Implementation of the CATHARSIS TECHNIQUE at South Lyon Central Hospital – Geriatric and Gerontological Medical Practice of Professor Bonnefoy

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Report by Maryane Quenin, psychologist

THE IMPLEMENTATION OF THE TECHNIQUE:
The Catharsis Technique is a psycho-musical technique, a supplement to traditional medical therapies, designed to improve the care and well being of the patients, as well as the doctor-patient relationship.

THE DESIGNERS OF THE TECHNIQUE:
Mrs. C. Desmoulins, inventor of the Catharsis Technique, in collaboration with Dr. A. Amouyal.

THE PARTICIPANTS:
- Mrs. Geraldine FOREST, occupational therapist
- Mrs. Maryane QUENIN, psychologist
- Mrs. Maria GARCIA, certified nursing assistant
- Mrs. Chantal Desmoulins, supervision

THE AREAS OF FOCUS:
- Long and short-term care services
- Palliative care services

THE CARE-GIVING GOALS:
- *In long and short-term care services*
    - Means of expression for demented or extremely disoriented persons who have difficulties communicating,
    - Assistance in the reassurance and calming of agitated or aggressive persons,
    - Relief of insomnia
    - Relief of pain for dependant individuals under continuous care, reduction of psychotropic doses,
    - Enrichment of doctor-patient-family communication.

- *Palliative care services*
    - Accompaniment of individuals in terminal phases,
    - Relief of suffering, as a complement to traditional treatment,
    - More meaningful human interactions,
    - More holistic and personalized approach to the patient.

PROTOCOL USED:
- Graphic expression under musical induction: in weekly sessions with patients suffering from dementia or Alzheimer’s.
- Musical listening without graphic expression: in individual sessions, with patients suffering from various pathologies.

Music and Expression Group – presentation

Long-term care – Michel Perret RDC – South Lyon Central Hospital — France

I. Introduction

After completing a training given by Chantal Desmoulins for a musical mediation therapy technique that had already been tried and proven in numerous care sectors, we established a "music and expression" group for psychiatric care with musical mediation with a group of long-term care patients beginning on the 21st of September. This type of care pertains to all patients who suffer psychically and have difficulties speaking; they can benefit from the musical induction, the graphic expression, and the support of the group to express their emotional and psychic issues.

We initiate a weekly session with 12 meetings on Friday afternoons, led by Maria Garcia, a trained orderly at the facility and myself. We welcome a group of five patients presenting problems of dementia accompanied by disorientation, nervous agitation, traumatic experiences, and/or issues of abandonment.

II. Organization of the meetings

The time of preparation for the meetings is vital to guarantee a stable and reassuring setting for the patients who are, for the most part, demented and disoriented. Therefore, the room also has to be available every Friday afternoon at 2pm.

The group starts at 2:30pm; the patients are awakened by the morning staff and reminded about their participation in the group well in advance so that they can be mentally prepared. The meeting lasts 45min to an hour. Maria and I accompany the residents to their room at the end of the sessions.

The meeting is split into two sections:

- A listening time with the music. This is a time where the patients don't speak much, but are focused on themselves. They each have drawing paper and pencils, allowing them to draw according to their inspiration, as a support of the expressive process.
- A speaking time, to share experiences, what was enjoyable or difficult, and the impressions brought up by the music: life experiences, personal history from childhood or more recent anguish. It is a time for sharing individual experiences, but also a time for interaction and participation, which has as much to do with how the group experiences each particular session as with the individuals.

The creation of a group "spirit" is the goal of our project as well, the group being an important support for the expressive process. To further this goal, it has to be a closed group, meaning that we have decided not to admit any other patients within the course of the 12 meetings, even if one of the patients is absent for a prolonged time.

III. Members of the group and goals

Mrs. G is a 97-year-old woman who entered long-term care on November 9th, 2006 after a stroke in July of the same year. She presents with behavioral and linguistic problems, as well as difficulty with recognition.

A widow since 1953, Mrs. G worked rigorously after her husband's death; she was a very active woman. She has three children: two girls who are active in her life and a 70-year-old son.

At this time, difficulties with recognition and disorientation are especially noticeable and have produced an anguished state that Mrs. G had first tried to control with endless walking. Since her recent fall in the hallway, Mrs. G can no longer walk and is totally dependent for her physical needs and dressing. Since the fall, she screams repetitively, sometimes shouting out significant words or sounds while in a state of great anguish.
For this woman, we hope that the group sessions will reestablish an important sense of space-time: the regular meeting time, in a stable environment, will help her to organize herself temporally. We also hope that they will give a means of expression to her experiences and her distress: the drawn line, the music, and hearing other's stories, which she can relate to, will help her find expression when her own words fail. Finally, we hope that Mrs. G will feel secure enough in the group to allow herself to experience a kind of "release" that will ease her sufferings.

Mr. P is an 87-year-old man. He entered long-term care after increasing dementia left him incapable of performing the acts of daily life. He was then placed under legal protection. He was diagnosed with Alzheimer's with episodes of aggression. In his history, one notes a left hip replacement in 2004 and a fall with a pelvic fracture in 2006.
Mr. P has two sons who are very involved; I never met them. Mr. P's wife used to live in the ward; she was there before his arrival but passed away in November 2006. The file doesn't mention Mr. P's occupation.
Mr. P is able to feed himself but is completely dependent for all other acts of daily life. He moves about in a wheelchair pushed by someone, as do the other patients who participate in this group. This man is very touch-oriented, enjoying the physical closeness of certain residents and care personnel.
Mr. P is temporally disoriented. He speaks well and relates well with others, oscillating vis-à-vis the facilitators between demonstrations of affection and aggressive behaviors that are linked to delusions of persecution that he has difficulties separating himself from: it's a question of "needing to call the police," and imminent danger. These episodes are accompanied with anxiety. These delirious ideas often manifest themselves when he is taken to the bathroom or transferred, moments when Mr. P is being handled and in a situation of vulnerability. The anguished episodes often last long after the handling is over. At other times, he is able to relate well, easily expressing himself with utterances that are nevertheless poorly timed and disoriented.
By including Mr. P in the "music and expression" group, we hope that he will be able to give expression to his anxiety around persecution by attempting, with him, to elaborate on the themes that are associated with it through drawing and verbalizing. We also hope that he will be able to develop and internalize a more reassuring way of relating to others.

Mrs. P is a 95-year-old woman suffering from advanced Alzheimer's who is incapable of caring for herself.
She was widowed 10 year ago and has two daughters who are very active in her life.
Mrs. P is totally dependent for her daily acts and can no longer walk. She is, however, able to interact and expresses herself well, although disoriented with a past/present confusion, she is nevertheless able to orient when addressed.
Mrs. P presents with episodes of anxious agitation that manifest verbally through repeated phrases and delirious speech having to do with abandoned or endangered children…

These episodes are often linked to the moment of separation from her daughters. She also presents with persistent scratching.

We hope that this woman will be able to elaborate on the question of separation through the regular rhythm of the group sessions, where one is separated and reunited at regular intervals. We also hope to help her to expand on the symptoms that are associated with her anxiety.

Mrs. B is a 75-year-old woman who was admitted to long-term care on June 10th, 2004 after repeated collapses into dementia left her unable to care for herself. Her medical history includes: surgery for breast cancer of the right breast, which was followed by chemotherapy, herpetic meningo-encephalitis in April 2004, and an ischemic stroke complicated by convulsions with residual left paralysis in June of the same year.

She is a widow with five children: three girls and two boys. She worked as a vegetable gardener. Mrs. B feeds herself but is completely dependent for other daily acts. She is disoriented but expresses herself easily nonetheless and is able to relate with others.

Mrs. B, often distressed, is always demanding attention, a demand that she communicates by repeatedly tapping an object on the table. For a little while now, she presents with episodes of aggression and insults when being taken to the bathroom.

Over the course of the group sessions, we hope to allow Mrs. B to expound on and give expression to the anxiety that is the root of her incessant demands and her aggressive episodes so that she can find a certain calm.

Mrs. N is a 99-year-old woman admitted to the hospital for rehabilitation after fracturing her radius, with the plan for her eventual return home. However, her “bold attitude” (the doctor’s words) makes her return home problematic. Mrs. N is accordingly placed in long-term care, the decision being presented to her as a “temporary placement”. Since then, this question has been discussed with her and her granddaughter, but Mrs. N remains steadfast in her demand for a return to her home that won’t come. Today, she remains focused on her past life in Messimy, where she lived; she gives the impression of being locked in time. She used to present with crying episodes; for some time now she presents opposition. She often cries out: “I am all alone” or “there is no one”, even when she is surrounded by other patients. I often hear Mrs. N say that phrase as she is being helped in the hall, a very open place with few people. It is then accompanied by anxious exclamations such as: “Oh dear!” or even “Frightful!”

In addition, Mrs. N presents with significant scratching compulsions. A little while before the group begins, Mrs. N refuses to eat.

Mrs. N has been a widow for 20 years. She had a son who passed away leaving behind a wife and two granddaughters, just before she entered the hospital, an event she remembers with confusion. Of her daughter-in-law, Mrs. N says “I never see her”, even denying her presence when said daughter-in-law comes to visit her. Their relationship had always been marked by conflict. Mrs. N is catholic and worked as a laborer in the silk printing industry. In her files, the occupation of butcher is noted.

She has a history of anxiety and depression, and a cerebellar disorder with resulting poor balance and recurring falls. Also noted are temporal disorientation and forgetfulness.

Mrs. N is able to eat alone and to stand, but can no longer walk. She is dependent on others for her daily care.

Through the group sessions, we hope to allow Mrs. N to give expression, even experience a kind of processing, of her experience of solitude in the supportive, listening environment of the group and to help her organize herself temporally.

We also hope to allow Mrs. N to identify herself as a member of a group in order to reconnect with the present, invest in the “here and now”.

IV. The place of the group in the life of the facility

A regular correlation meeting with the entire care-giving team (especially during case meetings) is very important for me in order to have details over the daily life of the residents and the eventual effects of the sessions (unusually calm or agitated, etc….), so that what happens in the group can be related to what happens in daily life and what happens in the daily life can be related to what happens in the group.

This interaction is fundamental to better understanding the residents in the entirety of their behaviors and one can know how much of a calming effect it can have to give meaning to their behaviors (that often register as impossible-to-articulate demands).

V. Evaluation

The observations made over the course of the sessions are noted in individual notebooks that keep track of the development of each patient in the group. The co-facilitator orderly, as well as the whole care-giving team, can note observations made in the daily life of the patient. This evaluation is part of a comprehensive technique of research around the “Catharsis Technique". At the end of the 12 sessions, we will thus be able to note the benefits of this kind of group work for each patient and for long-term geriatric care patients in general. We will then decide, based on the outcome, on the continuation or non-continuation of the group.

Music and Expression Group – RESULTS

By Maryane Quenin, clinical psychologist – Long-term Care Ward – Michel Perret RDC– South Lyon Central Hospital

I. Introduction

These are the results of a series of 12 sessions of a "music and expression" group based on the Catharsis Technique. The group was co-led by myself, a psychologist, and by Maria Garcia, a hospital orderly.

It was initially made up of five participants: Mrs. G, Mrs. P, Mrs. B, Mr. P, and Mrs. N. One of the participants, Mrs. P left the group after a few meetings after her daughters' refused to see their mother continue with the group, in spite of their initial agreement, the consent of the patient, and the information given beforehand.

II. Comprehensive results

Before detailing the individual progress of each patient, we can note the following group phenomena:

- From the first meeting, bonds were created by verbal exchanges that were, at first, dualistic and then collective. After a very chaotic beginning, having to do with the issues endemic to the patients (demented, anxious and disoriented, with issues of abandonment and solitude…), I was surprised by the change observed after only one session: the patients talked and interacted with each other right away from the first meeting.
- For the four participants, absences were rare, in average, one out of 12 sessions and always for physical reasons. The participants were invited to agree to the session anew each week. They always answered affirmatively.
- Out of the 12 meetings, two were truly disturbed by coordination problems with the care-giving team: patients were not awakened, not taken to the toilette, and were not prepared for the session. These difficulties had a significant effect on the beginnings of those two sessions: I remember that the patients were spatially and temporally disoriented. Patients who are not prepared and not informed arrive to the group scattered and agitated and require much more time to settle into the group setting.

Mrs. G, after having arrived late for the group due to not being taken to the toilette in time, tells us in an agitated manner: "I'm bursting! I'm bursting!", then, with obvious distress: "I'm not dressed!". Which necessitates an intervention on our part in order to contain her distress, reassuring her that she was in fact properly dressed. Those who had had to wait are also scattered and agitated: one of the patients asks to leave, complaining of discomfort. The respect for the temporal framework of the session seems to be fundamentally important for the patients.

It should be noted that the consultation with the care-givers about the patients in the group was insufficient, the availability of the psychologist in the facility being too reduced to allow my presence at morning rounds. Additionally, the case conferences are too often eliminated, with the consent of the team, for reasons of under-staffing or others. This time of consultation would surely have limited these problems of coordination.

- Within the group, it was possible to observe the simultaneous development of individual processing (each individual came to find relief from individual issues and to play them out in the group), but also the group process.

A real group spirit formed with the sharing of certain elements: the insults put out by Mrs. G were taken up by the other participants, approved and repeated, until Mrs. G abandoned them. These insults have become the group's business.

- An attitude of openness to the others is noticeable in each participant, verbally and/or in their posture.
- For most of the participants, the moments of agitation that had run through the meetings give way to moments of relaxation.
- The vocalizations of some of the members, which at first had been incomprehensible, become more and more clear, and, finally, are understood by the others.
- The emergence of anxieties that find relief within the group.
- The emergence of personal experiences, sometimes difficult, sometimes positive, followed for the most part by periods of calm once they have been expressed.
- The mediation of the music and drawing allows issues to be addressed that certainly would not be possible in a traditional (i.e. without music), face-to-face therapy session.
- The music itself is sometimes received positively, sometimes stressful. The musical sequences are constructed with phases of stimulation and phases of relaxation that one sees reflected in the emotional, gesticulatory, and verbal movements of each of the participants.

Mrs. G

I. Progress in the group

Mrs. G took a lot of time to find her place in the group.
In the first meetings, she presented a great deal of unrest in the form of cries, insults, muscular tension, or moments where we had no hold on her. As if walled up in her anguish, Mrs. G felt not understood and couldn't comprehend what was echoed back to her.
Later, this agitation came as a reaction to provocations on the part of Mr. P, the only male participant, who takes a distinct pleasure in provoking Mrs. G's agitation as soon as it seems to be calming down. This game of provocation/response slowly transforms into a game of seduction until Mrs. G finally succeeds in making her refusal clear:
"I really like you," says Mr. P.
"Well, I don't like you!" exclaims Mrs. G.
From that moment on, Mrs. G manages to distance herself from Mr. P's provocations with moments of calm and relaxation, even falling asleep at times.
We thus observe an alternation between moments of agitation and moments of calm with more and more verbalizations that the group can understand. At the beginning of the sessions, Mrs. G greets the other participants, asking them "How are you?"
Mrs. N asks me several times what Mrs. G is saying; we acknowledge the fact that "it is sometimes difficult for Mrs. G to speak." Mrs. N and Mrs. B treat her with indulgence and never complain about her outbursts. Mrs. G is supported by the others and appears calmer as she increasingly interacts verbally with her neighbors.
It remains difficult for Mrs. G to respect the silence of the listening time throughout the durations of the sessions, even though a positive change is noticed over time. After we decided, with Maria, to complete the rule of silence with a gesture (a finger raised to the mouth) to signal the expected silence during the listening time, Mrs. G seems better able to understand the rules and, when I remind her, makes the sign of silence herself, saying "Oh, yes….", or gets irritated.

II. The representations that emerge

Until the 7th meeting, there are few drawings; Mrs. G is rather agitated and doesn't understand what is being said around her.
At the 7th meeting, she recalls her husband during the listening time: "He was good". She then says: "I was left alone with five children."
"Six, counting me," says Mr. P.
"Shit!" she screams at him.
During the listening times, Mrs. G comments on her feelings, telling us:
"I'm ok, I'm ok…," or "I'm not ok, I'm not ok…," at times when the music takes a darker note.
At the 9th session, Mrs. G tells us:
"I don't have my Dad anymore, I don't have my Mom anymore," and begins to cry, with a noticeable muscular tension. When I accompany her back to her room after the group, she asks her daughter where Denise, her sister, was. Her daughter explains that she is "no longer there".
At the next meeting, Mrs. G falls asleep in an attitude of complete relaxation. After the listening time, she says to us: "I sleep; I fall asleep. Why? Is it forbidden?" She falls asleep in the following session as well. Mrs. G begins to find pleasure in being in the group (by now, we have reached the 10th session); when I accompany her back to her room, she asks me what she "will be able to do here, all alone."

III. Relationships with the other patients

As she is able to calm down, Mrs. G opens up to the others, for example, asking her neighbor, Mrs. N, the name of the other woman (Mrs. B).

But Mrs. G remains equally trapped in a desire to protect herself from being overwhelmed by the others, separates her things from those of the others, and hides her drawings behind her drawing kit… This corresponds to her daughter's observation when we meet often after the sessions: "My mother had times when she had a strong desire to be with people, and others when she wanted to be alone in order to renew herself."

Mrs. G becomes interested in Mr. P, who, since the third meeting, focus his attention on her, courting her as soon as she has calmed down. Initially, this only increases her agitation. But later, Mrs. G responds to him, insulting Mr. P and making fun of him when he laughs: "Tee hee hee," she says, with a mocking air. Finally, she is able, intermittently, to ignore him and to relax.

With respect to Mr. P, Mrs. G does verbally refuse him, but she also sometimes participates in the game, becoming his accomplice; for example, Mr. P compliments her hair and Mrs. G then requests several times to have her hair brushed before coming to the group.

IV. Conclusion

Mrs. G definitely appears more and more capable of "letting go", even to the point of falling asleep, from the beginning to the end of the sessions. She seems to relate to the facilitators better, as well as to the other participants. She becomes a central element in the group, the others approving her insults: "Well said!" Mrs. N often exclaims. Mrs. G's absence at the last meeting adds to everyone's difficulty to see the group end, to see something end. "She is tired. She needs to rest," Mr. P tells us at the end of that last meeting.

Mr. P

I. Progress in the group

Mr. P is immediately involved in the group. He experiences difficult moments as significant anxieties emerge, and which find some relief in the context of the group. During these episodes of anxiety, aggressive behaviors appear: it seems that Mr. P attempts to regulate his anxiety in and through aggressiveness.

After these phases of anxiety, Mr. P shows overwhelming amorous demonstrations that are focused primarily on Mrs. G, but that also extend to the others, participants and facilitators alike. These demonstrations are first expressed in a release of excitement and then increasingly find their voice in verbalizations.

Through out the entirety of the sessions, it remains difficult for Mr. P to silently respect the listening time, during which time he cannot seem to stop talking, laughing at our attempts to bring him back in line. Mr. P takes refuge in a "rebel" persona and tests the limits of the group framework in an attempt to find out whether or not this framework is capable of holding the intensity of his instinctual outbursts. We did occasionally find it necessary to intervene in the menacing gestures that he directed at Mrs. G.

Nevertheless, Mr. P does attempt to internalize the instructions, repeating them to the other patients: "listen to the music," he says to Mrs. G. He also tells her: "make me a nice drawing as it comes to you" - "As it comes" is one of the expressions that I regularly use as explanation to lead the patients to draw with a certain "let-go".

II. The representations that emerge

In the first two sessions, primal anxieties around "devouring" appear in his drawings and what he says about them: "an eagle attacks a lamb in the woods, an eagle is stronger than a lamb, he carries it away to eat it (…) The wolf is eaten by the lamb." After that session, Mr. P tries to bite the orderly's hand, an attempt that he repeats with me as I accompany him to his room. Mr. P is then overcome by his anxieties; they are impossible for him to articulate.

In the subsequent sessions, he presents demonstrations of affection and/or aggression toward Mrs. G (whom he calls "Mrs. B" in a kind of confusion). He goads her, becoming more and more attached to provoking ever-increasing reactions in her. A drawing of a rooster and a farmyard takes the place of the one with the wolf and the lamb: does Mr. P feel like a rooster at the center of a farmyard? "I need two women," he says several times. For him, the group becomes a place where he can express his instinctual life.

The group setting also awakens certain memories: Mr. P had animals at his home, especially sheep, he tells us. He also recalls his marriage, saying of his wife that she "left with another man"; he adds: "she was jealous," and finally says: "I need two women." An important narcissistic wound surfaces from this idea of couple life, for which he attempts to compensate in a revenge of "hyper-virility" as the man with "two women."

III. Relationships with the other patients

Mr. P focuses all of his attention on Mrs. G, who seems to represent for him the entirety of the feminine race. Actually, Mr. P plays on his confusion between Mrs. B and Mrs. G, expresses his need to have two women, and sometimes addresses himself to Mrs. B, who, hearing her name, reacts to his provocations. The place that Mrs. G holds for Mr. P evolves over the course of the sessions. At first, she is for Mr. P an object of desire and aggression, and not allowed to speak: "We'll make love. Be quiet! I love you. I'm not married…

I want a woman," he says at the third meeting. But then Mr. P begins, little by little, to integrate Mrs. G's point of view, namely her refusal to the relationship: "It's too late, you already have a husband, a wedding ring," he says at the seventh session. Until, finally, he is able to fully realize her unavailability: "She is tired; she needs to rest," he says at the end of the last session, marked as it is by bedridden-Mrs. G's absence.

IV. Conclusion

Mr. P's progress in the group can be described in three phases:
- In a first phase (sessions 1 and 2), plays out his anxiety around devouring, an anxiety that, without a doubt, finds its origin in his experience of persecution and his aggression while being handled. Do these infantile anxieties come back to play out as an experience of overpowering in his history?
- The second phase, in which Mr. P experiences himself as all-powerfully sexual, denying the desire, his inability, the question of aging, not to mention the refusal of his overtures by the other party. One can hypothesize that Mr. P is thus attempting to assert a virility that had, perhaps, been undermined at some point in his past: what can we think about the role of the male in a couple whose wife makes him call her "Mama"? "Mama" was actually what Mr. P called his wife, currently deceased. The earlier anxieties around being consumed could possibly also speak of an experience of overpowering in a couple whose dominant figure seems to be the "Mother".
- In the last phase, Mr. P begins to process his limits and his inabilities through several drawings, one of a "lamb who's lost his tail" (session 4), and then one of a man without legs: "A man without legs. What would his mother say?" Mr. P tells us during the last meeting. It appears that Mr. P has oriented to present time since he's using the conditional tense to speak about his wife. In the drawing, "A Man without Legs" (in his drawing, the man is standing on both legs) it seems that Mr. P is attempting a kind of portrait of himself as handicapped, but nevertheless, a man who faces the world "standing".

Mrs. B

I. Progress in the group

Mrs. B quickly identifies the rhythms of the group, always saying, “See you Friday!” when I see her in the ward. She always expresses her desire to participate in the sessions, missing only one of them due to illness.

Mrs. B immediately shows herself to be respectful of the directions despite the agitation of the other patients. Her attitude is predominantly relaxed, seeming a little set apart from the rest of the group in a kind of internalization during the listening time, reacting nonetheless to the other’s demonstrations when they become too overwhelming for her. Mrs. B draws right from the beginning, taking advantage of the music that is played and then expressing the important elements in her psychic life.

II. The representations that emerge

Right away in the first session, and then coming back as an important theme in later sessions, Mrs. B recalls her dog through the drawing: “her dog’s house.” She tells us that she had a dog named Orpheus that she had had to leave with her daughter when she entered long-term care. It was a German shepherd; “She doesn't let anyone in, but she is really very gentle,” she adds as description. She also tells us that it is her husband who had wanted to have a dog. The memory of her husband is certainly linked to that of the dog. Behind this recurrent image of the doghouse, there is also the question of home, the house that appears as an essential preoccupation for Mrs. B: How to feel “at home” in a hospital room whose boundaries are so permeable? How to feel “at home” in oneself in a body whose limits are so often determined by others (i.e. the caregiver) in daily life?

Mrs. B explores these difficulties, “On the one hand, it’s not really obvious,” she says about her drawing. At the end of a session, she tells us spontaneously, “I’ve been here for a year and a half now,” then, after a long silence, “It’s hard.” Mrs. B also draws “a bench” that she sees from the window, saying, “But I can’t walk to go there.”

She expresses her connection to the music, telling us on several occasions how much she loves it. Mrs. B sometimes draws reassuring elements from her daily life such as “the couch from her house” that her son brought here, but also sometimes draws things that represent difficulties, such as the doghouse that she couldn’t bring with her or the bench that she can’t get to, no longer being able to walk. During the sessions, Mrs. B begins to hammer objects on the table like she did in the ward, although it is often in rhythm with the music. During the last session, the group is invited to talk about their repetitive behaviors and we recall Mrs. G’s insults that the others had asked her about. So I ask Mrs. B about the significance of her hammering: “Well, I must need something!” she says. This all happens as if Mrs. B is experiencing a regression when she’s in the ward, expressing herself by regressive actions even though she’s very capable of expressing herself verbally.

III. Interactions with the other patients

Mrs. B presents herself as being very tolerant of Mrs. G’s outbursts, reacting occasionally to her cries with: “Well, ok then!” She complains, on the other hand, to Mr. P’s provocations by saying, “That’s fine, but there’s always someone who opens his trap, if you see whom I mean,” while looking at Mr. P. Mrs. B expressed her disagreement several times when confronted with Mr. P’s advances, which he mistakenly addressed to her, believing he was speaking to Mrs. G. Mrs. B has very little interaction with Mrs. N (they are seated at the same end of the table).

IV. Conclusions

Mrs. B takes the group over with her presence. She is very demanding when it comes to taking part in activities with a special involvement with music. Within the group she is able to begin to release her difficulties. For her, the continuation with individual or group therapy would certainly be helpful. The mediation of the music and drawing allows her to address themes that she certainly wouldn't be able to address in traditional (i.e. without music) one-on-one therapy. Finally, it is of primary importance to encourage this woman in the further verbalization of her demands, instead of a regression to stereotyped gestures, such as hammering objects on a table. Mrs. B needs daily personal interaction, in a group setting and in intimate relationships.

Mrs. N

I. Progress in the group

She presents with significant difficulties seeing that seem to have played a role in her refusal to draw as well as in her trouble to integrate herself in the group.

At the beginning of the group, Mrs. N seems locked in time, remaining fixated on periods in the past with a regular demand to go home: “I want to be at home,” she often says. Despite the four years she has spent in long-term care, Mrs. N doesn’t consider her room to be “home”.

She expresses her experience of solitude in a repetitive manner.

Mrs. N’s connection with the group is very variable, from moments of withdrawal and retreat to moments where she benefits from what happens, sometimes sharing some important aspects of her feelings and her history and integrating herself in the group interaction.

Mrs. N often expresses her desire to come to the next session. She misses one of the session that she agreed to attend, but it is because of an organizational problem with the team; she has been brought in too early and has to wait for quite a while. After this period of waiting, Mrs. N expresses herself to be unwell, “head spinning” and a “swaying” feeling, and has to excuse herself from the group.

At the end of the 11th session, when I ask her if she would attend the last meeting, she says, “The last meeting? Of course, I need to.”

Mrs. N didn’t want to draw. In the first meetings, she aggressively refuses the crayons, rejecting them. After which, she calmly tells us, “That doesn’t speak to me.”

During the group, Mrs. N experiences moments of anxiety that express themselves in wails that she can't process. She also experiences some moments of calm, and even seems to fall asleep at times.

Throughout the sessions, Mrs. N complains about the heat. This complaint is based in reality: the room is always over-heated. I need a long time beforehand to correct the temperature. Mrs. N also complains about the door being shut. I explain that the door needs to be shut so that we are not disturbed and in order to “be together”; and make clear that the room in which we hold the group doesn’t have a window. I hypothesize that behind this complaint are anxieties around being part of a group. The issue of solitude and “being with” seem to be omnipresent with Mrs. N.

II. The representations that emerge and her interactions with other patients

The framework of the group brings out, at the second meeting, a representation linked to the music: Mrs. N remembers her husband who “played piano.” In response to the music, Mrs. N tells us: “Sometimes it’s painful, sometimes it’s good.” Actually, the music is constructed with periods of stimulation and periods of relaxation that are easily observed in the patients’ emotional, gesticulatory, and verbal movements.

Mrs. N expresses many somatic complaints: “It’s too hot,” “heart-ache,” “feeling nauseous,” “head-ache,” “head is spinning” or even “Look! I’m wobbling.” The somatic complaints are certainly the privileged mode of expression of her trials.

The issue of solitude is unmistakable with Mrs. N. At the first meeting, she tells us in regards to the others, “I don’t know them,” but nevertheless then reacts to what is being said around her. She then proceeds to punctuate the other’s remarks: “Well done!” and “Well said!” she says when Mrs. G screams her rebellious insults. The other thus expresses the revolt that she cannot authorize herself to express. At the fourth session, Mrs. N takes up a song initiated by another patient and begins singing, “little Father Christmas…” in its entirety and not missing a word.

She then tells us: “It’s an old song; everyone knows it.” At this moment, Mrs. N speaks in the name of the group, thus recognizing herself as a member. It is during this same session that Mrs. N tells us: “I’m not all alone,” when I ask her how the session went for her.
Mrs. N is often interested in Mrs. G’s remarks, asking me what she says (they are seated next to each other). There are interactions between the two at a material level: each one guards the limits of their own space by taking back materials that invaded the space of the other. There are also a few verbal exchanges with my assistance.
At the end of the seventh session, Mrs. N says she had a “bizarre” experience and adds: “Before I was all alone and then there were a lot of people and then after that I was alone.”
“And now, do you feel alone?” I ask her.
“No, not really.”
“Is it better to be here?”
“That depends,” she says.
“There are good moments and difficult moments?” I ask.
“Sometimes it is good to be alone,” she said.
She would repeat at the next meeting, “I am not all alone.”
Over the course of the sessions, Mrs. N brings up and gives voice to her issue: solitude. We can understand that being with people that she doesn’t know leads her to feel alone, but that she is nevertheless able to experience herself as a member of a group of people when she can identify them and that in that framework she can even experience solitude without it being accompanied by anxiety: “Sometimes it is good to be alone,” she says.
The last session revitalizes difficult issues for her: “I don’t care! I’ve had enough!” she says.
“Of what?” I ask her.
“Of everything, of life.”
“Of everyday life?”
“No, I don’t want people to fuck with me,” reprising Mrs. G’s insult, which had become a group expression.
The moment of separation seems difficult for her to process. It is important to note Mrs. G’s absence at this last meeting, who had played an important role for Mrs. N in as much as she expressed the rebellion that Mrs. N could feel without daring to show.

III. Conclusion

Within the group, Mrs. N was able to work on her issue of solitude. I have a feeling that this woman is just at the start of this process and more sessions will be needed in order to follow up. Mrs. N’s growth can be better seen in her attitude that in her verbalizations: Mrs. N is gradually opening herself up to relationships with others and is forging bonds. Her physical attitude is also changing, from a bent-over and stooping posture to sitting erect, available to others, and ready to listen to what is said and even allowing herself to react.

Synthesis and Opening

We have attempted to accompany each of these patients in a process that is their own:

- For Mrs. B, towards an expression of her losses: loss of her dog, of her familiar environment, her ability to walk, and the use of her left hand…
- For Mrs. G, towards the development of a more acceptable speech that is understood by others. By accepting her speech, she is also accepted, to such a degree that she became one of the pillar-members of the group, the one who, through her cries, became the bearer of everyone else's inner revolt: "Well said!" says Mrs. N to Mrs. G's insults.
- For Mr. P, from the expression of his anxieties of being devoured and persecuted, and then to a delusion of hyper-sexual power towards an integration of the other as subject to accepting the other's desire, stopping his own desire, and revealing his own limits and inabilities: Mr. P is perhaps a kind of "man without legs," but nevertheless a man with desires and a rich fantasy life.
- For Mrs. N, towards an elaboration of her experience of solitude to the experience of pleasure at being part of a group, but also in the rediscovered pleasure of being alone.

Instead of talking about the "end" of the group, the participants enacted it; each person renewed his/her characteristic gesture: Mr. P offered his indecent remarks that Mrs. B had quenched. Mrs. N reacted to them, "How horrible! Terrible!" to which Mr. P answered, "It's not horrible; it's a drawing." They were, in fact, playing with the drawings, the representations. Mr. P thus understood that for us, in this group, it was about playing with representations: "We are here to talk about things, not to do them," I have to tell him when he moves in a menacing way toward Mrs. G. And in that sense, the space of the group is a space of freedom in which all can find acceptance.

Just as I was getting ready to close the group, Mr. P reminded us of Mrs. G's absence: "She is tired; she needed to rest." Mrs. G's absence hangs over the group like a void, difficult to overcome.

We should have organized an additional meeting in order to allow the participants to better internalize "the end". It is not possible for me to imagine a reunion at this time because of coordination difficulties between my work and that of the care-giving team. However, in terms of practicalities for the group, this coordination is essential. I was able to experience just how much the lack of coordination between the patient's daily cares and the organization of the group can affect the group and create difficulties for the patients who arrive at the session "scattered": it expresses itself in agitation and a physical experience of unease…

How to ensure that everyone's attention is brought to these small details that are so fundamental for the vulnerable individuals who we care for in long-term geriatric care? To hear a woman who tells us, "I'm bursting… I'm not dressed…" or another who tells us, "My head is spinning… I'm wobbling…" and to hear that they are talking about "experiences of collapse": dissolution of physical boundaries for the one, lack of support for the other, and that we really are talking here about experiences that are comparable to those that face psychotic or autistic patients and which, when faced with, we cannot think to reduce to simply caring for physical needs. To work in geriatrics demands sensitivity, listening, and a solid training in the nuances of helping, similar to those that care personnel in psychiatric medicine receive.

The design of this group is certainly a plan that should be repeated in long-term care, a plan that allows space for expression, out of which the wounds and anxieties, but also the desires and fantasies of the patients, those things that keep them firmly on this side of life, can be explored.

The psychic care, that is to say, the opening of a space for verbal, graphic, gesticulatory expression for the other – created with a method like the Catharsis Technique – where listening takes precedence over intervention, is the duty of all those who work in geriatric care. The psychologist is only there as reference and surety.