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Group Work in Mental Hospitals*

By MAXWELL JONES

Many mental hospitals are practising some form of group treatment either intra- or extramurally or both. (Martin, 1962; Clark, 1964; Freeman and Farndale, 1961). Thus, ward meetings with as many as 60 patients and staff (Jones and Hollingsworth, 1963), small therapeutic groups of selected patients limited to 8 or 10 individuals (Foulkes and Anthony, 1965), family groups involving single families or several families taken as one group, follow-up groups with ex-patients and many other patterns are being developed. Most of the literature available and most of the training is based on the classical model (Bion, 1961) of the psychoanalytically-orientated group of selected patients, mainly cases of psycho-neurosis and character disorders, who have been suitable for this type of therapy.

In hospitals, little attention has as yet been paid to the optimal use of the social environment for treatment purposes. Thus, the typical admission ward in a psychiatric hospital takes patients with widely differing clinical pictures, and it is not yet clear just how therapeutic or anti-therapeutic such a mixture of clinical types may be. The simplest example is the character disorder patient. Many people feel that the presence of so-called psychopathic personalities in a ward which has a mixed psychotic population can be extremely disruptive and may adversely affect treatment of the psychotic patients. There is, however, a trend in the direction of closer selection. Alcoholic wards or units (Kessel and Walton, 1965) are beginning to appear, and to a lesser extent units for psychopaths (Jones, 1953). The fact is that as yet we are sadly lacking in knowledge regarding the optimal size of patient units, the most appropriate distribution of clinical types and the social organization of the unit itself.

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Group treatment in mental hospitals cannot be considered in isolation but must be related to the culture of the hospital as a whole. Thus an admission ward may have its own daily group treatment session, but the effectiveness of this treatment will depend not only on the skill and sensitivity of the group members but also on the attitude of the hospital towards this ward. If the nurses and patients from other wards tend to devalue the group, and feel that nothing is being "done" to counteract the destructive and antisocial behaviour of some of the admission ward patients, this may have a very adverse effect on the group treatment programme.

To date, hospitals have paid surprisingly little attention to the social organization and what one might call the "therapeutic culture" of the hospital as a whole. In industry, progressive firms employ industrial psychologists and various training devices in order to make their junior and senior executives more alive to the importance of the social environment. Sensitivity training, or what is more commonly called T group training, is becoming increasingly common in the United States and to some extent in this country.

Part of the problem may lie with the medical schools. Students operate in a very authoritarian structure, and there is relatively little opportunity for exchange of ideas and two-way communication. The hospital hierarchy does not encourage any examination or criticism of the social structure, and students tend to accept what they are taught without question. On the other hand, research is being given an increasingly important place in medical education, and this, apart from its obvious value for the development of medical science, may ultimately force the medical profession to pay far more attention to certain social problems when the facts are presented, as a result of competent research, as "hard data". As an example,

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Revans (1964) studying the wastage of nurses (in some areas 50 per cent. of all students failed to finish their training) showed in a very convincing way that this wastage could not all be attributed to such obvious factors as marriage. He showed that an important aspect of the problem was the social climate within the hospital and the extent to which the key person of the ward sister was able to keep open communication with her seniors and with the nurses on the ward. "Thus, if the junior student nurses felt their Sisters evasive and unhelpful in resolving their problems, so that they were unable to learn, they would develop anxieties and, after a mounting sickness record, would withdraw from training. The reasons they gave were not the real ones. In one Hospital Group, in which the younger nurses moved sequentially from one hospital to another, it was easy to show that, while serving at one particular hospital their sickness rate was significantly higher than it was when they served at the others, both in frequency and in severity; and that it was at this hospital that the girls, in free interview, expressed the greatest fear of being assigned difficult or unexplained tasks. The concept of the intelligibility of the work situation—in the sense that it could, by being understood, also be controlled by those within it—which had emerged in studying innovation in factories, was now seen strongly reflected within the hospitals. Those whose system of management and organization offered ready learning opportunities, to nurse and patient alike, seemed both better able to keep their staff and to help their patients, than those whose learning opportunities, by the infirmities of communication, left much to be desired" (Revans, personal communication).

It would seem that if group work in hospital is to be effective it must have a favourable social climate in both hospital and the surrounding community. It is difficult enough to get the optimal social organization within the hospital, but it is even more difficult in the outside community. As an example, family doctors often find it very difficult to understand the purpose of group treatment and may communicate their disapproval to their patients, either overtly or covertly. This is not difficult to understand, because the doctor is taught to believe implicitly in the value of confidential communication. In the medical model this is essentially a two-person relationship between doctor and patient. Other medical or paramedical personnel may be involved, but how far the physician divulges what has been told to him in confidence by his patient is left entirely in the hands of the physician. The increasing use of team-work, particularly in psychiatric hospitals, is tending to undermine the absolute quality of such confidentiality in the psychiatric setting. In fact, the whole concept of group treatment implies that patients confide to their own peers as well as to medical and other trained staff. For the family physician this may run counter to his own attitudes and beliefs, and only exposure to some kind of group treatment theory and/or practice can help him to achieve a positive identification with such a treatment procedure. More important still is the fact that our whole civilization is based on principles which deny feelings by direct expression and call for carefully prepared and censored communications to one's fellows. Even the parent-child relationship suffers in such a culture, and it would, I think, be reasonably accurate to say that most psychiatric patients cannot find anyone to whom they can turn and express feelings without fear of misunderstanding or ridicule.

From what has been said it is clear that there is a world of difference between a psychoanalytic group of eight or ten patients with similar problems, meeting weekly for a long period and having no contact with each other between meetings, and a therapeutic group in a hospital setting. In the latter, the patients are part of the hospital world, and the group experience may well be overshadowed by social forces in the hospital environment generally. The social structure of the hospital must try to complement and not antagonize the practice of therapeutic groups. In order to accomplish this, a great deal of time must be spent on trying to develop a social structure which differs in certain fundamental respects from the typical hierarchical hospital organization. At least two prerequisites would seem to be imperative. One, that communications of a two-way kind are established throughout the hospital, and, secondly, that a democratic decision-making machinery is

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established and involves all patients and staff as far as this is practicable. Given such circumstances, a hospital is in a position to constantly examine what it is doing, and for what reason. Decisions concerning staff or patients are arrived at as a result of discussion between the individuals concerned and the final outcome is the product of two-way communication, examination of feelings, and learning. Learning is a social process involving interaction between interested people. It results in modification of attitudes and beliefs and implies that as understanding and insight grow further, modification through a learning process can occur. This is different to much teaching in school or university, which all too frequently limits itself to the uncritical absorption of facts and beliefs by the student. McGuire (1963), in studying written examinations currently used in medical schools in the United States, has shown that fewer than ten per cent. of the questions asked anything other than the candidate's ability to recall isolated information. She concludes that, in all medical disciplines studied to date, evaluation of competence is limited essentially to measurement of the ability to recall fragmentary information. In another paper (C. McGuire Masserman, 1964) she concludes: "Ability to integrate data, to analyse problems, to develop a test hypothesis, to take a medical history, to observe clinical phenomena, and to synthetize these into a logical differential diagnosis and plan of management, are only rarely, if ever, adequately assayed."

If one looks at the types of groups that may be found in psychiatric hospitals, they range from the classical, psychoanalytic type of group to the simple devices such as activity groups which bring about interaction between long-stay patients and the staff. In addition, one has to consider staff groups, which may be seen as an important aspect of hospital life, both from the administrative and training points of view. I should like to examine briefly some of the types of group which one has to consider.

1. *The psychoanalytic group.* This type of group has relatively little place in the average psychiatric hospital, and is reserved in the main for out-patient groups of selected patients, usually with psychoneurotic problems, well educated, highly motivated to treatment, and familiar with conceptual thinking.

2. *Ward meetings.* Such meetings may involve as many as 60 patients, with the staff who come in contact with them (Jones, 1962; Jones and Hollingsworth, 1963). If held daily, they result in regular examination of what is happening in the ward situation. This may apply to both patients and staff, and there will inevitably be a good deal of interaction between both during the ward meeting. Such meetings tend to limit themselves to practical and material problems, but may, if skill and motivation exist in the staff, progress to an examination of what lies behind behaviour. Certainly there are the ingredients for valuable learning experiences for both patients and staff. In addition, the patients may choose to use this meeting to discuss their own personal problems, which almost inevitably have much in common with many of the other patients' problems. Thus, if a patient talks about his feelings of antagonism towards authority or feelings of isolation, it is almost certain that a large part of the patient population will be able to contribute from their own experience. Many patients come to a hospital because they are unable to cope with the stresses of life outside. One of the main shortcomings in this type of patient is their inability to make use of the facilities, social and otherwise, which exist in any ordinary community. By working through some of their problems in hospital they can experience a living-learning situation which can be applied when they return to the world outside. Such ward meetings should, whenever possible, be followed by a review session with the staff alone. At this meeting the staff examine how they interacted with the patients and also examine their feelings about each other. It is not uncommon for staff to manifest conflicting attitudes towards the same patient, and they may become aware of feelings of rivalry, etc. amongst themselves. In the review, the staff may have representatives from the various disciplines, nursing, social work, psychology and psychiatry. Everyone has been exposed to the same ward meeting, and people tend to react and interpret what has happened in the light of

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their previous training and personality. The day-in day-out examination of ward situations in this way leads to examination of roles and role-relationships, and may ultimately produce a therapeutic culture in the ward which will reflect the needs of the patient more accurately than the formal hierarchical structure usually does.

3. *The family group*. There seems to be a strong case for every patient being seen in relation to his family, if any. If possible, the family should be involved from the start and be present at the initial interview. At this first contact there would seem to be advantages in having the whole therapeutic team present and not just the doctor. In this way the nurse and other treatment personnel have an opportunity of getting the family in some kind of perspective, and are given clues about how to approach the patient's own individual problem. Such initial contact will tend to impress on all staff members the need for further group contact. Ideally, one would like to set up a family group with every new admission where this is practicable, and continue to see the patient with his family at weekly intervals during his stay in hospital. Such a programme would call for many groups and may make it impossible to have only doctors as group leaders. Given an adequate group training programme, there seems no reason why the group leader should be limited to the medical profession, as social workers, psychologists, nurses and others can readily acquire sufficient skills to carry out some form of group therapy. There would seem to be no real need for extensive psychoanalytic group work training, provided one limits oneself to here-and-now situations. There seems to be a good case, however, for supervision by some well-trained group worker, so that the less experienced group therapist can avoid getting into serious difficulty and at the same time be in a continuous training situation.

4. *Activity groups*. With many long-stay schizophrenics and with organic and geriatric patients, there seems to be less value in ward meetings or other forms of discussion group than there is in the admission and medium-stay wards. There seems to be more interaction possible when, say, five patients are formed into a group associated with a staff member, and develop whatever kind of activity programme they feel to be appropriate and within their competence. It may be that they choose some kind of artistic activity such as painting, or simply playing a game of dominoes. Alternatively, they may choose to take up some form of long-term plan like making Christmas decorations, or developing a puppet show. Given a group task, interaction seems to grow more readily than when they are expected to talk in a formal setting. Here again it would seem important that group meetings should be followed by a review involving all the staff who have participated in such groups. In this way the staff's feeling of frustration and futility, their incapacity to understand schizophrenic communication, or their feelings about the way in which patients are being handled can be discussed and used as a learning situation.

5. *Informal groups*. Patients interact in ways which are frequently not too well understood by the staff (Caudill *et al.*, 1952). In the relatively articulate short-stay admission ward, patients have very positive views about treatment and about the staff generally. Attitudes and insights learnt in group therapy can often bring a more positive contribution to informal groups where patients can themselves act as therapists. The formal structure of therapeutic groups may slowly become modified in the direction of more spontaneous interaction between patients and staff. The schizophrenic treatment project at Kingsley Hall, London, associated with Dr. R. Laing, is an example of such an unstructured group (Esterson *et al.*, 1965). In this setting there is no formal distinction between patients and staff, and the community live together quite informally. This seems to help communication, and through time it is possible to come closer to the schizophrenic and understand him much more readily than one could in a formal ward structure.

6. *Administrative and training groups*. If a hospital is so organized that communications are relatively open and all decision-making is done by involving those people who will ultimately be concerned in carrying them out, then many

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administrative groups are essential. When an administrative problem comes up for discussion by a staff committee, it may become clear that the point at issue is not as important as the hidden agenda. Whether administrative meetings can attempt to look at what feelings lie behind a problem, and begin to examine inter-staff problems, is a matter for the group itself to decide. However, it would seem that this kind of examination of a hidden agenda can be very useful for training administrators and making them more part of the therapeutic community. In the same way, review sessions following patient group sessions, can bring out strong feelings between staff members. There would seem to be every reason to try to work through some of these feelings with a view to resolving them and to further training. Such living-learning situations seem to apply equally to both staff and patients, and raise the interesting problem of how far treatment of patients and training of staff overlap.

One could describe many more types of groups which are to be found in psychiatric hospitals, but the above gives a selection of fairly familiar groups currently in practice.

Conclusion

The point of view expressed in this paper is that it is impossible to consider group treatment in psychiatric hospitals without referring to the social structure of the hospital as a whole. Treatment groups can be seen as somewhat artificial situations in which interaction between patients and staff is encouraged. It may be that through time more and more attention will come to be paid to the informal interaction which occurs between people; this may have more potentialities for treatment and training. Formal groups are less representative of the life that patients lead outside hospital. Moreover, the view is adopted that if staff do not spend a great deal of time examining their own inter-personal problems and how to deal with them it is doubtful if they are fully prepared to help patients in handling their problems of living.

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Maxwell Jones, C.B.E., M.D., M.R.C.P.E., D.P.M., *Physician Superintendent, Dingleton Hospital, Melrose, Roxburghshire, Scotland*

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