Looking for Unicorns: Process Work at the Princess Royal Hospital

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A seminar participant and frequent patient at the hospital asked me (Arlene) to meet someone. We were introduced and sat down for a smoke. I asked him about himself. Before being in the hospital, he had traveled the world searching for two lost unicorns. I told him he was a spiritual man on a long journey; unicorns weren't easy to find these days. He nodded. How was life in the hospital? Great, he said, not only because he could focus on his search, but because fate brought him to meet his wife-to-be. I'd met a brother in spirit. We too were seeking unicorns at Princess Royal, tracking the mercurial mystery of life in the unexpected and irrational which slip through the fabric of social adaptation.

Society sends people with overwhelming emotional and perceptual experiences to psychiatric hospitals, not only from compassion, but due to fear and prejudice toward highly emotional states. Psychiatric patients often feel misunderstood, lost in inner turmoil. Their freedom goes. Along with the patients, professionals often take the brunt of wider social issues involved. They feel ignored for their efforts, and challenged to the limits of knowledge and energy when faced with acute and chronic extreme states categorized as "mental disorders."

This article describes our experiences at the Princess Royal Hospital in Haywards Heath, outside of London, where we gave five seminars over a four year period. We hope to add to the growing literature on extreme states and inspire those working in similar situations who may be stimulated to discuss the ideas or try something similar (or different) in their own environments. The article focuses on:

a) the history of the seminars and how and why their format and content evolved over the years. Originally the seminars were designed to introduce Process Work to psychiatric professionals. They evolved into training and experiential seminars, where professionals, patients and process work students joined to explore the multi-leveled dynamics in mental health issues.

b) the connections among an individual focus with people in extreme states, issues concerning therapist and client roles, and underlying social and human issues. We addressed these areas in group processes made up of patients, psychiatric professionals and process work students.

What is a psychiatric hospital?

The definition of a psychiatric hospital depends on one's perspective. For the man mentioned above, it was a place to search for unicorns and meet his wife-to-be. For society, the psychiatric hospital houses and rehabilitates people in wild states in order to protect the person and the community. Psychiatric hospitals are places where people are diagnosed, receive medications and get therapy. Some receive shock treatment. Some come for a day or two, others for thirty years. Sometimes patients receive loving and skilled help through times of inner turmoil. Sometimes help doesn't come.

Some patients experience the hospital as a place to take a break from the pressures of daily life

while receiving assistance with a crisis. Others experience it as a prison. At Princess Royal, some patients are "leveled" out of concern that they might hurt themselves or others. This means that they require certain levels of observation until they are considered of sound judgment, free to go out into the community for an evening, permanently, or until the next hospital visit. Personal freedom and basic human rights become important issues.

Psychiatric professionals such as psychiatrists, internists, nurses, art therapists, occupational therapists, psychotherapists and social workers are usually deeply involved with their work. While some consider this work as just a job, the majority have a strong interest in helping others. The mental health professional holds a complex job. She is held responsible for the safety of patients and the community. She is asked to heal the patient, although both diagnoses and methods of treatment remain uncertain. While exciting team work across disciplines and opportunities to learn from others occur, she is often on her own. There is never enough time. She fights hopelessness and burnout daily.

Many hospitals focus on research to gain knowledge to work better with physical or mental illness. The National Health Services partially sponsored our seminars over the past five years. Thanks go to Sheila McClelland, Dr. Alison Abrahams and the interdisciplinary process work group that formed at Princess Royal.

For us, working in a psychiatric hospital has been challenging and fun. We have been interested for many years in how to bring a process work approach into contact with community services, including mental health, prisoner rehabilitation and social action projects. We were therefore happy to support Sheila McClelland's project at Princess Royal.

The hospital setting allowed us to use the process orientation to extreme states. We assumed that they contain an impulse for the system's evolution, within the evolving system! Psychiatric hospitals are microcosms of society's tendency towards homeostasis. They reflect the desire to keep out trouble, and the tendency for trouble and extreme states to erupt. These hospitals sit at the "edge" of culture. They are intended to protect the status quo, retaining patients until they can safely return as functioning members of society. Sitting on the edge of society, a psychiatric hospital provides prime ground to research and bring awareness to collective and individual issues surrounding extreme states (see Arlene Audergon 1990).

History of the project

After the first process work seminar she attended, Sheila McClelland began to experiment with Process Work. With enthusiasm and persistence, she tried out process work methods, created her own methods to access and amplify processes using art materials, and talked about Process Work around Princess Royal Hospital. She emerged from the inner sanctum of her far-out art therapy office and began tackling the "system." Dr. Alison Abrahams, a senior psychiatrist, became interested in Sheila's work.[1] Soon, they invited us to give our first seminar.

The first seminars

We planned the first seminar with respect for the existing system. We hoped to contribute a taste of Process Work as an orientation and methodology which might prove useful to people in addition to their existing framework and skills. This was a one day introductory seminar for about sixty psychiatric professionals. We gave a brief presentation of the process-oriented approach, highlighting special methods of working with acute states. We included case material and some simple exercises for communicating with people in extreme states. The day was very well received. The following day in the morning, we worked privately with clients and their therapists and videotaped these sessions. In the afternoon, we held a case-control and video study session. The two days were exciting and created enthusiasm for further learning.

The following year, we used a similar format, adding an extra day. Process work students were invited to join the seminar and to participate in an extended video study and case control session. Late at night, we studied the day on video with process work students and some staff members to prepare for the next day's presentation. The video study spurred interest in further training in observational skills leading to accurate interventions in unfolding processes.

The third seminar

Sheila and her colleagues worked closely with us in developing the seminar design. We extended

the seminar to four days and changed the format. The staff expressed interest in training to deal with everyday situations. These ranged from working with acute psychotic states through crisis and suicide to addressing issues of hopelessness and abuse with outpatients.

The seminar was designed for professional training. Clients interested in the opportunity to work on personal issues in this setting also attended portions of the seminar. In the morning we presented theory and skills, then people met in subgroups where patients had the opportunity to work on personal issues. The five subgroups were facilitated by psychiatric professionals or process work students. Each day, a different group of five patients attended. The two of us supervised the groups. We worked with patients, supported students and professionals in their learning, and frequently helped with relationship issues between patients and their regular therapists. It was a large bite to chew but worked very well. Afterwards, we met in the large group for theory, to complete unfinished issues from the small groups, and to practice skill building exercises. In the evening, we did video case studies.

We wanted to invite patients into the whole seminar if they wished to attend, but they expressed concern about confidentiality amongst themselves. Therapists also worried that if clients came to the seminar, therapists would feel obliged to stay in a caretaking role and thus not feel free to engage as seminar participants. The direct involvement of patients in the seminar excited professionals and students. Most patients were eager for this opportunity to work on personal issues. It was also touching to see their interest and support of professionals wanting to learn. While the seminar was designed for professional training, patients were invited to stay for the afternoon sessions on days they came to work with personal issues. Most did.

Seeing issues emerge for therapists, we changed our training focus. We realized that many of the problems therapists face have to do with a learned need to keep distance from their patients. Also, they feel afraid to be themselves and use their experience and perceptions. Focusing on "special methods of working with acute states" inadvertently supported the learned tendency to work "on the client." Hence, our focus turned to bringing awareness to the feelings and behaviors of the therapists. We wanted to find out how the therapists' processes fit together in a systemic way with the patients' signals and processes. For example, a therapist could help the client pick up the "healer," "nourishing parent," "doer" or "critic," instead of the therapist staying unconsciously identified with these qualities. As therapists began to process the unconscious identification with certain roles and behaviors, they experienced a connection with another person's totality. This was relevant to the therapists' concerns of having to caretake patients during the seminars. There was a lot of learning going on and it was fun and dynamic for most everyone involved. We were excited that the basic skills and methods of Process Work helped therapists establish communication with their clients. Process Work also helped support therapists' freedom and curiosity to unfold the most difficult experiences.

Another change involved doing a group process session on the final day, when many of the patients attended. Around this time, the National Health Services (NHS) in England underwent a major shift in structure which deeply affected everyone. This created uncertainty as to the professionals' jobs and the availability of services for clients. The NHS was moving toward local rather than central management. These changes stirred the hospital's homeostasis.

Doing a group process with patients and psychiatric staff together was experienced as revolutionary in this environment. There was usually more separation between patients and staff. The group process began with a discussion of the mental health workers' problems with the administration. Two important events during this process became the basis for structural changes in later seminars. One was that the patients became very active. They were shocked to see that their therapists felt powerless against the system. Until now, the patients had identified as powerless and seen the therapists as the "system." The patients were suddenly freed of their role and strongly challenged the mental health workers not to act like administrators themselves and to be human. The mental health workers acknowledged their strong feelings and need for one another. They broke the tendency to remain isolated in their professional personae and separate jobs. Then some began to pick up their own authority rather than splitting it off on the administration. They began to organize ongoing groups to support one another and work on relationship issues.

The seminar received very positive feedback, which in true British understatement means people were highly emotional and happy. The main wish for a change in the following year's seminar was that patients were eager to participate. Therapists learned they could handle this and did not have to feel stuck in the caretaker role.

The fourth seminar

This year the seminar was geared for professionals, process work students and patients. Rather than coming only on the days that they worked on personal issues, patients participated in the whole seminar. We could feel the tension and excitement. We were all doing something a bit revolutionary.

The medium is the message

Having the seminar with professionals, psychiatric patients and process work students together as participants seems utterly sensible and natural, no big deal, yet it is deeply radical. A format which combines these groups breaks a major societal agreement or collective edge. It steps over a boundary which allows us to keep our society intact by splitting off and projecting what we fear as the irrational. This format steps over the boundary which allows us to know who is crazy and who is not. Breaking these implicit agreements gave us the opportunity to process these issues together as a group. The format clearly reflected our goal to create a forum where all are equal and supported to be their whole selves.

The common myth —what links patients, professionals and students

We started the seminar addressing the group's common concerns. These included the emotional world, the search for meaning, and the importance of finding a way to be oneself in relationship to others and in the community. We talked about the pain, which most of us know, of being diagnosed and labeled. We talked about the difficulty of being a patient or a therapist. Mention you are a psychiatric patient at a cocktail party and you get blank stares and flat conversation. You get the same stare if you mention you are in the psychiatric professions.

Though we have different roles, we are linked. Several years ago, when we worked in a psychiatric hospital in Milwaukee, Wisconsin, we went to a local bar one night. The "normal" people there looked more "altered" than anything we had encountered in the most acute unit of the hospital. We realized that many of us exist in altered states most of the time. At least on the ward there was awareness about this. Whether patients or professionals, we all somehow share a myth. We are face to face with ourselves, looking for meaning in our most impossible emotions and altered states.

One of the most humiliating things for anyone is to have his or her perception denied repeatedly. This is one of the problems of western psychiatry. Someone behaves strangely and says he sees the devil or that a spirit talks to him. After compiling the symptoms systematically, a diagnosis is made. The illness is perhaps caused by a biochemical disturbance. The perception of the devil or spirit is denied and understood only as a hallucination. While the fact that the person hallucinates is carefully recorded, the content of the hallucination is often disregarded as meaningless.

In cultures with shamanistic practices, we might see an individual act wild and announce that he sees or hears a spirit. While the experience might be welcomed for its spiritual value, it is likely that he too will be considered ill and even become an outcast. But there tends to be an agreement as to what caused the illness! The healers and the sufferer both believe a spirit is at work. They share a basic agreement of perception. The shaman and the ill person deal with the same stuff, operate in the same territory.

In a sense, this seminar began to create a place where patients and professionals operated in the same territory. They shared awareness of a field in which we are all involved with altered states, emotions and the challenge to become ourselves in this world. In western medicine and psychiatry, this territory is rarely shared. The therapist or doctor tends to observe from a distance, evaluating the patient's experience from a safe spot in a separate world.

Contempt and fascination for the irrational

When in extreme states territory, we deal with the world of the irrational, the unknown. Most people try to repress, split off and project this realm onto others. We coined the word "psychephobia" to describe this fear of the soul, fear of the irrational, which is left to patients and their mental health workers to deal with in hospitals. This attitude is at the seat of prejudice. We seek out a group of people different than ourselves and project everything we don't know in ourselves onto them. We imagine these qualities belong to

the other group, and this imagination is in turn supported by collective fantasies. We form attitudes and judgments towards the group based on our projections.

The projection of the unknown in our society is compounded by the value placed on the rational and logical. Those who hold social, political and economic power identify with the rational. Strong emotions and all that is irrational are projected and assigned to other groups. The privilege of identifying with this power while projecting unknown aspects of ourselves onto others, accompanied by fascination and contempt, add up to oppression. This "psychephobia" is one link between sexism, homophobia and racism. Strong emotions and violence are projected on people of color. Gays are considered child molesters. Moodiness and weakness are projected on women and homosexuals.

We are quick to split off and project the irrational onto people who give free expression to their emotions and altered perceptions. This tendency to believe that the irrational belongs to these "others" and not to "us" makes all people feel isolated. The ones suffering these states feel truly cut off in a time when they could most use support for their difficult experiences. Isolation and loneliness are immense social problems even for the mainstream. Such loneliness stems in part from the mechanism of splitting off parts of ourselves and enduring this separation.

Through circular thinking, this process leads to a kind of collective muteness or trance, a lack of societal reaction to these issues. Take the example of sexism. Speaking out tends to go like this: a woman speaks out about what she feels is a sexist attitude towards her. She is told she is too sensitive. If she reacts to this accusation of being too sensitive, she is labeled hysterical. She grows furious, and the others use this to reinforce their prejudice and sexism.

Take the example of racism. You react to the prejudice and racism in society. Mainstream society may retreat and think, "Good that you speak out, it's not my problem." Mainstream culture may also feel threatened and lash back in the form of hate groups or trying to equalize the suffering inherent in mainstream problems, i.e., "my neighbor suffered from reverse racism." Again left alone with the issue, you can either stand boldly or retreat in hopelessness. This reinforces the mainstream prejudices: "those people of color are all overboard about this racism stuff" or "look how those people of color lack ambition." Perhaps you react with a rage. The mainstream thinks, "I always knew these people were violent." This mechanism creates and reinforces isolation between ethnic groups. The privileged perpetuate this hurt on a daily basis by disowning their own behaviors and projecting them on other groups over whom they have social and economic advantages.

As we talked about these issues in the seminar, a strong response of recognition welled up in the group. Many women felt their own situations around mental health problems were strongly linked with issues of sexism. Some felt the pattern of being called hysterical and too emotional had escalated until they landed in the hospital. Both men and women felt this circular reinforcement of their diagnoses as particularly oppressive. As soon as they received a mental illness label, it was used to reinforce prejudice against their behavior. Once labeled, they were treated with disdain and the label was used to shut them up. Any display of emotion or reaction of anger would elicit comments about the need to cool off or go back to the hospital.

We spoke with therapists about recognizing the political dimension of their communication and intervention with patients. Every intervention is a social and political action, not only a therapeutic one. You may choose to encourage someone to settle down or to support their emotional reactions or bring out your own emotional reactions to the social issues involved.

Style: learning about prejudice and polarization

One of the seminar participants, a frequent inpatient, currently an outpatient, was very pleased to attend the seminar for the second year. One day, as we broke for lunch, a hospital administrator came in and spoke to him in front of the group. She said he must leave the premises promptly at the end of the day and not linger on the hospital grounds. We had understood that in the morning he had been stopped in the building and had not been believed when he said he was attending a seminar. We responded that this might have hurt him, but did not mention how the current interaction was hurtful. The participant politely agreed to do as requested.

Much later we found out that we had gotten the facts wrong. The administrator had asked the man to leave for a different reason, because he had

arrived that morning in the casualty department, requesting treatment, apparently on drugs. He was also found to be carrying knives. The casualty unit was busy with acutely medically ill patients. Porters were called to remove him and one got slightly cut. The patient had been carrying knives recently due to neighbors threatening him in connection with drugs. In the process described below, we think that while we misunderstood these initial facts, the process that came up concerning split off aggression as a major collective issue was to the point.

We had initially thought the unpredictability and violence was projected on this man only because of his appearance. It turned out this was not only a projection. Had we known the facts, we would have supported the administrator to ask him to take responsibility for his behavior, while supporting the patient in his perceptions. We want to emphasize, however, that he is an identified patient or "disturber" in a society which is filled with violence belonging to all of us! The following interventions involved not wanting to leave him alone in this role.

We left for lunch and realized over a sandwich that we felt hurt and furious. We realized people treated this man as threatening because of his wild appearance. He dressed in far-out, creative clothes, wore beads and had long hair. He carried himself with an air of defiance. We saw projection and prejudice at work and decided to bring this issue back into the group. Stumbling into our hotel room half laughing and half in a huff, we gathered up our wildest clothes—an orange sweatshirt and orange socks, our hats and sunglasses.

Sitting on the floor instead of chairs, we peered through our tinted shades and opened the afternoon session. Jean-Claude said he felt rage about prejudice against different styles of behavior and how people projected their own violence on anyone looking a bit wild. Ready to enter a different style of communication and express his rage rather than talk about it, he asked people who were afraid of strong emotional expression to hang on to someone near them. Then he yelled. A few others joined in and began to yell. A therapist expressed her rage at being constantly under suspicion, her every move watched if she did anything out of the norm around the hospital.

A group process unfolded between those who were furious and those in shock and afraid of such emotions. First we supported those in tears, both patients and therapists who had been abused or who felt frightened by expressions of anger. Encouraged to express their fears, those who had been most afraid said they felt a deep relief to see it was possible to express rage with consciousness and safety.

The group experimented with standing up for different communication styles and a leadership process emerged in which a small group of patients began to lead the seminar. Working as a team, they were fabulous at facilitating the discussion which revolved around problems of pathologizing and labeling.

What emerged was a group in which people differentiated themselves from their roles. We were people, not "clients" or "therapists." As we seemed to be closing with a feeling of our common humanity, the therapists began to stand up for their work, clarifying that a therapist is certainly a person first, but with a job to use her humanity along with special skills in a way which is useful to the client. They expressed their need to be valued. This brought out the issue of therapists feeling subtly despised for asking for money for such a personal business. The clients loved this! They spoke about their need for support in times of crisis. They also needed challenges and skills from the therapists.

The group began to form subgroups for follow-up after the seminar. They discussed setting up a group in which everyone could work further on such issues together. They talked squarely about distinguishing when therapists would be working for the clients' needs and should be paid. A professional group formed to work on its own issues. We have never seen a group of people able to divide themselves into subgroups so clearly, without painful feelings about insider/outsider issues. Once the common humanity was shared, differentiation was both needed and easy.

The man who had dressed in wild clothes appeared promptly the next morning. He wore a three piece suit, his hair neatly tied back. He was especially friendly. We had the feeling he had gone to this trouble to help us make our point. He had learned something and been touched. We were impressed by his fluidity. He reminded us not to unconsciously identify with any one part of a process, but to maintain the fluidity to support all the interactions. We learned to intervene without fear of feedback, and without unconsciously expecting to "change" or "heal" the

system. We learned to intervene, to react, and then to simply pick up and support the feedback. After the seminar, this man was said to be "acting out" around the hospital. One main problem had to do with drug use and pushing drugs on other clients. He was, however, communicative and very loving with his therapist who had been with him at the seminar. Later, he viewed tapes from the seminar with her, took a good look at himself, and went out and got his life together. He hasn't been back to the hospital, though he keeps in touch. We hear many such stories of people who have come to the seminar and gained something for themselves.

The fifth seminar

At this seminar we had the feeling of coming full circle. We went from introducing a process approach to working with extreme states, through working with the systemic relationships between therapists and clients, to addressing social issues concerning prejudice, fear of the irrational and the political dimension of mental health issues, and finally to a forum which included all these elements. The interplay of these levels, particularly individual and group work, brought tremendous learning. We chose a format similar to the previous year, with patients, professionals and process work students learning together about many aspects of mental health issues. This year, we had a session in which top managers came to discuss an issue with the process work group at Princess Royal. We worked with patients in acute states in the center of the large group in addition to working in the small groups.

From pathology to focus on individual needs

During the fourth seminar, there had been open seat times when anyone could work with us in the middle of the group. We explicitly presented this as an opportunity for students or mental health professionals to work. Identified patients had either worked in the small group sessions or were shy to show themselves to one another. Professionals felt leery of asking patients to work in the middle, due to the history of psychiatry where patients were "shown" in front of groups of doctors.

We liked the idea of professionals and students working in the middle to support the awareness that we all have issues and are growing. We thought it might reduce the tendency for everyone to pathologize the patients. It worked very well. We decided in the fifth seminar to try something new, integrating what we had learned from the group process in which group members had first shed identification with "therapist" and "patient" roles and then were able to differentiate the actual needs behind these roles. We learned that if the field is addressed with respect to unconscious identification with roles, the fear of the irrational, along with such issues as sexism, racism, and homophobia, we can again focus intently on individuals in acute states. Once the field is addressed, one can focus on an individual with compassion, without prejudice and pathologizing. Pathologizing means burdening someone with individual and collective projections.

In the fifth seminar, we worked each day with one or two individuals in acute states in the center of the large group. These sessions were often experienced as life changing for the individual and radically affected the atmosphere of the whole group. We also focused deeply on group process. Interweaving different levels clearly created a useful forum for working with extreme states, in which the individual is not used as a scapegoat for split off processes of the group or society, nor is the individual forgotten. The highlight of this seminar was how the individual sessions combined with group process. This gave most people an emotional grasp of the connection between individual mental health issues and social issues.

Listening: power, sexism and mental health issues

a. Management and clinicians

At this seminar, hearing emotions and hearing one another was a main issue. In one session top managers and the interdisciplinary group of psychiatric professionals worked as a subgroup in the center of the large group. There was a common complaint that each felt unheard by the other, although both sides wanted to listen. It became apparent that what was not heard was pain. The psychiatric professionals felt despair because their clinical input was ignored in administrative decisions. The managers in turn felt unheard and misunderstood. They felt they alone had to take the pressure to make necessary cuts so the hospital could survive financially. The process came to a close when the managers felt touched as they listened to a patient speak emotionally about his very personal story in relation to financial cuts.

Managers then expressed their need to hear the patients and the clinicians. The managers recognized

that they had been afraid to listen for fear of having to make painful decisions regardless of what they heard. They realized they needed this input to fight for resources and to make informed decisions, even when they hurt. The professionals realized their need to stand up and offer to get involved in the tough decision making process rather than remain identified as victims of the hospital administrators. Both realized they were in a position to work together when they listened to the patients they were there to serve.

b. Linking the individual and the group: men, women and the recurring auditory hallucination

On the last day, we had a group process session about issues between men and women. The day before, a man inadvertently started a group process by telling a sexist joke. Men had been asked if they would be willing to listen to the women's side for 30 seconds. As is often the case around this issue, the men focused on their feelings and need to first be heard and understood for their side of the issue.

The connection between the individual and the collective and particularly the connection between sexism, power, communication style and mental health issues became strikingly apparent. In the midst of this process a young woman began to shake and complain that her auditory hallucination of her pleading father had returned. The previous day, this woman worked in the middle of the group on the constant guilt she experienced since her father's suicide. For two years she had heard his voice pleading nonstop in her head, "Help me, help me." The voice made her frantic. She felt guilty for his suicide because she had reached her limits in helping him with his chronic depression and had asked him to get help from a doctor. He had committed suicide the same night.

The enormous quantities of psychotropic drugs her doctors gave her didn't help. She was left shaking and frozen with a flat affect from the drugs and her own altered state. A whole system of doctors, psychiatrists, social workers and therapists had been unable to help. She came to us as a last resort. She had participated in the fourth seminar. Although she had enjoyed it, the work in the small group had not changed her hallucinations. She worked in the middle of the group at her own request. The whole system involved with her care, including her therapist and the seminar participants, all felt under pressure to do something and guilty they couldn't do more.

In her individual work, we told her we felt helpless, yet didn't want to feel guilty. Together with us, we wanted her to find a solution to an impossible situation. She suggested perhaps she should commit suicide. We strongly asked her not to act like her father. We proposed that she seek other solutions rather than leaving it to us. Her long-term therapist asked to come in. Lovingly, and very loudly, she yelled at and pleaded with her client to stop listening to the father's voice and to recognize her father as the abuser, not the victim. He had left her with this shit when he committed suicide. It was time for her to tell the voice to "fuck off"! The therapist too was tired of feeling guilty for being unable to help! The client seemed to wake out of a daze, looked around and started to cry. She apologized to the therapist and to the group for acting like her father and making everyone feel guilty. We acknowledged her deep feeling and power to be able to apologize in such a difficult situation.

She said she had never had the courage to face the voice coming from over her shoulder. Did we think that saying "fuck off" would help? She gathered up her courage, and following a body signal, held herself high. She looked over her shoulder. In a stronger voice than we had heard her use she said the two words. The voice went away for the first time in two years. She kept telling us during the day she felt she was in a dream. She wondered whether it was real and if it would last.

About 24 hours later the voice came back. She heard it at the moment in the group process when the men pleaded to be heard first and complained that the environment felt unsafe because the women were so angry. The whole discussion was tense but subdued. We pointed out that the solution the day before had occurred when her therapist burst out emotionally. She had challenged the woman's relationship to her father's lament and her lack of awareness that he had been the abuser, not the victim. We suggested a need for an emotional style in the group process. This might help the woman get rid of the voice again and help the group go further with the issue of sexism. The connection was recognized, picked up and led to a dramatic change both in the individual and in the group.

A female therapist spoke out emotionally. She felt fed up with men for never listening to anyone unless their feelings were cared for first. Then a man, a professional, began to talk very rationally

about his point of view. He went on at least a minute when the young woman who was hearing the voice of her father stopped shaking and shouted "fuck off." This time her eyes were open and she looked directly at the man who was speaking. He stopped in mid-sentence. Her internal voice stopped, too. The next moment, another woman who had suffered a breakdown and had worked in a small group on issues of abuse stretched out her arms and hands. She closed her eyes, and with great intensity chanted, "No, no, no, you may not do this," as if an internal drama was finally closed. A third woman, who had worked in the middle of the group on horrendous abuse issues and had emerged from an acute state of severe suicidal depression, spoke lucidly and lovingly that we needed to remember that all men were not bad and that she had three sons whom she loved and needed to help grow up in this world. We agreed that men were not bad—the issue had to do with listening to women's hurt, instead of focusing only on themselves.

A man, a patient with extreme states, picked up her comments and stated that his mother had treated him badly and that he was angry at her. We said we were aware mothers could do awful things, but wanted to check—where was his father in his story? Without hesitation, he replied that his father abused his mother consistently. Silence came over the room. At this point, men began to listen and speak out. One after the other, men and women spoke movingly about how easily they had always blamed their mothers instead of fathers. A man expressed his sadness as he realized how he had constantly tried to inhibit and control the wildness of his daughter. The feeling was not of expressing guilt, but of true recognition.

A young man, a client who had suffered chronic depression, panic and anxiety since his mother's death, spoke about how he suffered from seeing his mother constantly put down by his father, grandmother and family. He had tried but couldn't help her. Tears flowing freely, he implored the world to answer to why women are treated as second class citizens. The man who had been so rational at the beginning spoke. He realized he had also blamed his mother and had kept himself distant from his own children while blaming his wife and remaining identified with his professional status. Another patient on the ward who was trembling, her face buried in someone's arms, emerged with a beaming smile and said, "That's like my dad." The session ended with most everyone deeply touched, in tears, holding hands. It was a striking demonstration and group discovery of the connection between sexism and many mental health problems.

c. Discussion

This process brings up questions about the relevance of doing group process on social issues as part of a seminar on extreme states. It also brought up the relevance of doing such seminars in a psychiatric hospital. Could this be done on a regular basis, with a resident facilitator? How could clients, staff and professionals best evolve in their learning and skills? What kinds of processes would we expect to deal with in addition to sexism and abuse, which are major issues in connection to mental health? Would the processes of individuals diagnosed as bi-polar, schizophrenic, catatonic or paranoid connect with specific kinds of group processes?

In the moment, staff are learning to deal with reactions of patients who have either participated in the seminar or heard about it. Some of the staff who did not participate in the seminar, and some who did, feel criticized by patients who want more of this work. Some staff feel unappreciated for their regular work. These issues need careful attention and an opportunity to be processed. Those with such feelings who are already involved with the seminars will be interested in processing their feelings and conflicts. For those who do not want to come to the seminars, there is no consensus to meet and deal with these issues. We are studying ways of supporting all points of view. If more psychiatrists and ward staff could feel welcomed and needed in such an experiment, it would be very exciting.

Communication and awareness at our edges—the process paradigm

To bring Process Work to a psychiatric hospital means much more than introducing an orientation and methods of working with individuals in acute states. The methods of Process Work allow us to work with the individual, with the dynamics between therapist and client and with the wider systemic issues of the field, be it the environment of the hospital or the society in which we live.

We were first invited to Princess Royal to teach the usefulness of Process Work methods in reaching people in acute states. Sheila's work caught the attention of the psychiatric professionals in large

part because of her "results." Doctors and therapists sent her patients they could not reach, and she found ways to work deeply and help them. Their rate of return to the community without coming back to the hospital was unusually high. This matches the goal of the hospital. Sheila had written an article about her powerful experiences doing brief therapy with people in acute states using Process Work and Art Therapy. Brief therapy is an important concept in public mental health systems. It suggests clarity in respect to effectiveness and accountability and it costs less.

Process Work was seen as an effective method of treatment, helping people lead more functional lives. A process orientation views extreme states not as illnesses in need of treatment, but as impulses of potential growth for the individual and the field in which she lives. The "metaskills" or attitudes which allow a process worker access to his or her skills involve welcoming and unfolding trouble, rather than trying to eliminate problems to make the person function better.

One possibility is to debate the conflict of orientations. Process Work welcomes and unfolds the unexpected in what appears as the worst problem or acute state. One goal of Process Work is to bring awareness to the field and to different levels of interaction, from the intrapsychic to relationships and societal debates. It does not pathologize the patient, but sees extreme states as containing valuable information needed by the individual and the community. The medical model at the hospital is oriented towards pathology and healing. It is interested in making accurate diagnoses and finding methods of treatment, with the goal of helping people return to normal lives. We found that debating a pathological vs. a creative approach to extreme states, and trying to talk people into a new orientation, was not the most useful approach. It leads to a tendency to "heal" the system by challenging its orientation of pathology and healing.

Process Work offers a new orientation that need not be at odds with the dominant paradigm in psychiatry. The new "world view" of Process Work does not conflict with the questions and methods which were based on the assumptions of the previous paradigm. In fact the process paradigm addresses these questions while also producing a new set of questions and methods (see Kuhn 1970). Although Process Work is not based on a premise of pathology and healing, it addresses the very real goals and needs of therapists and clients to find methods of working with acute states. It offers no panacea, but often "works" to reach people quickly, defrost long-term frozen states, and communicate with and unfold highly emotional experiences and altered states.

At the same time, a process orientation makes one humble before the long-term, circuitous and surprising nature of process. It is nature, not the method, which is truly awesome. A process orientation also observes the importance of the social environment of the client and the wider societal issues and collective dynamics that are linked to mental health issues and which concern us all.

A process orientation also means staying with hot spots, bringing awareness to the moment of change where the energy emerges from the process itself. Having a process approach in the hospital means supporting the reactions of excitement as well as the resistance and conflicts we encounter. It means working with the interests and needs of the therapists and clients as well as the momentary and long-term feedback of the system. It involves learning from the process by staying with the hot spots or "edges" as they arise at different levels of the system.

It is a matter of habit and comfort to become identified with certain behaviors, attitudes, theories and methods of work. Many therapists become interested in learning when they start to feel bored, drained of energy and dissatisfied with their work. This describes the situation of many of the hospital staff and community professionals who attended the seminars. They are talented and overwhelmed with very difficult situations. It also describes the situation of the National Health Services which are in dire need of another form of energy, money.

In the hospital, the process feels energetic when we address edges of awareness at various levels of interaction: individual processes, the roles of therapist and client, management and professionals. The group is excited when we process social issues which arise in the group format. Professionals and patients feel energized at their growing edges. People often fear the energy it takes to study, learn and grow. Staying away from one's edges may work well for a while, but over time leads to loss of energy. Cycling around the same issues or homeostasis leads to "negentropy" or "burnout." At one's growing edges nature offers change and life energy.

Process Work is a powerful tool and its relevance in the long term depends on the attitudes of the person using it. A basic question in any intervention concerns your goal. If you identify with a goal of getting "results," you may soon feel exhausted if your client doesn't change. If you do not identify with a goal, you can follow the process that includes your goals and which expresses itself in the most impossible disturbances. In the first case, you begin to resent your job, yourself or the client. In the second, you'll have fun, whatever the pain and sorrow involved, because you'll be connected to a deeper source, life's creative energy.

This attitude helped as we attempted to work with the feedback of the system over time. At one point we noticed we were pushing against fear and resistance to the seminars. We decided, together with Sheila, to pick up the resistance and stop pushing the project, even to drop it all together. Then the process work group at Princess Royal picked up the energy and made the project happen. This group evolved over time and became deeply involved with studying. They began to have philosophical conflicts and relationship issues, which they took as opportunities to learn. Therapists and clients study videos and research their work together. Process work students around England are stimulated in their studies. Thus the edges of the system are addressed throughout the year.

New management appeared with a philosophy of empowerment and communication, a difficult ideal to implement, and one which many feel is not happening. When the interdisciplinary process work group at Princess Royal addressed the management with their concerns, the top management was motivated to work with them in the seminar. Some felt that the session only pointed out the tip of the iceberg. Others found it fruitful. One of the managers appeared strongly moved. It will be interesting to study the dialogue around this topic after the seminar.

Most people felt deeply touched and awed by the last group process on sexism and mental health issues. It also brought up controversy. Some "backlash" and relationship issues may emerge. These present opportunities for continued communication and awareness around the hot spots and growing edges of the field, which will lead the development of this project at Princess Royal.

Summary and follow up

We found that Process Work gave us an extraordinary toolkit to work with the many different issues and levels of interaction at the hospital. The process has been our teacher in the situations we encountered and in the evolution of seminar format and content. The seminars reflected Sheila's vision of bringing Process Work to the hospital and Arlene's idea that an institutional setting has the potential to be our community's learning ground (see Arlene Audergon 1990). Given tools of awareness as a guide, and given the structure of the psychiatric hospital, there is a place, time, energy and interest to unravel issues of community life.

We hold the idea of a sustainable culture where large groups of people, including those suffering mental health issues, work together to process issues for the benefit of all. Mental hospitals may offer fertile ground for this to happen. Rather than only housing and rehabilitating people in extreme states, they could provide the container to explore the link between deeply personal and collective issues in our communities.

We were interested in how strikingly apparent the connections became between mental health and sexism. We addressed racism and homophobia, but these issues were not focused on deeply in the group sessions. The group was for the most part European, predominantly white. How do racism and cultural prejudices link specifically to issues of mental health? How would it look to process issues of homophobia in their link with mental health issues? Homosexuality has until recently been classified as a mental disorder; in some circles it is still considered a mental illness. We are also interested in exploring the link between specific mental health issues and social issues. For example, some people we met at the hospital were plagued by a compulsion about cleanliness. Would working on environmental issues alter these processes?

We did not set out to do a long-term research project, but it would be interesting to study how the seminars and the follow up between seminars has affected patients and therapists. Some patients and therapists have attended several seminars. We hear many anecdotal comments about their development over time. We have heard strong feedback that not having to stay stuck in a role as therapist or client has proven extremely useful to both therapists and clients. For therapists, this feeling

has increased their professional growth and freedom to learn from their experiences. It would be interesting to further investigate and report on long-term developmental issues.

An area of ongoing learning for us has to do with bringing a process orientation into the hospital in a way which does not impose a new system, but brings awareness to the ongoing edges of growth in this project and the environment. When old models are challenged, some people feel frightened because new possibilities and power issues arise. We are interested in how to support people to process tensions concerning the introduction of Process Work in a hospital. These include relationship issues, competition and conflict about working methods which arise among staff. We are also very interested in supporting patients to address the systems in which they live. For the next seminar, we may consider adding a day or two to link the events of the seminar with daily life. We would invite people to bring their families, community members, or perhaps ward staff who are not attending the whole seminar to come to sessions. They could work together in small groups, in subgroups in the middle of the large group, or in the large group on personal and community issues.

We have not addressed the wide use of psychotropic drugs in the hospital and would like to focus on this issue more in future seminars. Psychotropic drugs help many people and provide a necessary ally for some patients and doctors in the mental health system. Many patients have been helped to return to their lives, their families, jobs and communities. Our opinion is that psychotropic drugs are overused as the major way of attempting to hold down acute states for lack of other ways to deal with the situation. This is frequently an emotional topic for both patients and doctors. It raises clinical and social issues. The use and abuse of drugs, whether legal or illegal, to alter our emotions, moods and perception, is a major collective problem that deserves attention.

We sent special word to invite the unicorn man to the most recent seminar, since we met him only moments before the end of the fourth seminar. He couldn't come because he was involved with pushing drugs to other patients and therefore not wanted around the hospital. We were quite disappointed. If you see him, tell him we sighted unicorns at Princess Royal and are still shivering!

Note

1. Sheila began training groups for professionals in the hospital and the community. These groups evolved into a weekly process work group. She wrote a chapter on "Brief Art Therapy in Acute States: a Process Oriented Approach." (McClelland, in *Art Therapy, a Handbook.* D. Waller and A. Gilroy, (Eds). Open University Press: Buckingham/Philadelphia, 1992.) She also co-authored an article on Process Work and Art Therapy with two clients ("The Art of Science with Clients." Sheila McClelland, Pat and Ann. In *One River, Many Currents.* Helen Payne, (Ed). London: Jessica Kingsley, 1993). Sheila's unit is called the Process Work and Art Therapy Unit—perhaps the only one of its kind to date in a psychiatric hospital.

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