Interpretive Psychotherapy in the Inpatient Community Meeting on a Short-Term Unit

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The authors present a model of inpatient community meetings conducted as large-group interpretive psychotherapy. The model focuses on the examination of relationships between patients and staff in the here-and-now and the patient group's maladaptive ways of interpreting staff members' behavior. The group leader and other staff members listen to patients' comments and questions and identify underlying group themes that reflect how patients are experiencing their relationship to staff. This model is useful even on short-term, acute inpatient units because it can provide an up-to-date monitor of the milieu, illuminate undesirable patient and staff behavior, uncover nontherapeutic activities or attitudes of staff, help improve patients' compliance with treatment, and reduce tension on the unit. (*Psychiatric Services* 48:91–92, 1997)

A large-group interpretive model for the community meeting in inpatient psychiatric settings has previously been described by Winer and colleagues (1–3). The model focuses on examination of the relationships between patients and staff in the here-and-now, and the patient group's maladaptive and rigid ways of interpreting staff behavior are the center of concern (1,2). Despite dramatically shortened lengths of stay in inpatient psychiatric settings (4), this model of the community meeting retains its utility and is currently in use on the short-term, acute, general adult inpatient units with which the authors are affiliated.

In our model of large-group interpretive psychotherapy oriented in the here-and-now of the unit, genetic interpretations, as well as any other individual interpretations, are discouraged (1,2). The model is based on the premise that patients inevitably respond to current staff-related events with an implicit group theme involving self and others (1,2).

Gill (5) stated that in individual dynamic psychotherapy, a patient may be expected to resist being aware of feelings and attitudes toward the therapist and to use two defenses to keep this awareness from consciousness—displacement of feelings onto a person other than the therapist and transitory identification with or unconscious imitation of the therapist (5,6). We use these concepts in community meetings to interpret patients' resistance to their awareness of attitudes toward staff.

The purpose of the community meeting is to uncover the attitudes that patients have toward staff in the here-and-now and to explore the meanings of these attitudes. Typically, these attitudes and behaviors will coalesce around some staff-related action of unitwide importance. Examples include staff members' joining or leaving the unit, a patient's being put into restraints, the arrival of new trainees, or a patient's receiving a course of electroconvulsive therapy after this intervention has not been used for some weeks.

Staff techniques

Guidelines for staff techniques in using the large-group interpretive model for inpatient community meetings are as follows (1):

- Assign a designated staff member who is experienced with the model, such as the unit director or head nurse, to serve as the leader. The leader should begin the meeting with the explicit statement that "the purpose of this meeting is to talk about the patients' experience of their relationship with staff."
- Do not discuss patients' requests for medication changes, passes, and discharges in the meeting.
- Hold community meetings at least twice a week for 45 to 60 minutes. Begin and end promptly.
- After announcements and introductions, allow patients to comment while staff members listen and observe. Do not call on individual patients.
- Answer questions that cannot be answered elsewhere, for example, questions about when residents would be rotating off the unit or what happened to a patient who became physically ill and was transferred to a medical floor. If such questions dominate the meeting, listen for a group theme disguised in the questions.
- Resist the impulse to squelch in-

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fantile, narcissistic, or maladaptive views. Otherwise, patients may never have the opportunity to become aware of the weak evidence they use to support these views.

♦ Do not insist that patients act normally or participate in the meeting. However, staff should set limits on behavior that is disruptive or dangerous.

♦ Do not introduce topics. Rather, focus on what the patients are thinking and feeling as a group and may be reluctant to verbalize.

♦ Although staff members may be attacked, confronted, or criticized by patients for real or alleged shortcomings, they should avoid becoming defensive. It is essential to hold a wrap-up meeting for staff immediately after the community meeting to process feelings that may arise.

♦ Do not make individual interpretations, as they tend to interfere with the emergence of a shared group theme.

Three overall guidelines summarize these points. First, patients are likely to bring up seemingly unrelated topics. Staff must listen and identify disguised allusions to underlying group themes that reflect how patients are experiencing the relationship to staff. Second, staff must determine which staff-related event or events have been unconsciously selected by the patients as a theme. Third, staff must discover the specific, common, stereotypical meaning that the majority of the group has attributed to the staff-related event or events.

In actual practice, these three components are merged into well-timed and appropriate group interpretations. For example, one community meeting, which was held the day after an HIV-positive patient who had threatened to bite staff was transferred from the unit, began with a discussion of the no-smoking policy. Several patients commented that the policy was unfair because staff members who smoked could go outside to do so. Another patient commented that staff at another hospital had put him in restraints and left him unattended. Another patient stated that she knew the patient who was transferred and had liked her, even though the transferred patient was very sick and needed help. The psychiatrist who was leading the group stated that patients had been talking about staff both at this hospital and another hospital as uncaring and as putting their own needs first. He asked if patients might not also be feeling that staff had neglected a needy patient, who had been transferred, and therefore, might well neglect the patients in the group as well.

The short-term unit

How can a large-group interpretive psychotherapy model for community meetings be useful on today's short-term, acute treatment units, where medical models of intervention predominate? Such a model provides useful information in several ways.

First, a community meeting of this type provides a "snapshot" of the unit that may prove invaluable to its management. Through the meeting, staff get an up-to-date reading of the milieu.

Second, the community meeting provides a form of quality control for both patients and staff. Destructive, sexualized, or other acting-out behavior is quite often well known among the patients, but is hidden from the staff. Incidents of this nature are often alluded to in the community meeting and can be brought to light when discussed explicitly in the meeting. Undesirable staff behavior can also be illuminated.

Third, the meeting provides a useful forum for feedback to staff, although staff may find it hard to have their actions criticized (7). In the search for the behavior that is the lightning rod for patients' transference attitudes, staff must look at themselves. In doing so, undesirable, nontherapeutic activities or attitudes are often identified. If staff are able to minimize their defensiveness, they may be able to change these attitudes and behaviors.

Fourth, although today's inpatient units increasingly rely on pharmacologic interventions, psychodynamic understanding of patients is of no less importance than in the past. Psychodynamic understanding may help improve patients' compliance with treatment interventions, allow patients to identify psychological barriers to getting well, and improve planning of appropriate aftercare. Finally, community meetings with an interpretive psychotherapeutic approach may be useful in reducing tension on inpatient units.

Although we believe our model of interpretive large-group therapy (1–3) can be helpful on today's short-term units, several cautions are advisable. Patients who are so psychotic or agitated that they are unable to remain seated throughout a group meeting or who are unable to respond appropriately to redirection should be asked to leave the meeting or barred from attending. In addition, issues of obvious importance that remain unmentioned should be introduced by staff. For example, if patients in a community meeting held soon after a patient struck a staff member do not bring up the incident in the first 15 minutes of the meeting, a staff member should introduce the topic.

Conclusions

Through community meetings that use a large-group interpretive psychotherapeutic approach, patients may become aware that the fixed and often negative meanings they attribute to staff members' behavior may not be the only way to see things. Even some of the most severely ill patients may become familiar with their own idiosyncratic assignment of meanings to interpersonal situations. Staff may also learn to pay attention to how they affect patients, even when acting with the best of intentions. ♦

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