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The life of a group on a locked ward

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Group therapy in an out-patient setting has been well established for over 40 years. Today, most acute wards offer some in-patient group therapy experience. Duration of in-patient stay (Yalom, 1983), the type of group therapy offered (Cox, 1976; Kanas, 1980) and patient psychopathology, can all alter efficacy of in-patient group therapy. However, in-patient units do appear to benefit from group therapy programmes, although some approaches are more effective than others and psychotic patients may suffer from the traditional group therapy approach (Cox, 1983).

Group therapy in the context of a secure setting for offender-patients has been described by Cox (1976) who points out the particular problems of dealing with a population which may be resident 'without limit of time'. Moreover, such patients often have fantasies of aggression and violence which can cause considerable stress to the group, and therapist; possibly this is why Cox recommends carrying no more than one current psychotic patient in each group. However, Novosel (1986) has described his experiences of conducting a group using an insight directed model within a secure setting, where members are all chronically psychotic.

Our own experience of group meetings in a secure setting is reported here. The principles and format of our in-patient group therapy programme did not, however, follow an interpretative dynamic model. They were based on Yalom's model for Lower Level and Team groups where the aims are to provide an experience of success in an atmosphere of low anxiety and considerable support; a sealing over process rather than an 'opening up' one.

The unit

The unit is a locked ward at Whitchurch Hospital, Cardiff which serves two functions. First, it accepts offender-patients many of whom are on Court Hospital Orders or Restriction Orders. Second, it acts as an intensive care unit for those patients who have become unmanageable on open wards, either through aggressive or suicidal behaviour. Such patients stay for short periods of time (average two and a half weeks) compared to offender-patients, who are in effect resident 'without limit of time'. Intensive care patients tend to be more agitated, fragmented and regressed than the offender population. The ward is mixed, with separate male and female dormitories, and is usually full on the male side. Some are actively psychotic, others in remission from a functional psychosis, and others recovering from a drug-induced psychosis. Many have personality problems as well.

This then is a mixed diagnostic population where some members are integrated, others are not. The turnover is fast and the atmosphere tense and pressurised, there being inadequate space and little opportunity for activities on the ward. When I arrived there was only one part-time physiotherapist visiting the ward three times per week and no occupational therapist. The morale amongst the staff was low; some considered their role as solely custodial.

The group structure

Following lengthy discussion among staff, we decided to begin a group therapy programme tailored to the needs of the ward, based on Yalom's groups for poorly functioning in-patients. Before each session, therapists met for 15 minutes to discuss the overall direction of the group and what exercises would be most suitable for that week's mix of patients.

Because of nursing shifts and problems which arose on the ward which will be described later, it was not possible to have the same nurses attending each week. On average, we aimed at a ratio of two patients to one therapist within the group. The ward's social worker and physiotherapist attended most weeks. The structure of each meeting was as follows:

(a) orientation and preparation 2–5 minutes
(b) warm-up 5–10 minutes
(c) structured exercises 10–30 minutes
(d) review of session 5–10 minutes.

Orientation and preparation of each group was always important, given the high turnover on the ward and presence of disturbed patients. The aims were to introduce members to each other and staff, and communicate the purpose and procedure of the group session.

The warm-up exercise was designed as an ice-breaker. It consisted of gentle, non-threatening exercises. With experience, we found that the most successful were those consisting of vigorous physical exercises or competitive games; for example, a human 'noughts and crosses' or throwing a soft ball at someone, simultaneously making an observation about him/her.

The structured exercises monopolised most of the meetings. They usually concentrated on a theme such as social skills, personal development and change, self-perception, tension-release, self-disclosure. These exercises drew heavily on techniques of psychodrama. An example is the Road Map where members made a road map of their life so far, beginning with birth and extending to the present. Each map shows good places (scenic spots) and bad places (hairpin bends, bumpy spots), hospital experience (road works), times of indecision (roundabouts) as well as barriers, detours, etc. Such an exercise would be interspersed with those requiring short, undemanding interaction. These broke up the time spent on solo activity, which could be too demanding on the attention span of disturbed patients and provided an oppportunity for developing social skills. Interactive tasks also allowed for ventilation.

The final stage of the group consisted of a review of the session. Members were invited to comment on the most and least valuable, funniest or saddest part of the meeting. Observations were encouraged on other members' behaviour during the meeting. The aim of this was to encourage patients to live more in the here-and-now, and to attend as fully as possible to their own and other's participation.

We decided to adopt an unusual attitude towards membership of the group. In systems theory terms we set up a nuclear group which was designed to be 'porous'. This group sat in a circle of chairs in a large room; patients therefore could leave this part of the group for another part of the room or the ward when meetings became too threatening and they could return later. It was thought that this flexibility would allow disturbed patients to protect themselves by 'opting-out' when necessary. However, they could stay in the room, in earshot, and so remain a passive participant in the group.

The life of the group

Over the 13 weeks of groups, 29 patients attended; 11 of these were long-stay in-patients and the rest were intensive care patients. In spite of optional attendance, six of the long-stay patients attended regularly and the majority of intensive care patients attended all meetings while resident on the ward. Following a short honeymoon period, we found that certain themes recurred, some of which had particular pertinence to offender-patient status. These included issues of trust, anger with authority figures and emotive publicity from the media. Although attendance was good, members took advantage of the 'porosity' of the group by wandering in and out of the group as necessary.

It is impossible to document in this short report the many dramatic events which occurred during the life of this group. In spite of its unconventionality, many orthodox therapeutic factors emerged, not only during the life-time of the group for the central core of regular attenders, but also in single sessions.

The main problems which we encountered were those of high turnover, inability to do termination work and working with a heterogenous diagnostic mix. Group porosity meant that members walked in and out as they pleased and this could be disruptive, perhaps rather more so to therapists than other members. In addition, the variable constitution of the group each week was demanding on therapists who had to tailor depth and pace accordingly.

Staff response and the life of the ward

The initial response to the group was friendly and enthusiastic. However, many of the staff were apprehensive and admitted that they felt threatened by taking on an unfamiliar therapeutic role in the context of the more egalitarian situation of a group meeting. Halfway through the group's life, the senior nursing staff started to hold their own weekly handover meetings, timed to coincide with the in-patient's group. They allocated three student nurses with no group-therapy experience to the patients' group. Predictably, the group suffered; patients declared strongly that they wanted to go home and exercises became superficial and fragmentary for a time. However, the student nurses were enthusiastic and with the continuing support of our social worker and physiotherapist the group recovered. In fact, following my departure these individuals continued to run group sessions.

Conclusions

What was learnt from this experience of a group on a locked ward?

Our main aim had been to create a therapeutic activity which patients of varying orders of integration could come away from with an experience of success. Patients' attendance rates and feedback suggested to us that this was often achieved. Important factors which contributed to this were:

(a) therapists with a flexible approach who were prepared to alter depth and pace accordingly
(b) a porous group system, where patients could

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protect themselves from threatening material by leaving and returning to the group as they wished.

We found that because of rapid turnover of patients, the longitudinal time frame of conventional out-patient groups could not be observed; thus the life of the group had to last a single session in many cases. In spite of this, orthodox therapeutic factors appeared to operate. It was impossible to regard the in-patient group as an independent entity. Our experience demonstrated how group work spills over onto the entire psychiatric ward and vice versa. Staff can feel very threatened by assuming the dual role of therapist and custodian. They need considerably more support and supervision than we provided. Finally, particular benefits accrued from the presence of psychotic members in the group who often penetrated effectively the defences of more integrated patients through their primary process thinking.

It was not our aim to determine the efficacy of our tailored group programme, but simply to see whether it could operate with a heterogenous population of patients. It is hoped that our experience will stimulate interest in using structured groups for the patient population described here and warn of the pitfalls.

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Who uses a day hospital and for how long?

A Liverpool study

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The dichotomy caused by the National Health Service Act, Section 28, which split the responsibility for the mentally disordered between the Minister of Health and local authorities has remained with us. Along with a separate GP service this dichotomy has caused inconsistencies, confusion and overlap in day care facilities. Although psychiatric day care has now become accepted as an essential element in the comprehensive psychiatric care of the mentally ill, its development has been unplanned and there is a great regional variation (Vaughan, 1983).

We report on the usage of a purpose built 40 place day hospital situated on the second floor of the main teaching hospital in Liverpool. The day hospital staff includes one sister, two staff nurses, two state enrolled nurses, one nursing auxiliary, one senior occupational therapist, one occupational therapy helper, one industrial helper, one part-time clerk and one full-time registrar from the Liverpool Rotational Training Scheme. Adjacent to the day hospital are two in-patient wards, an out-patient clinic and the University Department of Psychiatry. The catchment area served by the day hospital is that of an inner city area with a population of approximately 80,000 – identified by Jarman in 1983 as the most underprivileged wards in Liverpool.

Our study aimed to answer a number of questions:

(a) who is the referring agent and what is the goal on admission?
(b) what type of patient is admitted?
(c) how long do they stay and what factors influence the length of stay?
(d) why are they discharged?