

Between “Yesterday and Today”. A description of group therapy in the Department of Child and Adolescent Psychiatry, Jagiellonian University Medical College, Krakow

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Abstract

The following article is an attempt to present the model of group interaction conducted in the Department of Child and Adolescent Psychiatry of the University Hospital in Krakow. It describes both the beginnings of group interaction conducted by the team of Prof. M. Orwid, Prof. J. Bomba and dr W. Badure-Madej as well as the model developed by the current team of the clinic. The structure and setting of group interaction conducted in the stationary ward, the therapeutic framework, supervision process, and the method of conducting group therapy are described. The article describes the changes in the understanding and conduct of group therapy that have taken place over the years.

adolescence; hospitalization; group therapy

INTRODUCTION

Between Tradition and Today

Mental crisis is an individual experience. In many cases, it handicaps relationships with others. Interpersonal difficulties that appear

while functioning in a group are also an important risk factor for the development of a mental crisis or even its origins [1]. A group also has the power to positively influence an individual's mental state. Therefore, various types of group activities are an important form of help in a mental crisis. With the development of child and adolescent psychiatry and psychotherapy, group activities have been added to the work with mental disorders in that area [1,2].

The beginnings of group interaction in the post-war period taking place in the Krakow Psychiatry Clinic are associated with the running of community groups since 1955, and later group

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therapy in the Men's Ward run by Prof. Kępiński from 1957 [1].

The 1960s brought a change in the perception of the significance of adolescence in the context of mental problems and disorders. Within stationary psychiatric wards, there was a need to organize group classes during which topics specific to adolescence could be discussed. In November 1967, the first group meeting of patients between 14 and 19 years of age from all four departments of the Clinic took place. Initially, meetings were held twice and then (at the request of the patients themselves) 3 times per week, and organizational; administrative, general and sometimes also personal, issues were discussed [1,2]. In 1968, the first therapeutic group for adolescents hospitalized in the ward was launched in the clinic. Its activity was initiated by Dr. (later Prof.) Maria Orwid and Dr. Wanda Badura-Madej. Over time, the team was supplemented by Dr. Jacek Bomba (later Prof.) and Ewa Domagalska-Kurdziel, MA. They were pioneers in conducting group interaction in youth wards in Poland [1]. Group activities continued in the newly established youth department in 1968, with the therapeutic community becoming the basis of its activity.

The group included all hospitalized adolescent patients; hence the group was described as extremely diverse, which was both a resource and a challenge [1,3]. The only exclusion criteria were "mental debility or an acute period of psychosis" [4]. The common denominator for such a diverse group consisted of the dilemmas related to puberty that all hospitalized patients faced [3]. The group was led by two therapists – a doctor and a psychologist; male and female whenever possible. It was noted that the group should include a similar number of girls and boys, and its size should not exceed 10 people. Most young patients attended 10-12 group meetings [2].

Thanks to participation in group therapy, adolescent patients could learn about themselves in the area of Self-Other [5] and build a group bond – the sense of "we feeling" so important in adolescence [6]. Comparing oneself with others as part of group therapy provided the opportunity to both look for similarities with others and one's own distinctiveness [5]. For withdrawn patients, immersed in the world of psychotic experiences, it provided an opportunity

to create partnerships and establish contacts or friendship in the real world. This signalled the possibility of reducing autistic isolation and creating more mature relationships with others [7].

At that time, there was no possibility of supervision "from the outside", so the leaders supervised the group themselves, which was of course an extremely difficult task.

Later, the group was mainly influenced by Agata Siudak, M.Sc., who worked in the ward, until her retirement. The group in the Child and Adolescent Psychiatry Ward has been running continuously since 1968, and is also run in the day ward.

Since then, group interaction has been constantly conducted in the Department of Child and Adolescent Psychiatry of the University Hospital and is one of the most important forms of work with hospitalized patients. Although many issues have changed since Professor Maria Orwid, Professor Jacek Bomba and Dr. Wanda Badura-Madej started group therapy with adolescents, their achievements and the way of looking at the treatment of adolescents also has a huge impact on the therapists currently working in the Department.

HOSPITALIZATION IN ADOLESCENCE

The hospitalization of adolescents is a huge psychological burden both for them and their families. A young person must simultaneously face crises on many levels, e.g., health crisis, hospitalization crisis, separation crisis from loved ones, and adolescence crisis. Coping with them requires great effort and clearly burdens the adaptation mechanisms of both the individual and the entire family system [8]. It should be remembered that an adolescent faces not only a health crisis but also hospitalization itself. The hospital belongs to the so-called total institutions, and staying there is one of the important external stressors [3]. The strength of the impact of hospitalization is demonstrated, for example, by the fact that changes in health, leading to hospitalization, are high on the list of life stressors by Holmes and Rahe (serious illness or accident with bodily injury – 53; significant change in health or behaviour of a family member – 44) [8,9]. The factors that are associated with the

hospitalization of children and adolescents are primarily: separation anxiety (often in younger children; separation experience); fear of procedures (examination anxiety); and fear of diagnosis or ineffective treatment (often concerns parents) [8].

The form of admission: acute or planned, also has an impact on the experience of stress related to hospitalization. It should be remembered that preparing a child for hospitalization reduces the shock associated with it, which often hinders and prolongs the adaptation process. That is why it is such an important, but also difficult, task in the youth ward to create a therapeutic environment that enables efficient adaptation and then improves treatment [3].

Young people aged 14 to 18 are admitted to the Department of Child and Adolescent Psychiatry at the University Hospital in Krakow. Thus, most hospitalized patients are already in the second phase of puberty, or ending the first phase [10]. They face entering adulthood and the dilemmas related to it. The need to sign consent for hospitalization, which is required upon reaching the age of 16, is also an important element reminding them of their approaching adulthood. Puberty, the emergence of sexual urges, new desires, and expectations from others/the world often cause a breakdown in development [10,11]. Their appearance makes it necessary to rebuild the relationship with both parents and the world [10,12]. At the same time, the approaching adulthood and the resulting requirements are often the reason for crises [13], which sometimes result in actions leading to hospitalization. It is therefore important that hospitalization, which requires entering into dependence, does not hinder the development of young people. Crises that often lead to hospitalization are a result of a lack of support from peer groups, a sense of loneliness, rejection or inability to seek support.

Thus, it seems that group interaction may be one of the important forms of therapeutic work in youth psychiatric wards [15]. The desire to be close to others and to be part of a group are obvious factors conducive to forming a group, but achieving coherence and cooperation due to youthful egocentrism is much more difficult [3,10].

Description of the Group Interactions Model in the Department of Child and Adolescent Psy-

chiatry of the University of Social Sciences and Humanities.

In the ward, hospitalized patients have the opportunity to participate in many forms of group interaction. The most important of them include:

1. Group therapy
2. Therapeutic community
3. Occupational therapy (including therapeutic walks, music therapy, work with drawing, and film therapy)

THERAPEUTIC COMMUNITY

During their stay in the ward, young people experience several forms of group interaction. The first consists of community meetings held three times per week [3,15,16]. They allow us to observe, on the one hand, the possibilities of limiting hospitalized patients in social functioning, or coping with frustrations or environmental requirements. On the other hand, they are an important exercise in performing social roles, communicating expectations, but also accepting the limitations resulting from the situation in which the adolescents find themselves. Of course, community meetings based on co-responsibility and democracy are particularly difficult in the group of adolescents, which was pointed out by Prof. Maria Orwid when introducing this form of influence in the Psychiatry Ward. Adolescents are particularly sensitive to rejection by the group, the value of solidarity towards peers, reluctance or difficulty in communicating messages that may cause distress to other patients, and even seeing profit in the form of a more distant good [3]. This is most visible in discussions regarding teenagers hiding items in the ward that could later be used for self-injury.

Meetings begin at a fixed time, with their duration depending on the number of raised cases and discussed issues. The principle is that all hospitalized patients and the entire treatment team are invited to the “community”. The meeting of the community is conducted by the leader – a hospitalized adolescent, elected by patients in a vote. The leader is supported by a deputy, who becomes the leader the following week. The term of office of the leader lasts one week. New recruits introduce themselves during this meeting and have the opportunity to meet all

patients and staff. This is an important moment for building a sense of security. All hospitalized patients summarize the period between community meetings. At community meetings, problems or important events of the ward, such as conflicts between patients, are discussed [15]. The community has undergone a revolution due to the change in the self-determination of patients. This was due to, among others, changes in the legal norms. Previously, patients decided, for example, who could go on a pass, and there were opportunities to go for walks under the care of other patients.

Currently, one of the most important elements of the community is sensitizing patients to the problems of other hospitalized patients, dilemmas related to interaction between patients and staff, between adolescents themselves and in relation to the hospital institution. There is also the possibility of observing deviant phenomena such as: double life in the ward, signs of aggressive behaviour, and the exclusion of others from the peer group, etc.

OCCUPATIONAL THERAPY

Another form of group interaction consists of classes with ward tutors and occupational therapists. They include music therapy, art therapy, and group walks. Such interaction takes place daily and depends on the current composition of the leaders. Hospitalized adolescents are invited to attend, and their absence from classes is most often discussed at therapeutic community meetings. Both collective and individual works are often presented, for example, by being displayed on the walls of the ward, or presented at a community meeting. Occupational therapy is often an undervalued form of influence in the area [17,18].

Expressing oneself through artistic creations, drawings, selection of a poem or a piece of music prepares one for a conversation about the inner world. It can also integrate a group, indicating everything that is common in experiencing the world. For some patients, it can be very important, e.g., people with alexithymia, difficulties in mentalization. Talking about a book, understanding connections in terms of the relationships of literary and film characters, can be an

important introduction to a conversation about oneself.

GROUP THERAPY

The last form of interaction is group therapy, which must take into account the conditions of hospitalization in the ward [19]. Group therapy meetings are held three times a week, with each session lasting 60 minutes. The therapeutic group working in the ward is semi-open, heterogeneous, and is conducted continuously throughout the year. The group has been operating with short breaks (e.g., during the pandemic) since 1968. The therapeutic group is run on the basis of psychodynamic understanding, but due to the specificity of the ward's work, it is also extended to other forms of therapeutic interaction (e.g., elements of psychoeducation).

Group therapy is always conducted by two therapists. The people leading the group are the most experienced therapists working in the ward, with most of them having several years of therapeutic experience, specializations in clinical psychology of children and adolescents, specializations in psychotherapy of children and adolescents or psychotherapeutic certificates. Group therapists change approximately every 3-6 months depending on the capacity of the hosts and the dynamics of the group. Changes of therapists "overlap", so 2 therapists never leave the group at the same time. Therapists are an important element of building a sense of security, so special attention should be paid to the moments changes are introduced. Currently, pairs working in the ward are usually a male therapist and female therapist, or two female therapists. In the history of working with a group, however, there have also been situations where a group was led by two male therapists. Our experience, however, shows that mixed therapist pairs are the most likely to encourage projection in adolescents.

Qualification to the therapeutic group takes place in several stages. The first stage usually covers the first two weeks, when the patients are in the diagnostic ward, where their condition, severity of symptoms and needs for therapy are assessed. Then, in the ward, a decision is made to invite the adolescent to a therapeutic group.

This is done in consultation with the treatment team directly treating the teenager, taking into account, among others, the probable period of hospitalization and the current severity of symptoms. As a rule, patients whose hospitalization will last at least 4 weeks (12 sessions) are invited to the therapeutic group. Qualification by those leading the group takes into account the motivation of the participants, and the potential benefits considered by both the adolescents and the therapeutic team. Contraindications to use the therapeutic group are active psychotic symptoms, intellectual disability to the extent that communication is difficult, and significant somatic burden (e.g., very low BMI).

Co-therapists are an important element of group work. Most often, these are trainees specializing in the clinical psychology of children and adolescents, people in the course of specialization in the psychotherapy of children and adolescents, and those who have completed a psychotherapy course and are undergoing an internship related to a psychotherapeutic certificate. Behind a one-way mirror, the group is also observed and analysed by future group therapists, i.e., psychotherapists who will replace the current leaders of the group. They keep a record of the course of the group and take part in the analysis of the group session. When an agitated teenager leaves the group, their task is to draw the attention of the attending physicians and the nursing team to the fact that this is the moment when the adolescent is probably experiencing something very difficult and may require intervention. This allows the group to reduce fear and anxiety about the person leaving the group.

Since the group in the ward is semi-open, the interaction model must constantly take into account its variability. Adding new members to an intensively working group often results in a return to earlier stages of its development and, depending on the severity of anxiety, levels of openness [19,20]. The adolescent group rarely experiences anger at new members, activating more caring aspects of the self, in contrast to adult groups, where new people are often treated as intruders [21]. New patients start the therapy group on Mondays and usually stay in the group until their discharge from the ward. Therefore, it is a model in which young people remain in a constant process of adapting to

changes, bonding with others and then dealing with losses. As a result, the most common topics are dealing with abandonment, loneliness, but also the fear of rejection, and uncertainty of acceptance.

In such a situation, it is very important to ensure a sense of security and stability. This is achieved by taking care of the therapeutic framework, which supports both the therapists and other participants of the group [19]. Group policies are introduced by group members. In the first place, the issues of boundaries are usually indicated: the duration of the group, the ban on leaving the group – going out, the ban on eating meals and the issue of suspending participation in the group.

A person who leaves the group twice in a row is suspended for the next week. This is the time when we once again examine the expectations and motivation of a person for group work. A single exit from the group is always commented on and deeply experienced by the group, providing material for working on abandonment, fear of intimacy, but also acting out, so common in youth groups. If the group starts working, people who are late cannot participate in the session. Then, the group usually introduces the co-therapists who observe the group from behind a one-way-mirror. At the request of the group, these people come and introduce themselves to the group. Intensively working groups also point out the issues of confidentiality of group work, openness and readiness to communicate emotions.

Considering the nature of the group, and in particular its semi-open nature, during periods of intense participant involvement, it remains between the phases of group and work cohesion, and during periods of reduced involvement it remains between the phases of creating and achieving cohesion. In a group process, it is very difficult to achieve a balance between destructive and creative forces, which is particularly evident when working with adolescents. Chaos and adolescent anxiety often make it difficult to achieve a state in which the group is treated as a safe environment, enabling deep regression. Adolescents, who have often just started separation processes, are afraid of re-entering dependency. The group usually starts with the so-called “round”, in which participants com-

municate their emotional state, most often extending it with attempts to explain the causes or factors affecting the current mood. Therapists in this phase often question individual participants, trying to broaden the perspective of both individuals and the whole group. After the "round", therapists most often 'make an intervention' that unifies the statements of all or most people, providing the opportunity to continue the topic that manifested itself in the descriptions of the participants. After the mutual sharing phase, group work continues depending on the readiness or current needs of the group or its individual members. Therapists actively influence the level of regression in the group, which is especially important due to its semi-open character.

In the therapy of young people, destructive group processes are also visible, i.e., malicious reflection or the anti-group [22;23]. Of particular importance is the notion of the anti-group proposed by Nitsun. This is due to heteronomy in the selection of patients, variability and instability occurring in adolescence, and the frequently described phenomenon of young people taking on the role of a temporary outsider.

Natural development phenomena are also significant. Group therapists have to face the manifestations of adolescent rebellion focused on them, which can often affect the maintenance of the therapeutic potential of the group. It should be noted, however, that if we do not observe phenomena typical of puberty in the adolescent group, it may indicate excessive dependence on therapists, which is unfavourable from the development perspective. This aspect of the specificity of youth groups is fundamentally different from adult groups. Some phenomena in an adult group would be considered deviant or non-adaptive, while in a group of teenagers they are an expression of the developmental phase.

Each group ends with a 30-minute discussion that the co-therapists from behind the mirror and people leading the group take part in. In the first part, the observations and analyses of people from behind the mirror are discussed, with them being encouraged to freely interpret the behaviour and interventions of therapists and other members of the group. The second part is devoted to the reflection of group therapists on

a given therapeutic session. The most important issues concerning the work of the group are also presented during the morning discussions of the entire treatment team.

Once a week the group process is supervised. During the supervision process, all sessions from a given week are described and often read out. Both therapists leading the group and trainees "from behind the mirror" take part in the supervision. Over the last 10 years, the group in the ward has been supervised by 2 supervisors of the Polish Psychiatric Association, first Roman Kwiatkowski, MA, and currently for several years by Teresa Żuchowicz, MA.

Frequent discussions with the whole team, co-therapists and supervisor are an important element of the work of group therapists. On the one hand, they allow the provision of information about a given patient to the treatment team and, on the other hand, the experiences, thoughts, and understanding of the therapists themselves can be organised. This prevents therapists from burning out and helps in creating an optimal treatment plan for patients [19; 24; 25].

SUMMARY

Although it seems that the current model of group work in the ward has significantly improved the treatment of adolescents, many issues remain unresolved. A small group of patients, about 10-20%, still resign from or stop group therapy. Therefore, a question arises regarding the reasons for these departures, which may be related both to the individual characteristics of the participants that make it difficult to use this form of therapy, as well as to the model of therapeutic work itself. Hence, issues related to the criteria for accepting/inviting to a group, the method of therapeutic work or the setting of group therapy in the structure of the ward should be subject to constant analysis.

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