Group Psychotherapy in the Public Sector: The Impact of the Organisation on the Primary Task

Paula Godfrey, Robin Smith

Abstract

In this paper we will discuss psychoanalytic group psychotherapy in the process of treating complex patients as part of their clinical management, both of which are set within the context of a large and changing public sector organisation in the United Kingdom. Included in this we will examine how the many correlative services can be slotted together, acting like a jigsaw of provision, and consider their impact upon group psychotherapy. We will explore how this can lead to the organisation being both a container of high levels of disturbance, but also become a platform for the projection of both an individual pathology and the anxieties within the group itself, there by potentially both enabling and compromising the quality of patient care. Furthermore, we will consider how the organisational dynamics interact with and at times conflate the disturbance within the group itself, the psychotherapists and the patients, thus creating a system where a complex set of dynamics continually moves and at times converges, impacting on the primary task of group psychotherapy in this setting.

Key words: group psychotherapy, public sector

Setting and Context

The group is run as part of the provision of psychological support within a psychotherapy department provided by the British National Health Service (NHS), a government-funded health care system that is paid for through taxation within the UK. It provides a comprehensive range of services addressing physical and mental illness. Generally, most patients seen in the service have voiced a sense of reassurance about receiving treatment from the public sector. This appears to be associated with a sense of familiarity and also in relation to the motives of psychotherapists in their provision of treatment. That treatment is free at the point of delivery and based on the principles of universality (available to all).

The group is set within a psychiatric hospital in a major British city. The hospital is typical of many of its type, comprising three acute wards for adults who present with an acute phase or relapse of a serious mental illness. The level of presenting risk of harm to self or others is deemed to be high and therefore patients are not able to be managed within the community. They require admission onto a ward with access to 24-hour care and experienced and specialist staff trained in the treatment of mental illness. In addition to the three

wards, there are associated administrative offices and clinical services such as crisis services (that is, a walk-in assessment unit), outpatient services and other related clinical services. This includes the psychotherapy department which referred all of the patients who attend the group on an outpatient basis.

The group itselfis not time-limited and is run by two psychotherapists, one male and one female. It meets for weekly 90 minute sessions, offers places for up to eight outpatients to attend and takes place in the same room each week, two floors above the inpatient wards. The group room is regularly used either for meetings, training or psychotherapy groups. Therefore, although there is a degree of physical separateness from the wards, patients attending the group often come into contact with others using services in the hospital, for example in the communal areas of the lift or corridor, which are accessed by inpatients as well as outpatients.

As part of the provision, patients are issued with a care plan as their treatment in the group commences, which in part contributes to the strategy of clinical governance within the Trust (an umbrella organisationthat is part of the NHS, and isresponsible for the running ofmany services in the provision of health, including those within this hospital). Clinical governance can be understood as a systematic approach to maintaining and improving the quality of patient care within the public health care system in the UK. It deems organisations be responsible for interventions that are safe, caring, effectiveand well-led. In line with this, the care plan which takes the form of a written document shared with the patient and staff involved in their care, names the treatment (in this case group psychotherapy) and strategies to manage risk for the patients attending the treatment; namely, additional services and named contacts that they can access, in addition to the group itself, for support. This can include an out-of-hours crisis service, GP or Consultant Psychiatrist. This care plan puts them in potential contact, either face to face or via phone, with numerous staff members who have different trainings, such as medical, nursing, support workers and administrative staff. These staff members will have differing levels of experience and approaches related to the treatment of mental illness.

These additional layers of services and their associated staffthat formpotential support, mean patients experiencing more severe pathologies are able to remain safe whilst accessing group psychotherapy. As such, patients attending the group have varying histories that include severe depression, suicidal attempts, severe substance misuse, anti-social behaviour and experiences of severe abuse. This structure, as part of a strategy of clinical governance, provides group members with potential contact with many services, and although this jigs allows these types of patients to receive psychotherapeutic treatment**,** it also provides increased potential for disruption to the dynamics in group psychotherapy, thus compromising the primary task.

The above goes in parallel with the potential for disruption and enactment by the organisation itself, which diverts from its primary task of the treatment and recovery of people experiencing mental illness. This is evident in thelandscape of constant organisational change, with services often reconfiguring and a focus on expansion; by providing services not related solely to mental health, such as community physical health services, whilst continuing to operate in a climate of reduced financial funding for public health resources. Furthermore, the organisation operates within a backdrop of associated factors such as staff turnover, an emphasis on a bureaucratic response to incidents and over-demand for its services.

Some Theoretical Considerations

We would now like to touch on a few areas of theory which are relevant, both to group psychotherapy and organisational dynamics. The first area concerns Bion's work with groups and it is worth highlighting several important concepts that he brought to public attention.

In *Experiences in Groups*, Bion stated that a Work Group is set up to pursue a particular task, something realistic and within the scope of the group and its members. The task that the group undertakes is known as the primary task, which will "keep the group anchored to a sophisticated and rational level of behaviour" (Bion, 1961, p. 66). The Work Group's primary task is to do Work, and in this context could include, as a first step in making changes, group members recognising through interactions in the group, a dysfunctional way of relating to others that pervades all relationships in their life. In contrast, the primary task of the Basic Assumption Group is to survive, along the projective identification-based notion that the basic assumption functioning of the group will ensure this. In addition, according to Bion, the healthier Work Group actually floats in and out of functioning as a Work Group and as a Basic Assumption Group, in a way that a more stuck group cannot.

Basic Assumption functioning can be identified in three ways: dependency, pairing and fight/flight. In dependency, a leader is invested with omnipotent and omniscient powers, which provide security and protection for the other group members, who remain in a state of passivity and dependency. The eventual resentment of this dependency means that the group leader may be taken down and replaced, with the process being repeated with another leader. Pairing involves two of the group members carrying out the work of the group, the unconscious fantasy being that through their coupling a Messiah figure will emerge, either a person or an idea, that will save the group. Pairing brings hope and anticipation, but this will vanish if anything is created in actuality. The third basic assumption is fight/flight, which assumes that the group has come together for the purpose of preservation. Fight is achieved either by attacking a

common enemy, for example in-fights amongst group members, and flight by getting away from something unwanted, such as an evacuation of someone from the group itself. Bion stated that within basic assumption functioning, the two characteristics of time and development are inherently absent, and that the presence of either is felt to be threatening, persecutory and met with a hostile response. Indeed, Bion stated that "the continuity of social structure through time is a function of the Work Group" (Bion, 1952, p. 240). Basic assumptions will submerge the Work Group if the group is unorganised, since "group organisation gives stability and […] organisation and structure are weapons of the Work Group" (Bion, 1952, p. 239).

The second theoretical area which we feel has relevance to the scope of this paper, involves the work of Isabel Menzies Lyth and Elliott Jaques, and their seminal papers *The Functioning of Social Systems as a Defence Against Anxiety* (1959) and *Social Systems as a Defence Against Persecutory and Depressive Anxiety* (1955) respectively. Their work brought understanding to the idea that organisations are built up and inherently seek to maintain a structure and a way of operating that alleviates anxiety, since it is anxiety that threatens its very survival. Individuals invest in this structure by "externalising those impulses and internal objects that would otherwise give rise to psychotic anxiety and pooling them in the life of the social institutions in which they associate" (Jaques, 1955, p. 478). Furthermore, externalising "gives substance in objective reality to their characteristic psychic defence mechanisms" (Menzies Lyth, 1959, p. 51).

There is no doubt that these ideas and the dynamic understanding of organisations is particularly pertinent when working in the therapeutic community and in the setting of a psychiatric hospital, where relationships are intense and mental illness is often severe. As a result, the ability to contain and tolerate feelings of anxiety amongst patients is limited and the pressures and strain on staff to perform this task is high. Furthermore, there is the potential for group members to have contact with the different aspects of the organisation and the staff there in, who will have very different levels of experience and training in the field of mental health. Therefore, it can be seen that there is a real likelihood of people on both sides being pulled into unconscious re-enactments of early traumatic experiences as a method of alleviating persecutory anxiety.

The Primary Task of Group Psychotherapy

Given that the group under discussion in this paper is a psychotherapy group, the primary task should be thought of as psychotherapeutic. But views on what that actually means may vary between group members, group psychotherapists, and the different layers of the system of care. There may be a tacit assumption

that the primary task is to get better, but each individual may have a unique idea of what that means to them. Group psychotherapists may think of the primary task as building ego strength; and the ability to tolerate anxiety rather than be overwhelmed by it and act out; and to stay with thinking and words rather than actions, all of which enable the potential growth and formation of more stable healthy relationships and the possibility of change to occur. Transformation for the group can be seen as stemming from a link that people maintain with other people, things and their own intra-psychic features which are conducive to increments of knowledge and allows for becoming or being at one with oneself. This possibility of change is a potential source of anxiety in itself, since as Menzies Lyth pointed out "change is inevitably to some extent an excursion into the unknown. It implies a commitment to future events that are not entirely predictable and to their consequences, and inevitably provokes doubt and anxiety" (Menzies Lyth, 1959, p. 62).

In terms of the wider reaches of the hospital, it could be stated that the primary task of the group is to cure its members, to get them into a position where they can recover and no longer need psychotherapeutic intervention. Each group member will have their own reasons for being present and may share this somewhat fantastical view of the gains possible, perhaps grounded in an idealised, phantasy-based idea of group psychotherapy. In some cases, the reason for attendance is an outside authority figure, a Consultant Psychiatrist for example, suggesting that group psychotherapy is the best option for them.

Given how each individual's perception as to the primary task of group psychotherapy is subject to their own conscious and unconscious dynamics, and the high levels of psychological disturbance within the group members themselves, the group can take on a character of confusion and a sense of disorganisation, where the primary task of fostering healthy change and growth is lost or diverted, by using the group only as an opportunity to evacuate. When this occurs, there is a likelihood of the group simply trying to survive, leading to it functioning as a basic assumption group, rather than functioning on a rational and introspective level, and able to keep to the primary task of Work.

A final point is the way in which the dynamics of the organisation itself can be projected into the group and its psychotherapists, further impacting on the primary task; for example, the psychotherapists' experience of reward in terms of experiential learning rather than financial remuneration, perhaps leading to a question of the desirability of working for an organisation that on the one hand holds a core value of being caring, versus the experience of working unpaid, and in turn may lead to a question of the perceived regard of the actual service (in this case group psychotherapy). This is compounded by additional demands from the organisation that distract from the primary task of clinical work. One example of this is a requirement to record information on a protracted computerised patient record system, which can be seen a stipulation imposed

by the organisation, in part congruent with its bureaucratic response to the anxiety of managing high levels of disturbance evident in its patients.

Clinical Material

We would now like to introduce some clinical material which is pertinent to thinking about how an organisation can impact upon group psychotherapy in the public sector, and how in turn the organisation can become a platform for the projection of both an individual pathology and the anxieties within the group itself.

The case involves Theo, a 31-year man who has attended the group since its commencement. He presents as a man with a high propensity to be drawn into the excitement around subverting established agreements or rules, in an attempt to divert from feelings of, for example, anxiety. In particular, this is in relation to the possibility of developing intimacy with others, including those within the group. This conceivably perverse way of relating occurs in every area of his life including within the context of the group where on behalf of himself and others he communicates this through various presentations of enactment. One clear example has been persistent lateness. For over twenty months in the group he was late for almost every session, from 2 minutes and up to 75 minutes.

For many weeks, whilst the group was running, the lift that taxis group members from the reception area to the floor where the group takes place broke down. This experience of something breaking down in the internal structure of the organisation directly interfered with the process of coming together for group therapy, in that the patients were unable to make their way to the group room independently. Instead, they had to wait collectively in the communal reception area on the ground floor of the hospital, where one of the psychotherapists would collect them prior to the start of the group, and were then escorted via a different route to the room that the group took place in. Access was dependent on the use of a set of keys carried by staff, which were required to be signed out prior to use. Therefore, if a patient was late they were unable to get to the group. This illuminates how the dynamics between individuals, the group and the organisation, at times merge and pervade each other. In this situation, the organisation itself can be seen to have taken on the features of a dependency group, where the flawed mechanics of its lift, coupled with its rigid internal structure of locked doors, conveyed the message that ideas such as individuality, independence and even free association are not only disallowed but even potentially dangerous; thus providing a platform which contributes to Theo's inclination to maintain a sense of independence through subversion, deviousness and delinquency.

Due to his lateness, this resulted in a number of occasions when Theo was left sitting in a stairwell behind a set of locked fire doors and consequently locked

out of the group. In this situation he would miss the majority of the session and wait opportunistically for another staff member to pass by and let him access the floor where the group room is situated. This pattern of events occurred for several weeks and despite persistent and robust challenges from psychotherapists and other group members, Theo was unable to attend on time, resulting in him excluding himself from the session, only to disrupt things when he finally gained access and came into the group. These events perhaps also converge with Theo's propensity to preserve an absence of need of others, as it is notable that other group members responded to this breakdown by ensuring their prompt arrival for the session thus avoiding getting locked out.

However, as was clear from the content of group therapy sessions taking place over this period, for example unexplained and unplanned absences by other members from the group, this propensity and need was not located just in Theo. His subversive presence and behaviour expressed and made permissible something for others and the group as a whole.This was further evidenced by the anger and challenge from others, seemingly in response to his tardiness being employed to activate a fight/flight response, so that Theo's continued lateness became a vehicle to challenge his actual place in the group. Therefore, during this period Theo was experienced as a subversive element that could be potentially evacuated from the group providing a sense of temporary relief and preservation.

On one occasion, Theo was once again not present at the start of the session. He entered the room around 10 minutes late dangling a set of keys. When asked, Theo relayed that he had been given a key by "the nice bloke downstairs on reception". On further discussion it was established that Theo had signed for and been given a set of keys only intended for staff use. The keys enabled access not only through the doors to the floor on which the group ran but also offices and clinical areas such as the inpatient wards, which patients were clearly not allowed unsupervised access to. This unauthorised use of the keys had the potential to be dangerous for both patients resident on the wards and also members of the public, particularly in consideration of the patients' acute and severe mental health issues and the associated risk of absconding. Once again, this highlights the sinuous dynamic flow between the individuals, the group and the organisation itself, with the organisation taking on features of a basic assumption group, flipping from dependency restricting movements and complete reliance on staff, to a fight or flight organisation where patients can literally run off and harm others.

The psychotherapists, perhaps stunned by Theo's casual statement or perhaps due to their own anxieties over the issue and a wish to brush the incident under the carpet, seemed unable to tackle the matter within the group itself. Afterwards, the psychotherapists spoke to the staff member concerned, relaying what had occurred. He looked visibly shocked and stated that he thought Theo

was a staff member, and actually the psychotherapist for the group. Although he was initially sure that Theo had told him this, on reflection he said that he just seemed like a member of staff. No doubt this belief was in part due to the fact that Theo dressed in a shirt, suit trousers and smart shoes, which made sense given that he had come directly to the group from his work, where such attire was required, but perhaps there was also a denial of difference in role, since the male psychotherapist in the group wore a similar style of clothing. This was highlighted very strikingly in one session, when Theo and the male psychotherapist were dressed identically!

The receptionist reassured the psychotherapists that it wouldn't happen again and requested that the incident not be taken any further. However, after the session it was established that, in light of the potentially serious security risks, the incident and associated transgression of polices and rules had to be reported to the managers of the hospital. In response, the management of the hospital reviewed associated policies and procedures and addressed the issue with both the individual concerned and all reception staff.

This incident highlights how Theo's propensity to subvert rules and expose the weaknesses of others gets played out within the organisation, and how, when exposed, the organisation can quickly switch from being a container of disturbance to a stage for enactment. The organisation demonstrates that it can be tempted to shift from one basic assumption way of functioning to another, with Work getting lost in between. Furthermore, the dynamics of the individual, the group, the organisation and the psychotherapists, all converged, and can be clearly seen both in the response of the staff member in handing over the keys to Theo, but also in the silent response of the psychotherapists and other group members within the session when such a violation became visible, yet was left unchallenged. As well as this, there were the unexplained and unplanned absences by other members from the group around this time, all of which ensured that the possibility of Work and the primary task of the group were temporarily lost.

Discussion

In view of the theoretical concepts highlighted previously, there was an enactment carried out by one particular patient, but done so on behalf of the group, and furthermore, this enactment was facilitated by the organisation. It can be seen that Theo's own pathology and ways of relating were projected into the multiple layers of the organisation, which having met the projection, conflated this in the group, and as a result compromised its ability to do Work. On an individual level, Theo's tendency to subvert rules and agreements is in part an attempt to divert at all costs from the development of intimate relationships, where, amongst other things, potential for dependency and the

subsequent opening up of the possibility of loss can develop, perhaps tracking back to an early and profound experience of containment failing, seen in his experience, brought to the group, of a depressed father and emotionally unresponsive mother.

This reflects the anxiety inherent in meeting the primary task of group psychotherapy, to not just survive but to Work, which was felt to be too overwhelming for the group and its individuals, and since this was unable to be expressed and thought about (i.e. actually carry out the primary task), it was acted out, in this case with one member being locked out with the potential of actually being ejected from the group.

This idea of being locked out of a relationship is relevant to all patients within the group, who struggled to form and maintain healthy relationships and intimacy in their lives, and were left in a confused state when trying to assuage the impact they had on others, and vice versa. This was communicated with various examples from group members of feeling unable, due to previous experiences of neglect or abuse, to really make connections with others, leading to varying ways in which others were locked out. This included a heightened sense of persecution at the hands of others or violent outbursts that came to be understood as self-harm in response to a sense of void and distance in the relationships in their lives; much safer therefore, for the group itself to be kept locked out of deeper, more intense interactions with those around them.

When one of the layers of the organisation conflated this tendency to subvert by providing him with a key to gain access to the group room, Theo had now been elevated to member of staff, albeit temporarily, and provided him with the possibility of gaining access to many previously restricted areas of the hospital, subverting and exposing something in the security system of the hospital. His propensity to subvert the rules of the group is evident in the fact that Theo often got caught up in adopting a superficial stance of pseudo-listening and empathising that was in actuality used as an opportunity to get in somewhere, usually a point of pain, glean information and become excited by exposing the vulnerability in others. Furthermore, this behaviour can be understood as an attempt to mock or demolish the role and work of the group psychotherapists and enable him to deny difference between himself and them. The idea of getting somewhere restricted, in a system or an object, is something that is acted out on behalf of the group, in order to maintain a particular way of relating, because the inherent vulnerabilities and anxieties of developing intimacy with others on an emotional and rational level, was felt to be too overwhelming for the group as a whole.

It is interesting to note that the psychotherapists only reported the key incident with a considerable degree of reluctance, and not only did they experience some anxiety about getting their colleague in trouble, they also felt a strong desire to stay removed from something perceived as potentially messy within

the functioning of the organisation. It was felt that reporting the incident would interfere with the group's task by coming into close contact with one of the layers of support, in this case another service and its associated staff, and potentially highlight a breakdown there in. There was also an anticipation of an anxious bureaucratic response from the organisation, due to the fact that certain rules and procedures had been breached. Perhaps though, this unwillingness to report the incident was in part an example of the group psychotherapists temporarily colluding with the organisation, Theo and the group as a whole, to deny a conceivably dangerous reality where a breakdown in the ability of the organisation to provide containment, inflated the potential of harm to others, through the risk of patients absconding. It can also be seen as an expression of a desire for the group to be special and to not come into contact with the reality that it was simply one piece of a jigsaw. It appears that there was a phantasy that the group be run outside of the wider policies and procedures of its setting, and in effect to operate as some kind of Messiah Group, able to cure and solve the ills of the patients on its own.

This clinical example highlights the way in which the pathology of a group member can be used to fulfil a particular function on behalf of the group, and is facilitated by others and the organisation within which it exists. Additionally, it shows how an organisation impacts on the primary task of group psychotherapy in response to its own dysfunctional and compromised dynamics.This landscape of complex dynamics, that are in part visible and yet at other times obscure and unconscious to the individuals, the group and the organisation, pervade each other and converge to create a space, where the anxiety of getting into relationships with others does not happen and something other than Work and the primary task takes place.

Summary

In this paper we have attempted to show how a changing organisation, with its correlative services slotted together, acting like a jigsaw of potential support and contact, can potentially disrupt the treatment of patients in group psychotherapy in a public sector setting. Whilst there is no doubt that given the severe pathologies present amongst group members and the overwhelming anxieties that result, the group could not be run without these additional layers of support, this many-layered approach cannot be seen as isolated services working without impact on each other. Whilst attempting to keep patient's safe and treatments effective, the inevitable confusions and failures within this complex system, in this example comprising patients, psychotherapists, group psychotherapy and the organisation, and all of their associated dynamics, are used by the group as a way of containing their anxieties. Moreover, the different layers of support and the dynamics that flow, converge and at times inflate disturbance, greatly confuses the work of the group, further complicating and disrupting its primary task.

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About the authors

Paula Godfrey: group psychotherapist, London. British National Health Service (NHS).

Robin Smith: group psychotherapist, London. British National Health Service (NHS).

e-mail-mail address: paulagodfrey1972@hotmail.com

robinjamessmith@gmail.com