

Coffee & Cookies group

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Abstract

We propose the presentation of an experience in hospital and day-hospital units: "the coffee and cookies group." This verbal group, created in 1997 in the psycho-educational dependence of hospitals units of UPDM continues today in the actual context of the Day Hospital. This group is led by a psychologist and an educator, as well as by a co-entertaining nurse. It represents one of the first attempts of group work in hospital surroundings, with a population composed of adults with intellectual disability, mild to severe, and of important behaviour disorders, with or without autistic troubles.

Key words: psycho-educational group, intellectual disability, homogeneous groups

We can also, for some patients, consider the diagnosis of 'personality disorders' of the borderline type. These people all have problems in the handling and adapting to the social situations of every day life. They also present problems when in handling their emotions (anger, sadness, fear, joy), in identifying them and in expressing them.

Patients frequent the day hospital living in our residences or families, or they participate to this therapeutic activity from the hospital, in this case patients are "in preparation" to be discharged

The originality of these verbal groups, resides in the possible intervention on individuals presenting a very low tolerance to social stress and possessing a reduced verbal skill.

The advantage of the group situation for these people is above all of all to put the persons in a therapeutic situation to correct the situation of "natural group", as the meat, the meeting in the residences in Institution or in the family. We also offer tools allowing a better adaptation to reality, and thus a better access to social interaction. From the theoretical level, considering a psychotic population, Brenner highlighted the importance of the interaction of four functional levels: a primary level of "perception/attention", a cognitive level, a micro-social level linked to relational contexts and a macro-social level, more oriented toward the assumption of a role in society.

We have observed the necessity of exposing our patients in a manner cautious both in intensity and complexity, to different sensorial perceptions and to re-educate them to attention through pleasant activities, which provoke relatively little stress. At the cognitive level, always respecting the different anxiety tolerance thresholds, we placed them in situations where the use of concepts, although simple, as well as the use of language can in some way be a source of gratification. The successive

elaboration of socially acceptable behaviours also had gratifying connotations, involving valorisation within a group. We evaluated our experience and we noticed that a therapy involving a 'group dynamic' could be modulated with individual demands and became accessible also to patients having a very low tolerance to social stress.

Constitution of coffee & biscuit groups

The coffee & biscuit group has been the reference verbal group for the constitution of therapeutic groups of the same type within the Day-Hospital infra-structure created in 1999 in the Psychiatric Unit for Mental Development.

There was a fundamental reticence in the patients when it came to attend a structure logistically close to a psychiatric hospital entering the Hospital. We therefore had to encourage them to come and, more important, come regularly to the group; adapting the strategies of therapeutic seduction to patients with important troubles at the level of their communication and social interaction. We also had to prevent challenging behaviours and other important behavioural disorders during the group, which are sources of possible accidents, by introducing a solid and regular framework, with a very containing structure but without neglecting the gratifying aspect, for example the coffee and the cookies. This component, in fact, is far from being anodyne. Our challenge was the following: to progressively bring our patients to a reciprocal exchange, around a concrete context favouring relationships, in an atmosphere aiming at relaxation and conviviality, without the impression of being in a situation involving examination and failure.

This 45' verbal group takes place on Friday afternoon and consists of a co-ed group of patients. Being at the end of the week, it is therefore very charged emotionally, for it represents the accumulation of the whole week, as well as being aimed at preparing the separation from therapists during the weekend.

Another objective of this rehabilitative group directly involves the learning of socially acceptable behaviours. This is obtained through social exchanges in the "hic and nunc" mode and observance of clearly defined social rules, while maintaining a friendly atmosphere.

The therapists have to adapt the level of the exchanges to the cognitive skills of patients and to their psychiatric pathologies. This makes the notion of pleasure very important, as group container. The hypothesis was the following: the pleasure of drinking the coffee and eating the cookies facilitates social exchanges, gives to the patients a profound sense of social belonging to a group and generates the atmosphere necessary to elaboration. Very rapidly, around this concrete support, emerged very personal questions, which we could re-group according to more general themes: week end activities, desires for change of the working or occupational activities, desires to change living environment, in other words the difficulties of every day life.

The patients meet up and review their week with the daily problems and the successes, which we highlight and put emphasis on.

The rules of the group can be resumed as follows:

Respect for the therapeutic framework (punctuality, regularity): for this point, the patients do not have big problems and they respecting this framework perfectly, being very attentive on time. This is how G is our “clock” and even in the middle of a phrase, he can stand up, come towards us, tell us pointing at his watch: “it is quarter to!” and leave immediately. He has approximately learnt to wait the end of the phrase to say goodbye and leave. Therefore we can note a rigidity of the patients with respect to the therapeutic framework, above all when these patients present obsessive symptoms. It was therefore necessary to arrive at an increased flexibility and fitting to the therapeutic framework allowing a better modulation of their reactions, the acceptance of exceptions to rules and the adoption of less explosive behaviours.

Remain seated until the end of the group with an adequate behaviour. Not going to the toilet or consuming cookies and coffee without limit, or isolating themselves have also been difficult objectives to reach: they all, from the beginning of the group, presented problems of psycho-motor agitation, internal tensions that push them to sometimes stand up, and move in all directions. Therefore, a whole process of physical and psychic framing had to be carried out.

Another important rule has been the non-aggression contract (physical or verbal aggression).The therapeutic idea is to teach them alternative methods to express their needs or their aggressiveness when faced with unknown variables linked to unclear (from their point of view) situations.

Starting from simply explanation of difficult situations, little by little, the therapists could make the patients put words on feelings, “saying” internal tensions, doubts, confusions, and fears; all emotions which form the base of possible violence. The hypothesis is that their behavioural disorders are for the most part the visible part of the iceberg, the declared symptom linked essentially to a poor comprehension of certain emotional or social situations too difficult to decode.

On top of this, always related to the rehabilitation aspect, without this looking like a sensu strictu rule, a certain ‘correct’ behaviour is demanded, a certain social behaviour in front of the others. They must learn, or re-learn to look at each other when speaking, to listen to each other, to sit properly on a chair without lying down or moving too much. They must learn to wait for their turn before speaking, and to not interrupt others at any given moment. The end of the group is marked by a short summary where each individual takes a role in restitution of the content of the group. In this way the group works perception and memory, and all the patients have the possibility to be present.

To resume we can say that to put in words difficulties, to express them, to find alternatives, re-learn certain social behaviours; control their own emotions during the group; measure emotional movements, after having identified them, to learn ‘each person in turn’ instead of ‘each one for themselves’, these are our aims. It is important for each of them to experiment a social situation with the goal of

ameliorating their skill to interaction. The relaxing, and friendly atmosphere around the context opens a way to social exchanges, which become increasingly reciprocal. We target our work on the progress and successes of each person, so they may take away with them a better image of themselves in the every day life.

Subjective Evaluation

The coffee & biscuit group reveals itself as particularly effective according to qualitative and quantitative results which have allowed us to measure them. This group, has allowed a solid references in space and time. Progressively the content of the group became more attractive than the material aspect of coffee and cookies, eating and drinking became secondary, allowing relational exchanges more and more reciprocal in the group and make possible some polite manners (ex: serve the other, passing the tray of cookies, offer to others, etc,...). At the moment, the patients come more to talk to each other, to exchange and make conversation, showing pleasure of exchange than to eat cookies and drink coffee. Nevertheless this “therapeutic seduction” has been fundamental to create the structure of this group.

Objective Evaluation

We choose to use a clinical evaluation scale, The Aberrant Behaviour Checklist, to be able to quantify, in a more precise and less intuitive manner, behaviours and achieved progress.

"The Aberrant Behaviour Checklist" (ABC - Autors: Aman M.G. Singh N.N., Stewart A.W. et Field C.J., 1985).

This is an evaluation scale, developed by the authors (translated and adapted by the authors in 1994), describing the effects of drug treatments (and other forms of treatments) on behavior in a population with intellectual disability. This scale is composed of 58 items composing 5 factors: 1) irritability, agitation, crying (15items); 2) lethargy, self social isolation (16 items) ; 3) stereotyped behavior (7items); 4) hyperactivity, insubordination (16 items) ; 5) inappropriate language or inappropriate words (4 items). The items are ranked according to a 4 point scale, from 0 to 3, according to the degree of severity. This scale can be periodically completed by the health care team (after a one week long observation of each patient). This scale allows measuring the clinical changes in behaviour, their evolution, following any type of treatment (not only drug related). So we can have a better idea regarding behaviour troubles, their frequency, their intensity, and their repercussions on the functioning or on the development of the individual. This scale is part of today's clinical practice. The patients were informed, and have consented to undergo it. We noted a better values on ABC scale in a majority of our patients in therapy.

Description of a group situation (January 2001)

Participants: Catherine-Viviane-Léa-Sonia-Gilles-Jean-Henry; one therapist Danièle, and 2 co-therapists Maria and Josiane.

One of the co-therapist, Marie, announces her departure after two years of participation. Vehement protests from Gilles: "I don't agree, I don't like changes." (he crosses his arms, puts his head down, and looks at the floor.)

Danièle, therapist: "But this doesn't stop you from having drinks and cookies!»

Henry lunges for the cookies, whilst Lea gets up to propose mineral water to the people in the group.

Catherine: "Henry, watch out, you are taking our part of the cookies".

Gilles: "Oh, that Henry, it's always the same thing with him. I don't like him."

Henry puts the plate containing cookies back down; and goes to sit down, very vexed: "but I always want to succeed in being good and at being adult!»

Catherine: "Tank you Henry, in any case, here we take turns for the cookies, as well as for talking.

But why, Marie, the co-therapist is leaving us? Will she also leave the day Hospital?

Marie, co-therapist: "Because life is change, I am leaving, but other therapists will come to take my place. I can already tell you that it will be Viviane and Christine."

Danièle, therapist: "the coffee & cookies group will continue with other therapists, but I remain the therapist of this group, just like before."

Léa starts to swing herself.

Catherine (very worried): "There she goes swinging again; why do you swing yourself like that? That's not right."

Léa: "I am sad because co-therapist is leaving. I too would like to leave, and in any case, I am leaving the whole of next week so you won't see me again."

Josiane co-therapist: "But maybe you are trying to tell us that Marie's departure makes you sad, and a little bit angry at the same time."

Silence on Léa's as well as on the part of the whole group.

Danièle, therapist: "We are now going to talk about what went well during the past week."

Catherine: "For me, the swimming pool went well, because I did not think of smoking whilst I was swimming."

Sonia, triumphantly: "Me, I ran away, yesterday."

Danièle, therapist: "And you say it smiling?"

Sonia: "No, I felt very bad yesterday, I saw ghosts again, so I left."

Danièle, therapist: "So running away is when you feel bad? Is it something known by some people here in the group?"

Léa: "Me, when I feel bad, I run away tor town, and I phone everyone all the time."

Gilles: "Me too, before, I used to run away and insult people on the streets, but now that's finished: I do outings to town. But when will I be able to stop the workshop to be able to go to town all the time?"

Catherine: "Oh! Gilles, you are not going to start with that again, you know you still have to come to day hospital and follow your program like us, otherwise, things will go badly for you, and for me too by the way."

Gilles starts to whine: “Oh, but I always think of my parents. (Whom are dead).”

Catherine: “Me too, one day I am going to lose them: that is maybe why I do not want to stay alone at my house, or alone in town: I was advised to live in a home, one day, if it was to happen to me.” Sombre face.

Léa: “I am fed up of this program, fed up of all of you: I want to live my life like everyone else.”

Henry: “But you too you have problems, you are ill, how will you manage alone in the city the whole day?”

Léa swings for all answer.

Catherine: “If we are talking about pleasures of the week, I have to tell you that I saw my son on Wednesday and that we ate together.”

Silence in the group.

Viviane: “Me too, I ran away and I was very frightened; I got lost in a forest.”

Catherine: “But when was that? Last week?”

Viviane: “No, when I was small.”

Catherine: “But you haven’t understood anything; we have to talk about successes of the past week.”

Viviane: “Well, if we can’t speak anymore, I am silent. (Very vexed)”

Danièle, therapist: “You can speak about that with me in individual therapy, but in this group we have to talk about what worked well in the past week, Ok, Viviane?” (Viviane nods.)

Jean: “I liked the farm group, seeing animals makes me happy, I also was very happy at the buying group, because I was helped in buying clothing.”

Henry: “Well, I prefer sleeping in my hiding place, because everything is really too difficult!”

Catherine: “But you can’t spend the rest of your life sleeping, otherwise you will become fat like me. You have to move.”

Henry: “Oh, no! Otherwise I will have too much difficulty in keeping my “A” (that it means too much difficulty in controlling myself.)

Then, the therapists evoke different fears, for example the fear of not succeeding in daily activities, fears which can push us to hide, run away; eat too much, smoke too much.

Danièle, therapist: “What if now we talked about the week-end?”

Henry: “Well, to be able to keep my “A"s, I will stay the whole week-end lying down in my hiding place.”

Protests from the group.

Catherine: “But you could go for a walk, take a bus, instead of going to lie down.”

Viviane: “You should just watch films on TV.”

Henry: “Ah! No, all of that is much too complicated. I will simply go in my hiding place, and by one single Ice tea so I won’t be too excited.”

Gilles: “In town.”

The intrigued group asks for details.

Gilles: "You to stop me from going to town?"

Catherine: "No, don't worry."

Sonia: "He's always grumpy, that one."

Gilles: "I'll go in the lower roads to see if I find an accordion" (Gilles is really doing better than usual today. Everyone applauds.)

Sabina: "This week end, I will go skiing with my parents."

Jean: "Not much, I will be calm, and go outside and take care of my cats."

Catherine: "I have a cat, but it doesn't stop me from looking after myself. This week end I will go the hair dressers to have a brushing, so there you go." (Looking at Jean) but why don't you ever take care of yourself?"

Jean puts his head down.

Marie, co-therapist: "Jean, did you predict buying things this week end?"

Jean: "Oh, I will see. I thing there is an egg left in my fridge."

Catherine: "But we are worried for you. You take better care of your cats than of yourself, that's not good."

The group approves.

Viviane: "This week end I am sleeping at my boyfriend's house. Maybe it won't turn out well between us, and they'll forbid me of seeing him again, but it is still too frightening to sleep alone in my apartment."

Léa: "I'll go see my god mother Saturday, and Sunday I will go at the mountains with the educators. I would prefer to go to Paris alone."

As we can see, horizontal exchanges are important. Here patients can talk about their fears and face them together without feeling the only ones to live such situations. We all exchange advices on how to better manage these situations. As we have already seen, the patients can leave with a less negative image of themselves, having evoked the successes of the past week, and having seen them confirmed through the others. They can also evoke projects for the weekend or listen to others proposing them in case lack of ideas. The access to words that allows a formulation of feelings and emotions represents an alternative to actions, or unpredictable reactions, which can sometimes be violent. This is how, little by little, answers or behavioural strategies are more effective, and alternatives to aggressive actions have emerged with the help of reciprocal exchanges.

Conclusion

On the clinical plan, it is important to note that our patients have been able to evolve in certain domains treated in the group "coffee & cookies". We have noted a better handling of emotions, a considerable decrease in anxiety when faced with change, an anticipation for situations (weekend) and an important amelioration of verbal and non-verbal communication, with a certain impact on dual social relations. We also assisted an amelioration of hygiene. In a general sense, behaviour has become more acceptable. Consequence of all these ameliorations has been an important increase in autonomy in every day life for practically all the patients of the group, which has

helped their integration in residences and workshops. Considering the more personal changes, we have noted a greater capability of verbal and non verbal expression, a reduction of egocentric, as well as withdrawal and run away attitudes. The presence of a containing framework has allowed patients to look for and find personal and social roles more adapted to their needs and aspirations allowing a compromise between idealistic desires and a frustrating reality. For instance a patient could assume a role that joins the service to the other participants with a privilege of being the helper of the therapist bringing coffee to the group. This act has had also the role to rhythm the special moment of the start of the group. We must note the very ceremonial aspect, nearly ritualistic, which take on these different roles, which each person likes to respect very regularly and seriously. This group has allowed them to enjoy to a greater degree of their perception (see, listen, smell, be attentive to others' feelings, recognise and identify them). We also witness a better comprehension of each other's demands through a clarification work of the content. The patients can now say they do not understand and are better equipped to ask for help, or to search for information and adapted answers. In this way, we were able to point out a better social strategy, which can eventually break up conflicts or problems regarding a possible violence.

A noticeable diminution of inadequate behaviour (run away, rejection of the context, anger towards themselves or others) has been established, with persistence of a somewhat labile thymie (sadness, depression, anger, temporary euphoria) for most of them.

It seemed interesting, through "The Aberrant Behaviour Checklist" questionnaire, to objectify the evolution of patients treated in this group.

This tool refers itself specifically to the behaviour disorders presented by this population. We propose to measure the evolution of patients with this tool, which take into account, in a specific manner, the presence and gravity of behavioural disorders. This type of tool, normally used to test the effectiveness of various treatments, allows also the identification and the measurement of "the crisis", characterised by the presence of behavioural disorders of varying severity. Precise and regular information related to the crisis state of the patients may be obtained in this way, allowing for their definition and quantification, in order to reach a more rational care taking and a better inter-disciplinary transmission of clinical appreciation of the patient.

Using the ABC we have carried out three studies between 1997 and 1999. The results in 1999 show a higher incidence in most of the patients of the factor "depression" maybe linked to a noticeable amelioration on the "insight" level: the patients can now say that they are sad and lonely, and these different feelings can be recognised and felt. This acquired competence seems to give them access to a better understanding of their psychic reality, of their life, felt on the emotional level, and therefore, at times, of melancholic movements. This competence causes a more marked tendency to

depression taking the place of the aggressive behaviour, with the advantage of the possibility of a further elaboration, which is absent in the action. The stimulus to communication has been useful for a real increase of the verbal and expressive capabilities, and this has helped our patients to better handle their needs and to satisfy them more autonomously. Beyond the reduction of symptoms, we have noticed a very important decrease in hospitalisation time for most patients, leading to a faster reintegration in their home and work place. We can say that, even we did not manage to make our patients happier in their lives, we have been able to offer them some moments of happiness.

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