6-1983

Dynamic In-patient Therapy: A Team Approach

Le Van Cao

ABSTRACT

DYNAMIC IN-PATIENT THERAPY: A TEAM APPROACH

by

Le Van Cao

The paper reports on the philosophy and clinical results of an individualized but concentrated team approach to hospitalized patients undergoing a psychological crisis. The team focuses on the patient's key vital coping technique as the source of his vulnerability and assists the patient toward constructive self-understanding. The approach favors maximum therapeutic benefit from a short hospital stay. Follow-up of the first fifteen cases managed by this method discloses a significantly low percentage of relapse and rehospitalization, and demonstrates that even such relapses can be turned to therapeutic benefit.

LOMA LINDA UNIVERSITY

GRADUATE SCHOOL

DYNAMIC IN-PATIENT THERAPY: A TEAM APPROACH

by

Le Van Cao

A Manuscript in Partial Fulfillment of the Requirements

for the Degree Master of Science

in Psychiatry

June 1983

Each person whose signature appears below certifies that this manuscript in his opinion is adequate, in scope and quality, in lieu of a thesis for the degree Master of Science.

Benjamin Kovitz M.D. , Chairman
Benjamin Kovitz, Professor of Psychiatry

William H. McGhee, M.D
William H. McGhee, Assistant Professor of Psychiatry

Ronald L. Warnell
Ronald L. Warnell, Assistant Professor of Psychiatry

Present day psychiatry works under continual pressure to provide treatment that is as brief, effective, and inexpensive as possible. Economics and cost-effectiveness can no longer be ignored under current conditions. Traditional psychoanalysis was never feasible for most patients, and was adapted by a number of clinicians to developments such as the "short-term dynamic psychotherapy" of Davanloo[1] and others[2]. Such treatment methods are intended for out-patients and in any case may run from three to twelve months. The need for rapid and expeditious treatment is even more pressing when hospitalization is involved.

This paper describes a method, evolved in the psychiatric service of a county general hospital, for achieving maximal therapeutic gains during the acute crises that require hospital care. The technique is applicable to crisis situations even in patients who have, as so many do, a more chronic underlying problem. Furthermore, the method of patient management facilitates the transition from in-patient to out-patient care and the patient's readiness to profit from longer term out-patient psychotherapy when it is indicated. Our approach tries to make the most out of the conditions that obtain on an acute in-patient unit with its rapid turnover and constant pressure to discharge patients after six or seven weeks at the very most. In contrast to out-patient conditions, the in-patient setting permits constant and intensive observation and contact with the patient throughout the day. The shock of hospital admission tends to confront the patient emphatically with the fact that he has a problem and how serious the problem really is. The challenge facing our staff has been how to achieve an optimal therapeutic payoff

despite the time pressure, and perhaps even because of it.

The common element in our patient population is the experience of an acute crisis, with everything this involves, not only in the negative sense of situational stress, defective coping and disturbed homeostasis, but also by way of a positive opportunity to mobilize resources and expand potentialities for healthy adaptation.[3] Common clinical situations are acute non-psychotic suicidal states and decompensations, not always psychotic in nature, in otherwise stabilized psychotic patients who are encountering new stresses.

One cornerstone of our method is rapid assessment of what we call the patient's vital coping technique (VCT). By this term we understand his characteristic mode of responding to stresses and sources of anxiety. This phrase was selected to include both conscious and unconscious methods of coping with problems of living. It comprises a person's security operations, character defenses, and conscious responses to difficulty, organized typically into a specific pattern or style. Some cases are described below.

Our crisis patients are those whose habitual VCT's have failed them at some critical juncture. The positive aspect of such a crisis is the possibility now offered to the patient to begin to understand his own VCT and to work at revising it when necessary. If the problem is primarily environmental, the patient may be soon ready to leave the hospital with his VCT intact, but in most cases the patient's habitual lifestyle contributes significantly to his crisis and is in urgent need of reshaping. In the sanctuary of the hospital, the patient inevitably tends to fall back on his characteristic ways of dealing with people.

The staff initially observes tolerantly and supportively, avoiding too hasty a response to the behavior, often of an immature, demanding or hostile character, that betrays the patient's limitations. Staff members at this stage need to be on guard against their own counter-transference responses. As the permissive atmosphere encourages patients to expose their pathological styles, micro-crises arise that are then put to therapeutic use. Take as an example the dependent individual whose mounting demands provoke frustration and finally culminate in an outburst of anger. An opportunity now exists to help such a patient confront the inappropriate nature of his "neurotic claims"[4] and the unfortunate consequences of his hitherto unquestioned assumptions.

The essence of our method is the cooperation of the unit team in both diagnosis and management. Diagnosis in this context refers, of course, to the recognition of the patient's self-damaging techniques, rather than the act of cataloging symptoms according to DSM III. Useful diagnostic assessment in this sense requires constant sharing of observations and understanding by all members of the team. The data that soon accumulate about the patient's conduct all day long, under different circumstances and with different people, provide a wealth of revelation about the patient's difficulties that might not appear for months or ever in a traditional out-patient setting.

The next phase in this approach is application of the team's cumulative understanding to individual work with a primary therapist. With due care to avoid either intellectualization or ill-advised confrontations that provoke resistance and denial, the therapist reviews with the patient the specific experiences of the day and week while they

are fresh in mind. The patient is encouraged to relive these events and feelings and to begin to understand his behavior as it appears to others. The focus is to help the patient discover and become more objective about his own VCT, and to recognize how it contributes to his crisis. It is the responsibility of the primary therapist, of course, to establish a personal rapport and to explore the relevant life story as a foundation for this focused concentration on discovering and correcting the flaws in the patient's VCT. Efforts to change conduct are encouraged at every opportunity. The most immediately useful field for such experimentation is the group therapy session, as well as all other interactions with peers and staff. The team regularly reports the patient's behavior, and the individual therapist reviews the experiences in daily sessions with the patient. In crisis situations, medication is used primarily to allay excessive anxiety or to relieve severe depression.

The discharge date is determined by the reduction in anxiety, the growing emergence of a more accurate and useful self-image, and the patient's readiness for constructive planning. Satisfactory progress is often marked by the general consensus of the staff that he no longer needs to be in the hospital. The entire process typically takes at the most four to six weeks, and at this point the patient is ready to continue with out-patient work.

The hospital psychiatric service carries a total patient population of 35 to 40. Of these no more than a third, usually 10 to 15, are carried by our treatment team, which includes at least a psychiatrist, a social worker, a nurse, a psychologist, an occupational therapist and

a mental health worker. The team has evolved to holding two 90-minute meetings at least twice a week, where each patient is discussed and information shared. One goal of the meetings is educational. The members become informed about medications, their proper application and their side effects. Negative views and disagreements are aired and clarified. Team members collaborate in planning strategy and assigning appropriate therapeutic roles, with attention, for example, to the patient's needs for a particular kind of identification or parenting. The team operates as a nucleus that transmits information and guidance to other members of the staff, so that ultimately each patient benefits from a carefully coordinated individual treatment plan.

Some Illustrative Cases

Case 1. A chronic schizophrenic woman of 26 with multiple hospital admissions became acutely hallucinated and suicidal after an ill-advised sexual involvement with a married man. Careful inquiry revealed that the patient's deepest fear was that her mother would reject her because of her sexual acting-out. Constructive communication with the mother resolved the crisis successfully, and the patient resumed her usual adjustment at her schizophrenic baseline. Her vital coping technique involved a conflict between incompatible goals, that is, between an impulsive search for security through sex and a deep symbiotic need for maternal acceptance through moral conformity.

Case 2. A 33-year-old woman slashed her wrists in a mood of intense disillusionment when her boyfriend and her trusted roommate ran

off together. When her first appeal for help to a former physician met with coolness, her immediate urge was to commit suicide. In this case the vital coping technique was marked by immature idealization and over-dependency on others, with an inappropriately demanding and erotic attachment to men, leading to inevitable disappointment. Recognition of her futile expectations and fuller use of her available resources resulted in improvement.

Case 3. A man of 44 in serious depression, discharged prematurely after symptomatic improvement on medication, returned to the hospital because of a suicide attempt following rejections by his family. This time a series of therapeutic micro-crises effectively disclosed the nature and consequences of his hostile dependency, with rapid and significant improvement. Here the vital coping technique was typified by inordinate demands, whose inevitable frustration provoked outbursts of rage that served to obscure a deeper sense of guilt. Repetition of this pattern in the therapy group was followed by a clarifying confrontation and a sudden realization how this destructive sequence had been wrecking his personal relationships.

Case 4. A man of 49, with borderline character features, chronically depressed and quarrelsome, angry because he was not discharged on demand, finally learned to recognize his depressive denials of his intense needs, and was thereafter able to continue out-patient therapy. Here, too, the vital coping technique involved excessive demands and hypersensitivity to frustration, but the anger with which the patient reacted was consciously unacceptable, and he was repeatedly plunged directly into depression. Again, the therapist's willingness to elicit and tolerate

the patient's feelings of hurt and anger led to a constructive shift in the defense system.

Statistical Resume of First Fifteen Patients

Age	Sex	Admission	Discharge	Readmission	Diagnosis
59	F	8/5/79	8/20/79	--	latent schizophrenia
27	M	8/22/79	9/13/79	--	latent schizophrenia
29	F	8/27/79	9/19/79	--	latent schizophrenia
28	F	8/28/79	8/31/79	--	latent schizophrenia
26	F	8/29/79	9/5/79	5/6-8/80	chronic schizophrenia
33	F	9/23/79	11/2/79	--	depressive neurosis
58	F	9/26/79	10/2/79	--	latent schizophrenia
50	M	10/10/79	10/19/79	--	depressive neurosis
32	F	10/28/79	11/8/79	--	depressive neurosis
22	F	11/7/79	11/16/79	triage 10/8/80	depressive neurosis
44	M	12/17/79	1/15/80	1/22/80-2/6/80	depressive neurosis
49	M	1/15/80	2/28/80	--	depressive neurosis
40	F	4/10/80	4/13/80	7/10/80-7/15/80	psychotic depression
23	F	4/29/80	6/3/80	triage	depressive neurosis
35	F	6/3/80	6/28/80	--	hysterical neurosis

Of these first fifteen admissions between August, 1979, and June, 1980, to date there have been three readmissions. Two patients were seen again briefly in triage.

Conclusion

The paper describes a system for intensive short-term management of hospitalized patients in crisis. The aim goes beyond customary supportive and symptomatic care; working with a limited number of patients at a time, a therapeutic team endeavors to turn the crisis into an opportunity for productive change. A concerted diagnostic assessment of the patient's characteristic vital coping technique facilitates constructive self-confrontation at a time when the patient is especially open to the need for change. The essence of the approach consists in rapid intensive study of the patient's behavior, followed by individualized application of the resulting insights to daily living on an in-patient unit. It is the particular merit of this system that the team collaborates in a personalized therapeutic approach instead of the more impersonal and generalized methods so typical of in-patient treatment under conditions of limited time and funds.

References

1. Davanloo H (ed): Basic Principles and Techniques in Short-term Dynamic Psychotherapy. New York, Spectrum Publications, 1978

2. Bellak L and Small L: Emergency Psychotherapy and Brief Psychotherapy. New York, Grune and Stratton, 1965

3. Caplan G: Principles of Preventive Psychiatry. New York, Basic Books, 1964

4. Horney K: Neurosis and Human Growth. New York, Norton, 1950