Working with the nursing staff of an in-patient admission ward

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Abstract

What follows is a clinical description of some experiences and observations which have arisen out of my acting as group work Supervisor for a group of nurses in an in-patient acute psychiatric admission ward, and as facilitator of a Staff Support Group made up of the same nurses, over the last three years.

Key words: nursing staff, day hospital, group, support, separation anxiety

This paper has been published on the British Association of Group Psychotherapists Newsletter special NHS issue, Vol 3, N. 2, Summer 1997, pp.6-9.

The initial contract

I spent about the first six months providing only the group work supervision, and then for about another year I also ran the staff support group. For the past 18 months I have continued to facilitate the Staff Support Group, while another colleague has taken over the group work supervision.

I had agreed with the ward manager during our initial contact, that my work as supervisor would last for one year initially, after which the situation would be reviewed. I thought it important to leave open the possibility for both parties to withdraw from the commitment, in a not too difficult and / or painful manner.

Even though I was working within the same Health Trust, my main duties were almost entirely concentrated in an out - patient psychotherapy department, situated in a totally different building and distinct from the in-patient wards, so I was therefore able to be considered as very similar to an external consultant.

When I started my involvement with this ward, I was puzzled by the difficulty the nurses had in working psychodynamically in a group since there had been a previous supervision that had lasted for some years.

Some very basic concepts and technical requirements seemed to me to be almost totally ignored and / or misinterpreted.

Apart from the content of the nurses' interventions in the group, I was struck by their apparent unawareness of the importance and limitations of the setting they were working within.

Attendance at the twice-weekly ward group was poor and they didn't seem to worry too much about the less than optimal physical space where they held the group.

This was a room in the middle of the ward, adjoining the kitchen, which could hardly provide the bare minimum of privacy necessary for it to be used as a container, and a

stable and safe enough setting to make the disclosure of very personal communications possible.

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The specific nature of the work: Separation anxiety

As this is an acute psychiatric admission ward, patients tend to be admitted for a limited length of time; usually a few weeks but occasionally a few months.
This is largely due to the relative lack of resources available in the NHS for these clinical facilities, and the pressures on this kind of ward for beds is always quite high.
I have heard of beds being taken over by newly admitted patients within a couple of hours of the previous occupant committing suicide.
The implication of working with a rapid turn over of patients, who are bound to be discharged without actually having improved to a more satisfactory degree, is that it rarely allows enough scope to establish deeper and more meaningful relationships, and this therefore seems to be one of the main issues and difficulties which the staff have to come to terms with. It is quite possible therefore, that this unstable and chaotic atmosphere that impregnated the whole ward, was also being mirrored in the chaotic setting and regularity of the ward's groups.
The rotation system, which affects the junior medical staff even more than the nurses implies continuous changes in personnel, separations and mutual readjustments.
In one Staff Support Group session, the junior doctor attached to the ward disclosed that he was supposed to be leaving in two months time, having spent no longer than six months there altogether. He expressed how angry and frustrated he felt about that. He would have liked to be able to work more thoroughly and to become more deeply involved with the ward, so that he could have matured and absorbed properly his experience there before moving on. The value of moving somewhere else at the right time after an experience of growth was very different from the waste of moving too prematurely, he claimed. He liked working in that ward and appreciated the support group as a place "to think", develop and grow.
Thus separation anxiety and the related defensive reactions, easily became the central focus to be tackled in this clinical kind of setting.

The beginning of the consultancy

When I started the actual work in the ward, the initial response I got from the nurses was extremely ambivalent.
Some immediately expressed their eagerness and were well disposed to me taking over the supervision group, but others did not conceal their considerable hostility and antagonism. This tension was not only directed at me but was also apparent in their relationships with each other.
It was only later that I realised how much this resentment and anger may have stemmed from a feeling of being abandoned by the previous supervisor that was then projected on to me. The quality of their attitude to me also suggested a number of unresolved issues with my predecessor.

During the first six months or so in particular, I found myself several times feeling very angry at what was happening in the supervision group, and about the nurses' work with their patient's groups. I was feeling very frustrated and quite unable to break through their contemptuous and defiant attitude.
Any comment I tried to make, any interpretation and / or suggestion I could provide on how and why it might have been more appropriate to tackle some of the situations which were being reported to me differently, was often met with either a challenging and rejecting attitude, or with a rather more silent and compliant, but in fact equally aggressive response. Their behaviour didn't seem to be open to much modification.
The themes frequently presented in the patient's group meetings centred around the ward feeling like a Hotel lobby, where a lot of people were coming in and out, while the meaning of being there, sitting around, seemed to remain quite obscure to too many of them most of the time.
I sometimes felt that these associations could easily have also applied to how the nurses themselves were possibly feeling; confused and uncertain about their own roles, passively watching the rapidly changing patient's population, without feeling quite able to relate properly with them. I was struck by how little the nurses often seemed to know about the patient's own lives and background. It seemed to me as if they actually did not want to know. The fear of intimacy and depth in relationships at so serious a risk of separation and loss, seemed to be quite an impossible thing to tolerate.
New arrivals or discharges, changes among staff, turnover of nurses who were running the groups, or even of consultant's, didn't seem to be felt to be topics worthy of discussion and elaboration.
My frustration with the work I was trying to do, was making me feel quite isolated. At some point, I acted that out and wrote to the consultant of the ward to arrange a meeting, hoping to share some mutual feedback that I thought might have helped me in overcoming the standstill I seemed to have got myself into. That meeting in fact never took place.
In my fantasy, I could feel a growing anger also towards the previous supervisor whom I felt had to be partly responsible for the impossible situation I faced. I began to realise through my own countertransference, how similar to me the nurses had probably been feeling, i.e. isolated, excluded and angry with everybody else, desperately needing some help. It may be of some interest to add that I was never told by any of them of anything which had actually taken place in the previous supervision, nor in the one which later took over from my own supervision, after we had decided that I would concentrate on facilitating only the Staff Support group.

It was within that context that after a few months I happened to hear about the existence of a weekly staff support group on the ward. My own despair and feeling of being stuck in the group supervision made me ask straight away what the other group was like, with the not so secret hope of getting some additional clues or information

which might possibly have helped me to understand better what was actually going on in the ward, and how to overcome the impasse.
My questioning was sufficient for the ward-manager to ask me directly whether I might have been interested in running that group as well, since it had no conductor and there seemed to be mixed feelings as to how it was going.
That was how, in spite of a lot of doubts and uncertainty, I decided nevertheless to go along with this suggestion and see what would come of it.

The suicides and the mastering of the trauma

Not long after I became the Staff Support Group conductor, the difficult atmosphere and angry tension that seemed to be dominant among the staff, reached its worst peak.
Suddenly, for a ward where there had not been any suicide for several years, two suicides occurred within about a month of each other.
What followed from that, was a very intense upheaval of feelings in the staff, where depression, over idealisation, guilt and anger became the main issues. A lot of very personal feelings began to come out into the open and became the focus of the group discussions.
Some of the nurses had to ask for emergency individual psychological help; a lot of absences occurred due to sick leave, and eventually we seemed to witness what I would refer to as a kind of reactive suicide of the whole staff team.
It happened that, within about three months, most of the staff that had been working on the ward, including some who had been there for a very long time, resigned and moved somewhere else. It looked very much as if the staff was in turn killing itself off.
In almost any Staff Support Group we had been having throughout that period, and for several months afterwards, a sort of repetitive kind of ritual seemed to arise as a constant group theme, as one staff member after another communicated to the rest of the group that he / she also had decided to leave. .
The group as a whole would then express its recognition and acknowledgement of the worth of the colleague who had decided to leave, sharing with him / its sorrow, mutual appreciation and affection and its gratitude. I had the impression that some sort of enactment was taking place, whereby a lot of the feelings the staff had been experiencing towards the patients, but were unable to talk enough about, like for instance feelings of attachment followed by traumatic separation, as with and about the suicides, were being redirected and displaced onto other members of staff, and acted out.
It seemed as this ritual may have had the unconscious purpose, on one hand, of expressing the anger and the retaliatory wish that followed both the previous departures of the other colleagues and the patient suicides that had left the staff feeling betrayed and abandoned. On the other hand, the need to be reassured and to be for once "on stage" as it were, getting their own share of acknowledgement and

acceptance, needing to feel needed, and being able to become themselves the "abandoning" and the betraying ones, rather than the "abandoned "ones, seemed equally important.
The staff was using one another to compensate for what they couldn't get from the patients. Their fear of the separation did not allow them to engage enough in the relationships with them and it was very difficult for feelings of attachment to be acknowledged or expressed. The ritual had acquired the flavour of an institutional compulsion to repeat, in order to get some control over a very traumatic separation.
The feeling of disintegration and collapse in the ward was quite tangible.
The ward manager had been the one who set the whole process off, and had been the first one to resign from the post. He had been there for several years and had become quite a charismatic figure for the rest of the staff who had developed a very dependent, child - like relationship with him. The ward seemed to have become his own personal territory; the junior medical staff never stayed long and the consultants kept a low profile. In practice the day to day running of the ward, in goodness and badness, was almost entirely left up to the manager.

I now wonder whether and to what extent my presence in the ward may have contributed to the manager's decision to leave. He very rarely came to the Staff Support Group sessions, and I guess he probably was himself quite ambivalent about my being there. If that were the case, I must admit that I did collude with him because at the time I was rather confused, and I did not take it up with him. I suppose I may have also been made blinded by the fact that I resented the anger directed at me, with little chance of knowing and understanding what was going on in the ward when I wasn't there.

The two interacting fields: relating among staff and with patients

Witnessing all these happenings in the ward, I had the impression that there was a mutual and constant flowing of feelings to and from the two fields, the one of staff and the one of patients. In some circumstances it seemed easier for the staff to displace and project their emotional attitudes and reactions towards the patients onto the team, as outlined above in the suicide cases, on the likely ground of it being easier and safer to invest affectively among themselves, rather than in patients. The latter in fact either could not deal with such feelings or, because of their limited stay on the ward, might have constituted a wasted emotional investment anyway. The silence which often arose during the staff support groups also seemed to be concerned with something which had been bothering the staff in its relationships with the patients. On one occasion, following a very long and uncomfortable silence that I was trying to break up, one of the nurses, referring to it, admitted that for once, she wanted "to be naughty", like the patients, and be challenging and irresponsible as the patients very often can be. In other words, she was expressing the rivalry and competitive feelings

about all the things patients were allowed to do and the staff was not: like a parent who envies the child's privilege to be so.
Another example of how these two fields of patients and nurses continuously interacted with each other emerged when one of the staff became pregnant. Her colleagues became very protective of this young woman, and in our groups she was often given a lot of attention with genuine concern. At one point this nurse was able to say how she was feeling increasingly uneasy and guilty about this, as if she was feeling she was stealing away from the patients', the attention and care she and her colleagues were supposed to be giving them. The roles seemed to be somehow inverted.

Other times the situation would arise, whereby the conflict within the staff would be acted out with patients, because it felt more important to safeguard the relationships with the colleagues rather than the ones with the patients. In one instance, several members of the team expressed very angry feelings against a woman patient who had been very manipulative and had even made an official complaint about the bad way she thought she had been treated on the ward. Through talking more about it, it became apparent how the whole team was going through a particularly difficult and angry phase in their relationships with one another, largely due to the consultant of the ward having resigned. It seemed possible, under those circumstances, that the patient might have partly become the scapegoat of the angry feelings the team was experiencing towards the consultant, by whom they were feeling abandoned, manipulated and ill-treated. Similar tensions in the ward did also arise whenever it happened that I had to cancel some sessions.

Authority
Another issue which came up more frequently in supervision than in the staff support groups, had to do with authority. Not only was there a difficulty in getting patients to attend groups as I have already mentioned, but also those patients who did not attend were allowed to come in and out of the room where the groups were run, causing a considerable degree of stress and rivalry with and among those patients who did attend, and the whole situation was very chaotic. This inevitably led us to talk about boundaries, containment and authority. The staff underlined how much it was part of the ward philosophy to act as democratically as possible, without forcing patients to do something unless absolutely necessary.
Thus the staff's concept of "political correctedness" was applied literally in all circumstances on the ward with little understanding of the patient's need for containment. I struggled quite a lot trying to correct such gross misinterpretations, but I am afraid with little avail. Their ideological standpoint and the related fear of being rejected by the patients were being used as a defence against the necessary use of authority.

While discussing these issues, it came up one day that some of the nurses felt quite anxious about the idea of possibly having all the 13 or 14 patients in the group, and that they dreaded having to deal with that number. I suppose the fear was of being totally devoured by all the demands put on them by those hungry and starving patients.
Together with that, there probably was also an even less conscious wish to attack the authority figures, like myself, and the consultants who were felt to be believers in this kind of treatment, and therefore responsible for inflicting on them an extra source of anxiety and stress.
On the other hand, when the nurses were talking about "treatment", it was obvious that what they actually were talking about and meant was just and only "medications", and the idea that group therapy could also be considered as an integral and valuable part of the whole treatment, seemed rather foreign to them.
On another occasion, when we had been talking about pros and cons of restraining patients who become violent when it happened that the patient's primary nurse had to be the one to exercise that power, one of the nurses was able to say how she was actually very aware of their authority as staff, and of their own very great power over the patients. She also said that such awareness was quite scaring though, and it was quite difficult to come to terms with the guilt and the fear of the responsibility associated with it.

The need to preserve one's own identity

The continuous interaction between the internal world of nurses and the one of patients' cannot but bring about the need for a safe refuge.
When we examined in the supervision group the need for a more stable and private space where the groups could have been run, it was obvious for me to think and make reference to the possibility of using the same room (the so called staff-room) where we were having the staff group meetings. It was the only room really separate from the rest of the ward, which could have allowed the required privacy, offering at the same time a reasonable security being immediately outside the ward main entrance door.
That suggestion was met with strong resistance. One of the reasons given was that there were not enough chairs to contain " all" the patients, and another was that there were some bookcases with glass doors that could have easily been broken.
Such justifications seemed quite thin to me, but I realised how vital it was for the staff to have and keep its own physical space where they could withdraw to, defend and protect themselves in order to survive a working environment which was felt to be a continuous challenge and a threat. The fear was of merging their own precarious identity with the sick one of the patients'.

Parental ownership of the patients

Another of the things that struck me working in this ward was the attitude that was displayed towards agency nurses. The latter often had to step in when too many "close observations" were needed and / or when there was staff shortage in the ward, which quite often was the case. Agency nurses were being used as "bare manual labour", and they seemed to be an easy target for a lot of projected identifications from the permanent staff.
They were not allowed in the ward groups for fear that they could "talk to patients" and say something either very stupid and / or damaging. The awkwardness of this went as far as to instruct those agency nurses who were supposed to be closely observing patients attending the ward groups, to watch and check them from outside the room, through a small window on the door. I pointed out in the group's supervision that it was quite unrealistic of the permanent staff to think and expect that the agency nurses would not talk and / or relate at all to patients, because of course they would.
Even assuming that they could say or do silly things, it would have been easier to control them, and educate them, by letting them participate in all the ward activities. I said that approach would probably be much more productive.
What developed out of that discussion was that agency nurses were eventually allowed in the ward groups, but to my utter surprise, were instructed not to say or do anything there. This was another instance where the merely passive compliance to my suggestion, with no internal elaboration of the meaning of the behaviour we had been talking about, indicated a very strong resistance that it would not have been easy to get through and modify.

There were two issues at stake in this case. One was to do with the staff's jealousy and rivalry whenever they were feeling a possible intrusion on their parental role and / or a very slight challenge to it. The second issue probably had to do with a marked need to project on the agency nurses the exclusion, the powerlessness and helplessness that the rest of the staff in different ways was experiencing, but was finding rather difficult to acknowledge.

Impotence and omnipotence
There was a widespread feeling that only the psychotic patients were actually mentally ill and therefore deserving the nurses' full attention, while those patients with personality disorders were seen as a "pain in the neck". Their manipulative and attention seeking behaviour was felt to be not serious enough to require hospital admission and, above all, the nurses' emotional investment.
The real issue behind this differentiation seems to be that when dealing with psychotics, nurses are actually able to see the positive effect of the "treatment", i.e. of the medication they give the patient, and the relative recovery from the delusional state they are often in, when they are admitted. This is bound to produce an

omnipotent effect on the staff and a reinforcement of their own therapeutic function and identity.
When the nurses, on the contrary, are required to deal with neurotic patients, who may appear to be less sick than the other category, paradoxically the staff suddenly feels increasingly de-skilled and impotent, not quite knowing what to do with them or how to tackle the problems they pose on the ward. Moreover, the "personality disorders" psychopathology is much closer to their own, and therefore is much more threatening. It is interesting to observe this, for it probably constitutes a radical inversion of the way most psychotherapists would feel about patients, should these be seen in private practice.

Dependence and responsibility

Often in Staff Support Groups we can observe how strong the dependence on the conductor of the group is particularly at the beginning. If I had to cancel a session, most often the group would be cancelled. Very rarely it was reported to me that any "real work" had been done, on those few occasions when some of the staff met anyway, without me.
Another circumstance in which this dimension tended to come up was whenever we were facing long silences in the groups; the expectation seemed to be that I had to know what was going on in the ward magically and make it all right, without anyone telling me what the problem was all about.

On some occasions some of them were able to say how they felt much more reassured while I was there, when it was so much easier for them to deal with and express negative feelings or conflicts, to one another.
One day a nurse had to cope with a very difficult and life threatening situation, after a patient had cut herself in a very bad manner and he was the only one, though still junior, who had to sort the problem out. He felt very angry with the ward manager who apparently, accordingly to his account, had not given him the chance in the following days to talk enough about that incident, and allow him to work through it and get it satisfactorily out of his system. He had not been able to talk in staff support group about that episode, for several weeks. When eventually he was able to do so, he was also able to acknowledge how it was also part of his own responsibility to bring up whatever issue was worrying him. This allowed him not to put the blame on anyone else but himself, for having delayed so long the possibility of sharing his experience with the whole group and getting some relief out of a very uncomfortable situation.

Conclusion

I am still carrying on as facilitator to the Staff Support group in this ward. The dynamics in the group have gradually changed over the years, particularly during the last six months. Much more frequently than ever before personal disclosures have

taken place, and uneasy conflicts among staff have more openly been dealt with and talked about. I think I could say that the group now seems to have reached a more stable membership, developed a much better mutual trust, and the relationship with me has also become much more relaxed.

I have tried to give in this paper an outline of some psychodynamically relevant aspects of the group work that nurses carry out with their patients in an acute admission ward. I have also summarised some of the most important issues that have come up in the Staff Support group.
In particular, I have aimed at focusing on the complex relations between staff and patients, as seen from the point of view of the nurses' unconscious phantasies, anxieties and defences. I have tried to explore how the conductor's countertransference might throw some light on the unconscious processes operating in that setting, and might allow a better understanding of what it is likely to be going on within the staff group. Some predominant psychological features of this therapeutic setting have been identified , and so have some of its possible implications and consequences.

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