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to separate out personal difficulties from professional ones, and to direct them, where appropriate, to find the right kind of help. At other times I worked with the staff as a group, exploring their relationships and how these helped or hindered the task. Always my function was to facilitate an awareness of the emotional issues on the ward: the inevitable grief, pain, helplessness and sometimes hopelessness. Greater awareness and understanding of these feelings, and allowing for their expression, led to better working practices and to a happier ward.

Chapter 7

Containing anxiety in work with damaged children

Chris Mawson

There are mental pains to be borne in working at any task, and these have to be dealt with by us as individuals, each with a personal history of having developed ways of managing or evading situations of anxiety, pain, fear and depression. Collectively, in our institutions, we have also learned to do this, installing defences against the painful realities of the work into our ways of arranging our tasks, rules and procedures. It is incumbent on us to try in whatever way we can to explore these aspects of our working practices, in order that our ways of coping do not grossly interfere, subvert or even pervert our efforts.

To understand the worlds of work occupied by ourselves and others, we need to be aware of the particular kinds of pain and difficulty encountered in everyday work situations. As Obholzer has observed: 'In looking at institutional processes it is obviously very helpful to have some inkling of what the underlying anxieties inherent in the work of the institution are. . . . Given a knowledge of the nature of the task and work of an institution it is possible to have, in advance, a helpful, fairly specific understanding of what the underlying anxieties are likely to be, even though one might not know the "institution specific" nature of the defences' (1987: 203).

WORKING WITH DAMAGED CHILDREN

Thus, when I was asked to consult to a child health team in a large teaching hospital, I anticipated certain difficulties. I knew they were involved in the assessment, long-term treatment and support of very young children who had been physically or mentally damaged from birth or soon after, and I expected from the outset to encounter considerable mental pain both in myself and in members of the team stemming from the workers' close contact with these damaged children. I anticipated, as was indeed the case, that the workers would frequently feel depressed, despairing of being able to make a worthwhile difference in the children's lives. I also expected that they would sometimes feel intensely persecuted by these feelings, even to the extent of experiencing at some level a measure of hostility towards the children themselves. It was likely that such intensely guilt-inducing feelings would often be deflected outwards and

away from the work, in all probability finding their way into other parts of the institution, where they might well have adverse effects on working arrangements and interprofessional relationships.

In order to gain a real understanding of the team's experience of their work, I knew I would need to immerse myself in these experiences over a long period, as they shared them with me and with one another in our regular meetings. The following vignette, from one of my first meetings with the team, illustrates something of these problems:

> Marie, a young physiotherapist in the Walsingham Child Health Team, described her visits to the home of a small child with a deformed hand. Each time she went, she knew her treatment would cause the child intense pain. It was clearly saddening for Marie to see the child freeze and turn away from her as soon as she set foot in the family home. She began to adopt a brusque and matter-of-fact manner with both child and mother, at times being quite aware that she was being cold and impermeable, but for the most part conscious only of a heavy sense of persecution and dread whenever she visited. She felt ashamed and defensive whenever she discussed the child and her treatment with other members of the team, and came to feel that this one case was casting a shadow over her enjoyment of her work. To protect herself against her guilt, she tried to tell herself that she was only adopting an appropriately professional distance, and that the occasional reproaches from the child's mother were really evidence of the mother's inappropriate need for closeness with Marie.
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> When this was explored in one of the first meetings the team had with me, there was a powerful reaction against opening up the issue of professional distance, and great resistance to the idea that it can be used to defend us against painful feelings in our work. It was as though the whole group felt attacked by me, and for much of the meeting I felt as if I were a sadistic person forcing an unwanted and painful treatment on them. They told me forcefully that they did not want me to make the pain of their work more acute, even if this was only a temporary effect.

It was clearly important for Marie to feel that her colleagues from other disciplines, particularly those whose role did not involve physical contact with the child, realized Marie's sense of hurt and rejection when faced with a child who was afraid of her, who did not perceive her as a healer or helper but as a cruel and sadistic figure who came into her home only to cause her pain. Initially it was very painful for Marie to talk about experiences which caused her so much shame and guilt. The wish in the team was to treat it as Marie's problem, which added to her stress and interfered with the whole team's learning from her experience.

Once the team became able to discuss these kinds of experiences in a setting where anxiety and guilt over feeling inadequate could be contained and understood, it was possible for us to see the sad irony that becoming defensively hard and impenetrable had in fact made it much more likely that the child would

perceive the physiotherapist as sadistic. To work well with such children, and to be clear and supportive to their parents and families, professionals cannot afford to defend themselves by erecting these sorts of barriers.

PROVIDING A SAFE FORUM

Before such difficult feelings can be openly explored in a group, particularly when the members work together on a day-to-day basis, it is necessary to provide conditions of safety, respect and tolerance, so that anxiety and insecurity can be contained and examined productively. It is essential that a bounded space is created within which participants can begin to tolerate bringing more of their feelings than they are used to doing in other work activities, in an atmosphere which encourages openness and self-examination. Holding group meetings on the same day and at the same time each week helps strengthen this sense of containment, as does ending the meetings on time. It is not punctuality for its own sake that is important, but it is almost invariably disturbing for group members to feel that their emotions dictate the 'shape' and structure of the meeting, as well as its atmosphere and content.

The basic disposition of the consultant is important, too. The sense of security in the group is greatly encouraged by the consultant's restraint from judging and blaming, and 'knowing' too much too soon, or seeming to believe in quick solutions. It also helps if the membership of such a group is not constantly changing. The group often depend upon the consultant to stand up for the value of struggling for understanding, rather than rushing into the solving of concrete problems to get rid of uncomfortable feelings. They often find it useful to have such discussions in the presence of a consultant who is not a part of the organization, but this is not always the case.

Whether or not there is an external consultant, it is necessary for members to learn not just to listen to the content of what is brought to the discussion, but also to allow the emotional impact of the communications to work on and inside themselves. When primitive anxieties are stirred up, there is a natural tendency to try to rid ourselves of the uncomfortable and unwanted thoughts and feelings, locating them in others inside or outside the group, as described in Chapter 5. For example, recall how in the illustration given earlier I was temporarily experienced by the group as cruel, forcing on them an unwanted painful experience by looking at the issues in detail. When I was told that they were unsure they wanted such a painful 'treatment' if it made the pain of their work more acute, it was almost word for word what the parents had said to Marie. For a while, I had in turn felt in relation to the staff much as she must have felt with her young patient, saddened and guilty that my work was being experienced as cruelty. I had gone away from the meetings feeling somewhat persecuted, and had been tempted to defend myself by withdrawing from their reproaches and putting up something of a barrier, while telling myself that this was merely appropriate professional reserve. It was listening to my own feelings in this way

that helped me to see how similar all this was to Marie's predicament. It was therefore possible not only to hear her feelings, but also to recognize from first-hand experience how such feelings are defended against, not only by her but also by the entire group in the institution. Understanding gained in this way can sometimes be put back to the group, or by the worker to the client, and, if timed sensitively, tends to carry a great sense of conviction.

In describing difficult work situations, members of the group will not only be communicating information, but will also be conveying states of mind which are often very disturbing and painful. From infancy we evolve the expectation that we can gain some relief from these pressures by seeking a 'container' for the painful feelings and the part of ourselves that experiences them. Partly, we unconsciously try to rid ourselves of them, but there is also the hope that the recipient of the projected distress might be able to bear what we cannot, and, by articulating thoughts that we have found unthinkable, contribute to developing in us a capacity to think and to hold on to anxiety ourselves. (These complex processes, termed projective identification, were discussed in detail in Chapter 5. See also Bion 1967; Klein 1959.)

SHOULDERING INADEQUACY

In many work situations, the chief anxiety which needs to be contained is the experience of inadequacy. The following example is drawn from my consultation to the staff of the Tom Sawyer Adolescent Unit, who were complaining about a difficult group of adolescents:

> After several weeks of feeling increasingly useless as a consultant, inadequate and quite irrelevant to the needs of this hard-pressed group, I was told haughtily by one member that they would be better off without me. They would do better to organize a union meeting or an encounter group. I felt ridiculed, devalued and somewhat provoked. Another member of the team complained that I invariably took every opportunity to divert them from their real task. A third, speaking in falsely concerned tones and with knitted brows, asked why people like me were so intent on causing confusion by always looking more deeply into things. They were, after all, just honest workers whose only wish was to be left alone to get on with a difficult job, with little or no support. Yet another wondered why I bothered with them, and whether I was some kind of masochist.
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> Just when I had taken about as much as I could without losing my temper, another staff member, who up to that point had remained silent, said how despairing she had been feeling in her work lately, and how devalued. She felt her efforts had been under attack by some of the adolescent clients and their families. Another then added that it seemed their work was frequently undermined by the administrative staff who were supposed to be supporting them. It emerged that the whole team had been criticized recently by management for their handling of a difficult and sensitive situation in the unit.

It was at this point that I was able to make sense of my own feelings and the way I had been made to feel by the group. I could then put into words the team's deep sense that they and their work were under attack. In turn, they had needed to make me feel unwanted, ineffectual and under attack, partly to get rid of their own feelings, but also to show me what it felt like for them; this may have been the only way they were able to let me know. It extended to their trying to get me to give up on them, or else to retaliate. Just as they sometimes spoke of going home wondering whether they should resign, or whether or not to appear at work the next day, they had spent a month testing whether I would have the tenacity (or was it masochism?) to keep coming back to them. Another previously silent member confirmed this, saying she had secretly hoped that I would be able to keep going and not 'pack it in'. She also had wondered whether I had anyone to whom I could turn when the going got tough.

This led to a change of emotional climate in the meetings. It became possible to reflect on what had been taking place in the room and to make useful links to the current problems both in the team and in the wider institution. For example, it was possible to consider the predicament of some of the team's patients and families who, in extreme distress, often seemed to use the same projective mechanisms for alleviating their anxieties as the team had been doing with me. The feelings of the staff mirrored those of the parents, who had repeatedly been made to feel useless and impotent. When such feelings of inadequacy are unbearable the temptation to 'pack it in' can be too strong to resist, and this is precisely what had happened with many of the children there. Their presence on a psychiatric ward felt to them (and also to their parents) as evidence that the job of parenting them had become overwhelming and had been 'packed in'. The children had made the staff feel much as they had made their parents feel, and in turn the staff had made me bear the impact of these violent and demoralizing feelings. Furthermore, the question of whether I had my own sources of support could then be linked with the team's desperate need to find support and understanding in the face of such projections from their patients, so they would neither have to become masochistic nor have to 'pack it in' and resign.

The group came to feel that it had not so much been me who had been diverting them from their task, but that they had unconsciously been preventing me from doing my work with them. Their sense of having acted with some collective nastiness towards me made them feel guilty, but there was also the reality of what we had weathered and thus discovered together. This was of far greater value than any amount of abstract discussion or lectures – the latter having been suggested by them when free discussion had felt so bad and worthless. They had been able to experience someone who had obviously been buffeted by their attacks, but who had been able to contain feelings without hitting back or abandoning them. This demonstration of using reflection to

manage feelings and reach understanding carried great conviction and helped them to move forward. At the next meeting it was possible for them to connect their fear that I would give up on them with their patients' anxieties that the staff would stop caring for them if they were too negative and unrewarding. They were also able to acknowledge their own fear that they would become too full of hurt and anger to continue their work, and that they really were at risk of abandoning their already traumatized clients. This had been mirrored in my impulses to explode or leave them, which I had managed to contain before acting on them.

Another common anxiety met by hospital workers is related to their inadequacy in the face of death; this is especially painful when it is a child or baby that has died. There is grief about the death itself, but also the feeling of having failed to save a life. The following example is taken from my consultation to the Walsingham Child Health Team:

> As we were arranging the chairs into a circle a booming voice could be heard just outside the door – which was still open because there were five more minutes before our starting-time – saying 'Is this a séance?' The voice belonged to Dr Royce, a senior consultant paediatrician who did not attend the meetings, despite having been invited many times. There was no apparent reaction, as though nobody had heard this comment. However, when the meeting began, it seemed to me unusually sluggish and half-hearted, with team members looking at one another for an instant and then breaking off eye contact. There were then a few remarks complaining about the lack of participation by medical colleagues, and why they didn't value the meetings.
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> As I listened, I wondered what negative feelings about our work were being attributed to the 'absent profession'. I recalled similar remarks in the past about doctors' non-attendance: an often-shared attitude on the ward was that those who did not attend the meetings were commendably busy, while those who did had too much time on their hands. I also remembered that this had been a week in which the condition of several children on the ward had worsened, and a baby had died. There had been quite a subdued atmosphere before everyone had arranged their chairs, and nobody had made coffee today, which was unusual. I found myself thinking again about Dr Royce's jokey putdown. A séance is an attempt to contact the dead, and it suggests an unwillingness to face loss. Bearing all this in mind I decided to take up Dr Royce's remark, saying I had been surprised that not only had nobody commented on it, but there appeared to have been a concerted effort to act as though it had not been said. I wondered if they felt that their pain and loss could easily be denigrated.
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> Alison, a physiotherapist who tended to permit herself closer emotional contact with the children than most of the others, then spoke of the difficulties in expressing feelings of grief in the hospital. Joan, an occupational therapist, spoke of her relief when a senior paediatrician had wept at the child's bedside. Alison remarked that nurses were labelled 'emotionally over-involved' if they grieved, and others chimed in with complaints about the 'stiff upper lip' culture. There were a number of issues here, but what I chose to address was the way in which the group preferred at that moment to think of this repressive culture as belonging to the nurses, rather than as something in themselves. Only when the members could face their own 'stiff upper lips', and their conscious and unconscious equivalents of Dr Royce's mockery, would they be able to carry through the necessary work of mourning for the baby, and for the many experiences of failure and limitation represented by that loss.

This was a moving and productive discussion, but in spite of the obvious shared relief, I was left feeling doubtful about whether the lessons learned would be generalized and applied elsewhere. Perhaps it was only in that particular setting that professional defences could be lowered and such painful experiences explored.

CONCLUSION: CONDITIONS FOR GROWTH AND DEVELOPMENT

This raises a question about the potential for growth and development in groups, and how it can be supported. When painful work situations, such as those described here and in other chapters, are worked through again and again, it becomes possible for some degree of individual change to take place. Institutional practices can be scrutinized and sometimes changed, though this is rarely without difficulty and resistance. The 'change in emotional climate' mentioned above refers to shifts in the group from a highly defensive and mistrustful attitude towards one of regret verging on depression, as they recognized how efforts to protect themselves had led to treating others badly. The experiences I have described in this chapter stand out for me, not only because of the discomfort, but also because they are such vivid examples of the shift from a *paranoid-schizoid position* to one in which there was a preponderance of *depressive anxiety* (see Chapter 1). In the former position, the fear is of attack and annihilation, blame and punishment. Primitive defences against paranoid anxiety, if carried too far and with too much emotional violence, lead to the severance of contact with reality. For example, staff may deny the reality of the degree of damage, and of the limitations of what they can offer, as happened when the Walsingham team often felt under pressure to engender false hopes about the degree of improvement which could be expected in severely handicapped children.

The shift in emotional climate does not, however, result in freedom from anxiety. Instead, our fears of what others are doing to us are replaced by a fear of what we have done to others. This is the basis of genuine concern, but guilt and facing one's insufficiency are painful to bear. If these anxieties are not contained – and we therefore cannot bear them – there is likely to be a return to more primitive defences, to the detriment of our work and mental health, as was the case in the example of the staff grieving over the baby's death, where denial and

mocking took the place of sadness and loss until the feelings could be worked through in the group discussions.

I have tried to demonstrate how important it is for staff involved in painful and stressful work to be given space to think about the anxieties stirred up by the work and the effects of these anxieties on them. The cost of not having this is considerable, both to clients and to workers. As well as offering much needed support, consultation can offer the opportunity for insight and change in the group and wider institution, *if* the pains and difficulties can be tolerated.

Chapter 8

Till death us do part

Caring and uncaring in work with the elderly

Vega Zagier Roberts

Caring for elderly people brings with it particular stresses, insofar as ageing is the fate of all who live long enough. It inevitably stirs up anxieties about our own future physical and mental decay, and loss of independence. It also stirs up memories and fears about our relationships with older generations, especially parents, but also grandparents, teachers and others, towards whom we have felt and shown a mixture of caring and uncaring. This chapter discusses how these anxieties were dealt with in one geriatric hospital. However, the processes described exist to some extent in all caring work.

THE INSTITUTION

Shady Glen was a specialized hospital for severely impaired elderly people who, without being particularly ill, required intensive, long-term nursing care. It had two wings: the smaller North Wing had three rehabilitation wards for those patients who were thought likely to be able to leave the hospital eventually; South Wing had four 'continuing-care' wards for those who were not expected ever to be able to live outside the hospital again.

The four wards of South Wing were particularly bleak and depressing. The beds were arranged in a circle around the edge of each ward, pointing towards the centre, from where the nurse in charge could keep a watchful eye on everyone. Squeezed between each bed and the next one stood a small wardrobe and chest of drawers; there was little space for personal possessions, and virtually no privacy. A few patients could move about with walkers, but the others spent most of their time in bed or sitting immobile in chairs. Most were totally dependent on the nursing staff for all their physical needs, and were fed, toileted and bathed on a fixed schedule.

The nurses maintained a high standard of physical care. There were few bedsores or accidents, little illness, and the patients were clean and well nourished. However, the managers of Shady Glen were concerned about the poor quality of life for the patients in South Wing, and asked the senior nurses of the South Wing wards to form a working party to explore what could be done to improve the situation. It quickly became apparent that patients' quality of life