned and profited from the richness added by newer members.

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Into each life some confusion should come . . . also some enlightenment.

— Milton H. Erickson, M.D.
