WORK WITH LARGE GROUPS IN MENTAL HOSPITALS

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A certain amount of group psychotherapy is to be found in large state hospitals, Veterans Administration hospitals, and private psychiatric institutions; however, these groups tend to be small, with eight or ten selected patients, and a psychologist, psychiatrist, or group worker as leader. Too little is as yet known about the effectiveness of this contribution to treatment in mental hospitals. The same applies to group treatment in general, and for that matter to psychotherapy in general. Less controversial, perhaps, is the beneficial effect that these small treatment groups have in training staff personnel, the effect on ward morale, and the feeling by the patients that something is being done for them.

We would like to make a plea for greater use of large group meetings, ward community meetings. These can be applied in mental hospitals with the relatively unfavorable staff-patient ratio, which is the lot of most, if not all, large mental hospitals. When there is a lack of trained personnel, the economy of having all the staff in one group, appears to be obvious, regardless of the type of group program to be desired. Secondly, there seems to be merit in the idea of meeting with all of the people who are living together in order to study the patterns of interaction and to afford an opportunity for feeding back information from both patients and staff.

Selection of Patients

The first question we must face is the selection of patients for such a large group. We are talking about groups with as many as 80 patients, preferably of both sexes. In our experience, when more than 80 patients are present, it is difficult or impossible to become aware of even the gross outlines of the personalities of all the people involved. With this upper limit of 80, however, it is possible to have some awareness of group interaction and the group themes which tend to emerge. Obviously there is nothing like the same degree of awareness as one can get in a group of eight or ten patients. But by using, say, a ward as a treatment unit, we can assume a certain amount of interaction among its members. Many of the patients' problems tend to be acted

out on the ward during the day, and this material is frequently highly relevant for treatment.

Circumstances may in part determine the size of these large groups. For instance, if a long-stay ward has 60 patients, one is clearly tempted to have a ward meeting of this size. However, with regressed patients we feel that smaller groups are preferable with an upper limit of 40 to 50 patients. If, on the other hand, many of the wards are of 20 patients, it might be appropriate to bring two wards together, possibly a male and a female ward, and have one large group. Such a procedure gains much point, of course, if the two sexes are interacting during the day. Otherwise the content of the ward meeting may well be confusing as the one ward will be unaware of the significance of much of the behavior on the other ward.

Another matter of considerable importance is the nature of the clinical conditions being treated. Many of the wards in most psychiatric hospitals are for long-stay patients only. In such a situation the choice of this type of chronic patient might well be almost inevitable. However, many people are beginning to think that there is much advantage in mixing recent and chronic cases together in the same ward environment. This undoubtedly leads to much more active group interaction with considerable benefit to the chronic patient. Recent experience with groups in such a mixed population leads us to believe that there is a good deal of interaction between new admissions and chronic patients but less than had been expected. The chronic patients characteristically isolate themselves from the recent admissions, a phenomenon which needs further study. Also how far the situation is to the advantage of the recent admission is an open question.

All these issues are being brought into the foreground by the increasing number of hospitals with programs of decentralization. It is our opinion that as yet far too little attention is being paid to the optimal size for such decentralized units. For administrative and practical reasons these units have often as many as 500 or more patients. Here one must think about dividing the unit into sub-units of more appropriate size if ward meetings, or what we prefer to call community treatment, is to be instituted. Clearly, if patients live and interact together for a large part of the day, they will have many problems in common, but the size of the group affects the significance of this interaction. The optimal sized unit may well be one where basically all the patients can be known to each other and to the staff,

and the staff is of such a size that it can meet daily to discuss problems around administration and treatment.

PREPARING THE STAFF

In our opinion, ward or community meetings should be held daily with all patients and staff present (4). The greatest difficulty in staffing community meetings of this kind is that in most cases the leaders have little experience in group work and probably none with this large type of group. As yet there are few opportunities to learn techniques of this kind, and to a large extent they have to be learned on the job. At the same time we recognize that there is really no substitute for firsthand experience, and strongly recommend the practice of sending a staff member to work with a therapeutic community, if it can be found, for at least two months. Nevertheless, we think that a lot can be achieved, particularly by people with previous small group experience, if from the start the meetings are dealt with as a community project.

A preparatory stage is necessary in which the doctor discusses the possibility of community meetings with the staff and helps them look at some of the possible advantages. The formation of such a discussion group with all staff members present to consider a proposal of this kind, implies a certain learning situation for the staff. By meeting to discuss a common topic, many of their own problems will inevitably obtrude. We think that there is every advantage in allowing this preliminary workshop to be continued for considerable time in order that some of the staff differences may be worked through. The familiar unilateral decision-making procedure where problems are dealt with by administrative fiat rather than by being understood and worked through, is modified by this form of training. Unless this happens, there is little likelihood that the staff will be able to help the patients to do the same thing.

Another problem is to know how much coercion should be used regarding patient attendance. If one is dealing with a long-stay ward, there is tremendous apathy, and patients have little motivation to participate in meetings. Under such circumstances it seems reasonable to expect that the people closest to them, the aides and nurses, should by their behavior indicate the expectation that all the patients will attend. If the staff themselves are ambivalent about such meetings, the patients will sense this and full attendance will be difficult to bring about.

PROCESS OF THE COMMUNITY MEETINGS

Some of the problems which we have experienced in initiating meetings of this kind might be mentioned. The community meetings initially tend to get off to a slow start. The patients are not used to expressing their feelings, preferring understandably to ventilate these in their own informal groups in a climate where they feel secure. However, it soon becomes clear that the number of general problems is relatively small; and problems to do with the relationships, rivalries, leadership, fight or flight often recur. For example, a patient begins to use the meeting and to discuss his relationship problem with the charge aide or other authorities on the ward; it becomes apparent that this links up with problems of the same kind outside, perhaps initiated by an overbearing father; other patients find the theme familiar and relevant to their current relationship problem on the ward and may experience some relief of tension from the discussion. This, of course, implies that the staff will be able to cope with the material fed back to them without being punitive or judgmental. In our experience it generally takes several weeks before the patients begin to make use of the community meeting in much the same way as in the more simple design of small group meetings. As the patients begin to play a more responsible role in the community meeting in relation to their peers, there is frequently a change in perception of their role outside the meeting. They may begin to feel responsible for disturbed patients or help the patients who are physically handicapped.

Our experience has indicated that the feedback of material expressed by patients to the staff is invaluable in the evolution of this type of meeting. E.g., there may have been a disturbance on the ward during the night. The night nurse's report is frequently written from a purely subjective point of view and seldom shows any real understanding of the dynamics which are part of any ward disturbance. The night nurse herself unfortunately is seldom present at the community meeting, but some progress may be made by listening to the patients' analysis of what created the disturbance during the night. This results in at least a partial glimpse of the ward culture as it exists during those periods of time when most of the staff is not present. The development of what might be called a therapeutic culture is handicapped because the staff is divided into three separate shifts. As yet no satisfactory solution to this problem has been evolved, but we have seen a good deal accomplished by provisional arrangements such

as holding meetings at the time when the two day shifts can participate and occasionally getting the night staff to remain for a morning meeting. Obviously one hopes for the development of a consistent culture so that the patients are met by a familiar and understandable response from the staff during day and night. This process is certainly hastened if the patients themselves have sufficient strength to play a consistent role during the 24 hours, e.g., when the night shift is in need of help, the patients can play a role towards their peers which takes on many of the attributes of the staff role.

Activity programs are linked with group work (1). In many mental hospitals the patients go to various activities such as occupational, industrial, or recreational therapy in small groups, coalescing with many other groups from different wards. As yet little attempt has been made to develop activity programs which, as far as is practical, involve the total personnel of the ward, both patients and staff. Undoubtedly, such a program has many advantages in that the staff become much more intimately aware of the patients' behavior throughout the day and this information can be fed back to the community meetings.

SUBSEQUENT STAFF MEETINGS

It is, we think, important that from the start the community meetings should be followed by a staff meeting where there is plenty of time to discuss what happened in terms of both feeling and content. In this way the staff's feelings of frustration, their lack of confidence, or the apparently purposeless nature of the discussion can be examined.

The staff session may arouse curiosity amongst the patients. It is probably valid to allow them to drift into such a meeting and observe for themselves, on the condition that they make no verbal comment. Clearly there are some contra-indications to this practice, e.g., the intellectualizing patient is frequently attracted to listen to the staff discussions, but it is doubtful if it really helps him. However, observation may help to modify the patients' feelings that the meetings are a staff device to find out what patients feel and then punish them.

This raises the question of confidential communication and medical ethics, but our experience is that these issues never become serious. In a comparatively short time the whole community, both staff and patients, come to realize the community meetings are part of treatment and, therefore, privileged in the same way that the individual

interview or the small group rapidly comes to be accepted as privileged communication.

Another advantage of staff meetings is that the staff begin to examine their own roles, role relationships, and overall cultural concepts. It soon becomes apparent that there is a good deal of divergence in the staff's perception of the same role; for example, the aides may perceive their function by one set of criteria, and the charge nurse and the medical staff may be surprised to learn that this is how the aides actually interpret their role. By discussion of such differing concepts one moves towards a more cohesive overall ward attitude.

A procedure of this kind is often extremely painful for the leader. If through time the staff begins to feel secure enough to be able to express their feelings, then inevitably the doctor, or whoever is seen as the leader, will come in for a great deal of criticism. In fact, this is implicit in the role of the doctor to take a good deal of hostility, whether it is overt or covert. To make it overt means that the hostility towards the authority figure is then made available for discussion. In this context one can talk about treatment and training for the staff as well as for the patients. The problems of negative or positive staff feelings towards patients are also very appropriately dealt with in this staff meeting following the community meeting. This phenomenon is frequently seen in relation to the discharge of patients where the doctor whose case it happens to be may show a peculiar insensitivity to the group attitude, perceiving this simply as antagonistic to his patient. An examination of the situation will frequently make it clear to the person concerned that he or she has become emotionally involved with the patient in question.

We feel that the staff meeting with all professional personnel present has enormous potential for training and is invaluable in bringing about some understanding of the various disciplines and differing perceptions of treatment. Perhaps the most difficult task of all is to help the aides and student nurses to feel that their contributions are really required and welcome. They feel that what they have to say is unimportant and this reflects much of their own feeling of low status which is reinforced by the inadequate pay that they receive.

EMERGING ISSUES

Training of the type we are discussing leads to very complicated problems regarding the future of psychiatry (2). If, as we have seen on occasion, an aide becomes as perceptive and as skilled in this kind

of community work as, say, the psychologist or doctor, it becomes clear that we may some day have to review the whole question of status and pay. In other words, we are discussing a situation which leads to some leveling of status positions and blurring of roles. If we can see that there are advantages for the patient in this type of treatment community then we will have to be prepared to face some of the issues that will emerge.

Another issue which emerges with the initiation of community therapy concerns the development of a democratic equalitarian social structure. However, the staff has the ultimate responsibility for patients, and the extent to which they control or direct patient behavior, decision making, etc., will tend to be inversely proportional to the strength and integrity in the patient population at any one time. Thus, when the "group ego" of the patients is strong, the need for staff intervention is minimal and vice versa (5). This appears to be a poorly understood concept as one frequently hears comments that "the patients are running things." This might be partly true, at least temporarily in a well functioning group which has a good deal of integrity and strength. However, there is always the need for the judicious use of staff intervention if the group is in the process of temporary disintegration—such as might be due, e.g., to many recent discharges (6). The intervention has to be timed, and in this case be of such a type as to encourage growth and the assumption of responsibility in the remaining group members.

In conclusion, we believe that disturbances in a ward or unit usually emanate from some misunderstanding or interpersonal clash, either amongst the patients themselves or between staff and patients (7). With daily opportunities to examine and resolve these problems, the use of sedatives and even tranquilizers tends to drop considerably. At the same time we believe that units utilizing community treatment concepts seldom have recourse to restraints and other physical methods of treatment. Also, patients can play a very responsible role in their own treatment and the treatment of others. Their opinions have been surprisingly accurate when they have been involved in questions like discharge and re-admission (3).

SUMMARY

Group therapy techniques involving a ward or combination of wards, comprising as many as 80 patients, seem to have a useful role as a learning and treatment situation. But perhaps they are even

more effective in training the staff which is included in these daily community meetings, and meets by itself subsequently. The gradual tendency towards a democratic equalitarian structure, we believe, leads to the resolution of many of the problems which plague psychiatric wards.

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