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(1995) The unconscious impact of caring for acutely disturbed patients. *Journal of Psychiatric and Mental Health Nursing*, 2, 2; 227-233.

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ABSTRACT:
This paper is concerned with the emotional experience of working with acutely disturbed patients examining how the disturbance of the patient unconsciously impacts upon the nurse. Using a model of the unconscious, based upon classical psychoanalytic theory, a psychodynamic approach to clinical supervision in a group setting is described. This supervision process was found to be helpful in the therapeutic process, identifying unconscious dynamics as well as alleviating some of the distress of the clinical work. Vignettes illustrating this process of psychodynamic group supervision are presented.
KEY WORDS: Psychodynamic, Unconscious, Group Supervision.

INTRODUCTION

Distress for nurses appears to be an inevitable consequence of working closely with acutely disturbed patients who are either; suicidal, psychotic, violent or self-harming. It is the nursing team who, by virtue of their sustained intimate contact with the patient have to deal with the most acute episodes of disturbance. With a patient in acute crisis the task of nursing in the first instance is to create a therapeutic milieu that can **hold** the patient's disturbance. When a patient feels their distress is unbearable for them to hold onto for themselves, when their anxiety prevents them from rational and mature functioning, the holding process quite often involves actual physical holding. But this holding process may also be a mental activity where the patient is held **in mind** by the nurse. This concept of **holding** derives from the work of Winnicott (1974) and has recently been applied to mental health nursing (see Wright, 1993). The process of holding in mind is concerned with the containing and mediation of the complex feelings that are aroused in the nurse/patient relationship. Hepburn (1992) has described the onerous task of the therapist in having to hold on to the feelings that the patient projects, processing these feelings before presenting them back to the patient in a way that the patient will feel able to digest, understand and ultimately grow from.

SPLITTING AND INTROJECTION

Acutely disturbed patients frequently try to get rid of the pain or the hurt that they feel by splitting off the unbearable parts of themselves and attributing them to others. This splitting occurs as a result of projective mechanisms where intolerable bad experiences are rejected in order to sustain an internal feeling of goodness and well being (see Fairbairn, 1940 and for a history of the concept of splitting see; Grotstein, 1981). For example a client recently opened an individual session by saying; "You look weary today". The therapist however felt alert and soon into the session the client began talking about how tired, anxious and run down she felt. In this case the client had split off her weariness and attributed it to the therapist.

Nurses may become the recipient of unwanted aspects of the patients self. Significant figures from patient's past may become represented in their current relationships with the nursing team. Even the nurse's proper professional attempt at offering concern may be

perceived in a hostile way if the caring figures in the patient's past were persecutory for instance. Even the good experiences in the patient's current life may be attacked if the internal parental or authority figures from the past exert a unyielding influence. Object relations theory is helpful in understanding how this inner world drama unfolds (Ogden, 1983). Suicidal ideation might be understood as an attack on a internal object - a type of inner self murder (Freud, 1917; Klein, 1935; Kernberg, 1993). This inner attack may become externalized, manifest in an angry or possibly violent outburst directed at others who are perceived as hated figures.

Wittington et al (1994) has carried out extensive research of the effect on staff of working with violently disturbed patients. Wittington found that staff retained a painful memory of a violent incident long after the physical damage of the attack had been repaired. Even when the bruises have healed, years later a memory of an attack can still arouse distress. Attacks by patients on staff are not just experienced at a skin deep level, the impact is also on an emotional level. An experience which having been externalized by the patient is internalized by the nurse in their memory. Wittington's research is useful to us and like other studies of nursing staff burnout (McCarthy, 1985; Boyle et.al., 1991) keeps us mindful of the need for nurses to take care of themselves. But something more than being mindful of the distress is necessary.

Research into nursing staff burnout tends to follow a methodology that examines conscious or known data, focusing on the memories and recollections of the nurse. But what about the impact that is unknown or unseen and what about the painful aspects of difficult clinical work that is **not** remembered? For example, in a group supervision session a staff nurse was talking about how distressing she had found a particular patient group she had been in three weeks before when the patients had been talking about funerals and death. A colleague then said that he had been in that group and had also found the group very painful. He added that he had just realized that he had not been back into the patient group since and thought that he was probably avoiding the group without realizing it. It appeared that he did not want to remember the difficult group and his colleague appeared to jog his memory. In this vignette it is possible to see how an experience may become unconsciously "stored" exerting an unseen influence upon experience and behaviour. Sometimes however the dynamics between a nurse and patient may be very complicated and might take some time to unravel.

VIGNETTE - NURSING A SUICIDAL PATIENT

A female patient with a severe manic depressive illness was admitted to an acute intensive care ward. In the acute stage of her depression she was severely suicidal and needed continual nursing observation. Her progress towards recovery was slow and each step forward seemed characterized by two steps backwards. On the first occasions that the staff attempted to reduce her continuous nursing observations to a less intensive level, the patient reacted by attempting to suffocate herself. On the second occasion that her observation level was reduced she set fire to her bed. On each of these occasions her primary nurse was on duty. In her therapy it emerged that the self destructive attacks were attacks linked to a phantasy of abandonment. The patient feared that her psychosis would cause those caring for her to abandon her (see Jackson, 1993, p.115). Thus it seemed that she perceived the reduction in observations as an abandonment that left her feeling full of rage. Her response was to attack her carers by sadistically attacking her self.

The experience for nursing staff when working with this type of indirect attack is difficult to process. There is no visible bruising on the staff and this can quite easily lead to an underestimation of the emotional impact of the attack. Supervision is integral to helping nurses think about their work and where the impact of the work is difficult to measure "the help of another in the review of one's unconscious processes is a ...safeguard" (Main, 1957; p.130). Supervisory support, as Peplau (1994) has recently suggested, is clearly indicated if these unspoken dynamics are to be understood. Wright (1993) has stated that if the nurse is to **hold** the patient in their distress, then the nurse too must experience some sense of holding. Supervision should offer a sense of holding and offer the nurse an opportunity to process their subjective experience.

The development of clinical supervision has been identified as a priority in the development of mental health nursing practice in the years to come (MHNRT, 1994). Supervision may take place on an individual basis (a one to one setting) or in a group. Group supervision has the added dimension of peer supervision where the experience of one member of the group is helpful in offering feedback to another. Before presenting two vignettes illustrating group supervision in practice a model of the unconscious is briefly outlined.

A MODEL OF THE UNCONSCIOUS

Dreams are evidence of unconscious activity as well as a medium of research in to the unconscious itself (Freud, 1900). However dreams themselves are not the unconscious, rather they are the vehicle by which the unconscious communicates with the conscious. Dreams often disguise underlying anxiety or conflict, thus allowing the dreamer to sleep rather than being roused to act. There is a censor acting upon the dream, deciding what should and should not come through to the manifest dream content. A nightmare is less censored, an undisguised dream so to speak and a closer representation of the unconscious. Freud's (1900) model of the unconscious conceives it as two tiered. Firstly there is the "**manifest**" dream content which pertains to the sequences or images condensed in the dream that usually features fragments of recent experience. Secondly there is the "**latent**" dream content which is determined by the archaic desires driven by instinct or wishes which are fulfilled in the dream. The task of understanding the unconscious is therefore a process of looking beyond the manifest presentation of the dream content, de-coding it, in order to identify the anxieties and conflicts that might otherwise remain disguised.

It is striking how often in group supervision clinicians present dreams they have had about work. This informs us of dynamics on a number of levels; i) indicative of nurses taking their work home with them, ii) an indication that experiences at work have an impact at an unconscious level and iii) indicative of the psychodynamic inclination of the supervision process.

GROUP SUPERVISION VIGNETTE - A NURSES NIGHTMARE

A staff nurse shared the following dream in a group supervision session. In her dream, she said, she had cut off the head of her patient. She said she was embarrassed to speak of it now but she was surprised in her dream because said she felt no emotion. She said in her dream she had thought it strange because there had been no blood. The initial reaction of the group was a mix of anxiety and laughter. The nurse who brought the dream said she felt guilty. Her colleagues shared how difficult they had found working with this acutely suicidal patient whose self destructive acts included self laceration and immolation. The patient had also required naso-gastric feeding for some months. One of the group said that they thought

it was important that staff discharge themselves of the difficult feelings associated with this patient. A senior nurse said that it seemed that the patients projected into the staff the destructive things that they wanted to do to themselves. The staff identified with the difficult task they had of holding on to the distressing phantasies of this patient's destructiveness. There followed a discussion about a violent incident where this patient had punched one of the staff. The patient had needed physical restraining to prevent further violence. One of the nurses said that the patient "surrounded herself with barbed wire", another member agreed and said he was frightened to make eye contact with the patient. One of the group remarked that a colleague had been brave holding the patient's head during the restraining because the patient was likely to bite. The group supervisor said that not only was it distressing holding this patient physically, but also holding this patient in mind. The dream of the nurse cutting off the patients head could be linked to this not wanting to think about the pain of the clinical work or the pain that belonged to the patient.

It appeared that the staff were experiencing the destructive parts of the patients inner world which the patient had split off and externalized. The supervision helped to identify which aspects of the dream belonged to the nurse, for instance the natural reaction to want to avoid thinking about this difficult patient, to cut her off from thinking, and the part of the patients self destructiveness that had been projected into the nurse which had been unconsciously held in mind. The manifest material of the nurses dream was quite straight forward; the patients head is cut off, there is no blood and she feels no emotion. The latent material of the dream is more difficult to understand but was aided by the group free associating. The group associated "holding the biting head" with the dream. This was a particularly disturbing patient to think about and the natural reaction would be one of wishing to avoid thinking about the patient, in a sense a wish to cut her off from conscious thought. How often do we say; "I don't want to think about that right now", whether it's painful material from work or news about war or famine in another country. The lack of emotional content in the dream was also coded for later the nurse reported feelings of guilt, embarrassment and fear as the meaning of the dream was discerned. Also the emotional response of the group was visible as the staff struggled to face the work they were doing. The lack emotion resided in a psychical defence, possibly functional, against the intensity of emotional investment. The patient had attempted to cut herself off from her feelings through her suicide attempts. The comment in the group that "patients project their feelings into the staff", was a correct formulation, however many of these projective processes occur at an unconscious level.

This vignette describes how unconscious dynamics might be unravelled in a group setting. Palpably, when clinical material is presented in supervision, the task is to attempt to unfold the experience of the staff, rather than simply accept the material content at face value. The process is an experiential one that often features conflict and anxiety. There is an experiential learning cycle where the experience of being held in the group may be helpful in fostering a containing environment for the patient. A reference point for this process model of group supervision is the work described by Main (1957), Jackson and Cawley (1992), Jackson (1994) and Fabricius (1995). This approach attempts to understand the patient through the process of examining the experience of the staff. The group supervision setting in itself becomes a containing environment where disparate experiences can be brought together. For example one often hears about a patient who "splits" the nursing team. A failure to understand the dynamics that might underpin such a split may result in the staff unknowingly acting in a negative, punitive or inconsistent role. The patient's material then

can not be held in mind, the conflicts and anxieties of the patients become undifferentiated from the nurses anxieties and conflicts. Understanding the patient's disturbance is aided by a group process where the variety of responses among the staff can be examined. If the split off aspects of the patient that are projected into the staff can be understood, if the staff can review what is happening to them, then this may actually become a tool with which to understand the patient. The deciphering of the subjective experience is a process akin to de-coding a dream which may be a key to the underlying disturbance.

GROUP SUPERVISION VIGNETTE - A NURSING TEAM IN CONFLICT

In a group supervision session the staff talked about how one of the clients was prone to bouts of what the staff described as hysterical laughter. Some of the staff said they found the client infuriating because he could not take anything seriously. A pattern emerged in the supervision group whereby the female staff talked about how frustrated and angry they felt. One of the female staff said she wanted to "slap" the client. The male staff on the other hand clearly felt more tolerant of the client and appeared quite indifferent to the female staff's reaction. The male staff were surprised to hear the extent of the female staff's irritation. There followed a critical and accusatory discussion between the men and the women. When I asked about the clients history, they told me that he had memories of his uncontrollable laughter from the age of eleven. He also recalled at this time being beaten by his mother; "if you don't laugh you'll cry" he had said. Meanwhile his father, who was an alcoholic, took little or no responsibility for discipline in the home. As this jigsaw of material was pieced together it became apparent that the staff were unknowingly, enacting some of the clients family dynamics, unconsciously acting out a counter-transference. The male staff seemed to be playing the role of indifferent father and the female staff were seemingly in the role of irritated and attacking mother.

The importance of recognizing this enactment laid the foundations for a new synthesis in the minds of the staff thereby offering the potential of a new experience for the client of a collaborative parental couple who could contain him. Jackson and Cawley (1992) have described how countertransference responses may exert disturbance in the therapeutic milieu if they remain unconscious. Recognizing how staff patterns of feelings and behaviour can be understood in the context of the patients history is the basis for the creation of a therapeutic milieu. Utilizing the countertransference response in clinical nursing represents an avenue for further research (Winship et al, 1995).

DISCUSSION

Through the process of group supervision some semblance of understanding can be brought to patient and staff dynamics. In the work of disentangling these dynamics the aggregate experience of the group is helpful where many heads are better than one. When working with difficult patients, the sharing of experiences also enables staff to realize that they are not alone in their feelings and that the distress they feel. In this way the resources of the group are the means by which a sense of containment may be achieved. The work of the facilitator is to help the members **think** in a collaborative way to look beyond the manifest content of the material the group presents. There are impediments to thinking and if these remain unconscious then they are likely to exert more disturbance. Dartington (1993) has described how nurses may "collude in their unthinkingness" (p.22) where the emotional response to a patient may be understood in terms of Winnicott's (1949) notion of hate in the countertransference. Difficult emotions that remain unconscious may block clear thinking.

Group supervision provides a space to begin to bring into consciousness those emotions. The role of facilitating a supervision group involves making full use of the resources and creativity of the group (Pedder, 1986), creating an environment that enables staff to feel more capable of thinking on their feet in their clinical practice. Staff conflict can be understood as clinically relevant in terms of the supervision process that helps staff to identify what belongs to them and what belongs to the patient. However not all staff conflict can be, nor should be put down to the experience of working with the patient. Staff have their own inter-personal conflicts to work through - this is the role of a staff sensitivity group. A clinical group supervision process is distinct from a staff sensitivity insofar as clinical material is the central focus of group supervision, whereas in sensitivity groups the personal material of the staff is the focus of the group. In settings that have both supervision and sensitivity groups, there is a likely to be a crossover of experience: staff sensitivity groups should offer a supervisory learning experience and a group supervision process should be foster an atmosphere of sensitivity to the needs and feelings of colleagues. However, in order to ensure that the boundaries these two approach are not unnecessarily blurred it is important that the group supervisor has experience and training in facilitating staff sensitivity groups, clinical group supervision and group psychotherapy.

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