

# Inpatient groups: Working with staff, patients and the whole community: Personal reflections of a group analyst

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**Abstract:** *In this paper the author shares with the reader his reflections on running inpatient groups. He provides two detailed case studies of his groupwork. The first, took place in a traditional asylum in the early 1980s. The second was a more contemporary group, which took place in a hospital secure unit. Both case studies illustrate the importance of gaining the support of the ward team, including doctors and nurses, in establishing and maintaining a groupwork culture. He illustrates how groupwork can help individuals with serious mental disorders through exploration, reflection and acceptance. He ends by making a plea for using groupwork to cope with wider societal changes. Unlike the other papers in this series, this account has more of a narrative feel, and as such, it is told in the first person.*

**Keywords:** *'Anti-group' processes, nurturant factors, ward staff, clinical supervision, envy, attachment, the ward community, reflective space*

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## **Introduction**

This paper is about groups in inpatient settings, but it is also about groups generally to some extent. Inpatient groups are a very special and intense sort of experience, and for that reason they are both extremely useful and valuable and also attract a good deal of fear and apprehension. There are many reasons for this, some of which I will discuss later. In a group that is run on the basis of free-floating discussion, what we might hear may well be difficult and complex and not amenable to simple solutions. Many inpatient groups fail, or have very rocky and precarious existences, and I want to talk with you about some of the reasons for this and what you can do about it.

I am going to say something about the usefulness and desire for inpatient groups and also about some of the problems that they encounter; some of the 'anti group' processes, as Morris Nitsun called them (Nitsun, 1996). These thoughts are mine, drawn largely from my own experience. Over time, I have of course used the work and thoughts of others to help inform my views.

A group can be the generator and container of experience; as a place, or an organ, that can help us to think about and process emotions. Envy of this marvellous ability may well prove detrimental to the group process to the point of the destruction of creative potential. Open and covert issues of control and power may predominate, usually not to any good effect. Institutionalised responses from both staff and patients may work against the effort to provide space and time where people can communicate openly with one another. A simple reflective space where we can meet regularly and reliably to talk openly with each other may be highly desirable, but also unstable. This is already difficult and heady stuff! Sometimes you have to go back in order to go forward, so that is what I shall do.

## **Case study 1: Groupwork in the traditional asylum**

Many years ago, at the beginning of the eighties when I was beginning my group analytic training, I was required to run a group in a psychiatric setting. So not knowing any better, I talked my way into a local

psychiatric hospital; one of the large institutions that used to circle London and that have now been sold off for housing developments. One of the friendly and helpful psychiatrists suggested that they could do with a group for inpatients on the acute admissions ward, and that I could work with a doctor who was also interested in running groups. How lucky was I! And I mean that without a trace of irony.

It was my first incursion into the wacky world of a psychiatric institution and I had no idea what to expect. I'd seen some of Hogarth's pictures of the Harlot's and the Rake's Progress, of course, but nothing more recent, so, like the paying visitors to Bedlam, I possessed a freshly tuned curiosity with just a hint of voyeurism. The Ward Sister was very keen, and asked if she could join in. She enthusiastically recruited patients for the group and commanded that her nurses do likewise. There was little or no history of group therapy in the hospital, so far as I knew, although there was a well-established Occupational Therapy Department. The staff nurse knew that it was just as important for patients to be in a group as it was for them to be well fed, clean and take their medicines: and so we arranged a time for the group that seemed to best suit the ward business, and my availability, and began.

As it happened, the patients turned out to be relatively everyday members of the local community, not in the main shaven headed, and none that I can recall with visible black spot signs of syphilis like Hogarth's characters. They were just local people who because of unbearable stresses of various kinds were given sanctuary, temporary or long term, in the hospital. The hospital was near quite a wealthy town; the catchment area, and consequently most of the patients, could not be thought of as economically impoverished in any way.

We ran the group for well over a year, and it became very well established, and very well liked by the patients and staff. The patients, in the main, were surprised to find that there was a place where people were actually interested in who they were and what had brought them there, rather than in curing some odd symptom which they had developed.

After a while, because this was a large hospital with a well-developed internal structure and interpersonal communications network, one or two patients from the back wards started turning up. The doctor, whose attendance was intermittent, also told people whom she saw at the day hospital that they could go to the group. The patients would

just turn up and I didn't have the heart to turn them away, so after a while we had a sort of intergenerational community group consisting of newcomers to the mental health services who weren't yet inpatients, people who were probably short term inpatients in crisis and people who had been there for years.

One of my favourite memories is of a thirtyish chap from the back wards who for several weeks would stand at the door, often for the duration of the group, slowly opening and closing it, uncertain about whether or not to come in. Somebody suggested that we make a place and set out a chair for him. Eventually, he came fully through the door and took his place amongst us. He spoke in a strange, strangulated voice. Someone said, 'You've swallowed your voice, Richard. Come on, cough it up.' He told us a story about living in a shed at the bottom of his parents' garden. He couldn't be with them. And he couldn't leave them either. The tension in the house was unbearable, and yet he didn't have the confidence to leave. When our group ended, at the final session, he said, 'I've liked being here. Thank you for the atmosphere. I've been able to breathe.' And, in fact, although no one had paid much attention, his voice had become much more ordinary. He had come in from his back ward shed.

Another person was a woman whose husband was a city banker. She had come into hospital because she was spending 24 hours a day scrubbing and cleaning the house and preparing food that wasn't necessary. The house was spotless and the fridge and freezer were full to overflowing. She was exhausted and her hands were red raw. In a well-meaning attempt to help, her husband had taken her on a holiday trip to Africa. She told us about this in the group. They had visited an African village, and it had made a deep impression on her; the way in which the women all did their washing together, chattering and gossiping, the children ran about freely, playing with the animals, and the men sat around talking, playing dice, drinking beer and apparently doing very little. People seemed to be cheerful although they had none of the material things that she and her husband worked so hard for. She wondered if it would be better to be like the villagers. The group listened to her attentively. I thought about our funny little group-village where we had several generations, and where we could do our washing in public, but I didn't say anything.

## **Reflections on the groupwork experiences**

Understanding, or rather the *attempt* to understand is far more important than demonstrating that you understand, or trying to give words too soon to very complex matters. Bion talks about this in his concept of ‘-K,’ (Gordon, 1994) (Incidentally, the patient mentioned above may have been an undiagnosed early victim of the Affluenza virus, see James, 2007).

In the group, the questions that arose most frequently were ‘How did you get to be here? Who are you? How did this happen?’ It is strangely easy to ignore the fact that to be in a psychiatric inpatient unit of any kind something must have gone badly wrong. This happens because people in inpatient units are *all* there because something has gone badly wrong. If we lose that sense of surprise, of shock even, then we are in danger of accepting the breakdown of ordinary life as ordinary; of entering a meaningless universe. In the group, ‘I’m here because I’ve got depression, or obsessive compulsive disorder, or because the drugs aren’t working’ or whatever, more usefully becomes a question: ‘How did you get it?’ ‘What does it mean?’ Even the most thoughtless person would have to consider that if you are suffering from something unpleasant, it might have been caused by something that needs to change. And experience teaches us that change is very difficult.

When you become an inpatient you are a person who has become estranged from their group. For some reason or another your group can no longer hold you. You may have become intolerable to them, or they may have become unbearable to you. This is very often a humiliating or shameful experience. You become part of a community of people who have lost their group, or their group has lost them. So most inpatient settings are full of people who find it difficult to be in groups, and who generally speaking, don’t much want to be there at all. However, we were able to run a fascinating group, usually containing eight or nine people with a slow-open membership for well over a year, only ending when my placement finished.

Treatment is about how you treat people. R.D. Laing

You can see that this group was set up in a very benign environment. I was very lucky. I was bright eyed and bushy tailed, delighted to be

given this opportunity to be a proper group therapist, although I'd had several years experience in social groupwork and group relations training and as a participant in quite a few short term therapy groups by then. I had weekly supervision from a helpful and tolerant newly appointed Consultant Psychotherapist. Both Consultant Psychiatrists who shared duties on the acute admissions ward were wonderfully kind and helpful gentlemen, and 'prescribed' the group to suitable new patients. I had a surprise friend and enthusiastic ally in the Ward Sister, who wasn't afraid to boss her underlings and the patients around to some extent, and who gave the group a good press on the ward! I later found that this sort of ward 'insider' relationship was extremely useful, if not invaluable, in other inpatient settings. The patients already knew someone, hopefully whom they trusted and liked. (This is more important the more disturbed and psychotic the patient.)

I had a co-therapist who was a doctor, which gave our group additional status in the wider medical matrix. The Occupational Therapy Department which offered groups and experiences of various kinds to patients, were happy to synchronise their offerings so that the patients did not have to deal with 'timetable clashes'. The Admin. Secretary who administered the room bookings and also had a sort of receptionist role was very helpful and well liked by patients and staff alike. She allotted us a room near the Day Centre so that patients got away from the ward for their group (something which I came to feel was very important) and the room was always clean, tidy, light and airy with comfortable chairs. The heavy red-bricked hospital that contained the group had been there for about 100 years and felt as if its foundations had well and truly sunk into the earth. There was no hint yet of the hospital closures and the huge changes in the levels of general social insecurity that was to come in the eighties and beyond.

It is an African saying, I believe, that it takes a village to raise a child, and much the same can be said about containing, nurturing and growing a healthy group. This hospital village did a very good job of getting our group going, feeding it and looking after it. To operate a group where the aim is to provide a safe place where people can talk freely with one another about what is happening to them and explore their thoughts and feelings about their lives, one needs the support of the hospital village.

This group, interestingly, sort of grew its own extension into the

outside world of the hospital with the small number of day patient members, and also extended itself further into the body of the institution with visits from the long term inpatients. I think the group would have worked well anyway, but these additions gave the group an additional sense of reality and context, and also brought more overt psychosis into play, which was worked with in a surprisingly understanding and thoughtful way. I think because of the very fortunate evolution-friendly nurturant factors outlined above the group survived and flourished. The group itself was able to become the medium of treatment.

## **Case study 2: Groupwork in an inpatient secure unit**

Quite a few years later, post qualification, post 8 years as a Principal Psychotherapist in the NHS, I became a group analyst in an inpatient setting. One of my jobs was to run a group for very disturbed patients on a long-stay ward. I was fortunate again in being able to work with an enthusiastic and highly competent co-therapist who worked on the ward and who had done some intensive groupwork training. We managed to get a pleasant room down the corridor, not far from the ward, and started to recruit for our group. Of course, we began by working the network.

The Ward Manager treated us with a certain amount of polite suspicion, but seemed to like the idea of a group. But we couldn't be quite sure. The ward nurses smiled and nodded and said 'what a good idea, but you'll never get them to come'. We thought it best to interview patients ourselves to see what they made of the idea of a group, so we set up a series of appointments with likely candidates. We let the Consultant Psychiatrists who were responsible for the patients know what we were up to; that I was a group analyst and we were going to run a group under the auspices of the psychotherapy department. About half a dozen patients said they would like to attend. We set a start date.

Just the one man turned up, very smartly dressed in suit and tie. Despite the pre-group interview he appeared to think that we were a review body of some kind, which was one of the type of hospital groups he had previously experienced. We spent a very uncomfortable hour, the three of us. The following week, nobody turned up. We checked with

the ward. They had gone off to do other things; playing football with the nurses being one of them. The week after that, two people came. Then three. We stuck at three non- footballing members for a while. Not much of a group, but a start.

Following some enquiries, we discovered that one of the psychiatrists was actively discouraging patients from attending because they didn't want them distressed by 'having to talk about their childhoods'. My 'analyst' tag had worried them. I went along to see them to explain that the group was just a place where patients could talk with each other and perhaps learn to communicate their feelings a bit better. Nothing much, really. This produced a marked effect, the psychiatrist's anxiety was alleviated and more patients started to attend.

We also discovered that the nurses were not exactly being encouraging. It seemed that they were concerned about patients being taken off the ward, stirred up and then dumped back with them again. Apparently a previous therapist of some sort had done this some time in the past. Football was a much safer option, and the nurses could play too.

We thought about all this in supervision, and group numbers gradually crept up. Supervision was a vitally important part of the work and provided an essential thinking-space with a very experienced and expert senior colleague.

Something that really seemed to make a difference was when I began a group for the nurses on the ward where they could reflect upon and think about their experiences. Now they had their own group! Our numbers in the patients' group continued to increase and held at between six and eight with a fairly consistent slow-open membership for almost two years. Attendance at the staff 'reflective practice' group was also very high and consistent. Patients began to feel safe enough to start thinking about some extremely problematic and difficult material. Psychotic processes became more visible and able to be tolerated, or confronted and to be thought about. Communication developed and became deeper.

We therapists had to do considerable work protecting and maintaining the boundaries and space of the group. It helped a great deal that there were two of us to spread the workload, and that one of us worked on the ward was a huge benefit.



## **The Role of supervision**

Supervision from an experienced clinician is essential when running most kinds of groups, especially the more difficult kinds such as inpatient groups. A good supervisor will help you to keep your feet on the ground and to avoid being swayed by the powerful unconscious processes that are at work in groups.

In the second group described above, we were very fortunate in having our weekly supervision session almost immediately after each group. This model, which was adopted initially for logistical reasons, proved very effective in processing the psychotic material that the group produced. When you are doing very intensive work, especially if developing your professional interests in an unfamiliar area, one becomes a 'beginner' again and should have more or less the same time in supervision as in the clinical work: an hour doing therapy; an hour of supervision. Expert supervision is essential for the mental hygiene of therapists working in emotionally toxic environments; it is not an 'optional extra,' (Rosenfeld, 1987).

Training, is also of great importance; to be able to deal with strong emotion you need to be properly trained and supervised, and to have had as much personal group experience as possible.

## **Envy, attachment and nurturance**

Therapy groups seem to be responded to within institutions in fairly predictable ways. They are often welcomed, and even idealised, then treated in ways that can undermine them and even attack their existence. Therapists can feel undervalued and 'up against it', their enjoyment of their work and enthusiasm sapped and drained.

It may be that this effect is the result of unconscious envy in the interpersonal matrix that surrounds the group. Envy is a very strange emotion; often unconscious, we attack in others that which they have and we don't. What exactly is it about groups that may be envied?

There is a very basic human need for attachment. The work of Bowlby and others, (Bowlby, 1979) and the current burst of research in neuroscience, especially that of Allan Schore (Schore, 2003; Gerhardt, 2004), seems to indicate strongly that attachment to a figure (or possibly

a group) *felt to be protective and attuned to our emotional states* (or at least trying to understand us) may be a pre-requisite to the desirable ability to think about feelings (let alone the joy of simply feeling loved and protected). And unless we can experience and think about our feelings we cannot function cognitively as effectively as we might otherwise be able to. As the poet E.E. Cummings put it, 'feelings come first.' Schore calls this process 'emotional regulation', a difficulty especially prevalent in borderline, narcissistic and personality disordered states. Unless we are able to regulate our emotions, identify our own feelings and empathise with those of others we cannot engage in free-flowing social interaction, become socialised and function in groups.

Groups which offer the potential for group members to enjoy attached, attuned, empathic experiences are highly valuable objects, and may be subject to unconscious envious attacks from a surrounding environment. Groups also may well be an Object of Desire, (Nitsun, 2006) and as such subject to the usual idealisations and denigrations of loved objects. If you are felt to possess an object of desire, you may well be envied and you or your object or both of you destroyed. If all staff have the opportunity to be in a well run group, this goes some way to alleviating the problem of unconscious envy and negativity. Groups not only offer the *potential* for a reflective and emotionally attuned experience, but also provide a creative space, where ideas and thoughts and words can be put out into the group, taken back in, and where group members can safely be playful with each other. This can help build a gradual internalisation or 'store' of 'good' emotional experiences, creating good internal objects in the context of a reliable relationship (Celani, 1994), which is part of the psychotherapeutic aim of our work. This is a desirable process and a major aim of good clinical practice. An effective institutional environment will include the provision for all staff to be involved in groups run with the same skill, care and attention to detail as those provided for the patients, or the entire clinical work is at great risk of being undermined by a build up of negativity.

Many things can adversely affect the nurturing function of a group, even one that has had the best and most assiduous attention paid to its setting, context and dynamic administration. Especially when working with very emotionally deprived and damaged patients, the potentially destructive processes of splitting, and especially projective identification, can infect a group and easily spill out into the surrounding staff teams

and institutional dynamics, leading to defensive staff behaviours or enactments as bits of the patients' mental processes are pushed into staff teams and unconsciously played out. Abuse dynamics are especially pernicious in this respect. Dealing with pathological processes in groups and institutions is beyond the scope of this paper, and would be something of a digression; but it should be said our current social and institutional climates are far from the ones prevailing 20 years ago, and the social, as S.H. Foulkes remarked, does indeed 'permeate the individual to the core,' (Foulkes, 1948).

## **Conclusions**

This paper describes two successful and useful group experiences with very disturbed patients in inpatient environments. They show how the context and setting of the group is profoundly important; the surrounding professional matrix must be supportive, understanding and benign, and the therapists enthusiastic, reliable, well trained and properly supervised. Processes which work both for and against successful groupwork are discussed, and emphasis placed on the need for work with staff teams in order to preserve a constructive and positive emotional climate.

The recent Institute of Public Policy Research report (Margot et al, 2006) and other research (Palmer, 2007) indicate that, apart from a few impoverished ex-Soviet States, Britain is the worst place to grow up in the western world. British children also face more tests and achievement targets than anywhere else in the world. We are surrounded by a relentless culture of winning and competitiveness. We are confronted by 'achievement' targets, tick-boxes, media fixated on the inane cruelties of 'reality' TV with its manufactured exclusions and close-up humiliations. Our wider consumer-driven and affluent society faces economic insecurities, family and community breakdown, deeply problematic gender relationships and gross social and economic inequality where fear of failure or exclusion dressed up as 'performance appraisal' is used to motivate compliance.

Groupwork approaches which emphasise thoughtfulness, reflection, consistency, inclusion, tolerance, reliability, free group discussion and which take fully into account the inter-connectedness and complex

contexts of the 'virtual villages' of modern human life can go some way to alleviating distress. This means that we may have to work harder than ever to form and maintain our groups, and also that properly constructed, thoughtful and well maintained groupwork approaches are needed like never before given wider societal changes.

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