

Defocusing in the dying scene*

Introduction

Mourning, desperation, depressive crisis and infantile protest cause uncertainty in relatives, doctors and nurses in the dying scene. Therefore, dying Patients are being left alone, partly under worthless and inhuman conditions. We describe a specific method, which allows defocusing the trauma of dying and opening the blocked communications with relatives, doctors, nurses and voluntary helpers. The process of intuitive resonance with elements of sensitivity, mood and fantasy is the centre of this therapeutic and supervising method.

Medical science is in a difficult situation. Death and dying are taboos in the world of modern medicine. From the high point of its successes in surgery and in the war against contagious disease, it allows the fiction that death has been overcome, that sickness is only a functional disturbance, and that health can be restored by replacement of faulty parts. Grief, despair, crises of depression and childish protests disconcert family members as well as medical staff, leaving the dying patient alone in mute isolation under inhuman conditions. The family members attempt to handle their grief and guilt feelings by an elaborate and expensive funeral. In the nurses and doctors, working on wards with high mortality rates, psychological crises and personal tensions manifest themselves in a tendency to seek refuge in technology and self-distancing objectivity. Occasionally, someone will attempt black humour. But discomfort over the situation keeps growing, and the medical personnel must deal with this problem particular their situation without help. They experience, feelings of role insecurity, loss of professional competence and guilt, in the face of the death scene. The need for psychotherapeutic help, for relief, for professional training in this problematic field is immense. I had to leave behind my psychoanalytic orientation and describe a defocusing training method, in which I found a new approach to dying Patients.

The Balint Group

In my opinion, the Balint Group is at the moment the best and most efficient instrument for mobilising the potential of the participants in what Balint has termed "skilled professional guidance". Out of the first training groups for general practitioners organised in the 1950s by Michael Balint in London, an extensive Balint movement has since developed. Since then, many European physicians in private practice have come to realise the value of this opportunity for further professional training, by means of which they can better understand problems of relating and perceiving which arise in patient contact and thereby improve their psychotherapeutic approach to their patients.

In these Balint Groups psychosocial work skills were developed in order to sensitise the individual physician to emotional interaction in the doctor-patient relationship: these skills could then be employed daily in his practice. The practical relevance of this form of continuing professional education made it attractive to physicians and led to its rapid expansion. Since then, numerous other social-medical-educational groups for teachers, clergymen, social workers and nurses have been initiated.

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Prismatic Balint Groups

are a further development of classical Balint groups in the form of focusing on mood processes and on defocusing symptom and relation problems. The group method makes it possible to resolve relational conflicts, and above all traumatic sets of experiences which have taken root between doctors, nursing staff and their patients.

The prismatic method of working can be outlined as follows: After presentation of a relational conflict or a patient's problem to the group, the individual members of the group are required to describe their mood and their feelings and thereby not to analyse or to inter-

pret the problem that has been presented, but instead to introduce metaphorical fantasies in which their mood and their feelings seeks expression.

We describe this defocusing method also as intuitive dialogues. Intuitively we perceive the outer world before we are aware of it. Also the substance of our decisions is not uncommonly intuitively and "from the gut." When we are involved in supervisions, therapies, and counselling, intuitively oriented signals, perceptible by the senses, are received and formed to expand the realms of possible communications and of the poetic speech-guidance. The therapist develops into a mouthpiece of his patient, without being blocked by emotional paralysed relation patterns.

With the help of the intuitive method of working it is possible to make a patient's or client's conscious and unconscious components of experience visible in the group. This orientation was especially successful in different hospiz groups in Germany and Austria.

The various expressions of the state of health and mood of the individual group members are not interpreted or understood as a part of a relationship. Unpleasant feelings such as chaotic mortal fears, aggressive, erotic as well as depressing-distressing aspects of a patients or clients experience can unfold freely in the individual members of the group.

The group members learn to comprehend their sensory experience and their ideas as a creative achievement, as a resonant and creative ability as well as a willingness and ability to sustain a field of tension between the contents of the conflict and the various mood and fantasy processes in the group. In contrast to the classical Balint group process, in which there is a focus on relationship patterns, in defocusing prismatic groups the psychodynamic blockades can largely diminish. Therefore the prismatic group remains fully functional within an institution with participants from different occupational groups and hierarchy levels, as both role conflicts and relationship conflicts are defocused prismatically by mood and by a poetic orientation.

Prismatic

is a technical term for group processes created by the psychoanalyst W. Loch. He compared Balint groups to a prism as an aid to splitting up the doctor-patient relationship into shades of monochromatic light, without the necessity of employing genetic or resistive work. We have adopted this comparison from W. Loch and developed it further into mood-processes. We compare this process with the colours of the rainbow of white light which only become visible on a prismatic refraction. We are attempting to understand the shades of mood of an expression as a necessary tonal chromatic phase, to which the following tones and moods can unfold. Through these experiences and expressions of the individual group members, prismatically differentiated feelings lose their logical and semantic cohesion. Emotional patterns and complexes of conflict are defocused, transformed and so minimised. This approach increases, the sensual awareness and creative ability for dealing with complex material in the intermediate domain, written by Winnicott.

Mood

soon became the core and scope of the new orientation of our prismatic group work. This term incorporates atmosphere and climate, physical sensations and feelings. Mood became the basis, the framework, the variable medium and, finally, the content of the whole group process on which we managed with increasing success to focus our attention. The presupposition for this mood orientation is the ability to develop mood awareness and to transform emotions into mood feelings.

We have found a number of explanations allowing at least an approximate understanding of this phenomenon, which in its kaleidoscopic form of expression encompasses our whole existence. We cannot free ourselves from mood. We all know and feel the dependency of our decisions and motivations from our mood-feelings, which are influenced by internal and external factors. The advertising industry has realised the importance of mood-feelings for developing sales strategies. Politicians view their influence as crucial for elections. Mood, however, remains a neglected field of psychological research. Con-

sidering the considerable number of psychotherapeutic schools and methods, it is surprising that mood has hardly been dealt with at all.

Thure von Uexküll, the father of German psychosomatic, views mood as the central psychosomatic term. His concept of mood as pre-reality can be related to Winnicott's views on transitional space and objects, to Michael Balint's theory of "Primary Love" and "flash" and to a number of other theoretical approaches, which describe the absence of the Subject-object dimension as an unstructured transitional space in which the central therapeutic, creative and productive processes evolve.

In the prismatic group process an attempt is made to develop the complex of unstructured informations into mood-dynamics. These dynamics can only develop when the individual group members succeed in transforming teleological "why-because-question-complexes" as well as emotions and group dynamics into sensual-poetic experience. These processes of experience and transformation are what we understand under the expression of mood dynamics and poetic communication.

For our work it was viewed as particularly valuable to understand how transformation processes work. Thus we could study how chaotic unchained, unconscious feelings, above all fears of psychotic disintegration and fears of death by the patients, could increase emotional tension in a staff and adversely affect the dynamics of an institution. We understood that disassociated feelings could be transformed and thus tied to interaction patterns. On the other side: emotionally fixed experiences of conflict can be defocused and transformed into mood feelings with the help of mood and poetic orientation.

The poetic quality

of expressions plays an important role in this mood oriented group process. Fantasies and memories based on imagination and poetic elements are understood as mood process experience formed with images. We describe this linguistic imagery as "open fantasies" to stress, that its poetic content should not be reduced to a symbolic expression of a specific behaviour in configurations of relationship. The development of experience into poetic expression is understood in relation to the process. This means the individual metaphorical elements serve primarily as the elaboration and further development of each mood-process.

It is important to realise that poetic and rhetoric language is not an inferior, aesthetic side-track in the search of truth, but that through it, language complexity, archaicism, history, future and the multidimensionality of vital processes find their adequate expression, which we postulate here for the subject-object free intermediate domain of Winnicott. I learned, that the poetic aspect first of all has to develop a concrete image if it is to be understood in its complex contradictions, its past and present content. I also learned that if an image is understood simply as a symbolic expression of an emotional aspect, then it loses its open nature, its dynamic tension and its full truth.

Therapy

When I started therapy in a defocusing, poetic, mood- and resonance- oriented manner, very often the therapeutic scene changed immediately. The mood of patients, which is fixed on the trauma of dying, shifted and by this brought them relief. Soon, the blocked pretraumatic feelings returned, giving back patients the opportunity for their pretraumatic life memory. I come to the end and bring finally one example of poetic communication with a dying patient.

The Fear of Death

A 54 year old female patient, suffering from cancer, knows her illness is incurable. However, she hasn't been able to speak to anyone about her fears. Her relatives are also afraid of mentioning the subject. The doctor on the patients ward turns to a friend of his, a defocusing psychiatrist, for advice. This man recently told him about his poetic conversa-

tions with patients. The ward doctor told him that he was really inhibited about, going to see this woman with the large, questioning eyes. Since more than 4 weeks she does not answer to any question.

After the psychiatrist and a nurse, with the relevant training, have been briefly introduced by the doctor, the psychiatrist remarks how shocked he is by the barrenness of the room. No pictures, not even flowers. Outside the weather is also dark and miserable. The psychiatrist seeks the patient's dark look and asks her how she is, how she feels. The patient gives him an empty stare and does not reply. There follows a period of silence. The atmosphere is one of depression. The psychiatrist explains to the patient that he had learnt of the poor prospects for her illness, as well as of her inability to speak, and that is, why he is here. He says, he has noticed how pale and grey and unmoving her face is. After a short pause he tells her he would like to recount to her the images in his mind. He sees a long procession of people in black habits, crossing a wide plain like a pilgrimage procession. He describes the plain and the pilgrims in detail.

At the point the nurse interrupts in a cheerful, almost noisy tone of voice: „How strange.“ She had also had a dark, grey image, surrounded by mist in her mind at the beginning. Then, she had remembered her last holiday. She had been in the mountains with her husband and their two children, when they had run into a storm and sought shelter under a rock. But then the storm had passed over. They had only got a bit wet but then, a wonderful view, deep into the valley. They had.....At this point the patient begins to speak.

Tears are running down her face, but she is smiling at the same-time. She tells now, she had been to the mountains every year with her husband. "Yes, until two years ago". When asked to talk about it, she tells of how her husband died two years ago of a heart attack. Since then she hasn't been to the mountains any more. She now recounts, with increasing openness her experiences in a village. She describes in detail their close relationship with the landlady, who she had visited for many years. She simply must write to her again. The tears are still running down her cheeks. At the same time, her face is bearing with happy memories. The ward doctor is so surprised, he drops his bunch of keys on the floor. This makes the patient laugh and she then tells of how, on a walk in the mountains, her husband had dropped his car keys into a valley. This had helped to make the holiday one day longer. The patient now seems to be exhausted - but grateful. She asks the ward doctor to send the priest. "You know", she says, "the one with short hair, who always has such a funny smile on his face".

Finally

I would like to mention, that the defocusing, intuitive and poetic orientation is one of several successful methods in the dying scene. Its elements might be used by all psychologists, doctors, nurses and assistants. In case of paralysed transference and communication it seems meaningful for them to be a resonant player for the patient, in an encounter field, where mood, feelings and defocusing poetic speech guidance take over the place of emotional and focusing patterns.

Literature of the author about defocusing and prismatic methods:

- Drees, A. (1975) : Psychosocial Problems in dialysis units. *medicinal psicosomatica* 20, 392
- Drees, A. (1980): : Psychological Stress Factors in Dialysis Units
The International Journal of Medicine and Law. Vol.1/4, S. 475-482
- Drees, A. (1980) : Balint-Groups With Students in Teaching Psychosomatics.
In: Proceedings of the 13.th European Conference on Psychosomatic Research
- Drees, A.,
Gallagher, B. (1981) : Haemodialysis, Rehabilitation and Psycho-therapeutic. Sup-port.
In: Norman B. Levy, Psychonephrology 1 Plenum New York NY
- Drees, A. et al. (1981) : Balint-groups with Students in Teaching Psycho-somatics.
In: Günsel Koptagel. Proceedings Bozak printing Co, Istanbul
- Drees, A. (1983) : The Establishment of a Balint Group Among Nurses in a Psychosomatic Ward
In: *Medicin and Law*. Springer
- Drees, A. (1984) : Psychological Stress in Doctors Dealing with Patients Dying of Leukemia.
In: A.. Carmi, *Euthanasia Medicolegal Library*, S. 15-121. Springer-Verlag
- Drees, A. (1988) : Eine Balintgruppe mit Laienhelfern. *Wege zum Menschen*,
S.35-41 Vandenhoeck & Ruprecht
- Drees, A. (1989) : Guidelines for a Short-Therapy of a Torture Depression.
Journal of Traumatic Stress Vol 2, No.4, S. 549-554. Plenum-Press. New York-London
- Drees, A. (1990) : Sinnlich-imaginative Trainingsmethoden für Medizinstudenten.
Praxis der Psychotherapie und Psychosomatik,
Springer-Verlag S. 247-253, Sept. Bd. 35
- Drees, A. (1990) : Sensual-Imaginative Training Methods for Students of Medicine.
Psychotherapy and Psychosomatics 53/1-4, S. 68-74: Karger
- Drees, A. (1994) : Lösungen von Beziehungsblockaden mit Hilfe von freien Phantasien.
In: *Zeit für die Liebe. Visionen vom Wandel der Leistungsgesellschaft zur
Beziehungsgesellschaft.*
Veröffentlichung des Verbandes Katholischer Ehe-, Familien-, und
Lebensberaterinnen und -berater. S.46-83
- Drees, A. u.
Huhn-Gathmann, M.
(1994) : Freie Phantasien in der Sterbebegleitung durch den Hausarzt.
Der Allgemeinarzt 6, S. 480-486
- Drees, A. (1995) : Freie Phantasien. Vandenhoeck und Ruprecht. Göttingen
- Drees, A. (1996) : *Folter: Opfer, Täter, Therapeuten*. Psychosozial Verlag, Gießen
- Drees, A. (1996) : *Poetische Gesprächsführung in der Sterbeszene*. Video-Cooperat-Ruhr, Dortmund
- Drees, A. (1996) : Psychologischer Stress in der Sterbeszene.
In: Dahhan K.E. Kongreßbericht VIII Deutsch-Syrischer Ärztekongress
S.65-73 (deutsch), S.105-106 (arabisch)
- Drees, A. (1997) : *Poetische Gespräche in der Sterbeszene*. *Psychotherapeut* 42: 28-33
- Drees, A. (1997) : *Poetische Gesprächsführung in der Sterbeszene*. S.: 373-381.
In: P. Hofmann et al: *Klinische Psychotherapie*. Springer Wien, New York
- Drees, A. (1997) : Eine prismatische Balintgruppe in Kuwait.
Gruppenpsychotherapie und Gruppendynamik 3/1997
- Drees, A. (1997) : Torture and Mood-Oriented Prismatic Balint Groups.
In: *Int. Forum Psychoanalysis*, 6, S.225-230
- Drees, A. (1998) : *Verarbeitungsformen von Dialyse Stress - Intuitive Dialoge zur Lösung
von Teamkonflikten in Dialyseeinrichtungen*.
In: H.E. Franz, *Dialyse 1998*. Pabst Science Publishers
- Drees, A. (1999) : *Intuitive Gespräche in der Sterbeszene*.
In: H.E. Franz *Dialyse 1999* Pabst Science publishers

- Drees, A. (2000) : Intuitive dialogues in the field of victims of torture.
In: Torture, Volume 10. Nr. 3, 2000
- Drees, A. (2001) : Intuition in der Sterbebegleitung. Pabst Science Publishers Lengerich
- Drees, A. (2002) : Prismatische Balintgruppen. Pabst Science Publishers Lengerich
- Drees, A. (2002) : Identity, socialisation and artistic expression.
In: Hajo Drees: A. Comprehensive Interpretation Of The Life And Work
Of Christa Wolf The Edwin Mellen Press
- Drees, A. (2003) : Prismatische Sterbebegleitung in: Selbstbestimmung und Integrität am Lebensende
Arnoldsheim Haag und Herchen Verlag Bd.121; S. 35-56
- Drees, A. (2003) : Prismatisches Vorgehen in tiefenpsychologisch fundierter Psychotherapie.
Psychodynamische Psychotherapie; 2 ; S. 43-57
- Drees, A. (2003) : Sinnlich intuitives Erleben und freie Phantasien in der Sterbebegleitung.
In: Qualität in der Trauerbegleitung. Trauerinstitut Deutschland.
Hospiz Verl. Wuppertal S.25-36
- Drees, A. (2004) : Staunendes Miteinander in bildsprachlicher Kommunikation.
Soziale Psychiatrie 3 S.31- 33
- Drees, A. (2004) : Bildsprachliche Dialoge in der Psychiatrie.
Psychiatrische Pflege; 10 S. 1-6 Thieme Stuttgart
- Drees, A. (2004) : Prismatische Kommunikation in der Sterbe und Trauerbegleitung.
Bundes-Hospiz-Anzeiger 06
- Drees, A. (2004) : Humane Psychiatrie in den Erlebensberichten eines Psychiaters. Im Druck

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