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A SOCIOTHERAPEUTIC MILIEU IN INPATIENT TREATMENT OR COACHING

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N. van Tol: SOCIOTERAPEUTICKÉ PROSTREDIE V LIEČBE ALEBO VEDENÍ HOSPITALIZOVANÝCH PACIENTOV

Súhrn

Autor informuje o pregraduálnej príprave zdravotných sestier v Holandsku a zaoberá sa existujúcimi vzťahmi medzi lekármi, zdravotnými sestrami a pacientmi. Diskutuje o rozdieloch medzi starostlivosťou o pacienta (klienta) a jeho liečbou.

V posledných desaťročiach sa pregraduálna príprava zdravotných sestier orientuje na jednu z troch oblastí: na liečbu somatických chorôb, liečbu mentálne alebo intelektuálne poškodených jedincov, na liečbu alebo vedenie ľudí s psychologickými alebo psychiatrickými problémami – poruchami.

Jednou z charakteristík vzťahu medzi zdravotnou sestrou a lekárom je závislosť od lekára. Táto nerovnomernosť sa prenáša následne aj do vzťahov medzi sestrami a pacientmi. V Holandsku je snaha posilňovať nezávislosť a individuálnu zodpovednosť sestier za výkon ich povinností.

Lekári často preferujú liečbu pred starostlivosťou. Je to podmienené nižšími nákladmi na liečbu, ale aj tým, že liečba posilňuje existujúci nerovný stav medzi účastníkmi tohto procesu.

Autor sa podrobnejšie venuje socioterapii, ktorá má znaky starostlivosti (care) o pacientov. Za základné úlohy starostlivosti považuje nadviazanie kontaktu a zlepšenie interakcie. Socioterapia sa nezameriava na biologické faktory, nezaoberá sa sociálnym postavením pacientov. Kooperuje s ďalšími disciplínami, akými sú sociálna práca a vzťahová terapia. Dôležitým liečebným nástrojom je vzťah rovnocennosti medzi terapeutom a pacientom.

In the Netherlands, over the last decennia, nurses were educated in one of three disciplines:

1. those involved in the treatment of somatic diseases;
2. those involved in the treatment of mentally/intellectualy disabled people;
3. those involved in the treatment or coaching of people with psychological or psychiatrical problems/disorders.

I prefer, concerning sociotherapy, the term coaching instead of treatment.

During the last few years education of nurses is changing to a more allround basic education with a specialization on physical, psychiatrical or mental issues, during the last part of the training.

Historically, the nurses function(ed) an extension of the physician's policy. Coinciding with the evolution of the technical side of medical care and the increased professional identity, a trend towards more independent operational responsibility of nurses is observed.

Due to the historical situation of the professional nurse, where hierarchical relations may be obeserved between physician and client, nurse and physician and between the nurse and the client, special features can be observed in these relationships.

One of the characteristics of the relation between physician and nurse is the dependability of the nurse, which is based on "inequality". Inequality in sharing the same rights and values as a person (Goffman, 1980).

The recognition and acceptance of this "inequality" is important for the development of the sociotherapy.

The inequality between physician and nurse is expressed in:

– the difference in apparant competence;

– the difference in position in the "care– and cure center" and the difference in involvement in treatment and therapy;

– difference in salary and other ways of compensation;

– difference in social status and position;

– difference in organization level;

– difference in juridicial protection of the profession.

The relation between nurse and client shows identical signs of "inequality". This inequality is, in my opinion, induced/caused by the principle "inequality" between physician and nurse, as if the "gap of influence" between nurse and physician is copied to the relation between nurse and client.

The group of nurses identifying the "gap of influence" as a possible obstacle during coaching of clients with psychologial and psychiatrical problems are the sociotherapists. A methodological approach to the clinical environment, as a social system, is for sociotherapists very important to induce succesful coaching.

The sociotherapists are commonly trained/educated to be nurses with a specilization in psychiatry. Consensus has been reached among this group on the opinion that active participation of the clients during coaching might be of use only when there is "equality" between client and therapist.

If medical care is defined as modelling of cure and care systems, we can obeserve in the Netherlands that the medical care for psychiatric clients has a tendency to support cure models. Not because of a renaissance of the "healing optimism" but from the requirement to operate at a lower cost. And also because of the wish of the therapists to control and simplify the problems of the client.

In other words; Prozac is fashion, talking about feelings is rubbish. Or; cure is efficient, care is unprofessional. Focussing on symptoms is, from this point of view, better than looking at the human being as a complex entity of biological and personal factors also incluenced by situational– and factors.

The consequence of the sometimes almost unlimited subscription of anti–depressives, anti anxiety drugs, behavioural therapy etc. might in future cause new, uncontrolable problems for the personal behaviour and society. Penny wise can be pound foolish.

The mental healthcare has a closer resemblance to a care system compared to a cure system.

The oscilation between cure and care is reflected in the relation between physician and nurse and the relation between nurse and client.

In a cure system the inequality can be explained due to the difference in professional expertise between therapist and client. In a care system this inequality cannot be justified in this way, especially when we are working with persons which were involved with (organized) violence, maltreatment and severe neglection. Sociotherapists, occupied with the coaching of these clients try to work based on a fundamental equality with the client. During my work with psychiatric distorted clints, I frequently observe that cure, in the meaning of complete recovery, is not possible. Next to that it is difficult to resist the temptation to abuse your formal and educational advantage in complex situations during interaction with the client.

In this paper I will try to explain how sociotherapists, working with al kinds of clients, try to establish high quality care.

This raises questions as: What is sociotherapy and what can sociotherapists offer in relation with coaching clients with much diversity in disorders and symptoms. More specific coaching of people with all kinds of traumatic experiences, addictons, anti–social behaviour etc..

Sociotherapy is involved with the following basic principles. The key principle is the methodological creation of an environment for the clients (Janzing and Kerstens, 1989). An environment, meaning a new social system with an equal set of basic rules for all participants.

Sociotherapists deal with the actual situation, here and now. Negotiation with colleagues and clients is the most important tool to establish change.

The methodological approach and the mentioned principles are neccesary to reach the goals for changing the situation of each individual patient.

Sociotherapy is not a therapy to be applied for only a limited time per day, or meant for a few clients (van Tol, 1995).

Sociotherapy is a vision to create an environment where exchange of information and negociation, between everyone in the Clinic, are the determining factors.

During creation of a clinical sociotherapeutical environment, which is a contineous process, we have to consider the following prerequisites (Houweling–Meijers, Visser, 1993).

The participants experience the clinical setting as *significant and meaningfull.*

Internal participants are defined to be the clients, the therapists and the supporting services.

External participants are defined as the people being a part of the social network of the clients, the insurance companies, the primary healthcare and the government and related autorities.

Agreement about the *aim meaning* of the social system

Agreement on *how decisions are made* and the definition of the limitations of responsibilities and activities

Ensuring sufficient *energy* for the participants so the goals can be reached

Agreement on the *limits* and identity of the system with respect to surrounding systems.

An essential part of sociotherapy is to create the possibility for exchange and negociation which is the reason why communication is very important.

Communication may be redefined to contact and interaction (De Haas, 1993). Contact can be described as the extend to which people are open or secluded to information exchange with other persons in their environment. Interaction can be described as the extent to which people adapt to other people and their environment and the extent to which they are able to influence their own life.

The skills necessary to obtain contact are preceding the skills necessary to interact whith others. Without contact it is impossible to interact.

If persons are too open for contact, stimuli, there is a possibility they will be invaded or even they will become chaotic or psychotic. When people seclude contact with others they might isolate theirself.

Overadaption might lead to helpless following without the ability to influence. When people try to influence too much it might result in dominant behaviour.

When actions based on sociotherapeutical principles are executed, the most important factor is to show the clients the way how to obtain contact and how to interact. The predominant factor to achieve this, although it sounds like a paradox, is contact with the therapist. When clients acquire the ability to obtain contact and interaction it can be tried to increase the social skills. Practice and experimentation is of great importance and a clinical setting can be the appropriate environment to achieve this.

Sociotherapy is directed towards the executive functions of the ego (Cumming, J. and Cumming, E. 1970), among which are the ratio, sensorial observation and fysical properties. Hence, sociotherapy is focussing on the way how people may open up to others, isolate themself from others, adapt theirself and influence others.

When we observe the extended/delayed consequences at adults of psychological neglection, all kinds of violence and internal events we are able to identify ways how people react (Hovens, 1994):

1. Denial symptoms; avoidance of possible stress inducers, avoidance of negative confirmation and preventing, avoiding positive confirmation. Avoidance might cause isolation of the client. Due to this behaviour normal social situations will be avoided.

2. Depression symptoms, expressed as a lack of interest in the environment and a lack of emotions, feelings. Or the continuous and massiv experience/feeling of negative emotions.

The client is avoiding contact and is not able to interact socially, shows a lack of energy and feels depressed and/or empty.

3. Intrusion symptoms and nightmares, with a predominant lack to adapt to reality. Next to that phenomenum we observe that people will follow helplessly without the willingness to influence this, as if the client lost the ability to influence his own free will. This causes feeling of invasion/overwhelming.

4. Hyperarousal symptoms. The client experiences this to be a tempestuous level of energy resulting in a negative dominance, other people might be blamed for

failures. Focussing to external factors inhibits the evaluation of the own responsibility in relation to other people.

5. Internal events. We can also observe psychotic periodes in which the client can not be reached and is secluded for contact and interaction.

These reations can be linked to different types of personality. The interventions of the sociotherapists towards the reactions, symptoms will be tuned to the different types of personality.

Sociotherapists are focussing on the skills needed to obtain contact and interaction. The interventions of sociotherapists are (in general terms) directed to the following four types of personality (Millon, 1985):

1. detached personality: the sociotherapists should avoid isolation and support the client;

2. independent personality: the sociotherapists should deny challenges, build structures, point specifically to the rules applied, paying attention to that person in a friendly but determined way;

3. dependent personality: the sociotherapists should activate, stimulate, confront, neglect the over–reaction and they offer possibilities and stimulate personal initiatives;

4. ambivalent personality: the sociotherapist should support, offer limited and defined contact and should stimulate personal choices.

The systematical approach to restore contact and improve interaction in a specifically designed environment is in fact the basis of sociotherapy. This process requires a lot of effort of the sociotherapist and it requires real participation of the client and it requires an institution offering the right possibilites.

The sociotherapeutical profession is limited to the activities in the clinical system. This is defined so–called direct sociotherapy (Commissie Buys, 1981).

1. Sociotherapy is not focussing on genetical/biological or psychopathological personality factors. This is considered to be the profesional expertise of biologists, physicians, psychiatrists and psychotherapists.

2. Sociotherapy is not focussing on employment, salary, social security, ethnical background. This is considered to be the responsibility of political and social authorities.

3. The sociotherapist is cooperating (supporting and advising) with other disciplines such as social work and relation therapy. This to adress situational factors such as the loss of next or kin, loss of a job, debts, bad housing, bad relationships etc..

I hope this contribution gave you some insight in sociotherapy and the application to the treatment (cure/care?) of social, psychological and/or psychiatrical disturbed clients. The meaning of this paper is that people who feel suppressed, denied, disturbed etc. might be helped by treatment based on equality between therapist and client and in that way restore the confidence of the client to attain the skills, to think and act more competent and more in harmony with himself and others. This is a tedious and time consuming process. This way of treatment is expensive and I hope it will be supported by a society with true interest in people who have serious problems.

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