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Arriving, Settling-in, Settling-down, Leaving and Following-up: Stages of stay at the Arbours Centre*

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The Arbours Centre is a small psychodynamically oriented therapeutic community which accommodates three live-in psychotherapists and up to five 'guests' at any one time. This paper describes the 'stages of stay' which guests and therapists pass through during the course of an intervention at the Centre, and discusses their interactions during each of these periods.

The Arbours Centre is a facility of the Arbours Association, a registered charity founded in 1970 in order to help people in emotional distress and as an alternative to the traditional mental hospital regime. In addition to the Centre, the Arbours Association sponsors three long-stay therapeutic communities, a training programme in psychotherapy and social psychiatry and a consultation service.

The facility

The Centre itself was established in 1973 to provide immediate and intensive personal support and accommodation for individuals, couples or families threatened by sudden mental and social breakdown. Three resident psychotherapists. live at the Centre, a substantial, semi-detached Victorian house located in a quiet, residential neighbourhood of north London. For the resident therapists this house is their home. People who come to live at the Centre with them are their guests.

Referrals

The Centre receives referrals from psychiatrists, general practitioners, social workers and other professionals. as well as a couple of dozen direct calls or letters each week from people with all sorts of problems. For some the phone-in service seems to suffice. Otherwise we endeavour to arrange a prompt appointment at the Centre or at the home. The persons concerned are told that they will be meeting with a team of therapists from the Centre.

The therapist team

The Arbours' team consists of a resident therapist, a team leader and, when suitable, an Arbours trainee or other professional doing a placement at the Centre. After the initial consultation the team may continue to offer further consultations, make a referral to other agencies or offer a place at the Centre.

The team leader is an experienced psychotherapist whose function is to assist in the evaluation of the call and to coordinate the efforts of the team on behalf of the person or persons in difficulty. He or she may become the primary focus of transference feelings, or not, depending on the intervention.

The resident therapist is necessarily the focus of intense phantasies and a real role model for the guests. Each resident therapist is a member of one or two teams and shares responsibilities for the physical as well as emotional care of guests on other teams as well.

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The task of the third team member is deliberately left unclear. Often they form close relationships with guests outside the structure of formal team or house meetings and are able to provide a valuable perspective about problems which the guests are reluctant to bring to the therapists.

The guests

People who stay at the Centre are usually very depressed and anxious due to a wide variety of developmental, interpersonal or situational difficulties. Some have been going in and out of mental hospital for years. They come from all walks of life, from labourer to pop star, from homemaker to psychologist. We have been especially pleased to work effectively with members of religious and ethnic minorities who had previously been considered untreatable'.

The average length of stay is five to six weeks, although some guests only come for a few days and others, especially adolescents, have stayed for well over a year. Residence is on a voluntary basis. The Arbours Centre is the only facility that 1 know that will give support and shelter to an entire family on short notice, including the family pet (Berke, *1979, 1982).*

Goals

Our aim is not simply to stop bizarre or disruptive experience or behaviour, but to contain it and make sense of it. These goals are interconnected. Our guests need help because they are no longer able to keep in themselves, and to themselves, wildly distressing thoughts, feelings and wishes. The Centre, both the building and the therapists, provide this help by serving as temporary containers for intolerable rage, confusion and criticism. This process is akin to what passes between parents and children, when the child screams and the mother and father hold and absorb the screams and tears and make the world bearable again.

We make things bearable again by tolerating the pain and discomfort in ourselves, by suffering on behalf of another, and by trying to evaluate and understand what the distress is about. We seek to digest and assimilate the very experiences which, to our guests, appear crazy, unintelligible, dangerous and indigestible. By feeding our understanding back, gently, slowly, we help them to make links between what they have been feeling and what has been going on in their lives. Then they can regain and contain their experiences, and a sense of integrity and autonomy. In other words our task is to perceive and apperceive on behalf of our guests, to enable them to face reality and to dream.

Framework

During the course of the intervention we may spend a great deal of time with the guests and members of their family, or not. Some people prefer to be left more to themselves. We may do a lot of interpretive work, or very little. Every guest attends three or more team meetings plus three house meetings per week. The latter include all the residents at the Centre, guests and therapists, and are a powerful complement to the work done in the team. In addition, there are many opportunities for ad *hoc* discussions with the resident therapists during the day, early evening and, if necessary, during the night. All the guests are welcome to attend the Arbours' monthly network meeting, which takes place at one of our long-stay communities, and other Arbours activities.

Usually all the therapeutic work takes place at the Centre. However, when a guest is already in treatment before coming to the Centre, this may continue. We do our best to consult with the previous therapist and the resultant work may then be a collaborative effort.

Therapists' support systems

All the therapists have had or are having intensive analytic therapy. This allows them to develop their own psychic space and concomitantly expand the containing space of the Centre itself. In this way the Centre as a physical experience and the therapists as sensitive human beings are more able to carry the projected bits and pieces of others' distress, especially with guests who may be partially or wholly verbally inarticulate. These people rely on projective and introjective mechanisms to communicate and dramatize their condition. Often the resident therapists are only able to learn what is happening in and to them by tolerating and reflecting upon the pain and irrational feelings aroused in themselves. The emotional impact of these exchanges can be very intense, all the more because the guests tend to treat the therapists as a parental couple and may make tremendous efforts to come between them and disrupt their activities. Interestingly, they may also become upset when 'the couple' is apart, and make equally strong efforts to bring them together. The therapists are usually prepared for the angry attacks on their shared relationships, but they can be quite taken aback by the pressures put on them to be together.

The team leaders, individually and as a group, serve as an 'auxiliary ego' for the resident therapists. This 'auxiliary ego' operates at varied individual and group supervisory meetings and clinical discussions. The

same happens with other team members, trainees and professionals on placement, each of whom has personal supervision and the opportunity to actively participate in clinical meetings. Sometimes all this support seems useless and everything feels confused, chaotic and out of control. But we have begun to realize that a period of disequilibrium. in the team may be a prelude to helping certain guests, for once we can regain our own emotional, perceptual and intellectual equilibrium, they can regain theirs (Schlunke & Garnett, *1984).*

Stages of stay

There are five stages of stay which guests pass through during the course of the intervention, and five complementary stages involving the therapists. These stages of stay are: (1) Arriving, (2) Settling-in, *(3)* Settling-down, *(4)* Leaving and (5) Following-up.

Arriving

Regardless of other issues, the primary fears of new arrivals centre on leaving home, relating to a new place and new people, loss of control, regression and going mad. These need to be considered first.

The overt expression of arriving stress will be neurotic or psychotic, depressive or persecutory, depending on the person, immediate conflicts and underlying personality. A sense of inadequacy, worthlessness, shame for not coping, guilt for letting others down, helplessness and hopelessness characterize depressive anxieties. With one of our guests this encompassed both her social workers and herself. On the first visit, they were all close to tears. The young woman remained in the car and refused to come in. While 1 met with her social workers, the resident therapist spent over an hour in the car, talking about the Centre, bringing cups of tea and generally trying to put words to her reluctance to leave her previous abode.

In psychotic states all the above may occur but can be greatly exaggerated and lead to a terrifying sense of starvation, derealization, depersonalization, disintegration and annihilation. Perceptions are bizarre, chaotic, unbearably sensitive and persecuting. Communication tends to be non-verbal and accompanied by a considerable degree of acting out. Our involvement with a man who had years of unsuccessful treatment for schizophrenia indicates the degree to which these experiences are related to arriving at a

new place, and not simply an expression of underlying pathology. He seemed to wander around the house aimlessly, but when approached by a therapist or another guest, he would suddenly put his hands around their necks. Needless to say, this was quite frightening to everyone concerned and was an effective way of communicating his fright at being with us. The day after his arrival he greeted his team leader in the same fashion, hands around the neck. However, instead of immediately withdrawing or becoming angry, the therapist calmly commented that he thought that the man was doing this because he desperately wanted to make contact with people in this new environment, but feared rejection if he did so. The person obviously felt understood, for he dropped his hands and menacing pose and started to talk about his fears that the Centre would be like all the other places that had hurt him.

During this stage the therapy team, resident therapist, team leader and other members work jointly to assuage arriving fears, set the framework for the stay and mediate with the guest's family or social network. Where depressive issues predominate, the guest's social network tends to remain intact and may be a source of support. However, where persecutory issues predominate, the network itself may have broken down and can offer little effective help. Indeed, as in the example 1 just cited, the family may be positively persecuting and the team may have to protect the guest from family involvements until he or she has settled in.

Settling-in

The second stage is marked by a significant decrease in arrival fears and an increased ability to reflect on the underlying issues which brought the guest to the Centre. During this time the therapeutic alliance between guest and therapists should become more fully established, and the framework of meetings firmly fixed. With one person who was suffering a psychotic breakdown this included separate psychotherapeutic support for his wife (who was also very depressed, but not staying with him). These sessions took the edge off his external guilt feelings just enough to allow him to explore internal guilt feelings concerning an anniversary reaction. So the framework may, of necessity, include concurrent exploratory and supportive meetings with other members of the family or social network.

In the arrival stage the transference tends to be directed to the Centre as a whole, with the Centre providing and sometimes literally seen as calm, warmth, food and containment, in other words, the good breast. In the second stage this still happens, but the transference begins to be differentiated between the resident therapists, team leaders, students and other guests. The latter provide a useful projective focus and sometimes may be directly supportive themselves, as an older, more experienced child to a younger sibling.

During the settling-in period one sees a growing ability on the part of the guests to tolerate the psychic pain that their crisis has caused and which they need to work through. The therapists aim to support their perceptions and generally help them mobilize their ego resources and boundaries. This is a delicate matter of subtle negotiations between guests and therapists, really about accepting reality, or not. Those who succeed go on to Stage 3. Those who do not invariably leave.

Settling-down

The third stage is the occasion for interpersonal association and intrapsychic consolidation. It is when a great deal of the work involved in being at the Centre gets done. As one guest put it, it was a time when he was able to 'assume his depression', that is, face the depressive fears that lay behind his bizarre mannerisms and social withdrawal. His comments concisely caught a main goal of this period, which is to allow depressive anxieties to come to the fore as well as explore reparative capacities. Interestingly, in very depressed individuals settling-down usually coincides with the diminution of their depression. On the other hand, men and women with a borderline or schizoid personality structure inevitably become much more aware of theirs. Thus for many people the onset of depression is a positive sign, not a symptom of illness, and needs to be encouraged. It can denote a period of inner integration, discovery of self and creative identification with the therapists and the Centre. Specifically this means that the guests tend to take a much more active part in their team and house meetings as well as help with day-to-day tasks such as cleaning and cooking.

When the guest has settled in, and begun to settle down, the resident therapists serve as primary links between symbolic demands and practical needs. They function as mirrors, containers and role models. Indeed one of their most important tasks is to keep themselves intact. Essentially they follow Donald Winnicott's famous dictum about psychotherapy: 'Stay alive, stay well and stay awake'.

During the third stage the team leader serves to observe, encourage and mediate the differentiation of the transference towards the Centre and individual team members. Depending on the personality of the guest and the reasons for the intervention, this may develop as part of a formal relationship with the guest or supervisory role with the resident therapist. The more psychotic the guest the more important it is for there to be a differentiation of roles whereby the team leader establishes himself as an external libidinal focus via a carefully considered use of verbal interpretive interactions, in the manner of intensive, analytic psychotherapy (Berke, *1981).*

Where the presenting disturbance is more limited, and the guest's anxieties more easily contained, there exists greater scope for a reversal of roles whereby the resident therapist uses a direct interpretive framework, that is, in addition to informal interpretive exchanges, and the team's leader's prime concerns are to support the resident therapist and the guest's family or social network. In many instances we have successfully used a family systems approach to explore and defuse the group pressures that have led a particular family member to be seen as ill, and commence a career as an invalid.

In either case the team leader has to help the resident therapist to withstand intense libidinal and aggressive impulses which may take the form of excessive demands for time and attention, or a frustrating, angry rejection of the resident therapist's efforts. The latter commonly occurs with people who are beginning to develop positive feelings for the house and the therapists, but are frightened of getting close to others. Then, in order to protect themselves from their own worst fears of rejection and of doing damage, or out of envy and jealousy, they often try to parody the negative aspects of the therapist's personality and to fill him with bits and pieces of their own disturbance. This behaviour can be very stressful and arouse an unconscious desire for revenge, as happened with one person who alternated active hostile rejection with passive indifference. It transpired that his resident therapist unwittingly responded with criticism and apathy. Then the team leader has to support and protect the guest, especially when the resident therapist finds it hard to cope with his counter-transference reactions and tries to throw back angry, undigested feelings. These often take the form of subtle criticisms,

unavailability and excessive control. Usually this negative aspect of the relationship between the resident therapists and guests mellows and is resolved by the mutual respect and affection that develops during the course of the stay at the Centre.

Leaving

The fourth stage is concerned with leaving. This can precipitate a fresh crisis because leaving necessarily arouses ambivalence, sadness and depressive feelings which may seem too strong to bear. Therefore a wish to repeat the original breakdown tends to accompany leaving. The woman who had hid in a car and refused to come in, also found leaving terribly painful. She stayed at the Centre for almost a year and was going to move to one of our long-stay communities. Although we had discussed the move at great length, as her final month at the Centre approached she suddenly exploded with the full array of chaos and confusion that had brought her to the Centre in the first place, including regressive withdrawal, insistent voices demanding that she kill herself and us, mild attempts at mutilation and a bevy of somatic complaints. She was scared and so were we. In other circumstances the constellation of symptoms would have indicated a recurrent psychosis to be treated with medication as soon as possible in order to stop these manifestations of inner chaos and persecution. We thought the episode was a leaving crisis and responded to it as such, with more frequent team meetings, and especially important, a lot of extra time and attention by her resident therapist who was prepared to stay up three evenings with her when she was most upset. Eventually the storm passed with tears and a good night's sleep. Afterwards she was much more able to relate in a feeling way to concrete issues of leaving and use the episode as a positive learning experience.

It is worth noting that these crises are not only attempts to avoid sadness, but also encompass the wish to remain at the Centre. This is especially the case with individuals who have been moved from pillar to post and are desperate for a place, any place, which they can call 'home'. The symptoms say, 'Look, 1 am still too crazy, 1 am still a child, 1 want to stay'.

However, leaving is also a difficult time for the resident therapists, who may have taken in all the guest's fears about loss, abandonment, failure, worthlessness and inadequacy, and also have to cope with non-counter-transference feelings as well. These include great regret about losing someone they have grown to like and about whom they often feel very close. The response may be like a parent's dismay when a child grows up and leaves home, that is, a terrible sense of abandonment.

Moreover, the therapists need to work through other fears about taking in a disturbed newcomer. In these circumstances the old adage, 'The devil you know is better than the devil you don't', is particularly relevant.

A shared depression is a useful part of leaving for the resident therapists and guests, as is a shared sense of accomplishment. The latter is the treat for people who previously have only experienced treatment as hurtful. The task of the team leader is to help all sides acknowledge and accept the hurts and the treats. To a lesser extent similar feelings arise with all the residents in the house, because when one person leaves, they all feel a sense of loss. Indeed, a collective depression is a noticeable feature when a long-term resident departs. For this reason, we always have a formal ceremony, often a party, to acknowledge and celebrate the occasion.

Following up

The fifth and final stage can encompass the weeks and months after the guests have left. During the immediate aftermath arrangements will be made for two or more follow-up sessions at the Centre itself and then more intensive psychotherapeutic support as may be needed. In some instances where the breakdown was especially severe, or where the social relations of the guests were severely disrupted, the follow-up may include residency at a long-stay therapeutic community of the Arbours or half-way house of another group. In any case guests are welcome to attend the monthly network meetings of the Arbours which rotate among the various communities. Most ex-guests are content to know that they can attend, but some have come to these meetings over several months and used them	to maintain links with us and to continue the process of interpersonal and intrapsychic consolidation.

A detailed questionnaire presented to all ex-guests after three months and a brief one after nine months conclude the process of following up. The former allows for multiple choice and open-ended answers and

covers their view of their distress, their experience at the Centre and their life course since leaving. The latter is simply concerned with outcome.*

We have found that these questionnaires, which are regularly reviewed, are not only a useful source of feedback and information for ourselves, but that they can carry a therapeutic impact. The questionnaires make people mull over their stay and give them another chance to contribute to the Centre. Some express doubts about the usefulness of the Centre or their capacity to change. One woman who had come to the Centre after an abortion described her first impressions: 'The therapists looked too young and the whole thing reminded me of a hippy commune'. She thought that the Centre was 'just experimenting with alternative methods of therapy which might not work'. But after a few days she changed her mind and wanted to stay. She said it had helped to see others more distressed **than her and** to have **had** the chance to talk in depth about her problems.

Others have remarked on the positive features of their stay, that the very atmosphere of the Centre, the house, the residents, the nature of the support had a lot to do with their feeling better. A student wrote: 'At the Crisis Centre you are not made to feel inferior and, in my opinion, if the therapists are willing to live, eat and be with you, they are really interested in your well being. It was not a sterile place, but warm and homey'.

A homemaker concluded: 'I enjoyed the freedom ... to have honest, open conversations with strangers, whether therapists or patients. There was no sense of intrusion there, (but) knowing someone was there to talk or comfort me at any hour if 1 needed was a comfort in itself. 1 was treated with kindness, gentle understanding and respect, and at no time did 1 feel like a patient. 1 responded quickly to the relaxed, calm atmosphere and found answers to questions which had kept me on the edge for years'.

Discussion

The stages of stay - Arriving, Settling-in, Settling-down, Leaving and Following-up - may provide a model for therapeutic encounters in traditional as well as non-traditional mental health facilities.

I believe that these stages of stay are not unique to the Arbours Centre. All patients find hospitalization or resettlement outside their usual milieu a frightening experience. Too often the here and now aspect of the treatment is subordinated to problems of pathology. In part this may be because professionals find it hard to accept that their interventions, however welcome or necessary, may become an added source of distress. On the other hand, it is discouraging for them to see their best intentions and greatest efforts, whether by psychotherapy, medication or other means, sabotaged by ungrateful or seemingly untreatable patients. Such results are not necessarily intrinsic to the presenting pathology, whether neurotic or psychotic in nature, but to the human situation, where emotionally scarred or recently wounded people are scared of closeness or, once affection and trust has been established, are reluctant to part. In these circumstances interpretations or medications may simply solidify an inability to tolerate closeness or to part, and confirm pre-existing prejudices of patients towards staff and vice versa.

We are currently working on a five-year review. During a previous five-year period which involved 153 guests (80 male and 73 female) 106 returned home, 16 went to another Arbours community, six went to another community, three went on holiday, four went to stay with friends, five went to stay with relatives, one got a live-in job, three went to live in a newly obtained flat or house, seven went to hospital and one returned to a remand centre.

Paradoxically the arousal of depression is a prime element in an effective intervention. The adults and children who seek help have done damage, broken ties, upset others or generally been unable to put things right. More often than not the problem is not that they get depressed, but that they cannot feel appropriate remorse, sadness, depression and reparative desires. In-patient encounters, or their equivalents in therapeutic milieus like the Arbours, necessarily provide opportunities for this to happen. Whether it does depends on the extent to which both the immediate and consultant staff can tolerate the painful feelings evoked in them. If they can, then appropriate depressive features, and reactions to them, are more likely to be accepted as a necessary part of the relationship with a troubled human being, and not perceived nor treated as further signs of pathology.

All this leads to the realization that the feelings of doctors and nurses, therapists and helpers, are themselves an essential part of the treatment process, something long recognized by Dr Thomas Main, the former director of the Cassell Hospital in Surrey. In his well known paper, 'The ailment', he

demonstrated that treatment often increases or even begins at the moment when the nurse or therapist 'has reached the limit of her human resources and was no longer able to stand the patient's problems without anxiety, impatience, guilt, anger or despair' (1957).

The implication is that it is unhelpful to rush out and try to eliminate guilt and anger, despair or love in the staff, or root them out of patients (in order to decrease the pressure on others). But it is very helpful to provide sufficient personal support, so that both staff and patients can contain painful feelings, reflect on them, and use them without projecting them, that is, turning others into narcissistic extentions of themselves. Such accomplishments depend, in turn, on a careful understanding and working through of the feelings evoked during each of the five stages of stay in a therapeutic intervention. Hopefully the end result of all these deliberations will be an increase in psychic space and integrity in therapists and guests, or staff and patients, and a more satisfying, if not healthier, outcome for all concerned.

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