# Trainees' Forum

## A Community Group in the State Hospital: A Trainee's Experience

STEVEN NOVOSEL, Lecturer in Forensic Psychiatry, University of Edinburgh

It is often felt that group meetings with long term chronically psychotic patients have little therapeutic value and become weekly 'complaints' sessions. In this paper I would like to indicate that group work with such a population can be both a therapeutic and valuable training experience. I shall describe a group which I took over a six month period in one of the wards at the State Hospital, Carstairs Junction, Lanark.

The State Hospital cares for mentally ill and mentally handicapped patients who are considered to be dangerous or violent and require treatment in a secure setting. Patients are admitted to the hospital either directly from the courts or are transferred from prisons or other psychiatric hospitals. The wards are separate villa-styled buildings and other villas are devoted to a variety of occupations, e.g. tailoring, woodwork. The majority of patients spend most of their day in some form of occupation, and recreational and social functions are frequently held.

The ward in which the group was held cared for 29 patients. The population were all chronically, and intermittently acutely, psychotic patients, the majority having a diagnosis of schizophrenia. Others were diagnosed as suffering from paranoid states, epilepsy, schizo-affective and affective disorders.

**Establishing the group**

It took six months to set up the group. As security is of great importance in the State Hospital, numerous meetings were held with nursing and occupations staff to discuss the practical details of the group. One month before the group began the proposal was put to the patients themselves for discussion. Eventually the following plan was drawn up:

(1) The group would meet once per week for 45 minutes in the ward sitting room during the overlap period of the nursing shifts. This would then allow maximum nursing participation.

(2) All the patients were invited to take part in the group. It was anticipated that not all patients would wish to and so participation during the first six weeks would be optional. However, after the sixth week, those patients not wishing to take part would not be allowed to return to the group. Thus membership was by self-selection and inter-patient rivalries would be avoided.

(3) There were two limits on discussion: (a) Individual personal histories; (b) any topic that was considered to be a threat to security.

(4) After the group there would be a 30 minute feedback meeting amongst the staff.

**The life of the group**

At a pre-determined date the group held its first meeting. There was a general air of excitement and curiosity. I arrived to discover that chairs had carefully been arranged in a circle in the centre of the sitting room by the patients. However, there were clearly not enough chairs in the circle for everyone who was present. It appeared that only the patients sitting in the 'circle' were actually members of the group whereas those sitting in the periphery felt under no 'pressure' to participate. Some patients raised topics that might be discussed e.g. life in the hospital and the forthcoming new Mental Health Act. The less enthusiastic patients injected depressive comments indicating that the thoughts foremost in everybody's mind were the fact of detention and date of discharge. One patient, who had been in the hospital the longest, began to compete with me for leadership. He indicated that he had 'seen it all before', that I was 'too young' to be a psychiatrist and that the group was doomed to failure. The group ended with a clear division of enthusiasm.

The early meetings were dominated by complaints about the hospital, e.g. loss of liberty and the standard of the food. During those early weeks my role was to maintain enthusiasm that weekly ward meetings could be therapeutic. It seemed that the group had to have the opportunity to get these feelings 'off their chests' before we could progress.

As the weeks went by, patients would migrate into and out of the 'circle', depending on how they felt that particular week. If a patient, who was sitting in the 'circle' was invited to comment and found the experience unpleasant, the following week he would move to the 'safety' of the periphery. However, as the weeks passed, the magical boundary of the 'circle' blurred and disappeared; if an individual was anywhere in the ward at all during the meetings, he was a member of the group. Thus if a patient could not cope with sitting in a room for 45 minutes with 35–40 people, he could make a comment, leave the sitting room and know that he still belonged to the group.

After the sixth week, it was clear that it was neither possible nor desirable to adhere to the initial plan. The population was too volatile to be considered either permanent members of the group or equally to be excluded. If I

had placed any restrictions on the group membership, the meetings would not have survived. The group itself had decided on its own structure.

After five or six weeks the group gradually became more cohesive, developed trust, and competition for leadership diminished. Tentatively patients began to raise topics of a sensitive nature. Patients began talking about the social events in the hospital and the various merits of the female patients. Gradually this blended into the topic of homosexuality and masturbation. One patient known to be a homosexual declared his orientation, to be met with a hostile rejection by the group. Masturbation, as the only form of sexual relief, was discussed in detail. One patient complained of ejaculatory problems and asked if I felt that this was due to his medication. When I indicated that this might be the case, the atmosphere in the group immediately became tense and hostile. After indicating that this was a temporary phenomenon, the atmosphere gradually relaxed, although an air of suspicion remained. I had to repeat this comment in future meetings before it was finally accepted.

The patients' attitude to the staff was an issue in one meeting. An epileptic patient had just had three *grand mal* seizures on the morning of the group. The atmosphere in the meeting was tense and anxious. I was met with a storm of questions. 'What did the medical profession know about epilepsy?', 'Was there a cure?', 'What were my qualifications?', 'How long had I been a psychiatrist?' There was an uncomfortable silence as the group waited for me to reply. It took most of the meeting to allow the group to express its anxiety. My response was to acknowledge this anxiety, contain it and indicate that although epileptic patients receiving medication did occasionally have seizures, the staff were still in control of the situation. Gradually the atmosphere relaxed but, again, I had to repeat these comments over the next two to three weeks.

After about two months the group was cohesive. The patients no longer complained about the hospital. There was an unspoken acknowledgement that any topic, except personal history or issues of security, could be raised. This was confirmed after one very moving meeting. The homosexual patient 'confessed' to me that he had stolen a calculator earlier in the week, but had now returned it to its owner. The group knew of the incident and waited on my response. I indicated that the incident was now in the past and best kept there. The group agreed with this attitude and, having rejected him two weeks earlier because of his sexual orientation, now actively supported him in his tears. One patient took out his Bible and read a passage while everyone quietly listened. This meeting had cemented the feelings of trust and identity for the remaining life of the group.

The following week the meeting had to be unexpectedly cancelled, which met with an interesting response. On returning, I was met with a great reduction in the number of patients present. All the patients except four sat outside the 'circle' in the periphery. The atmosphere was tense and some patients indicated that they had decided not to attend future meetings. Others demanded an explanation as to my activities the previous week. Still others commented that I was 'clearly a very busy man'. The meeting ended, as it had begun, in tension. The following week, to my surprise, was met with the usual good attendance. The 'circle' was fully occupied and the atmosphere was relaxed and light-hearted. Discussion centred on events of the previous week and many jokes with a sexual innuendo were told. I had clearly been reprimanded for my absence and now the group could proceed.

After this experience I decided to announce a future two week absence four meetings in advance. These four meetings were very interesting. Whenever I reminded the group of the forthcoming absence, the conversation centred on nuclear war, space wars and Armaggedon. Intermittently the atmosphere became tense and demanded a lot of work from the staff to defuse it. On occasion the conversation became quite depressive, e.g. the hopelessness of their situation and that there was no cure for mental illness. To make matters worse, my forthcoming absence coincided with the hospital's annual sports day and this, when it came to light, added to the tension. I was frequently questioned as to the nature of my absence; informing the group that the absence was work-related eased the tension slightly. However, the conversation again focused on how busy I was. The last meeting before the break was initially tense but became more relaxed towards the end. When I returned two weeks later, I was unsure of the reception I would meet. I arrived to find the meeting fully attended with a full 'circle' and friendly 'normal' conversation about my trip. In return, I was informed of the success of the sports day. To my surprise the group had successfully used the four week period prior to the absence to work through their feelings about my temporary departure.

The last six weeks focused on ending the group. The atmosphere and content of the conversation fluctuated considerably. Many patients enquired whether the meetings would continue at a later date. A negative reply met with tension which blended into sadness. Some patients again discussed nuclear war and Armaggedon, and others spoke about the benefits of modern psychotropic medication. Some patients questioned my qualifications and then, in despair, commented that 'even doctors had bosses'. I was aware that ending the group aroused many feelings in myself. I felt that somehow I would arrange it so that the meetings would continue. I felt guilty at 'leaving and abandoning' the group. Nursing staff too wondered whether the meetings might continue and expressed their sadness.

On leaving the ward during those last weeks I was aware of a sense of loss. It was during those six weeks that supervision was at its most valuable. In the last two or three meetings patients asked me whether I considered the meetings a success. I indicated that I did and that I would always remember them fondly. Expressing my feelings on the success of the group appeared to allow the patients to do the same.

The first half of the last meeting was very tense. 'Nuclear war was imminent and there was no escape'. 'Psychiatrists

knew nothing about nor could cure schizophrenia.' The atmosphere then became depressive and there was a sense of panic and confusion. It seemed that, despite the real success of the meetings, the group was destined to end with an air of despair. Literally in the last few seconds, the most enthusiastic member of the group, James, said 'Oh schizophrenia! Will I be cursed with it forever?' After a few seconds of a very tense silence he continued, 'I'm sorry Dr Novosel. I get carried away sometimes. Don't worry about us, we'll be OK. Come back and see us when you can'.

With a few words James instantly transformed the atmosphere. The tension disappeared, to be replaced with a warm, relaxed, sad—but happy—feeling in everyone. It was a profoundly moving experience.

**Conclusion**

In attempting to describe my experience, I would like to indicate that group work with long term chronically psychotic patients can be successful. Too often such patients either do not have such meetings or, if they do, it is to 'receive' complaints or discuss who will wash up the dishes in the evenings.

In this experience, I felt that the group was therapeutic to both patients and staff. During the meetings a wide range of emotions were expressed and topics discussed which are too numerous to mention. I personally gained a greater understanding of what it means to live under conditions of maximum security and, more generally, what it means to live in a hospital for a period of years. The patients and staff felt that they gained the opportunity to sit down, as a group, and discuss issues that were important to them.

In describing my experience, I hope that consultants and their trainees might look at their 'chronic wards' and see that group meetings can be a valuable training experience. More importantly, they can be therapeutic to those patients and staff who frequently feel neglected and have a low morale.

*The views expressed are completely those of the author and are not to be taken as representing the views of the Scottish Home and Health Department or of the Management Committee of the State Hospital.*

ACKNOWLEDGEMENTS

I would like to express my gratitude to Dr Anne Macdonald, Consultant Forensic Psychiatrist, State Hospital for her supervision and support in establishing and running the group, to Mrs Beatrice McLelland for typing the minutes of the meetings and Miss Margaret Merrilees for typing the manuscript, to the nursing staff at the State Hospital for their enthusiasm and support in running the group and also, of course, the patients themselves without whom the group would not have been possible.

# What Makes Psychiatric Summaries Useful to General Practitioners?

M. W. ORRELL, SHO in Psychiatry, and M. GREENBERG, Consultant Psychiatrists (Correspondence), Jules Thorn Day Hospital, University College Hospital, London NW1

A general practitioner needs to be kept well-informed when a patient with a psychiatric disorder is admitted to hospital. This can be difficult because a number of professional workers, not all of whom are hospital based, become involved in management, and confusion over clinical responsibility may develop. In these circumstances communication usually depends upon the hospital discharge summary[1] which should contain information that is relevant to the GP's requirements.

Psychiatric discharge summaries are generally quite long and are extremely useful for hospital case records because they condense a considerable amount of information under organised headings. However, this does not necessarily mean that they meet the needs of GPs.

Previous investigations into communication between hospital doctors and GPs suggest that the latter are generally satisfied with the information they receive from hospitals and appreciate some explanation for the decisions that are reached.[2,3,4] In these studies GPs consistently point out that certain information is lacking; in particular, they want to know what their patients or their patients' relatives have been told, and what follow-up arrangements have been made. Furthermore, they also believe there is an unnecessary delay between the time of a patient's discharge and when they receive the summary.

There has been no previous investigation specifically into psychiatric discharge summaries. We therefore set out to discover whether GPs have read the psychiatric discharge summaries we send them, whether they found them useful, whether they had any criticisms of them, and what factors might be associated with these findings.

**The study**

Following a pilot study, which involved detailed interviews with five randomly selected GPs listed within the catchment area of University College Hospital, London, a 38-item questionnaire was developed.

The questions covered their attitudes toward the following aspects of the psychiatric summaries they received: *layout* (e.g. 'Are the present summaries you receive far too long/ too long/ about right/ too short/ far too short?'); *content* (e.g. 'How frequently do the summaries which you receive at the moment contain adequate information on arrangements for follow-up? Always/ often/ sometimes/