TRAINING & SUPPORT GROUP FOR HEALTHCARE PROFESSIONALS

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SUMMARY

Traditionally, healthcare professionals working at Hospitals were considered to perform a very burdensome and demanding task. Adding to that is the frustration expressed by patients and their relatives.

The difficulties encountered by healthcare professionals in daily clinical practice were investigated in the context of Consulting – Liaison Psychiatry.

It appears that the origin of these difficulties lies in the treatment of patients within the therapeutic relationship; sometimes healthcare professionals succeed in their approach but in others they fail. When they do fail, they tend to label patients as "difficult", "odd", "uncooperative", and often engage into disagreements with them.

Not only that, but doctors become rivals with the patient's family.

Therefore, we formed groups to explore the problems faced by healthcare professionals.

The research was conducted at the Psychiatric department of the METAXA Cancer Hospital in the context of Consulting – Liaison Psychiatry. The method applied was qualitative research.

The groups had a weekly frequency of 90 minutes and met for five years. The studies of Michael Balint and Kahana & Bibring were employed to gain an understanding of the patient on the basis of his personality type. The components included in the group work were the following: 1) instruction 2) experience 3) self-awareness 4) supervision work within the group.

Conclusions

- The psychodynamic concepts were assimilated fairly well.
- Characters or personality types encouraged members'self-awareness and patient understanding.
- Experiential processes and supervision work within the group promoted the members' interest.
- Participants believed that they gained a greater understanding of the patient; they felt more qualified to inform the patient and also reported that group sessions had a beneficial impact on their own personal relations.

Keywords: training, group, experiential, healthcare professionals, liaison psychiatry

Introduction

It is likely that the first group sessions that elaborated on man's concerns were the philosophical symposia in Ancient Greece. In recent years, even as early as the 20th century, it is clinical physicians who mostly showed an interest for group therapy. During the same time, Freud [1], fascinated by Le Bon's work “Psychologie des Foules” [2], took up the study of "group psychology". The first group in the field of health was set up by GP Joseph Pratt [3,4]. With a group consisting of approximately 25 TB patients, Joseph Pratt treated more the person and its problems as a result of the disease than the disease per se. Not long after, group psychotherapy grew mainly in the field of psychiatric health. Several therapists worked in groups such as E. Lasell, L.Wender, T. Burrow, S. Slavson, W. Bion, S. Foulkes, J. Moreno, F. Redl and others. Their contributions to the development of group psychotherapy [3] have been very helpful.

Encounter groups emerged in the early 1960s, mainly in the US. They were of short duration and focused on the psychological experience, on the here and now, on emotional expressivity and on self-revelation. They were addressed to "healthy individuals” or, for that matter, persons whose wished to participate was not a particular psychological problem. Predecessors to the encounter groups were Kurt Lewin’s workshops which were held in Connecticut, USA in order to combat racial prejudices. In effect, they were discussion groups where members engaged in an analysis of their day-to-day problems. [3]

During the 1960s, clinical-orientated group coordinators promoted a training group model which placed emphasis on the personal development of healthy, normal individuals. These coordinators advocated that group training not only helped doctors acquire interpersonal skills but also contributed to discovering their potential.[3]

During the 1950s, the psychoanalyst M. Balint [5,6] studied GP groups at the Tavistock Clinic of London. The purpose of his research was to explore the emotional reactions of Doctors to their patients in the context of the therapeutic relationship. To be precise, M. Balint studied Doctors' emotions of countertransference to their patients taking the view that these had an impact on the therapeutic relationship and the patient therapeutic process.

Grete Lehner Bibring [7,8] supported that psychoanalytic techniques needed to be incorporated into the practice of medicine and maintained that a successful treatment requires a doctor who is open to the patient's psychological needs and his personality.

During the same three decades, 1950-1980, the Psychosomatic Medicine and Consultation–Liaison Psychiatry which concerned somatically ill and not just physically ill patients was already growing [9,10]. Not long after, R. Kahana and G. Bibring [11] suggested the use of characters or personality types in order to develop an understanding of somatically ill patients.

The studies of P. B. Schneider greatly contributed to the therapeutic relationship [12].

In Greece, psychiatric clinics inside general hospitals were set up in the early 1980s, whilst Consultation – Liaison Psychiatry was developed at first by university clinics across the country and later incorporated into the National Health System. As part of a training program of the B΄ Psychiatric Clinic of the Aristotle University of Thessaloniki, an annual training program on C-L Psychiatry incorporating the works of Balint and Kahana & Bibring [13] was launched.

C-L Psychiatry was one of the services offered by the Psychiatric Department, within a General (not psychiatric) hospital.

The Psychiatric Department works together with other hospital departments and offers its valuable knowledge in terms of the patients' psychiatric aspect. This occurs either after a referral from the hospital departments or during the department activities where C-L Psychiatry participates such as diagnostic discussions, visits to the clinic etc.

The collaboration of the psychiatric department with the other units within the context of C-L Psychiatry typically revolved around four key areas:

1) The psychological reactions of the patient and family as a result of the disease;

2) The issue of informing the patient and his family;

3) The patient's psychiatric nosology;

4) The training in collaboration with other hospital departments in matters pertaining to the previous three areas of collaboration.

Based on all these reports, near the end of 1980s, a training group study began at the Metaxa Cancer Hospital in the context of C-L Psychiatry.

Building on the training aspect of C-L Psychiatry and aimed to set up a training and supportive group, the question was posed regarding the exploration of personnel problems and conditions.

C-L Psychiatry within an non-psychiatric Hospital took various forms, such as the therapeutic approach of patients suffering from a psychiatric disease, from organic psychosyndromes or psychological problems as a result of the disease. Collaboration also developed in a training level which occurs either with daily collaboration, or in the form of lectures or work groups.

Material And Methods

The collaboration with C-L Psychiatry served as a means to record problems and difficulties faced by the medical and nursing staff. These difficulties concerned the actual relationship with the patient: the labelling of the patient as "difficult", "odd", "uncooperative" when medical and nursing staff found it hard to cope with him. On other instances, the call for consultation psychiatry was made on the grounds that the patient "was uncooperative" or "denied treatment".

Difficulties and problems also concerned the issue of imparting information to the cancer patient and what form should this imparting take.

Major problems arose during the collaboration with the patient family which could reach rivalry.

The study has been carried out in the psychiatric department of the «METAXA» Cancer Hospital since 1989 in the framework of Consultation – Liaison (C-L) Psychiatry and it is still under way at the school of Health Sciences of the University of Athens [14].

For this aim the following are used

1) Training groups of doctors and nurses;

2) The C-L psychiatry section of the Psychiatry Department;

3) The training activity in the framework of C-L Psychiatry [15];

4) The annual seminars of psychooncology for healthcare professionals.

As method of research, the qualitative method [16] [17] [18] was employed on groups with doctors and nurses, while group research lasted for five years.

During those five years, we set up eight (8) groups, the three of these by doctors and five of nurses. The number of members in each group was 12 - 15 and they met weekly for 90 minutes each time. They took place for one academic year and the total time spent was 60 hours per year.

The group process is based in that of the analytic group, taking into consideration the therapeutic factors, particularly cohesiveness, interpersonal learning and universality, whilst the group coordinator should be trained in group psychotherapy.

The procedure of discourse is based on the inductive method and in the Socratic method as per A. Beck [19] [20].

It takes into account:

1) The Balint's group studies on Countertransference feelings in a Doctor-patient relationship [5][6];

2) The psychodynamic concepts in the understanding of medical patients [7] [8];

3) The understanding of patient by means of types of personality [11].

In the framework of Consultation-Liaison Psychiatry, in collaboration with the medical, surgical and radiotherapeutic clinics, the psychiatric department participated in training programs which discussed clinical issues about informing cancer patients. The annual psycho-oncology seminars for Health professionals consisted of six sessions (total 42 hours) per year where the results in groups and in C-L Psychiatry were discussed with a larger sample.

The mean of attendance in any seminar was 60 individuals.

The group had three goals: educational, experiential and supportive.

The educational factor concerns the synchronous teaching of psychodynamic concepts in relation to the patient, as well as the characters or personality types suggested by Kahana & Bibring for the development of a broader understanding of the patient.

Furthermore, the studies of Kübler Ross [21] in the approach of the cancer patient and the existing medical literature on patient informing were also taken into account.

The experiential function was based on the hypothesis that the therapeutic relationship is analogous to other human relationships such as the mother and infant. Therefore, information is gathered about the dynamics of other relationships through the study of the therapeutic relationship.

Based on the function of the analytic group, the following are taken into consideration: the here-and-now, the group therapeutic factors and the theoretical maxim of the constant health-disease [3].

The function of the group during the first year also had an experimental-exploratory nature.

During the first sessions an emphasis is placed on the:

1) the explanations given regarding the purpose and function of the group;

2) the gaining and maintenance of group cohesiveness;

3) the instructive and supporting aspect while it gradually becomes more experiential and insightful.

In terms of the instructive aspect of the group, it includes a material which refers to:

1) the therapeutic relationship; a) the professional relationship; b) the human relationship;

2) the psychodynamic concepts that assist in building a good therapeutic relationship.

These are [7,8,11]:

a) the concept of the unconscious

b) countertransference

c) transference

d) the defense mechanisms

3) characters or personality types and their exploitation [7,8,11, 12,13,14,22,23]:

a) in gaining an understanding of the patient;

b) the doctor's self-awareness;

c) the patient informing.

4) developing an understanding of the crisis suffered by patient and family [24,25,26]

5) the psychological reactions of the patient and family to the loss of health.

6) the family system dynamics [25,27]

7) the group dynamics with an emphasis on the therapeutic group [3]

8) the discussion is based on:

a) the scientific method of inductive cognitive process, which moves from the empirical facts to deducing a general principle.

b) the Socratic method as updated in A. Beck’s Cognitive Theory. [19,20]

During each session a discussion is initiated about the issues of the aforementioned teaching materials without actually teaching in the strictly academic sense i.e. when the issue for discussion is patient crisis, the discussion begins with a question without offering definitions or explanations: have you ever suffered a crisis in your life or are you dealing with a financial crisis (loss of money)? In this way, the group raises the issue of patient crisis (loss of health).

Furthermore, the members discuss the reactions and mechanisms revoked in crisis management and they explore ways to help the patient.

Towards the end of the group work, the coordinator recapitulates what has been discussed and may also become more instructive by citing cases in support of the group discussion.

When characters or personality types are included in the discussion, an analogous procedure is followed. Thus, members are invited to a self-cognitive process whereby they understand that patients too may have similar characteristics and the only difference between doctors and patients is the role, i.e. one being the doctor and the other the patient.

The issue of informing is posed inquiringly without adding different opinions of other scientists. Instead, emphasis is placed on the members' concerns and their feelings during patient informing. In addition, the therapists poses the question: Had we been on the side of the patient what would we ask of doctors? This question allows participants to experience and formulate a method of informing in an inductive way. The coordinator attends to and leads the discussion by using the Socratic – Cognitive process and the analytic group techniques.

A similar process is followed during the discussion regarding the patient's family system dynamics and the exploration of ways to collaborate with relatives and make them allies and not enemies.

Results - Discussion

During the first year of the study we created a group of 15 Nurses. The members of that group worked as department supervisors. They had a similar clinical experience which, obviously, promoted the goals of the study. The following two years, we created 4 groups of Nurses with 68 females and 2 males and also two groups of medical residents (16 females and 12 males).

In terms of the therapeutic factors of group psychotherapy, group cohesiveness was achieved after 2-4 sessions. This allowed the exploration of the remaining factors with an emphasis on those of interpersonal learning and universality. The achievement of group cohesiveness is considered a prerequisite for the smooth cooperation of group members and the exploration of the remaining therapeutic factors [3].

Psychodynamic concepts were satisfactorily elaborated by the participants. Elaborating on the concepts of transference and countertransference contributed in the understanding of the unconscious function and of the patient regression and denial mechanisms. During the 1940s, Grete Lehner Bibring supported the view that psychoanalytic techniques should be incorporated into medical practice [7,8]. In the 1950s M. Balint studied the countertransference elements in a group of General Practitioners and supported the usefulness of psychodynamic concepts in the therapeutic relationship [5,6].

The psychodynamic elements in a doctor/patient relationship are also supported by P. Schneider (12), whilst Kübler-Ross [21] stresses on the importance of the denial mechanism, which corresponds to the denial stage.

The study of the characters or personality types was welcomed by most members as well as the self-awareness process through their character profile. The first hypotheses regarding the exploration of characters in imparting information to the cancer patients were made within the groups [14,22]. The characters studied were those suggested by R. Kahana & G. Bibring [11] which were later included in the Greek version of psychiatry as [13]:

1) the controlling-orderly (compulsive) personality
2) the oral overdemanding (dependent) personality
3) the emotionally involved, captivating (dramatizing) personality
4) the personality with a feeling of superiority and arrogance (narcissistic)
5) the guarded, querulous (paranoid) personality
6) the long-suffering, self-sacrificing (masochistic) personality
7) the uninvolved and aloof (schizoid) personality

During our research, the terminology which seems to facilitate professional clinicians is:

1) controlling-orderly (compulsive) character or personality type
2) the dependent (oral) character or personality type
3) the emotional - hyperthymic (dramatizing) character or personality type
4) the emotional - hypothymic (depressive) character or personality type
5) the guarded – querulous (paranoid) character or personality type
6) the giving – self-sacrificing (mazochistic) character or personality type
7) the arrogant character or personality type with a feeling of superiority (narcissistic)
8) the avoidant character or personality type
9) the uninvolved and aloof (schizoid) character or personality type

The emotional-hypothymic (depressive) character or personality type and the avoidant character or personality type were added to the list [14].

In terms of the crisis experienced by the patient and family, there is usually sufficient theoretical knowledge to address crisis in an emergency clinic. But a patient facing health loss, such as that of cancer, experiences a crisis for a long time at personal, family, work and social level. Therefore, an understanding of the crisis and its implications and ways to manage it during the therapeutic relationship and patient follow-up is required [22]. When doctors develop a deeper understanding of the crisis, they use a more effective approach in helping the patient and family to restore lost balance [14,25,28,29].

Kübler Ross [21] included the crisis in the first stage of shock, which continues to the following stages described by her. The concept of system and mainly the concept of a family system contribute to understanding the crisis.

The latest concepts contribute to understanding the patient in relation to his family. The need to make relatives allies and not enemies is understood [14,25,20,28].

As the group becomes more cohesive so do the empathic and experiential processes become more reinforced. Such cohesiveness is achieved by means of the exploration of the analytical group psychotherapy techniques. The analogous use of the therapeutic relationship to other life relations attracts the members' interest i.e. the therapeutic relationship is an analogue to the mother/infant relationship and patient and infant analogies are explained. These are compulsive dependence, the revival of the primal magical thought seeking survival solutions. The cause of these analogies is the regression from a major stressful event. Based on the authority of the role and knowledge, the therapist cares and cures in ways that the patient does not know - in the same way as the mother cares for her infant [22]. The adult patient revives dependence by anticipating autonomy. It should be stressed here that the patient is an adult and at a logical level we should address the adult by taking into account the regressed "inner child". The idea of encouraging doctors to get into the patient's shoes and experience the "inner child" is explored either during the process or in role playing. The empathic, experiental process employed in the training group of healthcare professionals should not reach the degree of a therapeutic analytical group and to revelation of personal facts – hence, the group coordinator should be trained in group psychotherapy.

The discourse on patient informing concerns questions such as who should inform, when, how much and how the family is informed [22,14,25,28,29,30].

Also, countertransference, transference, the denial mechanism, character traits offer the background for individualizing patient informing [22,14,25]

The training group also performs supervision work, i.e. the participants bring into discussion problems from the day-to-day practice which are then elaborated by the group in order to find ways of dealing with them.

The group members completed an evaluation questionnaire which demonstrated: 1) that they had been benefited at a personal level; 2) that they had developed a better understanding of the patient and his relatives as well as of colleagues, nurses and doctors. Not only that, but the group contributed to their getting closer to their spouses, offspring and friends.

Discussion-Conclusions

The abovementioned training-experiential group may focus on different goals.

The above described training group aims at enhancing the therapeutic relationship and the therapists' self-awareness which in turn promotes a good therapeutic relationship.

The group work considers four factors:

1) education 2) experience 3) self-awareness 4) supervision.

These factors should be included in each training process addressed to healthcare professional learning [31,3].

Members seem to absorb the psychodynamic concepts fairly well as well as to benefit from the empathic understanding of the patient. According to their comments, among the defense mechanisms the most useful in the empathic understanding and patient informing process is the denial mechanism.

The study of characters or personality types seem to enhance the members' self-awareness and the empathic understanding of the patient and the informing process.

The further understanding of the crisis concept assists participants in helping patients in practice.

The experiential processes enhance the members' interest and increase self-awareness. The preferred topic is the therapeutic relationship being an analogue to the mother/infant relationship.

Supervision work within the group reinforces interest and is compared against academic courses in terms of patient informing. Patient informing should be individualized and take the following into account during assessment:

1) The denial mechanism

2) Countertransference 3) Transference 4) Character profile 5) Family dynamics.

References

1. Freud's Group Psychology and the analysis of the Ego. In Stackey J (Ed) Complete Psychological works of Sigmund Freud Standard Ed.vol 18 pp 69-143. New York: Norton. 1921.
2. Le Bon G.(Psychology of the masses). Psycologie des foules 1895. Ed.
3. Yalom Irvin D. and Leszcz Molyn. The Theory and Practice of Group Psychotherapy 1st Published by Basic Books, U.S.A. 2005.
4. Scheildlinger S. History of Group Psychotherapy In Kaplan H.I. and Sandock Bj (Eds) Comprehensive Group Psychotherapy 2 edition pp2-10 Baltimor Williams and Wilkins. 1993
5. Balint M: The Doctor, His patient and the Illness. 2nd Ed. Churchill, Livingstone 1990.
6. Balint M: Problems of Human Pleasure and Behaviors, Ed. Maresfield Library. London 1957;198-220.
7. Bibring G.L., Kahana R.J.. Lectures in medical Psychology:An Introduction to the Care of Patients. Arch Gen Psychiatry 1969;21(5):638-639.
8. Bibring G.L. The teaching of Dynamic Psychiatry. International Universities Press, USA, 1968.
9. Scwab J.J. Consultation - Liaison Psychiatry: Historical overview. Psychosomatics 1989;30(3):245-254.
10. Pasnau R. Consultation-Liaison Psychiatry at the Cross roads, in search of a definition for the 1980. Hospital and community psychiatry 1982;33 (12).
11. Kahana R, Bibring G. Personality Types in Medical Management. In: Zinberg N. Psychiatry and Medical Practice in a General Hospital. International University Press, Madison, USA, 1964;108-123.
12. Schneider BP. Psychologie Medical. Payot. Paris, 1969.
13. Manos N. The Fundamentals of Clinical Psychiatry. University Studio Press, Thessalonica, Greece, 1997:456-469 (in Greek)
14. Kallergis G. Using personality characteristics to individualize information to cancer patient. Journal of Buon 2008;13:415-420.
15. Kahana J. R, Teaching Medical Psychology through Psychiatric Consultation. Journal of Medical Education. 1959; 34(10):1004-9.
16. Pope C., Ziebland S., Mays N., Education and debate. Qualitative research in Health care. Analysing qualitative data. BMJ 2000;320:114-116.
17. Silverman D. Qualitative Research, Theory, Method and Practice. Sage Publ. 2004.
18. Elliott R, Fisher CT, Rennie DL. Evolving guidelines for publication of qualitative research studies in psychology and related fields. Br J Clin Psychol.1999;38 (3):215-29.
19. Beck A.T., Emery G. Anxiety disorders and Phobias, New York: Basic Books.1985.

20. Perris C. Cognitive therapy with schizophrenic patients. The Guilford Press. 1989.
21. Kübler-Ross E. On Death and Dying. New York Macmillan co. 1969.
22. Kallergis G. (ed) Information and Communication Guide with the Patients. Medical Graphics Editions, Piraeus, Greece,2003 (in Greek)
23. Oldham J. Morris L: The new personality self-portrait. Bantam Books. New York.1995.
24. Flannery BR, Everly SG. Crisis intervention: a review. Inter J Emerg Ment Health 2000;2:119-125.
25. Kallergis G: Informing the cancer patient and family. Journal of Buon 2009;14(1):109-114.
26. Parad H.J. Parad L.G. Crisis intervention: Book 2. The Practitioner's source book for brief therapy. Canada USA UK Manticore publ. 1990.
27. Minuchin S (Ed):Families and Family therapy. Cambridge, Mass, Harvard University Press,1974.
28. Kallergis G.(Ed) Informing Cancer patient. Medical Graphics Ed. Piraeus, Greece, 2008. (in Greek).
29. Kallergis G. (ed) Patient with Cancer and his Family. Medical Graphics Ed. Piraeus, Greece, 2008. (in Greek).
30. Novack H.D., Plummer P., Smith R.L. et al. Changes in Physicians attitudes toward telling the cancer patients JAMA. 1979:241(9):897-900.
31. Gask L; McGrath G. Psychotherapy and general practice. The British Journal of Psychiatry: the Journal of Mental Science 1989;154:445-53.