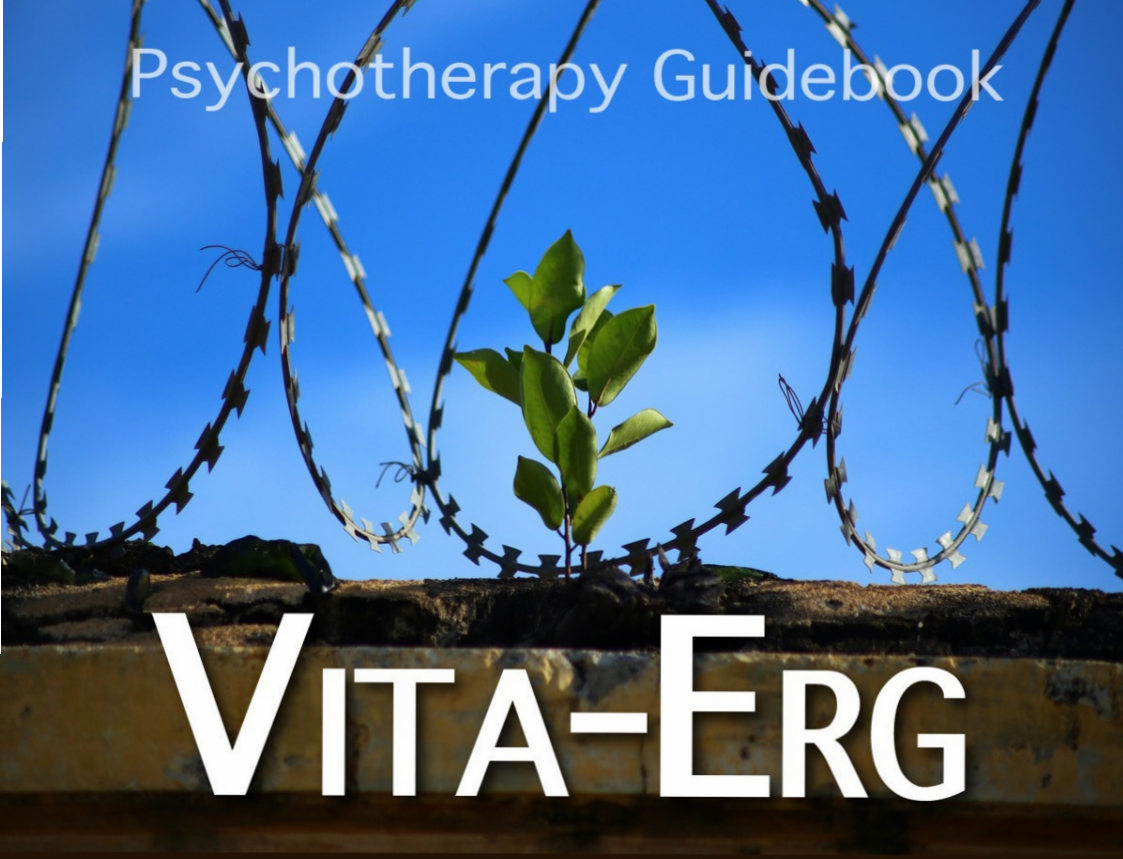
Psychotherapy Guidebook



Vita-Erg Therapy

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The basic psychotic process consists of the withdrawal from reality and the creation instead of hallucinatory distortion of actuality as well as adopting illusory defenses. Most often these defenses are mobilized against incestuous urges fed by unwise or pathogenic parents with which the ego of the potentially psychotic patient cannot deal and against murderous hostility toward parents, especially the mother and other persons as substitutes for them. The resulting states are either perpetual fear and overwhelming anxiety, which render the patient periodically frightened and submissive, or rage.

Ideally, the therapeutic requirements of such patients are 1) restitutive and rehabilitating efforts in the life setting of the patients, 2) appropriate chemotherapy reversing psychic energies from inward (centripetal) flow to outward (centrifugal) flow, and 3) increasing the patients' capacities (and tolerance) for human relationships, which are at a low ebb and often nonexistent. The general nature of therapy for patients on the mental hospital wards must be of a type that would activate them to respond to external stimuli, for self-initiated activities and responsibilities which they would voluntarily choose. Of equal or perhaps greater importance is their

relationship with the professional staff and particularly with the “attendants” with whom patients have the most prolonged relationships.

The totality of these multifarious influences I have given the name “Vita-Erg Therapy.” (The term is derived from the Latin roots for life and work.) Vita-Erg Therapy consists of a life setting in which patients are viewed and treated as persons, rather than individuals to be cared for, protected, directed, and served as though they were children. However, it is important that this setting and relationships do not replicate the insurmountable pressures and intolerable stresses of the complex family and social setting that caused the patient to withdraw and create a fantasy life.

HISTORY

The techniques and procedures of Vita-Erg Therapy were initiated by myself (S. R. Slavson) at the Brooklyn State Hospital (New York City) with two “disturbed” locked wards each housing sixty-five of the hospital’s most intractable as well as the most inaccessible female patients. While the hospital generally was under liberal directorship, with open wards and freedom of locomotion on and off the grounds, these two wards on the top floor of the building remained locked and patients were restricted from leaving them for any reason. Among, them were patients who hadn’t left the wards for two or three decades. They all looked disheveled and unkempt, bearing facial

expressions characteristic of mentally deteriorated individuals. The majority were uncommunicative and many were to varying degrees manic and assaultive. A number were in a permanent state of stupor and varying degrees of catatonia. No activities or occupations of any kind were provided for the patients excepting for making their own beds in the dormitory under authoritarian supervision of attendants who were ordinary, uneducated, and unschooled women. The relationships between these women and their charges has been that of strict, demanding mothers and obstreperous children. The latter were punished for the slightest transgression or oversight. In fact, on the wall of the nurses' office there was a list of the type of punishment to be applied to each of the patients.

TECHNIQUE

The approach to solving the problem was twofold; one was to alter the environment on the wards where patients could otherwise do nothing but sit and stare; the other was to change the attitude of the ward staff toward the patients, including the nurses and doctors, and create possibilities for active involvement with them rather than simply functioning as "baby nurses." The extent of this attitude is dramatically revealed by the fact that I found that about twenty-four adult patients had been spoon-fed by attendants for years. When asked why they did this, the reply was, "Because they can't feed themselves." In a discussion of this situation in one of our weekly seminars I

suggested that they place these patients in line with the others in the dining room to fetch their own trays and food, which they did without any problem or difficulty.

We installed an electric kitchen on the ward in which cooking and baking could be done; an electric laundry in another small room; a third room was equipped for beauty culture with mirrors on the walls where patients could primp themselves voluntarily; a fourth room was equipped for quiet conferences both for the ward staff and, most importantly, for patients (with a staff member present whenever they became disturbed). This prevented the infectiousness of psychotic outbreaks and conflicts that used to be seriously punished by being locked up in these rooms, as well as a free use of camisoles (straightjackets). It must be noted that these rooms were unused before for any purpose except as "lock-ups." A visit to the women's toilets revealed eight toilet bowls lined up against one wall and four facing them against the opposite wall with no partitions for privacy. This condition was rectified by building partitions with swinging doors. Similarly, in the showering room, no provision had been made for privacy for women taking showers and dressing and undressing. This was easily corrected by installing separating curtains.

On the main body of the ward we had established "four centers of activity" by doubling up tables and surrounding them with chairs. The materials placed on these tables served as visual suggestion and could be

used for serving and knitting of potholders, hats, sweaters, and dresses. Materials such as crayons, watercolors, drawing paper, and brushes; materials for cutting, pasting, crocheting, clay work, tiling, and other arts and crafts that are standard in occupational therapy. Two sewing machines were provided so that patients interested in larger projects could find an outlet.

Music and dancing were part of our program. For this a movable piano was made available exclusively to the two wards; also, much later in the program one of the recreation therapists assigned to our project, introduced group composing of plays that most often included music and dancing; from time to time performances were given to the occupants of both wards and a few times a year for the entire population of the hospital. Also, trips were arranged to places of interest in the nearby community and at times to Manhattan. During the summer, patients who so desired were taken in a hospital van to Coney Island where they swam, galloped, and helped and protected each other. It is of interest to note that only a few of the patients more in contact were given the opportunity for these experiences to expand their reality. Only the more regressed went on these swimming excursions.

The second major part of the Vita-Erg Therapy — namely, the change of attitudes and functions of staff in relationship to patients — was conducted through weekly seminar for attendants specifically gathered around a large executive office table with the top staff sitting apart around the room. The

content was drawn from my brief visits to the wards where I saw the improper reactions of the attendants to patients. Without, of course, revealing the names of the persons involved, discussions of how situations could have been dealt with more constructively always brought to the fore the patients' feelings.

One seminar a month was devoted to an in-depth study of one particular patient who was most puzzling or most difficult. This has never been done anywhere before. Such studies were in the past reserved for psychiatrists only. In these special seminars the social worker read the background history of each patient, the family relationships, the type of parents. We then identified the dynamics that resulted in, and the contributing events to, the patient's psychotic break.

APPLICATIONS

It is apparent that the basic content of the program we have introduced in rehabilitating these highly disturbed and regressed long-term patients is neither original nor new. The very impressive results that we have obtained lay in the alteration of the treatment of patients as though they were normal people, and the spontaneous arousal of wants and inner responses through the stimulation of the total program helped patients return to reality; supplying them with suitable activities unsupervised by staff. Instead, we

relied upon the spontaneous choices of patients for activities and interests. Perhaps one episode will illustrate this. A member of HEW was making an inspection visit to our two wards (the project was financed by HEW) and was impressed by a woman who was busily and interestedly doing cleaning. He asked her, “Why do you do this?” Her response was, “Because I live here.”

Vita-Erg Therapy obviously has its basic roots in Activity Group Therapy and Activity-Interview Psychotherapy for children and adolescents as well as from Progressive Education of which I had had an extensive experience some sixty years ago.