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Jacek Maślankowski

OPEN AND HIDDEN REALITY OF THE PSYCHOTHERAPEUTIC WARD – REFLECTION ON THE POSSIBILITIES OF UNDERSTANDING AND INTEGRATION.[1]

Psychiatry Clinic in Bydgoszcz, Anxiety and affective disorders ward

psychotherapeutic ward
common language
group

Summary

The text is part of the current dialogue in the team of the Center for the Treatment of Anxiety and Affective Disorders at the Psychiatry Clinic in Bydgoszcz, which revolves around the search for effective strategies to create the right environment for patients as part of the integration of psychotherapy processes with other therapeutic implementations. At the same time, the content fits into the broader context of the description of healing factors in psychiatric and psychotherapeutic departments, emphasizing the need for a coherent conceptualization resulting from the diagnostic process and patient activity at various levels of the ward's community. The author recalls the commonly known concepts of transference, countertransference and parallel processes, confirming their usefulness in the common language of psychotherapists and medical staff. At the same time, he points to the dangers of limiting the therapeutic context to the psychotherapist-patient dyad, while unread relationships with the active environment constituted by the diversity of the ward constantly deliver new open and secret facts. The author cites his clinical experience, illustrating the individual theoretical descriptions with cases. The article emphasizes the problem of the diversity of initial diagnoses, which makes it necessary to adjust therapeutic interventions to the patients' abilities. The usefulness of the method is emphasized even in the face of the variety of paradigms in the human resources of the staff.

There are psychiatric wards that call themselves therapeutic when at the same time the actions of specialists are contrary to the principle of the therapeutic community and the team as a coherent object. A kind of dictatorship based on individual ambitions dominates there, and patients become the background to competitive "healing" activities. All the more my gratitude to the head of the department and the team, thanks to whose efforts the multidimensionality of the process within the patient-team is recognized and becomes healing and constantly is subjected to reflection. It is not the task of this text

[1] The article is an extended version of the lecture that the author gave at the 47th Congress of Polish Psychiatrists on June 9 in Łódź.

to create a description that would become a practical hint, but more remaining in the current of reflection, it will slightly expand this already existing reflection. The structural and practical part in building a therapeutic department is not to be underestimated; however, the effectiveness of these modules depends on having the disposition to read relational processes in one language, which gives the opportunity to name what is visible and invisible, what is conscious and unconscious in a dynamic process which is individual and collective.

In the words of Philip Stokoe: “The group dynamic is the process that provides the unconscious momentum for the group behavior and preoccupations. This is not to suggest that there is an unconscious process in the group that is in some magical way independent of the individuals’ unconscious. There will be some form of unconscious communication between the individuals to lead to certain behaviours. The point is that, for the purposes of how groups seem to function, the notion of the group unconscious provides a very useful working model.” [1, pp. 53-54] Such a base opens up to a structure which, deprived of schematic hierarchy and statutory unreflectiveness, becomes a setting matrix where each element of the functioning of the ward gains the dimension of therapeutic space. This language developed by analysis can be available to everyone without fear, but at various levels depending on the place in the branch structure. This language can also be a direct tool of healing, but it can also remain only as an opportunity for reflection and understanding. It certainly avoids a situation in which the team would be divided into “knowers” (having secret knowledge) and “not knowers”, thus enabling the creation of a healing environment aware of its own interactions from different levels but in a coherent reflective space. The ideas of so-called relational psychoanalysis, as described by Stephen A. Mitchell and Margaret J. Black, become useful: “Relational psychoanalysis does not subordinate the therapist’s thinking to any particular theory, nor does it assume that there is a single point of view that is the best approach to each patient. We do not treat our theories as revealed truths to which everyone must be faithful, we see in them a set of ideas that require constant interpretation and rework as knowledge deepens.” [2, p. 26]

Therefore, it is worth starting by returning to the idea of psychoanalytic thinking in large groups as the basic psychotherapeutic tool of the therapeutic community. Wiser thanks to the benefit of the experience of the idea of a therapeutic community beginning in the 1930s of the in the activities of Wilfred R. Bion and S.H. Foulkes through the Italian experiments of Franco Basaglia to the native realizations described by Zdzisław Bizoń, I would encourage caution towards the traps of extremes: antipsychiatry versus the tendency to impoverish the understanding of group/ward processes to the conscious level. It will also be useful to depict the ward with the participation of the concepts of a large and small group. A large group is a ward community, a small group is psychodynamically oriented group psychotherapy for 8-10 people and psychoeducational groups, in addition, a group of staff. The similarities of these groups are inevitably occurring conscious and unconscious processes, the differences are a different readiness to read these processes and other methods used in the healing process and resulting from these readings or omissions in reading. The ordering postulate for the staff involves the need to read the processes in

each group formula, but with a different use of meanings and with the use of a different repertoire of therapeutic interventions. Christopher Bollas in Forces of Destiny writes: “By conventional standards psychoanalysts say quite strange things to analysands, and analysands are rather tolerant of the analysts’ psychoanalytic nature. Most patients know that what enters the analyst’s mind and exits as his discourse is specific to the analytical situation and that interpretations are socially odd creative objects. The psychoanalyst’s creativity is essential to the patient’s use of the analytic process” [3, p. 121]. This postulate should be made as a necessary common part in relation to other differences. However, before we talk about the interventional difference, I will try to weave a few useful concepts into the clinical reality of the ward – without the ambition to exhaust the topic, which would definitely exceed the intentions of this text.

Transference, parallel phenomena, replay, defense mechanisms

Concepts that often appear in psychotherapeutic literature should be put together and perceived as being on one continuum. The transfer triggers an internalized patient pattern visible in parallel phenomena and play, which are accompanied by defense mechanisms protecting against the activated conflict part. An alternative to play is the containerization process ending with a therapeutic/curative intervention.

The phenomena of **transference and countertransference,** which introduce complexity into a direct relational picture, seemingly complicate but realistically understood and seen bring relief because they free us from conflictual plays and give the right track to the process of psychotherapeutic treatment. **Transference**, in the description useful here, “means recreating in the present patterns of interaction derived from significant accounts of the past. A particular tendency to repeat in current interpersonal relationships has pathogenic experiences and relationships from the past that have influenced the structure of the personality [...]” [4, pp. 89-90]. We used to associate the phenomenon of transfer with the psychotherapeutic process, which is a special and unique phenomenon occurring in the patient-therapist dyad. However, this is a common process and applies to all communication without limitation to a meeting in the therapist’s office. Awareness of the universality of transfer is very useful in the conditions of creating conditions for the functioning of the therapeutic community and understanding the interactive complexity in the therapeutic ward. An inseparable element of the transfer is its **reenactment**, i.e. activating the memory of past experiences in action, thinking, emotions. The performance is a hindrance in the actual reception of the current environment and is at the same time an invitation to others to play the roles of past important objects in this peculiar theater.

Clinical example: Mrs. A. experiences a special symbiotic relationship with her mother, which is strengthened by the earlier rejection of the mother by her husband and the father by Mrs. A. The abandoned mother “anactivates” her daughter and gives her closeness, but in return expects exclusivity for love and activity in attacking the husband-father. Mrs. A. accepts the mother’s offer, experiencing uniqueness in the dyad with the other woman and internalizing the scheme in which it is necessary to maintain hostility

towards the man. In the ward, the attending physician is a woman, psychotherapy is conducted by a man – the patient cannot accept the current environment as a harbinger of coherent therapeutic interactions bringing the expected results – she plays past experiences by trying to conflict the doctor-therapist pair, idealizes the doctor and at the same time discredits the therapist.

Parallel phenomena are patterns of behavior, affects and conflicts that occur simultaneously in interactions with patients and in the situation of clinical discussions or supervision meetings. Significant historical events internalized by the patient, which appear in the process of psychotherapy in parallel, are shown during the therapist's meetings with the team. Often, a specialist may remain unaware of these phenomena and only the mindfulness of the supervisor or other participants of the meeting stops automatic, thoughtless plays. An example cited by Gediman and Wolkenfeld [5, pp. 234-255] may be a therapist who, during supervision, so tendentiously presents the course of a session with a patient that others feel helpless and have limited opportunities to comment – at the same time, the therapist complains about the lack of adequate material administered by the patient. We can say that the patient does not remember anything that has been forgotten and repressed, but **plays**. The patient reproduces it not as a memory, but repeats it in action. According to this view, if a therapist or other staff member does not understand the importance of the communication played by the patient, he can nevertheless convey its meaning through a parallel actuation. The performances themselves do not determine the effects of treatment, but this makes it impossible to understand this process in self-reflection or in the meta-level of group discourse. Stopping the reproduction of what was in the interpretative course of naming is of course not simple and requires knowledge, experience but also a certain knowledge of oneself.

An exemplification of the **concept of defense mechanisms** will be a brief reminder of Klein's idea, which included the idea of perspective/position in which the individual perceives himself and his relationship with the world. She distinguished two positions: paranoid-schizoid and depressive. The concept of the paranoid-schizoid position refers to the psychological configuration typical of a young child and describes the dominant persecutory anxiety and type of defense. Such a **defense** is a split way of functioning, making the patient experience people and events in an extreme way: as unrealistically wonderful (good), unrealistically frightening (bad). This state of mind is dominated by a tendency to focus on oneself, a sense of persecution in the face of suffering. In the reference to the nosological classification, we will locate this position in the spectrum of personality disorders at different levels of the organization.

How does the mechanism of cleavage of the patient interact in relation to the ward team? Some of the staff become frightening/evil objects and some are subject to the illusion of idealization of love. In both cases, there is a danger of being in a thoughtless state of acting: "evil" objects are unable to accommodate the insistent projection of hostile aspects of patients and respond with defensive anger/reluctance, inevitably generating the patient's belief in an aggressive object; "Good" objects seduced by a loving relationship, narcissistically fed will not be able to see the unfriendly parts of patients and may

enter into a coalition against “bad” objects, that is, another part of the staff. The internal fission experienced by the patient in the process of his projective interactions becomes visible and implemented in the external division of the team. A split is created based on an antagonistic separation between hostile-friendly, non-understanding-understanding, disciplining-allowing, etc. The same split that forms the basis of the pathological internal structure of the patient and has its origin in trauma and the need to start a fission-based defense. The image that is visible in the plane of group survival of countertransference is a valuable diagnostic clue and the current polarization can be integrated into the interpretative process of understanding the patient.

Below is a clinical example that can show the fission attempts made and the possibilities of intervention that will allow the therapist to get out of the invitation to act out and create a space for the patient to expand the awareness of the schemes used: during the psychotherapy session, patient B. blames another member of the ward team for inappropriate behavior, the therapist does not join the patient in the act of blaming and thus gives the possibility of two phenomena appearing. First of all, the therapist becomes an object that does not match the patient’s transferable expectation, and only now can he begin to think more realistically about what happened.

The inability to get out of entanglement in the process of cleavage means that the treatment does not lead to development and facilitation in the transition to a depressive position, but rather stops and blocks the patient in a series of plays. This expected transition will, as Nancy McWilliams [6, pp. 164-165] writes, significantly modify the personality but without the element of transformation. Expectations of transformation in personality disorders may affect further discrepancies, this time in the assessment of the effects of psychotherapy. The patient in “his” personality may be less destructive and taking a depressive position will be more important to others and his relationships will be more stable. “There is concern for others and the seeds of the ability to experience guilt over the harm that an individual feels is doing to a loved one or persons through feelings of frustration or anger.” [7, pp. 26-27]

Despite temporarily gaining the ability to experience depressive concern for others, the patient retreats to more egocentric attitudes and fears. Bion treated the relationship between these two attitudes as a continuous oscillation between the developmental phases. The therapist’s task is to identify the patient’s experiences in historical terms but also in the context of his presence in the ward, to determine which factors generate rigid defenses and which support his development. **The challenge for staff can be recurrent impulsive, aggressive behavior** of the patient – it can be useful to look from the perspective of psychodynamics of shame, which gives other meanings that free from imposing plays. Everyday wards are full of various relational events that result in narcissistic trauma, all the stronger because it causes a hidden feeling of shame. Shame, on the other hand, is defined as a feeling about the state of the whole self, in the harmful belief that I am bad, flawed, crippled. A belief that presupposes the immutability of this state of affairs and provokes passivity and inaction. On the other hand, admonishing others, expecting change involves the foundations of this thinking about oneself, causing reactions based on anger and fury.

A.P. Morrison writes: "Since anger is more evident among all emotions and is primarily intended to hide shame by turning a passive response into an active one, it is often anger that is noticed and treated, and the underlying shame is overlooked. In short, anger can be a major defense against unacceptable shame." [8, p. 21]

The overt and hidden reality of the ward

We return to the image of the ward seen in the structure of the groups. The patient who is admitted to the ward gets acquainted with the regulations, which are constructed (if it were understood as a therapeutic setting) so as to allow the patient to undertake treatment in a stable and predictable environment. The regulations understood in this way will foster an atmosphere in which the risky actions of the patient are not ignored and a common understanding of the state of mind is pursued, thus eliminating the mechanism of waiting for the restrictive severity of the staff. The patient becomes part of the ward community and thus the largest group within which his therapy will last – the initial discussion of the functions and structures of treatment sensitizes the patient to the specificity of therapy, which, however, will take place on many levels, starting from functioning in the first large group through other (depending on the needs) psychoeducational and psychotherapeutic groupings and realized in relations with other patients, doctor, psychotherapist, medical staff. The integrated image of the patient as a combination of full functioning in various areas of the ward structure enables the proper course of the diagnostic part and preparation for participation in psychotherapy, which process will continue to take place taking into account the broader context of patient implementation. The discussion of the treatment structure introduces the patient to the therapeutic area of the ward and its uniqueness consisting in a coherent reflection of the treatment team integrating the internal, hidden reality and external realizations of the patient. The variety of initial diagnoses makes it necessary to adapt therapeutic interventions to the capabilities of patients. Not everyone can maintain the process of constant confrontation with what is hidden, with the conflict part. Hence the idea of one language in the process of conceptualizing the patient and understanding relational complexity, but at the same time with the use of intervention techniques at different levels from a supportive attitude encouraging reflexivity and self-observation to insightful transferal interpretations. A common language that helps in the search for meanings that "(...) involves a particular relationship that each person seeks and establishes with themselves, and for many it may never rise to the level of objective thought. It is rather a sense that one's being is imbued with witnessed purpose, as if we are watched over by a muse who guides us through our life." [9, p. 169] A common language, but not the need to resign from linguistic diversity and the specificity of concepts, but rather as a link between the areas of external and internal reality and the scope of the medical and psychotherapeutic space. In this model, not only will patients with different needs find their place, but also a new dimension will be acquired by combining pharmacotherapy with psychotherapy and even the different modalities of therapists will become functional. If this link works, pharmacotherapy not devoid of a medical

context acquires objective meanings. The patient's experience of pharmacotherapeutic treatment, analyzed as another aspect of the relationship with the object, gives both the healer and the patient additional meanings that facilitate the therapy. Two modalities in synergistic action, as Sławomir Murawiec writes in his text about the use of drugs during psychotherapy – pharmacotherapy relieves current symptoms, enabling psychotherapy to "modify the emotional and relational scars of the past"[10, p.68]. In addition, the medicine experienced as an object can be a caring mother bringing relief, or in the opposite way as an object of a mother who gives relief but is associated with limiting dependence. The team of specialists, despite diverse tasks and competences as well as complex projection processes in relation to patients, thanks to the commonality of language, improves containerizing functions, does not stop at a superficial conflict level, and discovers the processes hidden in this group. Continuation of the author's reflections on combining the medical with the psychological are articles [11, 12] in which reflections and specific indications for integration within psychiatry, psychotherapeutic and psychiatric treatment are made. The author began research as part of his doctoral thesis, analyzing the effectiveness of such integrated treatment, with the possibility of indications for standardization of these procedures.

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Email address: yacek.maslankowski@gmail.com