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Training Mental Health Nurses at City University

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Some years ago, a senior nurse from an NHS trust complained about the standard of training of mental health nurses – some of the recently qualified nurses didn't know the classification categories for schizophrenia. So, was the training inadequate or could there be another explanation?

It might be supposed that a task is accomplished most effectively by a group or organisation. But studies demonstrate that groups often behave in ways that appear to be unprofessional, or even incompetent, disrupting healthy functioning. Central to our understanding of what makes things go wrong is the recognition that anxiety is experienced as threatening. When individuals feel too anxious, their ability to think in any complex way is compromised. They want certainty, so are more inclined to see the world as sharply divided between good and bad.

Groups react in a similar way, an observation first made by Wilfred Bion,[1] whose work at the Tavistock Clinic in London led him to conclude that groups organise themselves into defensive structures, aimed at reducing anxiety. He called these defensive structures 'basic assumption modes', because the group behaves as if there is a shared assumption about the best way to manage. For example, one of the basic assumptions is dependence. The group then behaves as if the most important task is to find the right leader. The assumption seems to be that the leader will protect them from the unwanted anxiety. Another basic assumption is that the anxiety is caused by an attack from outside. The only question then is whether to resist or run from the source of anxiety. Bion called this basic assumption 'fight/flight'.

Bion's work clearly shows how members of a group stop focusing on the task and instead become preoccupied with the organisation of the group itself: 'let's find the right leader' or 'should we flee or should we fight?'. Any group in this sort of state struggles even to remember the original task.

I tested the power of this phenomenon with a colleague of mine, Andrew Oatts, when we were training psychiatric nurses in group dynamics, back in 1980. The course handbook, which described the nature of the training, referred to a weekly experiential group. The other elements of the training were listed on one page, but we used a complete and separate page to write in large letters that the task of the experiential group was to notice the emotional impact of the training on the individual members. That was all. It was clear and simple, yet we predicted that nobody would be able to remember the task for at least the first three meetings. Our prediction proved to be true - and has remained true in my experience ever since.

Of course, it is not entirely irrational for a group or organisation to focus on something other than the original task. After all, the task is the main cause of anxiety. Working in health or care services also involves particularly high levels of anxiety, with nurses and doctors in the NHS expected to treat and heal people who are frightened and in pain. It's perhaps only with experience that we build up the capacity to manage the anxiety, rather than be driven by it into a state of avoidance or panic.

Many of you will recognise the anxiety of the professional, but the patient is also likely to be experiencing anxiety – and the emotional exchange between professional and patient bears further examination. Let's take the example of a newborn baby. When a baby cries, we often find ourselves filled with anxiety and unsure what to do. With hindsight and experience, it's pretty obvious that only a few things can be making a baby cry. The task is to go through them one by one until you find the cause. How is it, therefore, that adults can lose that calm and clear capacity to work out the source of the problem?

Melanie Klein was one of the first psychoanalysts to work directly with very young children. She noticed that babies deal with overwhelming feelings, such as hunger, by transmitting the unbearable feelings to another, a process she called projective identification.[2] If we go back to our newborn, the sense of panic that takes over as the baby cries is the *baby's* panic projected into us – Klein's projective identification.

If clinicians who work in frontline services are given the opportunity to meet and share their feelings about their work, their patients and their colleagues, these projections can be identified. They can then be used to think about and understand the work. It's not always easy. Members of such groups often feel, at least at the start, that they are talking about their *own* feelings rather than feelings that have been projected into them. But they gradually come to understand the way that feelings can lead to a deeper understanding of their patients.

In 1994 I joined the adult department of the Tavistock Clinic, where I designed and ran a ten-week programme to help people working in frontline services. Each week there was a lecture, followed by a meeting aimed at exploring the emotional experience of the members of the group. There was no agenda, just an opportunity to share how people were feeling - a bit like the experiential group described earlier. The programme ran for 17 years and was delivered to more than 60 organisations, allowing me and my team to learn a lot about how to enable professionals to discover the benefit of a space that transforms feelings into information.

About 20 years ago, I became involved in the training of mental health nurses at City University. With Sarah Campbell, a senior lecturer at the University and a qualified psychoanalytic psychotherapist, I devised a version of the system I had used at the Tavistock Clinic. We hoped that providing such a space for nurses, right from the beginning of their training, would enable them to understand the potential impact of their work.

Anyone who walks onto an acute mental health ward feels anxious. It's important to show new nurses that anxiety is not only normal, but also projected from the patients. The anxious feelings therefore carry information that can be translated into meaningful data about the work. If the nurses don't understand this process, they will believe the anxiety is their own problem, to be resolved in a personal way.

To be precise, I think the criticism of the training standards by the senior nurse was entirely to do with the vulnerability of newly qualified nurses as they walked onto those wards, no longer supported by the university, but entirely alone. Such anxiety, particularly when you feel it is your own problem, is bound to interfere with your capacity to think and will certainly disrupt your most recent memories.

We devised a plan to provide a meeting space to cohorts of up to 12 students, from the beginning of their mental health training through to its conclusion. These meetings, or personal and professional development (PPD) groups, began as a pilot for a subset of the students in 2011. We felt it was important to have two facilitators in each group, to minimise the risk of cancellation. Also, two facilitators would be more able to manage the emotional and psychological pressure. Of course, the facilitators would also be affected by unconscious emotional exchange, so I ran fortnightly meetings for all the staff involved in facilitating PPD groups.

It's important to note that we are not describing reflective practice, although I believe that the best reflective practice groups pay attention to the unconscious impact of the work on the clinician. The

PPD groups don't have an agenda or ask participants to bring clinical work. The expectation is only that the students feel free to talk about their experiences and their feelings. It is also made clear from the start that the group will not become a therapy group and will not treat members as patients. On the other hand, it's important for staff to be able to point out that the dynamic in the group might be moving towards making somebody *appear* to be a patient. Such a shift in the dynamic would then become a matter for interpretation and understanding.

A typical PDD group is made up of a mixture of young people who have had no experience of mental health nursing, plus three or four older students who have worked as care assistants in the hospital.

The younger students talk about the pressures of a new placement on a forensic unit. They also comment on the difficulty of engaging with patients because the permanent staff restrict their contact with patients in the unit.

In one meeting, a young woman talks about feeling disturbed by the way a male patient looks at her, which prompts a couple of the older students to explain how she should manage the situation. It seems to the facilitators that the vulnerability expressed by the young female is perceived as her own problem, caused by her lack of experience. As the meeting goes on, other members of the group also offer advice.

When they present the group at supervision, the facilitators express a feeling of inadequacy. They didn't like the way the group treated the young woman, but they didn't know how to intervene. In our discussion in the supervision meeting, it seemed helpful to start from the facilitators' sense of inadequacy. There seemed to be a pattern: on the placement, the permanent staff also seemed to feel unable to allow the students to engage with the patients.

It became clear that the sense of inadequacy was stimulated by the fear in the young students. The advice offered to the woman suggested that her feeling of intimidation, as well as the anxiety it produced, was somehow wrong, her fault. We were able to see that feeling frightened in a forensic ward might be a perfectly rational response to working with people who had done terrible things. In fact, the idea that she could follow some simple steps to eradicate such feelings could be the irrational response.

With this insight, the facilitators were free to look at what was going on in their PPD group, which could be seen as a common splitting mechanism. There was an advantage in keeping the frightened young woman in the role of victim, because it gave the illusion that everybody else was free from fear. The facilitators felt enabled to return to the meeting and talk about fear as a rational response to meeting these sorts of patients. Once such feelings could be accepted, it was possible to think about the work and how to approach it.

The Nursing and Midwifery Council (NMC), which inspects and registers nursing trainings, has since commended the PDD groups at City University. The effectiveness of the groups is also tested by an annual survey of the students. Interestingly, the first-year students almost always find it difficult to understand the point of PPD meetings. In contrast, students who are coming to the end of their training have always shown great appreciation for the PPD experience and a wish that such meeting spaces were available to qualified staff.

I am hopeful that the university will continue to fund the PDD groups for students. Maybe someday they will also be more widely available to help staff manage and learn from the complex and unconscious emotional exchange on a mental health ward.

References

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