Evaluation of a short-term group psychotherapy used as part of the rehabilitation process in nursing home patients

Joanna Szczepańska-Gierach1, Joanna Kowalska1, Malwina Pawik1, and Joanna Rymaszewska1,2

1Department of Physiotherapy, University School of Physical Education, Wrocław, Poland and 2Department of Psychiatry, Research Unit of Consultation-Liaison Psychiatry & Behavioral Medicine, Wrocław Medical University, Poland

Abstract

Purpose: The aim of this study was to assess the impact of a 4-week group psychotherapy on the efficacy of physiotherapy in patients rehabilitated in a nursing home (NH). Materials and methods: The study was performed on 28 women, aged 77.1 (±5.6) years. Thirty-six percent were rehabilitated due to orthopaedic injuries, 36% had undergone a stroke, 28% suffered from chronic diseases of old age. Subjects were divided into two groups: experimental (n = 13) and control (n = 15). In the experimental group, a short-term, goal-focused group psychotherapy was used. To assess cognitive impairment, mood and functional status the Mini Mental State Examination (MMSE), the Geriatric Depression Scale (GDS-15) and the Barthel Index (BI) were used. Results: In the experimental group a four times greater improvement in mood was observed and two times greater physiotherapy efficacy (PE) in the first month of stay in an NH as compared to the control group. The effects of psychotherapy were independent of the type of disease, the patients' age, number of comorbidities and cognitive status (ranging from 15 to 30 points on the MMSE). Conclusions: Short-term group psychotherapy can be an effective method of supporting the process of rehabilitating older, disabled people rehabilitated in an NH.

Implications for Rehabilitation

- Psychotherapy can improve the efficacy of treatment and rehabilitation in different somatic illnesses despite the advanced age of respondents, high disability rate, and the presence of cognitive impairments.
- Even short-term (4 weeks) group psychotherapy can provide effective support for the rehabilitation in the elderly.

Introduction

A major problem of healthcare systems of all developed countries is a growing population of elderly patients requiring treatment and rehabilitation in a long-term facility, usually a nursing home (NH) [1]. In this particular group of people, many health problems usually coexist. In addition to the disease, which is the main cause of rehabilitation (e.g. stroke or fractures), patients suffer from other diseases that complicate the treatment and the physiotherapy (e.g. heart problems, rheumatism, neurological diseases, diabetes, asthma, obesity). It was found that patients staying in the NH take seven different medications daily (6.7 ± 2.4) [2]. Another problem is the psychiatric disorders, including in particular mood disorders and cognitive impairment, which also significantly influence the course and final outcome of rehabilitation [3,4]. When a necessity of a long-term hospitalization, separation from family and friends, and problems with adapting to hospital conditions all join the long list of diseases of the old age, then physiotherapy becomes an extremely difficult process, often ineffective. Studies show that approximately one-third of NH patients achieve low physiotherapy efficacy (PE) [5]. In Poland, only 55.5% of seniors leave the unit within a period of less than 6 months, 18.5% stay there between 6 to 12 months, 19.5% from 12 to 24 months and 6.5% stay in NH even above a 2-year period [6].

Therefore, it is reasonable to search for ways to improve physiotherapy efficacy in this particular group of patients. Of course, any increase in the amount of therapy entails certain costs. In facilities financed by the public healthcare system it is usually not possible to radically increase employment in order to increase the intensity of the rehabilitation process.

Recent studies show that group psychotherapy can be an effective and relatively inexpensive method to help the treatment of somatic disorders [7]. Therefore, it may seem that a group form of therapy may play an important role in this case. The outlined project appears valid because there is still little research on the use of group psychotherapy in a NH. Our study has additionally this particular feature that it describes the role of psychotherapy.
not only in the context of improving the mood of patients, but also above all in the context of increasing the efficacy of physiotherapy and the changes in activities of daily living.

This study meanwhile is a continuation of our previous projects carried out under NH conditions which had shown that low physiotherapy efficacy is not dependent on the patient’s age or level of disability, but very often has to do with the presence of mood disorders [5]. It appears that patients with depression are not able to fully reap benefits from the rehabilitation. Considering that using antidepressants in patients who take many other medications (on average 7) is problematic due to the additional pharmacological burden on the organism and the possible interactions with other medications, psychotherapy becomes in this case the method of first choice. Therefore, the main assumption of the outlined project was the use of psychotherapy as a factor supporting the process of physiotherapy.

However, there are many doubts as to whether psychotherapy can be effective in this particular group of patients. First and foremost, there is the crucial question of motivation in psychotherapy. Will people in such advanced age and such specific circumstances have the motivation to undertake therapy? Perhaps the secondary benefits of disability (mainly the care and attention received from other people) will be greater than the desire to change this situation. A further question – is effective impact of psychotherapy possible in patients with impaired cognitive function, in whom cognitive processes are already somewhat limited? On the other hand, excluding these patients from the therapy would significantly limit the usefulness of the studied method, because in this specific population only 20–30% are cognitively intact [8,9]. The literature however provides evidence to support the efficacy of psychotherapy in patients with mild and even moderate cognitive deficits [10–13], this fact does encourage taking up the therapy of a relatively large group of seniors.

Bearing in mind the doubts mentioned earlier as to the motivation of patients, it was found that the goal of psychotherapy must be in line with the goal of staying at the NH, and that is improvement in physical functioning and regaining independence in basic activities of daily living. The faster the patient improves his performance, the quicker he can go home to live independently or under family care. Therefore, the fundamental goal of psychotherapy was to support the process of rehabilitation, which was to increase the effectiveness of this process and speed up patient’s return home.

The duration of treatment was planned for the first four weeks of hospitalization. Based on the previous results of tests carried out under the same conditions, it was found that it is a crucial period for further continuation of rehabilitation. The greater the improvement in motor skills a patient gains in this period, the better the results will be in the following months of hospitalization [5]. Thus, supporting physical therapy appears to be particularly important during this time. There is an important question here of course whether such a short-term form of therapy can be effective? However, study results Mączka et al. (2010) show that even eight sessions of group psychoeducation bring significant benefits in the treatment of mental illness [14]. Moreover, in the initial period of hospitalization, severity of difficult emotions is usually very large. The feeling of loneliness and longing for loved ones prevails during this period. Group therapy conducted through building a mental bond with others who are in a similar situation in life has a lot to offer here, to some extent it compensates for the absence of family and it reduces loneliness. In summary – the goal of performed therapy was a faster adaptation of patients to NH conditions, reducing mental health crisis and loneliness as well as building and strengthening patient’s active role in the rehabilitation process.

A detailed description of the intervention applied had been included in the section Materials and methods.

The aim of the project was to assess the impact of a short-term group psychotherapy on the course of a rehabilitation process and the effects of rehabilitation after the first 4 weeks of hospitalization in NH. Following research hypotheses were set forth:

(1) Participation in group psychotherapy will reduce the mood disorders of study group patients in comparison to the control group.

(2) Enhanced mood and increased sense of control on the course of the rehabilitation process will increase the willingness of patients to participate actively in this process and greater independence in activities of daily living.

(3) Physiotherapy efficacy in the experimental group will be greater than in the control group.

Materials and methods

The study sample was comprised of a group of 28 randomly selected women (those who satisfied the inclusion criteria) consecutively admitted for the first time to a NH for temporary rehabilitation. The inclusion criteria were: informed consent to participate in the study, age over 65 years, female gender, Mini Mental State Examination (MMSE) ≥15, ability to maintain a sitting position in a wheelchair for a minimum of 60 min. Exclusion criteria: aphasia and severe vision or hearing impairment that would disturb assessment of a cognitive function based on the MMSE, alcoholism, addiction to psychotropic drugs, presence of disturbances in consciousness at the time of study or medical records of mental retardation and severe mental disorders (e.g. schizophrenia and other delusional disorders, bipolar disorder), patient’s refusal at any stage of research. Patients had agreed to participate in the study, after being informed of the purpose and protocol of the study and possibility of resignation at any stage of the study.

Average age of patients was 77.1 (±5.6) years. Among the respondents, 36% (10/28) were rehabilitated due to orthopaedic injuries (fractures caused by a fall), 36% (10/28) had a stroke; 28% (8/28) suffered from chronic diseases of old age (e.g. degenerative arthritis, rheumatic diseases). Elementary and vocational education was declared by a total of 39% (11/28) of patients, the same amount of respondents declared secondary education (39%; 11/28), and only 22% (6/28) declared higher education. Most respondents were single or widows 68% (19/28), only 32% (9/28) were married. Based on the community nurse’s interview only 29% (8/28) of families declared full caring capacity as far as taking care of an elderly person with a disability is concerned. The functional status assessed on admission to the ward indicated a high degree of disability and the need to provide full-time care. Eighty-nine percent (25/28) of respondents obtained a BI ≤55 points, mean number of comorbid conditions was 4.8 (±1.9).

All persons meeting the inclusion criteria who were admitted to a NH in the first two months of the research project were qualified for the study group (n = 13), where apart from daily physiotherapy a short-term group psychotherapy was also used (instead of occupational therapy conducted in group conditions). Subsequent persons who fulfilled the inclusion criteria and who were admitted to NH in the next two months of study (n = 15) were qualified to a control group, where a standard process of rehabilitation was being carried out (individual physiotherapy and group occupational therapy).

The study had a sequential design – at first the experimental group was examined and then the control group, because the main assumption of the project was to conduct group psychotherapy (minimum of six people in a group) in the initial period of...
patients’ hospitalization. In the centre where research was conducted, approximately 6–12 new patients are admitted a month. Some of them (about half) do not meet the inclusion criteria because of aphasia, profound cognitive impairment (MMSE < 15) or poor health condition that makes adoption of a sitting position impossible. Therefore in one month, it was possible to observe only one group (experimental or control).

In the course of the experiment, there were no significant changes in the functioning of the centre (organizational or financial). The rehabilitation process proceeded with the same intensity; there were no changes in personnel or a holiday period. Overall, daily amount of therapy in both groups (experimental and control) was the same. Each patient every day (Monday to Friday) performed 60 min of individual physiotherapy. In addition, patients in the control group participated in occupational therapy as a group, which is a standard complement to physiotherapy in these types of care units. In the experimental group, in place of occupational therapy, a short-term group psychotherapy was used in the same time slot.

To assess the cognitive status an MMSE was used [15]. Severity of depressive symptoms was studied by means of a Geriatric Depression Scale (GDS) [16]. A shortened, 15-question version was used for the study, where sensitivity and specificity is high, assuming that MMSE ≥ 15 [17,18]. Functional status was measured using Barthel Index (BI), which is a tool commonly used to assess the degree of disability [19]. BI is applied to various diseases because it concerns universal skills and activities in everyday life, rather than selected motor dysfunctions typical of a particular disease. The functional status was assessed by a physiotherapist on the basis of observations of actual capabilities of patients in everyday functioning. Baseline measurements were performed after the patient had stayed in the unit for 3 full days, after an initial period of adaptation to the hospital. All tests (MMSE, GDS, BI) were in the form of a blank test. Data collection occurred independently from the intervention by a researcher who was blind to the form of intervention. The process of psychotherapy was subject to supervision.

Additional variables considered were: education, marital status, family caring capacity and clinical parameters such as age, type of disease being the main cause of rehabilitation and a number of comorbid conditions. Physiotherapy efficacy (PE) was determined on the basis of the difference between functional status on admission to the ward (BI0) and after a month of stay (BI1). On the basis of the difference between the result GDS0 (upon admission) and GDS1 (after a month stay at the NH), a mood improvement (MI) parameter was determined.

In a comparative analysis of the experimental and control groups, the Student’s t-test was used for independent samples, and in assessing the significance of changes observed in a period between the initial examination (at baseline) and end examination, Student’s t-test was used for dependent samples. For the assessment of categorical attributes (education, marital status, family caring capacity, etc.) a non-parametric test for independence, Pearson’s chi-square ($\chi^2$), was used. Correlations of research results were calculated using the linear Pearson’s correlation coefficient (r).

### Intervention

The basic assumptions and the general framework of a 4-week long treatment were as follows. In the first stage (about 2 weeks), patients get to know each other, talk about their illness, about the causes of their disability (stroke, fracture, chronic illness, etc.), also about their family situation. Aim was to establish a group relationship, reduce isolation and loneliness and build a sense of community with other people in similar circumstances. Patients are encouraged to express the emotions they are going through, to speak of their helplessness in the face of being treated like an object by medical personnel, anxiety about the future, lack of hope for improvement and so on. Aim was reduction of mental tension, discharge of accumulated emotions. At this stage of therapy, the primary medicinal factors are: group bond, catharsis and distraction from own problems when listening to others talk. An important factor here is also a relationship with a therapist, who mainly tries to adjust emotionally to patients, to fully see their situation, show empathy and respect for their suffering. During this time you cannot yet talk about improved mood, rather about preventing further deterioration, obtaining relative mental stability. This allows for a faster adaptation to the hospital environment, greater willingness to establish positive relations with the centre’s staff and undertake rehabilitation.

In the second stage (next 2 weeks), the therapist takes on more initiative and becomes more directive in his approach, focuses the attention on things that can improve patients’ situation “here and now”, reduce their suffering and ease functioning at the NH. At the same time, more and more attention is being given to modelling the right attitude of patients in the rehabilitation process, encouraging greater independence in activities of daily living. During this time, patients are given a list of five (developed by a physiotherapist) simple exercises to do independently in their free time after therapy. During the session, they discuss how many repetitions they are performing, what does it do to them, how could they benefit from it in the rehabilitation process. The more motivated, active patients become role models for others; they themselves get extra gratification in the form of praise from therapist and admiration from the group. The moment the first successes of particular individuals appear (e.g. first stand-alone steps), they are discussed during the session (“What has helped you to achieve such success?” “What does it mean to you?” “What do you want to achieve now?”). Example of other patients who are clearly improving their performance gives hope to other people, shapes the behaviour and proper attitude towards the rehabilitation process. The purpose of this step is to reduce passivity of patients, developing a sense of responsibility for the effects of rehabilitation, strengthening hopes for the success of rehabilitation.

In the final phase of the treatment, group attention is directed first of all to the future. The following questions arise: “What skills related to activities of daily living must I achieve in order to return home?”, “How and who can help me in my own home environment?”, “How can we best prepare for going home?”, “What will my day look like everyday?” “What work have I still got to do, what things do I want to do after leaving the care centre?” “What steps to take to prevent social exclusion?”, “What can I do to better care for my health and physical mobility in the future?” Directing attention onto the future is at the same time a “sowing” of the idea that rehabilitation will end successfully, and soon the patient will be discharged, but he must prepare for it well. This type of intervention is also to increase a sense of control over one’s health and life. An invitation to one of the sessions of a patient who had successfully completed the rehabilitation process and is going back home is also an important event. It tells about how the patient was able to achieve such success, what helped him, what speed up this process and what are the plans for future. The presence of this person is a strong reinforcement of earlier therapeutic interventions.

Basic assumptions of the undertaken therapy have been presented above; however, we need to stress again that a very important curative factor here is a therapeutic relationship, sincere interest in problems and feelings of patients who are more important than a rigid observance of a timetable and therapy schedule. The therapist must above all be attentive and open to
what the patients themselves bring to the session at a particular
time in order to be able to utilize their energy for achieving the
main goal of therapy. This way the therapist provides corrective
experiences to patients who up until now came across objectified
treatment from the medical staff, who generally ‘knew better
what is good for the individual’, and pursued their own goals
without considering whether they are consistent with the needs of
patients. The setting was fixed and unchanged: 4 times a week, for
1.5 hours, in closed groups of 6–8 people. The therapy is run by
two people, where the second acts as co-therapist providing
feedback on the course of the process of therapy. None of the
therapists know the results of tests on cognitive functions of
patients (all diagnostic tests were performed by clinical psych-
ologist not involved in the course of therapy, and it is the
psychologist who qualifies patients for the treatment). Otherwise
there is a risk that people with impaired cognitive function will be
(even subconsciously) omitted by the therapist or treated with less
commitment.

In every week of therapy, during one session there is a
physiotherapist involved who runs the patient’s rehabilitation,
who provides information on a particular person’s functional
status and progress of rehabilitation. The physiotherapist also
helps set realistic and measurable goals for a particular phase
of rehabilitation (in the coming week, two weeks at most).
An important task of a physiotherapist is to emphasize on the
group’s forum even the smallest successes achieved to date by a
particular person, appreciating the patient’s effort and commit-
tment to the rehabilitation and encouraging greater independence
in the activities of daily living (within safe limits set individually
for each patient).

Results

Among patients who have met inclusion criteria for the research
project, a mean GDS-15 score was 8.1 (±3.0) on admission to the
ward. Seventy-five percent (2128) of respondents obtained a
result (GDS-15) above 5 points, suggesting presence of mood
disorders and 39% (1128) obtained a result (GDS-15) over
10 points, confirming the presence of severe depressive symp-
toms. Mean MMSE score was 23.1 (±3.7) and 54% (1528) of
respondents obtained a score of MMSE≤24 points, suggesting a
presence of dementia. In the case of 54% (1528) of patients, mood
disorders and dementia (MMSE<24) coexisted.

Study group versus control group

At the time of admission to the rehabilitation ward, both groups
were comparable in terms of all of the examined socio-
demographic and clinical parameters (Tables 1 and 2A). After a
month of treatment, the study group reported significantly less
severe depressive symptoms (p<0.001), higher MI (p<0.001)
and higher PE (p=0.043) (Table 2B). Improved well-being
observed in the study group was four times higher as compared to
the control group (5.08 versus 1.27). In the experimental group at
baseline (before psychotherapy), 38% (513) of people obtained a
score pointing to the presence of severe symptoms of depression
(GDS ≥10); after one month of therapy nobody did. In the control
group, on admission 40% (615) of people achieved a score of
GDS ≥10, and after one month of rehabilitation, 20% (315) of
patients still felt severe symptoms of depression.

Physiotherapy efficacy in the experimental group was almost
two times greater than in the control group (19.23 versus 11.00).
All persons within the study group had after one month of
hospitalization a PE greater than 10 points. Whereas in the case of
20% of the patients in control group, no improvement in physical
performance was reported, or it was less than 10 points. In the
with psychotherapy, 38% (513) of patients achieved a score

<table>
<thead>
<tr>
<th>Type of disease</th>
<th>Control group (n=15) (%)</th>
<th>Experimental group (n=13) (%)</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthopedic injuries</td>
<td>33</td>
<td>38</td>
<td>0.879</td>
</tr>
<tr>
<td>Stroke</td>
<td>40</td>
<td>31</td>
<td>0.471</td>
</tr>
<tr>
<td>Chronic diseases</td>
<td>27</td>
<td>31</td>
<td>0.472</td>
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<tr>
<th>Education</th>
<th>Control group (n=15) (%)</th>
<th>Experimental group (n=13) (%)</th>
<th>p Value</th>
</tr>
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<tr>
<td>Elementary and vocational</td>
<td>40</td>
<td>38</td>
<td>0.986</td>
</tr>
<tr>
<td>Secondary</td>
<td>40</td>
<td>38</td>
<td>0.475</td>
</tr>
<tr>
<td>Higher</td>
<td>20</td>
<td>24</td>
<td>0.476</td>
</tr>
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<tr>
<th>Marital status</th>
<th>Control group (n=15) (%)</th>
<th>Experimental group (n=13) (%)</th>
<th>p Value</th>
</tr>
</thead>
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<tr>
<td>Single</td>
<td>27</td>
<td>23</td>
<td>0.945</td>
</tr>
<tr>
<td>Widows</td>
<td>40</td>
<td>46</td>
<td>0.479</td>
</tr>
<tr>
<td>Married</td>
<td>33</td>
<td>31</td>
<td>0.480</td>
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<th>Family caring capacity</th>
<th>Control group (n=15) (%)</th>
<th>Experimental group (n=13) (%)</th>
<th>p Value</th>
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<tr>
<td>Lack of care</td>
<td>13</td>
<td>15</td>
<td>0.947</td>
</tr>
<tr>
<td>Incomplete</td>
<td>60</td>
<td>54</td>
<td>0.482</td>
</tr>
<tr>
<td>Full</td>
<td>27</td>
<td>31</td>
<td>0.483</td>
</tr>
</tbody>
</table>

Table 2. Comparison of control and experimental group at baseline (A) and after 3-weeks treatment (B).

<table>
<thead>
<tr>
<th>A</th>
<th>Experimental group</th>
<th>Control group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mean SD</strong></td>
<td><strong>Mean SD</strong></td>
<td><strong>t</strong></td>
</tr>
<tr>
<td>Age</td>
<td>76.87 5.45</td>
<td>77.38 6.06</td>
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<tr>
<td>Comorbidities</td>
<td>4.73 1.44</td>
<td>4.92 2.40</td>
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<tr>
<td>MMSE</td>
<td>23.20 3.59</td>
<td>22.92 4.01</td>
</tr>
<tr>
<td>GDS≤10</td>
<td>8.07 2.89</td>
<td>8.23 3.24</td>
</tr>
<tr>
<td>BI≥10</td>
<td>41.67 16.87</td>
<td>39.23 15.25</td>
</tr>
<tr>
<td>B</td>
<td>Experimental group</td>
<td>Control group</td>
</tr>
<tr>
<td><strong>Mean SD</strong></td>
<td><strong>Mean SD</strong></td>
<td><strong>t</strong></td>
</tr>
<tr>
<td>GDS≤10</td>
<td>7.00 2.80</td>
<td>3.15 2.27</td>
</tr>
<tr>
<td>BI≥10</td>
<td>52.67 14.74</td>
<td>58.46 15.86</td>
</tr>
<tr>
<td>MI</td>
<td>1.27 1.49</td>
<td>5.08 2.50</td>
</tr>
<tr>
<td>PE</td>
<td>11.00 8.28</td>
<td>19.23 12.05</td>
</tr>
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</table>

Discussion

The experiment in question refers to a study published in 2010
[5]. It was found that in the case of one-third of nursing home
patients PE was very low. Regardless of the type of disease being
the leading cause of rehabilitation, psychiatric disorders had an
adverse impact on the course of rehabilitation. An increased risk
of psychotherapy failure in nursing home conditions was observed
in patients with severe depressive symptoms and cognitive
impairment [5]. The results of this study show that mood
disorders and cognitive function disorders are very common in
this specific group of patients. In 75% of patients, depressive
symptoms have been identified, and in 54%, mild or moderate
dementia. In the case of 54%, both mental problems coexisted.
At the same time other researchers confirm that anxiety disorders

Table 1. Comparison of control and experimental group (baseline measurement). Socio-demographic characteristics.
and cognitive problems are the most common mental health problems in older people who are subject to long-term care [20,21].

Regardless of the presence of psychiatric problems, every elderly person, who as a result of disability require round-the-clock, long-term hospitalization in the first days/weeks of their stay at the ward, feel strong distress because of their isolation from loved ones and their natural environment as well as the necessity to adapt to new conditions. Depending on the personality of the patient, earlier life experiences, acquired skills in dealing with difficult situations, and the pace of adaptation differs, and the accompanying feelings are less or more dramatic in intensity.

It was found that the first few weeks of hospitalization are crucial to a further progress of rehabilitation. Patients who in the first month of stay in NH achieved improved physical performance of less than 10 points in the BI also marginally increased their functional status after 3 months of rehabilitation. Thus, PE after the first month of hospitalization is an important predictor of the course of further rehabilitation [5]. Therefore, the experiment’s preliminary results obtained seem to be very interesting.

In the group subject psychotherapy in the first 4 weeks of hospitalization, the efficacy of psychotherapy was almost two times greater as compared to the control group. It should be noted that the pace of psychotherapy was assessed using the BI, which detects distinct changes in the functional status of a disabled person related to the most important areas of everyday functioning (washing, dressing, using the toilet, moving around, eating meals, etc.). Therefore an observed improvement on this scale shows a significant increase in self-sufficiency, and it’s certainly also noticed by the patient or by his caregivers.

The analysis of results obtained leaves no doubt that high PE in the experimental group had a close relationship with the observed improvement in mood. However, improvement in mood alone is not enough to initiate significant changes in such a short time, especially in the area of self-sufficiency, because life circumstances (age, fatigue, disability) predispose these people to passivity and helplessness. Expecting help from both family and staff is a way of making up for emotional deficits, it induces closeness of other people (even if only formally) and reduces the feeling of loneliness. It appears that in the initial period of therapy the need for closeness and a reduced sense of helplessness are most important. Results of studies of other authors have shown that a high level of helplessness at the beginning of treatment is a significant predictor of changes in the process of psychotherapy [22]. It seems that the increased helplessness at the beginning of treatment may be interpreted as a weakness in the face of health problems and life situations but not as a lack of motivation for the therapy.

When the group bond fills up the emptiness and loneliness, a good situation is created to change the attitude of patient. It is only then that both the psychotherapists and physiotherapist invited begin to model the attitude of patients. They are motivated to be more active, to self-care for one self and to commit to the process of rehabilitation; in exchange for their efforts they receive gratification in the form of interest, praise and admiration on the part of therapist and the group. Of course, these measures can be effective, provided that the base in the form of a strong therapeutic relationship, group bond and cohesion had already been built.

Encouraging patients to be independent and active is an important element of this treatment, because earlier studies have shown that the ability to be active is a strong predictor of changes in the process of psychotherapy [22].

The inclusion of an intensive group psychotherapy in the initial period of stay of patients in NH decreased crises associated with the need to adapt to new conditions and subsequently improved mood of the hospitalized elderly. This allowed for quick establishment of active cooperation with the staff and a taking on by the patient (at least partially) of responsibility for the effects of rehabilitation. Such attitudes positively affected the interaction between physiotherapist and patient and enabled more effective use of available time. Additionally, during the psychotherapy sessions the patients were motivated to perform (in their spare time) additional sets of exercises. It should be stressed that the amount of psychotherapy was not increased under the experiment, and the actions taken were intended to maximize the involvement of NH residents in the rehabilitation process.

The results show that short-term group psychotherapy can be an effective method of supporting the process of rehabilitation of older disabled people staying temporarily in NH. Long-term observation will help answer the question of whether improvement of PE in the first month of hospitalization will also increase (as we assume) the pace of psychotherapy in the coming months of hospitalization, and thus shorten the patients’ stay in the facility.

Nevertheless, the role of group psychotherapy carried out in NH conditions is not limited only to an increased efficacy of psychotherapy. Therapists’ observations of patients can be very helpful in the subsequent care of them. Many benefits arise from both the collaboration with a physician [23] as well as with the remaining staff (physiotherapists, nurses, occupational therapists, carers). Identifying areas in which a person needs more care and defining its specific needs allows that person to be better cared for in the process of treatment and rehabilitation. Moreover, patient’s improved mood, reduced mental tensions and greater independence in basic daily living activities – all achieved through psychotherapy – reduce the number of care problems and positively impact on relationships with staff. Considering the fact that staying in such facilities lasts for up to several months (usually away from home, family and friends) the relationship with personnel can be an important factor affecting the quality of life of older people.

Conclusions

The studies performed revealed that mood disorders and cognitive function impairments are common in older disabled people rehabilitated under NH conditions. In most cases, both these problems coexist. In the study group, a four times greater improvement in mood and two times greater effectiveness of psychotherapy have been observed as compared to the control group. The obtained results suggest that short-term (4 week) group psychotherapy can be an effective method of supporting the process of rehabilitation of older disabled people, both cognitively intact and cognitively deteriorated.

Limitations

The described study has several limitations (sequential design, small sample size, no calculations for the sample size needed for the questions posed and the measurements used). Therefore, further studies are necessary. We would call this project a promising pilot study that needs replication with a tighter design and a larger sample.

Declaration of interest

The authors report no declarations of interest.

References


