

Inpatient groupwork: The groupworker as consultant to the group

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Abstract: This paper introduces a model of inpatient groupwork, where the groupworker acts as consultant to the group facilitators. Based loosely on Yalom's model of inpatient groupwork, weekly sessions are run by two or three staff members. Supervision to the group facilitators is provided fortnightly by the groupwork consultant. This model enables several staff to develop the competencies required to facilitate groupwork in inpatient settings. It contrasts with the more common practice, where groupwork expertise is provided by external specialist practitioners, coming into the wards to conduct sessions. The authors provide some illustrative material from the group sessions. Additional material is provided from supervision sessions, which aim to help staff understand more about the group process and dynamics. In addition to involving more staff in groupwork, the model is also a highly efficient use of the Associate Specialist's time.

Keywords: Yalom's model; groupwork supervision; group facilitation; inpatient groupwork; containment

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Introduction

John Dickson Ward is an 18 bed male acute ward at Guys Hospital in inner London . As with most acute inpatient wards it is a busy place, with increasing numbers of forensic patients, short lengths of stay and a very rapid turnover of patients. There were already several Occupational Therapy based groups and activities on the ward but no formal therapy groups. It was decided just over a year ago to introduce a psychotherapeutic group onto the ward. At first, there was some interest and enthusiasm from ward staff but a lack of clarity about the group's purpose and how it might operate.

Various staff volunteered to take part in the project, including nursing staff, support workers, the ward occupational therapist and one of the senior doctors - the Associate Specialist. It has been an advantage to have such a range of the multidisciplinary ward team involved. Members had varying degrees of experience of groupwork from some to none.

Initially there were development meetings to discuss how the group would work. One early idea was that it would be a 'men's group'. There were arguments for and against this as a name and focus for an inpatient group. One argument was that most patients find themselves on the ward not so much because they are choosing to be in a single sex environment, but because they are experiencing symptoms of mental illness requiring admission to hospital.

While thinking about models and structure for the group there was a lot of debate about what the name of the group should be. This could be seen as providing a container for some of the anxiety about what the group would be like, and what staff would be doing within it once it started. It was eventually decided to call the group the 'Communication Group' as this was thought to convey the purpose of the group as clearly as possible. There was a lot of focus on organisational issues around the group - where would it happen and when? How could staff arrange to be available consistently, with all the difficulties of shift rotas and different timetables? Then the focus shifted to thinking about such things as: selecting patients who could use the group and preparing them for it, a clear structure for the sessions, likely problems, and finally how to go about facilitating the sessions. In the end it was decided to set up the group following the model of inpatient group psychotherapy described by Irving Yalom (1983).

Yalom's model of inpatient group psychotherapy

Yalom (1983,1985) has described six basic and achievable goals for inpatient group therapy.

1. Engaging patients in the therapeutic process
2. Demonstrating that talking helps
3. Problem spotting
4. Decreasing isolation
5. Being helpful to others
6. Alleviating hospital-related anxiety

Overall, the aim is not to 'cure' symptoms but to help to make more sense of the experience of being on the ward. The group aims to help interpersonal interactions between patients and between patients and staff. It can also help patients to make more sense of their current difficulties in the ward setting and in their lives outside. He describes modifications to group psychotherapy appropriate to an acute inpatient setting, typically with a rapid turnover of patients with a range of diagnoses and presenting problems.

In brief there are several key ideas. Each group session is thought of as a single session intervention, and has a 'here and now' focus. This helps to address both the rapid turnover and therefore frequent changes to group membership, and the often chaotic and fragmented nature of patients' mental states. This is quite different to other models of group psychotherapy where one would expect the group itself to hold more of a sense of history and continuity. So here each group session is seen as a new event in itself - and even if some of the members are the same from group to group, they are not expected to be responsible for carrying a sense of the structure or function of the group.

Facilitation of the group is active, with a much more directive and supportive approach than is the case in other group therapy. The style is supportive rather than aiming to provoke or stay with anxieties or be too challenging. This is an important consideration when working in groups with some members who may be experiencing psychotic symptoms (Kanas, 2000, p.127). Anxiety-raising silences are avoided. The facilitators need to step in and speak more in order to try to engage all the group members and to model open communication, rather than

taking a more passive approach. There is a clear structure and time limits, and these are re-stated every time the group meets.

How the group operates

The group takes place once a week in the afternoon for fifty minutes, followed by a fifteen-minute discussion session amongst facilitators. Every second week there is a one-hour supervision session attended by as many of the facilitation team as possible. The aim is for a minimum of 4 patients, and a maximum of 10 patients in the group. The average number has been around 6-7 group members per session. There are usually 2 or 3 staff facilitators each group.

Patients are encouraged to participate in the group as soon into their admission as possible, some within the first twenty-four hours after admission. The ward has a 'planning meeting' every morning and the group is mentioned there to patients. Patients who might attend the group are seen by a member of staff during the morning prior to the group, to discuss what the group involves, and are invited and encouraged to attend. Those invited to attend include some actively psychotic patients. The only exclusion criteria employed are firstly patients who it is thought are unable or very unlikely to manage to sit for the duration of the group for whatever reason. Secondly, those thought to pose a significant risk of aggression.

Illustrative material raised from groups

Section 17 leave (This is formally agreed time away from the ward for those detained in hospital under a section of the Mental Health Act.):

Actually I get anxious about going on leave ... this place turns into your home

...

I know what you mean, this place is safe, it's the outside you don't know about ...

I start to sweat about it you know...

No way, make the most of your leave, some of us are locked in here for no reason with no nothing, no leave, nothing, you should make the most it.

Another session discussing leave

I just want to get out of this place, can't be here anymore.

Do you know what I mean, got us banged up here with it all kicking off left, right and centre, and then we do want to go out we have to wait until a nurse is available ...

Facilitator: It sounds like there's a lot going on the ward at the moment, this might make you not want to be here? It sounds like you feel unsafe?

Yeah, there's all sorts, you got that one doing this and the other doing that.

Yeah, you have to watch your back and your stuff, my cigarettes got nicked.

Unsafe and neglected, nurses don't even have the time to take us out ... and then you're just waiting, everybody's just waiting to get out.

One group member displaying empathy

Everybody's problems are different you know. One day I overheard someone say 'what's the cleaner's problem today?'. ... I was like well why wouldn't they, even the cleaners has their own problems! No one person has no problems of their own.

Recognising one is 'unwell' How do you cope with being unwell on the ward? -Three different responses in the same session:

Listen to music, or change rooms as sometimes there are stray souls that linger in between the walls ...

Read the paper, or go have a chat with someone in the smoking room

If you're not well you know it for yourself and know how bad it is. You should be aware of your mental state, your behaviour and dress ... If you have your arm cut off etc you know that it's gone and something's not right-if you don't know you're mentally unwell then maybe you aren't that bad or mentally unwell in the first place.

Learning from one another/instilling hope

I realised that I was having these delusions, I can say this now because I know, I had delusions about the Nigerian government – about black and white people – it wasn't me at the time, I even tried to hurt a member of staff – but I feel better now, I'm even the community meeting patient link role on the ward

So they (staff) saw you get better and gave you responsibilities, so you can start to do that and know that you're a bit better when you start to do things like that.

Issues arising in supervision

With this model, the group is facilitated by ward staff with varying degrees of prior group experience, but with regular supervision of the work. This is unlike several other inpatient groups taking place in the wider organisation where the expertise is provided by specialist staff coming into the wards to conduct the sessions -sometimes jointly with ward staff. For this group, ward staff develop their own expertise, confidence and style of working in the groups over time, using the supervision to reflect on the work. Advantages include a different kind of ownership of the group by ward staff who develop their skills, and are integrated more both with the patients outside sessions, and with the life of the ward. Disadvantages to this approach include: staff having to learn more 'on the job' as they go along; some trial and error in applying principles to practice; not having an experienced group specialist in the sessions who can model appropriate interventions directly and who could observe the work.

There needed to be a lot of focus at the start on basic practical organisation of making sure that staff and patients were free to be at the sessions. Time has to be spent in supervision on these organisational issues because there is never going to be much other opportunity on a busy ward for the staff involved to meet and think about the group. It is not possible to separate this work from the rest of the supervision and it remains an ongoing issue. In addition one can expect there to be other pressures and forces at work on a ward which can disrupt the sessions in various ways and these need to be understood and worked through. However, over the course of a year the balance of time spent on organisational concerns and the group material has, compared with

the starting point, shifted markedly in favour of the group material .

One area that only became clear over time in supervision sessions was the effects of other events on the ward - the overall context for the group, on what happens in a session. The idea of events in the wider ward setting being played out in any group held within it, is familiar from the therapeutic community literature (e.g. Hinshelwood, 1987). However, it's not always easy at first to make these connections or see the relevance. A clear example is the effect of a violent incident, or particularly aggressive patient on the ward affecting the whole ward atmosphere. Another example was the puzzlement when the patients suddenly began to struggle much more than usual with the group structure. On one occasion the group members kept bringing up practical problems with the ward environment such as a broken shower. It turned out to be connected to the re-introduction of ward patient business meetings and the confusion for some patients about what should happen in which meeting.

In another session it was very hard to encourage anybody to speak in the group. Of course this can happen anyway from time to time, and when it does one tries to figure out what might be going on eg. are there particular anxieties for patients within the group itself or in the overall ward context? In this particular session where patients seemed especially unwilling to speak, it was discovered later in the supervision session that several of the patients at the group had also been to a 'relaxation/chill' out group that week which was all about relaxing and *not* talking. Such confusion about how to use the group, underlines the importance of re-stating the group's aims and structure each time the group meets.

Staff who take the lead facilitator role in the group often express concern about whether they have got the introduction 'right' in some way. It is an important intervention, in order to set the aims and establish a structure. However it can feel like there is a lot of pressure to get this 'right' so that it will somehow magically unlock the group and the conversation will flow easily. In reality there are always many variables at work, which determine whether the group achieves some useful dialogue. Staff have noticed that in the introductory round, a lot depends on which patient goes first in setting the group atmosphere. If the first one to speak does not talk much about themselves or their current concerns, then the rest of the group members tend to follow suit.

A useful strategy is to encourage one of the patients to start the round, who staff believe is more likely to feel confident in speaking, someone who seems more articulate, or has been to the group before.

One area that we have concentrated on in supervision is whether staff facilitators should ever introduce topics for discussion, rather than developing whatever material arises directly from the group members. Ideally, the round at the beginning brings concerns from the patients that can form the basis for dialogue and exploration. Then patients will talk to each other (not only via the facilitators) and will develop a dialogue in the group themselves. However this is often not the case, and the group can feel silently stuck - withdrawn and anxious, or alternatively lively, but very chaotic and fragmented. The pragmatic rule of thumb here, in order to facilitate the group process, is to try wherever possible, to draw on the concerns and topics raised by the patients themselves. Especially where the topic is likely to have some relevance to other group members. Drawing attention to what is happening, or being raised in the group itself in a 'here and now' way is usually successful in getting dialogue going.

Sometimes in this setting, this more focused attention from staff on what is happening in the group or on what individuals are talking about can feel like too much pressure and the group shuts down again. The group sometimes needs to find a safe way to begin dialogue by focusing on something outside the group itself. In other group psychotherapy one might point this out to the group as a group defence. Here in the inpatient setting, the 'here and now' focus can usefully be extended to the 'here and now' of the overall ward environment - and so staff might introduce topics about life on the ward which are likely to be relevant for most group members. Equally, for a particularly anxious group, discussions about football or TV programmes for example are seen as a way to begin a safe dialogue which will then be gently steered around towards more personal concerns. An example perhaps of Winnicott's ideas about how creative playing can open up a therapeutic dialogue, '... playing leads into group relationships.' (Winnicott, 1971, p.48)

In the supervision sessions staff are encouraged to present the latest group session in roughly chronological order. Who was there, the content of the introductory round, through to the sequence of dialogue in the session and the material raised, to finally the ending feedback round (How was it being in the group for you today?). It helps to hear

approximately what followed what in the session, in order to make sense of links made, and to consider the effects of staff interventions. It is however striking just how difficult facilitators find it to present the material chronologically. This reflects how chaotic, fragmented and often psychotic the group material can be, and how this can flood or disrupt thinking processes for staff as well as patients. A key factor is that the supervision meeting follows on directly from the group. The staff only have a very limited time available to process anything, and to 'recover their thinking' between the group and the supervision session. There is a 'ripple' effect from the group which carries not only the emotional tone of the group session, but less consciously carries over some of the disturbed thought processes. An example that illustrates this is from an encounter with staff just before the supervision session. Staff were chatting before the supervision session and this quickly turned to laughing and joking. People were making silly comments and enjoying very quick and witty banter in the moment. Soon afterwards in the supervision session it was reported that two manic and competing patients had dominated the group. Similarly, finding a supervision session itself to be particularly chaotic and hard to follow, or sleepy for example, gives clues to what the group members may have been experiencing or perhaps have projected into staff in some way. This kind of parallel process carried from the encounter with the patients into supervision has long been recognised in the analytic tradition (see for example Searles, 1955).

The common-sense assumption that it should be easy to remember and describe a session that one has just been part of is countered by these other factors. It is particularly the case when the ward overall is more disturbed, again demonstrating some of the effort involved for both staff and patients to get together in a group and to be thoughtful and reflective in the face of internal and external disturbance.

It has been useful at times to have a staff observer in the group taking notes in the session in order to help to piece the material together in the supervisions (see vignettes). Despite the risk that this may be off-putting for some patients, the group accepted this when it was clearly explained. The difficulties in thinking described above also emphasise the need for post group discussions, and time in supervision to make sense of the group experience.

Space does not allow a description of all of the issues discussed in

the supervisions, or to present more of the material raised in the group sessions by patients. A few common issues around how to intervene in the group have included:

- Dealing with patients, who speak too much and monopolise the group,
- How to deal with delusional or confusing material,
- Boundaries around people walking out and back into the group,
- Strategies for widening the discussion between group members when all dialogue is directed at the staff.

Overall, this group has been working well, however only as a result of a lot of sustained energy and commitments from a sufficient pool of ward staff. The rest of the staff if not directly involved in the group need to be sufficiently 'on board' - valuing the group in order to support it. Otherwise there are so many competing demands and priorities on a ward that can sabotage the sessions (Simpson, 2002). For example making sure that staff are really free to run the sessions and that other staff can respond to alarms etc during sessions, or that patients expected to attend the group are not called away for other reasons.

Conclusions

It was found that a weekly inpatient group based on Yalom's model of highly modified group therapy and using only ward staff as facilitators could be introduced on an adult acute inpatient ward. However for this to be done successfully and run smoothly, it required careful planning, regular high quality supervision as well as a large number of highly motivated staff. Given a sufficiently supporting framework, the group although not formally evaluated appears to have a valuable role to play in patient care as well as impacting positively on staff skills and morale. It is well recognised that inpatients on adult acute psychiatric wards often feel frightened of each other, isolated by their symptoms, disturbed and regressed to some degree. The regular structure and opportunity for communication that the group allows helps to provide a 'safe' environment for all patients where dialogue can occur which appears to help patients overcome these problems. Our experience shows that

the group helped patients to move from a position of isolation to one of a better understanding of their own and each other's problems. It therefore appears that the group helps to improve patients' overall experience during their time spent as an inpatient.

References

- Hinshelwood, R.D. (1987) *What Happens in Groups: Psychoanalysis, the individual and the community?* London: Free Association Books.
- Kanas, N. (2000) Group therapy and schizophrenia an integrative model. in B. Martindale, J. Johannessen, and J. Cullberg (Eds.) *Psychosis: Psychological Approaches and their Effectiveness. Putting Psychotherapies at the Centre of Treatment.* London: Gaskell.
- Searles, H.F. (1955) *The Informational Value of the Supervisor's Emotional Experience. Collected papers on schizophrenia and related subjects.* London: Hogarth Press.
- Simpson, I. (2002) Inpatient group work for patients with psychosis. *Nursing Times*, 98, 41, 33-35.
- Winnicott, D.W. (1971) *Playing and Reality.* London: Pelican.
- Yalom, I.D. (1983) *Inpatient Group Psychotherapy.* New York: Basic Books.
- Yalom, I.D. (1985) *Theory and Practice of Group Psychotherapy.* New York: Basic Books.