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Psychodynamically-informed discussion groups on acute inpatient wards

Jonathan Radcliffe[1] and Debora Diamond[2]

***Abstract**: This paper outlines the use of weekly psychodynamically-informed groups on inpatient acute wards. The authors run inpatient groups with nurses as co-therapists. The structure of such psychodynamic groups is outlined along with the use of 'here and now' interpretations and enactments. Psychodynamic concepts such as projection, denial and counter-transference are described and their use in working with paranoia and grandiosity. The authors illustrate the use of these concepts within their groupwork and provide case material that shows how these concepts can be applied in the inpatient setting.*

***Keywords**: groupwork; inpatient; group psychotherapy; psychodynamic; psychoanalytic; enactments*

1. Consultant Clinical Psychologist, Lewisham Psychological Therapies Service, South London and Maudsley NHS Foundation Trust

2. Consultant Counselling Psychologist, Plymouth Teaching Primary Care Trust

***Address for correspondence:** Jonathan Radcliffe, Consultant Clinical Psychologist, Lewisham Psychological Therapies Service, Ladywell Unit, Lewisham Hospital, London SE13 6LW. Jonathan.Radcliffe@slam.nhs.uk.*

A psychodynamically-informed therapy group on acute wards

From as early as 1921 group treatments were advocated as beneficial to the well-being of psychiatric inpatients (see Lazel, 1921). Since the 1950s the emphasis of psychodynamically-informed groups has been on patients' concerns in the here-and-now of interpersonal relationships. Work in the group has been seen to have a positive impact on relationships elsewhere in hospital (Frank, 1963, p.467). The authors hope to show how psychodynamically-informed groupwork can be used to help patients talk about and understand their problems. The aim is for patients to engage with each other and the therapists, to tell their story, think about what has happened and try to make sense of things. Problems and preoccupations are explored and there is a chance to talk about being in hospital. The content of the discussion is left open, but patients are encouraged to talk about their thoughts and feelings as well as their experiences. The therapists try to link the interpersonal with the intrapsychic and to help patients see connections between the two.

Bion's concept of containment provides a useful conceptual framework. Bion (1967, p.104) describes the infant projecting its disturbing indigestible feelings into its mother. The receptive mother allows herself to take-in and be disturbed by the projections, tolerating their disturbing effect, processing their meaning and offering some response that makes the infant feel contained. Patients who have broken down have by definition been uncontained by their environment in the face of unmanageable stress. Bion (1968) described how groups can offer containment if uncomfortable or disturbed states of mind can be sustained long enough for thinking to take place, as opposed to action. For this to occur staff must be interested in and curious about patients, and allow themselves to be disturbed by their interactions with them. Patients must allow themselves to be known. If containment is successful then patients can think about previously indigestible experiences, and adopt interest and curiosity in the contents of their own minds instead of trying to get rid of them. Institutional and individual defences may make workers less receptive to patients' disturbing projections (Menzies-Lyth, 1968). However, in addition to physical and chemical containment, well-functioning wards can offer patients emotional containment, and therapeutic groups can form a part of this.

Structure of a psychodynamically-informed inpatient group

The authors run a weekly hour-long group co-facilitated by a ward nurse. Support from senior staff such as the ward manager and senior doctors is invaluable in creating time and space and encouraging patients and staff to value the group. To provide containment, sessions start as near as possible on time, are held in the same place each week and are protected from interruptions. Over time the group can become a part of the ward culture, and a bank of nursing staff who have attended as co-facilitators is built-up and becomes a bridge between group and ward. Preparation and debriefing are vital, especially when establishing a new group. Once established, the routine is to go to the ward at least 20 minutes before the group. A ward nurse then goes round the ward encouraging patients to come, explaining that the group is a chance for them to talk about their experiences. The therapist acts as backup to the nurse during recruitment to encourage people to attend. The numbers attending range from one to nine with an average of four or five. Once in the room, after introductions each patient is asked how things are for them, and they are encouraged to find their voice in the first 20 minutes by saying something about themselves. The therapists regulate this process ensuring that each person does not talk for too long and everyone gets some time, for example saying 'that sounds important, we can come back to that'. There follows a freer, explorative period when the hope is that people will share more of themselves and interact with each other. This is new for some people who will need to learn to be in a group, and for that they need to feel safe and contained. Some will need gentle encouragement to talk.

More disturbed patients need to go at a slower pace. Yalom (1983) and Kanas (1996) recommend two levels of groups according to level of functioning. Although homogeneity has many advantages, it is possible to run a single weekly group which is open to patients of varying degrees of functioning. Whilst trying to maintain an atmosphere of thoughtful reflection, the group therapists may have to be assertive to manage the problem of patients who persistently interrupt or make personal attacks. On occasion this can mean asking them to leave. The therapist is far more active than with outpatient groups where there is time for issues to emerge and be dealt with by the group. The approach in each

session varies according to how many people are in the group, their personalities, the levels of functioning and disturbance, how well they know each other, how new they are to the ward, the ward atmosphere and so on, and a looseness of style is needed.

Here-and-now interpretations and enactments

Conflicts that take place in the group are seen as an externalisation of an internal conflict, and can be helpful when kept within manageable limits. The therapists try to step back to observe interactions. Although the full force of the encounter must be experienced first, it may then be possible to comment on what has happened in a way that makes sense to those involved. This can include making links to what has been happening on the ward, outside hospital or in the past. Links can provide continuity and context. The emotional atmosphere and the counter-transference effects patients have on each other and the therapists are closely attended to. A common response is for therapists to find themselves looking after one patient and neglecting another. In each case, the feelings evoked are a clue as to the defensive structures operating.

Whilst the therapists are highly active in conducting the group and may have potentially useful insights to offer there is a danger of trying to have all the answers. Many inpatients have lost confidence in themselves and project strengths and resources into professionals, but providing ready answers does not help patients move on from dependent states. The therapists therefore encourage patients to work at problems themselves, as well as offering their understanding when it seems helpful. Hearing from patients about their history together with information learned beforehand from other hospital staff enables psychodynamic formulations to be developed. The more that is known in advance or from the patient, the better, as patients may only attend once or twice.

A hospital admission represents a breakdown of normal defences and coping strategies because a psychic conflict has become so great that the patient has become unable to function independently. The therapists try to help patients express and acknowledge their feelings, look for meaning and communicate something of their internal world. When it

is functioning well, the group becomes a meeting place of internal and external worlds. A session may focus on inter-personal relationships within the group and on the ward and may be enough to offer the patient an increased sense of hopefulness. At other times it is possible to demonstrate the benefits of exploring feelings of anxiety, sadness, emptiness or rage as well as memories and psychotic symptoms. The task is to join together with each patient in struggling with some aspect of their internal world, bearing in mind that conflicts have become unconscious because they are disturbing. The hope is to help patients sustain feelings that are normally avoided through projection, action, drug-use, mania etc. Inevitable enactments in the group come under scrutiny and are commented upon when they are alive in the here-and-now in relation to other patients or the therapists.

Engaging with problems and emotions is difficult work for people in an acute state. Some may feel that this is too much, rationalising that it is better to 'be positive', 'look to the future', 'trust in God', or deny that they have got a problem; 'it's just you lot keeping me here'. Defences can be seen operating in quite a clear form in the group. Denial of the painful knowledge of an illness and its ramifications is common. Excessive activity or talk may also be used avoidantly. Mania is seen as an avoidance of underlying depression, disappointment or emptiness (Abraham, 1924). Psychotic grandiosity may be used to deny the real internal situation of feeling powerless and insignificant. Destructive feelings are seen as central to many depressive and psychotic breakdowns. When conflict becomes excessive and the person has insufficient internal resources to cope with it, there can follow a split. Parts of the self are split-off and projected out onto the environment or other people who are then experienced as persecuting them, causing paranoia, or they are experienced as persecutory voices coming from inside the head. At this point in time the person cannot integrate the different parts of the self because the conflict is too great and prevents them from functioning. In 'Mourning and Melancholia' (1917) Freud describes the impact of the loss of a previously loved person. The melancholic redirects the aggressive attack away from this lost person onto the self, resulting in depression. In the group patients at times can reconnect emotions with people in the past or outside hospital, although usually only if they come for several sessions. It must be emphasised that interpretations are only offered when a therapeutic relationship has

been established, as the following case examples illustrate. It should also be pointed out that although the examples may give the impression of order and insight, order and insight are by no means always present. A good deal of time is spent trying to engage people in talking and thinking without necessarily achieving much more, which with this client group is a very useful achievement in its own right.

Projection and denial

The following is an example of therapists starting to pick up on the types of defences that are operating in a patient coming to his first group session.

> Olu said that he had been upset the previous day but it was the fault of the system rather than any of the doctors or nurses. On enquiring, Olu explained that he had made several complaints to the unit's manager about various matters. Although Olu reported these in a reasonable, business-like manner, the therapist felt there was more feeling behind what was said than was being directly expressed. The therapist said that perhaps Olu was annoyed about being in hospital and with his consultant for putting him there. When Olu denied this the therapist said that Olu may not want to experience such feelings, and Olu agreed with this. He said that he was trying not to have bad feelings but this was not working. For instance, yesterday he had wanted to see his consultant in the ward round but was not called. Another patient with him was called instead. It seemed from what he said that he was trying to be cooperative but the result was that he was ignored. These snippets hinted that tremendous resentment and hatred were being experienced towards powerful feared external figures in authority. The group potentially could provide Olu with a space to think about these feelings more directly rather than making official complaints, which was action. Had more time been available, we would have tried to understand these in the context of what was going on in his current relationships and in his past.

Enactments

The concept of the unconscious marks out the psychodynamic approach. A unconscious conflict that is often enacted is when a patient angrily protests about being in hospital, runs away, refuses his medication and uses illegal drugs. His behaviour could almost be designed to result in him staying for longer, and one explanation is that it is, and that beneath his conscious wish to get away is an unconscious wish to remain.

The psychodynamic understanding of human behaviour is rooted in a developmental model. Serious problems that occur during childhood development create a vulnerability to later breakdown. Hospital represents a regression, a returning to a dependent state which is similar to being a child. Recovering involves gradually regaining adult coping resources. Being looked after and kept safe frees the person up to be able to concentrate their resources, which can make it possible to look at some of the intensely anxiety-provoking feelings that caused the breakdown. Unconscious internal representations of people colour perceptions of others we relate to in our daily lives. Personality-forming early relationships are internalised and transferred onto new relationships and internal conflicts are played out in relation to external people representing the internal world. Unconscious conflicts are therefore experienced interpersonally and these can be seen in inpatients' relationships on the ward and in the therapy group. A nurse becomes a caring mother-figure who will look after the patient whilst at another time they become a neglectful, uncaring mother. The consultant may be a strict, judgemental father-figure or at other times, a kindly supportive one. Fellow patients may be related to as siblings or partners. The group provides a space where interpersonal relationships can be thought about in relation to internal conflicts and breakdown.

> Emma was physically small and had learning disabilities. She also suffered from sickle cell anaemia which necessitated periodic hospitalisations. She was admitted to the psychiatric unit after smashing up her home. Whilst on the ward she fixated on an older female patient (who was also a group member) and she often went into her room and searched her belongings. In the group a furious argument immediately broke out between them, presenting significant management problems for the therapists, which could also be described as complete chaos. In successive groups one or

other patient stormed out. When present, Emma monopolised the space stirring up powerful resentments. The first author found himself giving her an undue amount of attention to keep her there which annoyed other patients to the extent that several walked out. This signalled that something unhelpful was being enacted; it took time to work out what this was.

Emma's main preoccupation in several groups was cigarettes. She explained that her mother entrusted small packs to the ward nurses to dole out to her. She constantly felt needy and deprived of cigarettes, which seemed to symbolise a general emotional neediness. Sometimes she gave cigarettes to other patients in the hope that they would return the favour, causing all kinds of problems as she constantly felt that they had more than her. We wondered why she did not keep her own cigarettes. Emma explained that her mother did not trust her and Emma felt that her mother was right. A picture was building up of a learning-disabled ill child who felt needy and deprived in relation to others, and who had got very angry about something which other people had which should be hers. Over several group sessions we learned that Emma had remained relatively dependent whilst her siblings grew up and started their own families. She explained that she had lived independently for several years but she had been feeling unsafe on her own in her home and a drug-addict friend had been exploiting her and giving her crack-cocaine. The situation had escalated until she had smashed up her home and was admitted. The therapists understood this as a self-destructive attack on her independent self. On the ward, she had an envy of other patients who she felt had more resources than her, especially those who were kind to her. They became the envied siblings who she tried to steal things from. The nurses became the parental figures who continued to treat her like a child, which her mother had always done. Hence Emma transferred onto the other patients and nurses relationships within the family and in the group she tried to 'gobble up' all the therapists' time and space. We gently put these ideas to Emma. In the remaining weeks of her attendance she became less demanding and more able to listen and think about her future.

Emma's case is an example of behaviour on the ward spilling over into the group, where it can be thought about.

Working with paranoia

A large proportion of our acute inpatients are anxious or paranoid. Freud (1894) described a process whereby paranoid patients project their own aggression outwards onto their environment. Some reality testing can be helpful, for example when patients are anxious about what is going on in the room. On the whole, however, it is more fruitful to try to look at the angry or aggressive parts of the self that are being dealt with through projection and link these to what has happened in the patient's life.

John was a passive, compliant patient. In the group he listened quietly without making any demands but cooperated when invited to speak. He had been admitted to hospital after climbing onto the roof of his house and throwing tiles at people below. The therapists were aware from nursing staff that John's wife was divorcing him, making him leave the family home. When they raised this with John, he denied feeling angry or bitter towards his wife. Instead these feelings were expressed towards the vindictive and unpleasant people who were out to get him. In this case, our formulation was that John was denying his angry attacking feelings towards his wife, and projecting an attacking aggressive part of himself onto the environment, creating sinister forces that then frightened him. He felt angry and anxious that he was being victimised by these forces. We asked John to tell us about his background. John described an unhappy childhood during which he was brutally beaten by his stepfather whilst his passive and depressed mother looked on.

John took to walking out of hospital and going home, where his wife would phone the hospital or police to take him back. Hospital was preferable to dealing with the hurt and pain of rejection by his wife and his consequent homelessness. He had learned indirectly that she wanted to get rid of him because the nurses told him that was what she had said. However, she had said to him that she did not want him to leave, according to the nurses because she did not want to disturb him further when he was ill. John attended several groups and was able to see links between his early experiences of violence in his family and his paranoia that others wanted to kill him. Over the course of time, he came to acknowledge that he was somewhat angry with his wife although he never acknowledged the extent of his despair about the ending of his marriage.

Grandiosity as a defence against powerlessness

Alice was a Caribbean woman in her 60s who said she was Jewish, Scottish, had a special relationship with Cliff Richard and was due to have tea with the Queen. She came to several groups and mainly listened. When she did speak her strong accent made her sometimes difficult to follow by patients from other cultures, and she used a somewhat relentless tone of voice. The therapists noticed after a while that she had said little about herself, and so invited her to say more. She then described a history of early deprivation and trauma including the murder of her father. She was now living on her own after decades working as a cleaner. Her husband had left and her daughters had their own families. Apparent was the stark contrast between her delusion of being of different races which we believed that she associated with high status, of mixing with admired and respected celebrities, and her internal reality of feeling abandoned and unwanted by her family after so many years of hard work. These interpretations were gently made. This, together with the attention paid to her, seemed to make a huge difference to her interactions within the group. Unlike many patients who can feel annoyed when their symptoms are interpreted, she acknowledged what was being said.

Conclusion

The case examples illustrate that acute psychiatric inpatients can engage in psychodynamically-informed groupwork. The group necessarily falls short of the ideal of working, thinking and achieving understanding of the problems that bring people in. And yet it can manage to deliver some quite profound insights to some patients. Our experience is that patients often want to explore their emotions and important events which have led up to their breakdown. As well as being a forum for the discussion of issues related to living on a ward, the group provides a medium for looking at symptoms and feelings which potentially can be thought about in relation to early and current relationships and experiences. Where possible this work can then be continued after discharge.

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