

Horticultural Therapy in a Psychiatric Hospital: Picking the Fruit

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INSTITUTIONAL SETTING

Langenfeld “Country Hospital” is a psychiatric state hospital for treatment of most psychiatric disorders. It lies in West Germany and is well known for some innovations. Each patient is “faced” by a medical service team, consisting of nurses, physicians, a psychologist, a social worker and a work therapist. In Germany, horticultural therapy is classified as a form of work therapy.

Horticultural Therapy—A Prescriptive Tool

Horticultural Therapy is prescribed by the ward physician or psychologist for rehabilitative reasons (22%) or simply to help structure the patient’s daily routine (78%). Twelve of our 40 wards prescribe horticultural therapy. Therefore, a regular consultation of all participants is hardly practical. As a horticultural work therapy unit, however, we have lots of time to spend with each patient—between two and six hours daily, depending on our contract. Three horticultural therapists care for up to 15 patients. Beginners receive special attention for diagnostic purposes. We produce vegetables and sell them. The work style is mainly task and group oriented.

The diagnoses and the underlying impairments of the patients are distributed as follows (based on 280 patients): schizophrenic and other non-organic psychoses, 62%; neuroses and personality disorders, 16%; alcohol and drug abuse and connected disorders, 13%; borderline, 5%; mental retardation, 4%. Underlying the clinical descriptions are a

multitude of problems or impairments, whereof matters of relation and contact are predominant.

My focus in this article is on the 10% of patients who see their stay in the hospital as a chance; they are willing to cooperate to find a solution of their problems. My idea is that the hospital can provide the time and the opportunity to look at these problems. Work in the garden, where growth is a tangible topic, provides a great chance for people with developmental deficits. There is also a chance for contact-impaired patients who work in the garden, where nothing comes off without “handling“ it.

The First Steps

Each patient who is prescribed horticultural therapy has an initial interview. I receive a survey of the patient’s life, which can be relevant for the therapeutic process. We make our first contact and look for decisive situations, (which can give me a clue for treatment applications). This procedure is the same for every patient, and reveals the patient’s willingness to cooperate on his problems.

Specific Goals

The specific goals of the horticultural therapy are as follows:

1. responsibility, communication skills, better response to work obligations, improved contact, and capability to maintain it;
2. continuity, perseverance, and stamina;
3. recognition that work cannot be delayed;
4. development of new preferences and interests;
5. discover of acceptable ways to reduce stress and tension;
6. acceptable behavior;
7. maintenance of personal boundaries, one’s own and other’s;
8. capability of keeping contracts;
9. adaptability to work and other rhythms.

THE GARDEN IN A FIGURATIVE SENSE—THE USE OF METAPHORS

Before I outline the application and implications of metaphors, I want to mention the methods we use.

Our Choice of Methods

The basics of our program are as follows:

1. a preliminary interview with the patient and the physician/psychologist to share ideas, goals, and interests;
2. an agreement between the patient, the horticultural therapist, and the physician/psychologist (a contract);

3. regular meetings and the readiness of the psychologist to be available for crisis intervention.

My own education is humanistically oriented and so are some of our methods, which include Carl Rogers' "self-concept" and therapeutic attitudes; the movement-oriented Gestalt therapy with its "figure/ground," "inner dialogue," and ego-boundary concepts. The idea of a "farm-organism" and a specific approach to the human-plant relation come from the anthroposophical background of the biodynamic gardening method we use.

Our aim is similar to that of "cognitive therapy": to help change verbal and pictorial cognitions and the premises, assumptions, and attitudes that underlie the cognitions. Goals and expectations should be realistic. We do not try to change the patient's personality, values, or lifestyle.

My Point of View

What I mostly look for is how the patients move and how they use their hands and feet. Movement tells a lot about how the patients handle other issues and how they make contact. The right task for each patient is the one with which he/she can identify. Because our patients have seldom been content or seen themselves as identities in the recent past, we reinforce them if they are whole-heartedly engaged in their work. We also need to know whether what they do matters to them. They then will tell us what comes next. They set the pace. They map out the space they want to explore. I reinforce their experimenting, and in the course of our communication, I recognize how "response-able" they are.

Metaphors as a Bridge

Every patient has had to face changes in the past with which he/she could not cope. Connections can easily be made to gardening, where everything is constantly changing (in a less emotionally confronting way). Here plants are sown, they grow and die; each seedling needs a good contact (with the earth)—must be firmly grounded—and must be well rooted in order to grow healthy and steadily.

So we have two sides to connect, the patients' on the one side and the "plant-iful" job on the other: here is where my "thinking over" begins, in order to bridge the gap between the patient and the garden. The garden has always been a rich source for metaphors that need only to be detected and made available for therapeutic gardening. The metaphor needs to have a meaning for the patient or else it does not work.

For example, I let a certain woman in our program weed. (Weeding is a kind of sorting out, which helps the patient identify herself with the performance.) When I then asked what she was doing, she said that she was only scratching the surface. She named the movement and dropped a hint as to what extent she was involved. When I asked if that had a meaning for her life back home, she answered that she did nothing else (than scratch the surface). I told her to go on weeding with the same movement; no changes. As she was moving the soil, she could see a result. Her biography revealed that she had difficulties recognizing that what she said or did really mattered. That is why every activity in the garden is so precious. Patients can come into contact with issues they have forgotten. They themselves are able to discover parallels between their own problem and the situation in the garden. It is a perfect place to visualize and experience, to plan and to gain practice. The key to personal metaphors lies in the movement, or Gestalt, that can be developed out of a specific job at a certain moment. The patient must be open, however.

Here we have another element of therapy, the timing of the therapeutic intervention. The patient must be prepared and be ready to see the "open door," and they must be willing

to give it a try. In order to explore “the field” we can bring the patients’ impairments face to face with a helpful activity. By helpful, I mean activities in which the patients can find the insights themselves. In this way, the job can work as a change-inducing “eye-opener”. It is extraordinarily helpful if the psychologist touches intentionally or casually the same issue (reinforcement). On the other hand, the patients can “work themselves through”; they can physically work out a problem that they have faced in a therapeutic session.

When we seek “the right work” for a patient, we have some key situations in mind. The patient will decide if he/she is ready to make use of the opportunity. I would like to illustrate this by an example. I had a therapeutic session with a very resistant woman and the psychologist. The issue was her auto-aggressive behavior (cutting herself). I had the idea that her behavior might be connected with her feelings when she felt stuck and others did not help her out. I wanted to know how (not why) she did the cutting at her forearm. In that way, I brought her into contact with her feelings and with what she did with her hands. She was astonished and moved. We all felt that we could not change anything by mere talking.

I went back to work with her. She had not gained a clear result from the session other than a heightened awareness of her hands. I suggested that we pick tomatoes together and hoped that the activity would yield some profit in addition to the picked fruit. She began talking to me. When she stopped (talking and harvesting), I asked her just to go on harvesting and to “concentrate on the tomatoes.” She continued talking to me. She had never before seen her situation so clearly. Without further directive intervention, her ability to express herself grew and her “response-ability” rose. It was amazing how her inner development became apparent. Within seven weeks she could be discharged.

My intention was to bridge the gap between images and reality by using metaphors in Horticultural Therapy. Used carefully, they prepare “food for thought”—something that the patients deserve, too.