Intensive Group Counseling & Psychotherapy
With Severely Disturbed Adolescents
CASP Convention, Long Beach
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Workshop W-11

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SUMMARY

Working with severely disturbed students requires both general and specific skill sets in order to enhance both safety and therapeutic effectiveness with these vulnerable subjects.

An effective yet cost effective model for the delivery of psychological services is within groups. However, these groups require specific structural components and therapeutic skills on the part of providers to be truly effective. This workshop will provide a developmental group counseling model which integrates components from objects relations / psychodynamic psychotherapy, person-centered therapy, and cognitive behavioral therapy.

Particular attention will be paid to teaching how to observe levels of engagement with subjects experiencing significant states of psychopathology, how to help mitigate internal states of splitting and fragmentation, and how to teach these fragile students how to enhance their coping skills, sense of self and communicative competence with peers and others.

Objectives of this workshop are:
1. To learn how to structure a therapeutic group effective in reducing states of psychopathology with either psychiatric in-patients, or adolescent students with severe states of emotional disturbance.
2. To teach therapists how to maintain psychological contact with severely disturbed subjects while understanding the roles of transference and counter-transference.
3. To understand how psychodynamic object relations, humanistic-existential, and cognitive behavioral methods can be combined to enhance therapeutic effectiveness.

Specific Skills taught include:
1. How the concepts of *"Bridging", "Joining"* and *"Feeding"* are combined within a therapeutic milieu.
2. How to track therapeutic engagement throughout the group process.
3. How to reinforce positive responding in order to improve resilience and adaptive coping behaviors both within the group which generalize to home, school or work, and community environments.
4. How to select clients appropriate for the group experience.

5. How to initially work with patients within the Psychiatric Emergency Room setting if needed.

Expected Learning Outcomes include:
1. Attendees will become more comfortable working with seriously emotionally disturbed adolescents or adults.
2. Attendees will learn skills in group process and facilitation.
3. Attendees will learn how effective group process may reduce the positive and negative symptoms found in schizophrenia, schizoaffective disorder, dissociative disorders, bipolar disorders, severe depression, and other severe emotional disturbances while promoting resilience and reducing episodes of emotional decompensation and hospitalization.
4. Attendees will learn methods for improving their own self-care skills essential to working with seriously disturbed and traumatized patients. General issues concerning environmental safety will also be addressed.

ABSTRACT

Intensive Group Counseling & Psychotherapy with Severely Disturbed Adolescents and Adults

Presented by Dr. Carl Totton, Professor of Psychology, Licensed Clinical and Educational Psychologist, Phillips Graduate University, Chatsworth, CA, & Independent Practice

This session will present a model for working with emotionally disturbed (ED) adolescent and adult patients within an intensive group counseling or psychotherapeutic structure. The settings could be either inpatient or outpatient, or within the therapeutic milieu of a mental health program within an educational environment; i.e. public or private school, residential treatment center, county or SELPA program for ED students, psychiatric or general hospital setting, day treatment program, etc. Using theoretical models derived from object relations / psychodynamic theory, person-centered humanistic-existential psychotherapy, and cognitive-behavioral methods, attendees will learn specific skills for attending, guiding, shaping, and influencing the interpersonal dynamics of severely disturbed subjects in order to promote resilience, intrapersonal cohesion, positive self-regard, teach prosocial behaviors and coping skills, and reduce pathological symptoms and future episodes of decompensation and hospitalization. The concepts of *bridging, joining*, and *feeding* will be explored with demonstrations and theoretical explanations. Attention will also be paid to issues of transference and counter-transference and how to best utilize the personhood of the therapist for both self-care and therapeutic effectiveness.

A. Hospital Life in Typical Los Angeles County DMH Psychiatric Facilities

1. Patient Populations:
Typically consists of those with newly diagnosed or chronic psychotic conditions such a schizophrenia, schizoaffective disorder; untreated bipolar disorder, major depressive disorders, severe affective disorders, severe personality disorders in states of decompensation, suicidal or homicidal persons with psychiatric disorders; and occasionally those with neuropsychiatric disorders such as dementias

2. Patient Environments:
a. Psychiatric Emergency Room: Patients here are typically referred on 5150 involuntary holds, and/or for evaluation prior to admission to one of the wards.

b. Inpatient Wards: Once formally admitted to the hospital the patient will be assigned to s ward of perhaps 20-25 patients often housed two per room. There will be staff and patient cafeterias.

c. Ward Activities: Daily activities may include medication management, community meetings, expressive arts activities, group therapy, films, occupational therapy, exercise groups, family meetings, meal times, medical/nursing/social work/psychiatric and/or psychological assessments, discharge planning, etc. In-service trainings and lectures for staff are also often scheduled.

3. Safety Concerns:
The hospital environment is designed with safety in mind. The wards are locked and require a key for admission, there are windows on the doors to facilitate visual inspections prior to entry, staff is asked to always remain alert and to walk close to walls where one's back is not exposed, etc. Staff is expected to work in pairs or groups with especially dangerous patients, to sit with a desk between oneself and such persons, to leave an escape route open when necessary, to know safety protocol such as color code alerts, and to have studied measures such as P.A.R.T. (Patient Assault Response Training), etc.

4. Daily Routines:
Staff is expected to know the ward daily activities calendar, to watch out for each other, to understand how to chart patient contacts and observations, evaluations and the like.

APPENDIX II:

B. Psychiatric Emergency Room Routines:

The purpose of the Psychiatric Emergency Room (ER) is to initially stabilize patient behaviors, provide a working diagnosis (DSM-5), bring in consultants as needed, maintain contacts with families or outside agencies, and to prepare to either admit the patients to the hospital inpatient ward, transfer them elsewhere, or release them back to their community, often with referrals.

In some facilities, the daily evaluations are accomplished within a group dynamic situation where all patients and staff sit within a large circle and introduce themselves while the group leader asks the patients to individually introduce themselves, and briefly describe what was going on to get them admitted to the hospital, and how are they feeing that day. The group leader is also careful to orient the group at the beginning by stating their name and title, where the group is located (name of hospital and city), what the date and time is, and what the purpose of the group is. This is typically the first activity of the morning and is then followed by other ER activities, meals, breaks, individual examinations, transfers to the general wards, etc.

In addition, on a daily basis, as new patients are brought in by family or law enforcement to the facility, a team member or paired members perform rapid mental status examinations to determine a working diagnosis and determine if the patient will be sent home with referrals for community outpatient treatment or transferred to another facility (for example to the VA if a military veteran) or admitted to the ER for consideration of formal hospital admittance.

C. **Hospital Staff:** MD psychiatrist usually ward chief, nursing staff (RN), nursing aides and/or orderlies, psychiatric technicians, clinical social workers, psychologists, recreational therapists, occupational therapists, pharmacists, and medical or psychology interns and /or fieldwork students.

I. Psychotherapeutic & Counseling Considerations

a. Psychodynamic Factors

Inpatients in hospital or residential treatment settings will likely be severely disturbed when you first encounter them. They may be uncommunicative, illogical, unable to maintain rapport or eye contact, be responding to internal stimuli, be disassociated, be experiencing extremes of behavior and emotions, have very inappropriate patterns of communication, might be incoherent, labile, experiencing depersonalization, delusional, paranoid, depressed, tangential, fragmented, disorganized, or have similar states of disconnected consciousness.

Melanie Klein, one of the founders of Object Relations Theory, felt that children had primitive internalized mental images which expressed themselves as unconscious phantasies. When experiencing states of high anxiety, primitive defense mechanisms come into play such as splitting, projective identification, and introjection. With the organizing part of the personality or ego in a primitive state, the child is unable to maintain a cohesive sense of self or others, so relationships tend to become associated with aspects or parts of objects are often split between good and bad. These negative aspects may then be disowned, projected into others and then experienced as being directed back at oneself (projective identification), or as aggression or paranoia.

If the infant's mother is "good enough" (Winnicott), then a healthy developing child will develop the capacity to integrate both the positive and more negative aspects of others and themselves into a cohesive whole, the basis for healthy self and interpersonal relationships. If not, then various types of psychopathology are likely to develop. Under stress or when aspects of the self have decompensated during psychotic, manic, depressive, schizoid and similar states (the very states one is highly likely to encounter with the inpatient setting of a psychiatric ward), then these primitive psychic states are very exposed and are capable of being directly engaged if the therapist can remain centered, accepting, grounded, and flexible. Freud's "evenly hovering attention".

In addition, due to traumatic experiences, many patients are highly reactive, easily triggered, are experiencing states of post-traumatic stress disorder, and as a result have very unstable and insecure forms of attachment. Their capacity for interpersonal connection, rational discourse, effective problem solving and affective emotional self-regulation may be severely impaired.

b. Humanistic-Existential (HE) Factors

This model of psychological functioning posits that human beings are innately motivated towards self-development as a whole person, is inherently prosocial and motivated towards personal growth freedom, responsibility, and meaning (Rogers, Maslow, Fromm,

May, others). When this drive towards growth was thwarted, an individual might experience deep states of anxiety, confusion, despair, meaninglessness, depression, shame, and guilt. Lack of psychic cohesion would likely become very prominent with unbalanced intrapersonal and interpersonal relationships a likely result. On the psychiatric ward these patterns are highly evident.

c. Cognitive-Behavioral Therapeutic (CBT) Factors
The CBT model sees human behavior as a learned product of social relationships, the intersection of how thoughts, behaviors, and emotions have influenced each other to create sates of prosocial adaptive functioning, or impaired states of faulty learning and interactional patterns maintained through the force of habit. Learning how to reinforce more adaptive forms of functioning while extinguishing more maladaptive patterns is a central focus of the therapeutic interventions (Beck, Wolpe, Ellis, and others). Learning how to pair states of relaxation, mindfulness, and self-acceptance to formerly anxiety producing thoughts, behaviors, situations, and relationships is an important aspect of the therapeutic process.

II. Applications to the Psychiatric Inpatient Population in Group Psychotherapy

While working and training in several psychiatric inpatient facilities (Brentwood Veterans' Administration, King-Drew Medical Center, Olive-View/UCLA Medical Center), I was exposed to a treatment model within both the Psychiatric Emergency Room and Inpatient Psychiatric Wards for conducting group psychotherapy with highly disturbed subjects. Sessions are typically 60-90 minutes with an ideal group size of six to eight (6-8), although I have conducted groups with as many as fourteen (14) subjects.

Some basic ground rules included safety aspects maintained, patients' interactions were somewhat structured, disruptive patients were not allowed to remain in group on any particular day until they developed better skills at self-management (often with pharmaceutical help), but were always warmly welcomed back, and all patients were always treated with empathy and respect. Group starts with the therapist having members sit in a circle. Therapist orients group to place, time, date, and purpose of the group while introducing themselves. Then each member is invited to state their name, how long they've been in the hospital, and to state how they are feeling and, if they wish, what was going on in their lives that led to their coming into the hospital. During group, the therapist is attentive and flexible while remaining sensitive to the ongoing flow and needs of the group and its individual members.

Over time, the combination of these methods within the dynamic structure of the group leads to these qualities becoming internalized by the group members as they generalize to later ward life and eventually after discharge at home, school, work, and in the community. Both the positive and negative symptoms of psychotic disorders tend to decrease, while positive coping behaviors, self-statements and self-concept tends to increase. Prosocial skills are enhanced while toxic acting out and schizoid avoidance and

withdrawal tends to become minimized. As reality testing improves, patient acting out and disruptive behaviors tend to diminish.

In addition, certain patients were seen individually for individual therapy and/or for psychological testing when the diagnosis was unclear. All patients' progress was discussed in a weekly staff meeting generally led by the chief psychiatrist on the ward.

Often the **S.O.A.P.** method of charting was employed (**S**ubjective, **O**bjective, **A**ssessment, **and Plan**):

<u>**S**</u>**ubjective:** What did the patient actually say or express?

<u>**O**</u>**bjective:** What did you observe in terms of non-verbal communication, appearance, and demeanor?

<u>**A**</u>**ssessment:** What is your assessment/diagnosis of the patient's current mental-emotional state?

<u>**P**</u>**lan:** How will you use the above information and the patient's therapeutic goals to plan for the next intervention or group session.

Some of the specific skills used within the group include the following:

a. **Bridging**: this involves attempting to connect, bridge or link one patient's experiences to that of another. Extremely important as these patients typically feel very isolated, misunderstood, and paralyzed by schizoid states of being. This emphasis on re-connecting dissociated states of being is informed by the object-relations methods of psychodynamic therapy. By not over-reacting or acting out at the patient's transference projections, they tend to internalize a more stable sense of reality testing and develop an improved means of relating to self and others.

b. **Joining**: this essentially consists of methods of expressing empathy towards a group member and becoming attuned to their psychological state of being. Very similar to the basic conditions of therapy as expressed by Carl Rogers's humanistic approach (genuineness, accurate empathy, nonjudgmental positive regard). These can be expressed both verbally and nonverbally through tone of voice, facial expressions, body posture, etc. This assists with their internal cohesion and the development of a positive sense of self and remaining in psychic contact with others. It also helps to reduce pathological spitting and dissociation, and the negative acting out or acting in that might result.

c. **Feeding**: this consists of positive reinforcement, reframing, changing the narrative, reality testing, and radical self-acceptance. Many of these stem from traditional cognitive-behavioral therapy (CBT) approaches and seek to encourage more adaptive ways of behavior and interactions while decreasing

maladaptive states of being. Some psycho-education and information sharing may be accomplished here as well.

Therapist Self-Care

Therapist self-care is very important in this setting. A regular practice of mindful meditation, yoga-like practices, adequate rest, sleep, exercise and nutrition helps, and debriefing with a supervisor, consultant, co-worker or other staff member helps maintain appropriate counter-transference boundaries and flexibility, as well as a feeling of being grounded and centered. A genuine feeling of extending goodwill and respect towards these subjects is absolutely essential as they are experts at detecting hypocrisy and a lack of acceptance. Within inpatient settings all interactions with patients must be charted the day they occur, with individual patient activities linked to their therapeutic goals.

APPENDIX IV:

Group Therapy Descriptions at Thoreau Psychiatric Facility in Boston, MA. (A private psychiatric facility)

Inpatient Psychiatric Care for Adults
We encourage patients to participate in the Thoreau Center's group programming. Our programs are designed to support patient's recovery and help them acquire knowledge and skills that will help them manage the issues that are important to them. Therapeutic group work also provides support and validation of an individual's feelings as they are given a platform to share their experiences and thoughts with others.

Groups are an essential part of a patient's treatment at the Thoreau Center. Groups are led by licensed counselors, licensed addiction counselors, expressive therapists, social workers, nurses and mental health counselors. Below is a listing of the groups that we offer.

AA/NA
This group is for individuals in recovery and uses the Alcoholics Anonymous (AA) model for education, dialogue, sharing and peer support.

Anger Management
This is an educational group focusing on building positive skills to help manage feelings of anger and increase positive communications skills. It additionally addresses the connection between anger and depression and negative behaviors.

Assessment Group
This group provides a time for patients to fill out their self-assessment forms. Staff uses these forms to support and update treatment plans and goals.

Cognitive Behavioral Therapy Group (CBT) Group
This group focuses on cognitive behavioral techniques which work towards changing behavior patterns through interrupting the cycle of thought, feeling and action. Themes focus on dealing with resiliency, cognitive distortions, automatic thoughts and overcoming fears and phobias.

Communications Group
A theme-focused group that supports increasing verbal and non-verbal communication skills. It addresses communication styles and their effectiveness or lack of effectiveness within various contexts. Role-playing and handouts are used to support new learning.

Community Meetings
A time for all patients and staff to discuss creating a positive milieu environment for recovery and to talk about their contribution to the recovery program. Patients are encouraged to bring ideas and concerns about making their stay here most beneficial.

Coping Skills Group
This is a dialectical behavioral therapy, cognitive behavioral therapy and stress management skill-based group. The use of skills to manage coping with triggers is critical to recovery. Grounding skills, focusing skills, communication skills and problem-solving skills are reviewed for daily application.

Daily Reflections and Substance Abuse Recovery Skills
We offer general recovery groups based on both "Smart Recovery" as well as a "12-Step Model" of sobriety maintenance by offering "Daily Reflections" as a select group for an identified group of patients. The focus will include coping strategies, the role that substance plays in life, relapse, relapse prevention, self-advocacy and how to ask for and use support/treatment.

Current Events
This group supports a daily understanding and orientation about what is going on in the world around us. It can be based on members' contributions or interests and provides a forum to discuss issues and perspectives about living in the world.

Dialectical Behavioral Therapy (DBT) Group
This group uses dialectical behavioral therapy to focus on mindfulness-based practices, distress tolerance, emotion regulation and interpersonal effectiveness.

Discharge Planning
This group focuses on setting goals for post-hospitalization. It supports the skills necessary to bring the work of recovery out into one's daily life. Concrete tools are provided to focus the transition from hospitalization through discharge and goals for the future.

Expressive Therapy Group
This group is a psychotherapy group that integrates the use of art, music, movement, writing and psychodrama. The group supports experiential learning and the integration of alternatives for coping with stress, self-care strategies and developing insight based on creative exploration and self-expression.

Family Issues
The objective of this group is to educate group members about the roles they may play in their families and the ways these roles affect them and their feelings about themselves. It

addresses the strengths and weaknesses of the different family roles and characteristics of healthy family systems.

Feelings Vocabulary
This group identifies feeling states and uses a psycho-educational model to help understand feelings better. It supports exploring a range of feelings and ways to manage feelings.

Gentle Stretch and Mindfulness
This group utilizes a mind/body approach to help increase overall functioning and to build skills for future use. Yoga postures are demonstrated for supporting mind/body/spirit integration and practice.

Goals Group
This group begins the day with a brief member check-in regarding feelings and setting a goal for the day. It gives group members a chance to reflect and share while encouraging them to set an intention for the day as a focusing tool.

Individual Assignments
This group uses a structured set of handouts that focus on different tools for coping and self-development. With the help of a mental health counselor or expressive therapist, handouts are chosen to focus on individual recovery work.

Medication Education
This group is an educational group that focuses on medication through addressing the major drug classifications: their effects, side effects, drug interactions, necessity of compliance and follow-up care.

Nutrition Group
This group provides patients with a comprehensive outlook on the biological responses to nutrients during the various stages of illness and recovery. Cognitive and behavioral techniques for combating common distortions about nutritional information will be reviewed. The information is presented in an interactive environment that encourages and enriches the learning.

Psycho-Educational Group
This group is aimed at dispelling myths and providing accurate and up-to-date information about a theme or diagnosis. Topics include medication management and education, stress management and healthy living.

Therapeutic Games
This group provides a forum for patients and staff to get together to play games, become comfortable in the milieu and encourages sharing among participants.

Weekend Planning
This group encourages patients to lead a balanced lifestyle by planning goals related to the use of leisure time including intellectual stimulation, exercise, sleep, good nutrition and emotional and spiritual well-being.

Wellness Group
This is an educational and skills-based group focused on various themes addressing the concept of wellness. Themes include self-esteem, identity, symptom management, goal setting and coping skills.

Resources, References, & Recommended Readings

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