Working With Polarities in A Psychiatric Hospital: Hopes and Boundaries

Ido Peleg, MD

Mazor mental health center, Israeli institute of group analysis and Technion IIT, Israel

EGATIN study days, Berlin 2025

Abstract:

Psychiatric hospitals are inhabited by people in extreme situations who can't be helped in the community. Sanity and insanity, freedom and restriction, dialogue and silencing are some of the polarities characterizing them. A person working in such a milieu must find his place between these polarities, a choice influenced by personal history and world view; and by the organizational climate and the social unconscious. For that to happen, processing these polarities is essential, followed by changes in the permeability of boundaries between subgroups and individuals. A clinical example will describe how a psychiatric department located at a culturally diverse area in Israel, negotiated its boundaries and polarities after the hospitalization of a transgender person.

Hi,

In this talk I will try to present some of my thoughts and experiences as a Psychiatrist, Group Analyst and Manager, working in "Mazor", a psychiatric hospital in the north of Israel. I will mainly concentrate on a clinical example that took place a few years ago, in a department which I directed. In the spirit of the therapeutic community ideas (Main, 1977; Whiteley, 2004), I tried to facilitate a culture of acceptance, open communication, engagement and reflectiveness in the department as a whole, and especially between patients and staff members. As you will see, this was opposed by staff members who did not figure the department that way. We had to negotiate our way together, allowing sealed boundaries that separated us to become more permeable and reduce polarization.

In its nature, a psychiatric hospital is a polarized space. A fence serves as a boundary that separates it from the outer world. Inside, it is divided into inmates and staff, those considered insane and those who seem sane, those who choose to be there and those who are forced. It holds conflicting functions of treatment, care and control. Treatment helps patients to overcome mental decompensation and to reintegrate into society.

Controlling patients and caring for them serves mainly societal needs. Society avoids unbearable emotions stirred up by these individuals by distancing, objectifying and labelling them as ill (Bott Spillius E., 2013).

Everyone who enters the hospital's gate, whether a patient, staff or family member, finds himself without the defending function of the fence. How should he behave now? What sort of boundary will he put around himself and how will he manage it?

Group analysis sees the facilitation of free, open communication and the expansion of the "common communicational zone" as central (Foulkes & Anthony, 1965). A communicative group with a polyphonic discourse is a fertile one (Schlapobersky, 1994). It helps its members to know and come closer to themselves and others. One could think of group therapy as an exploration of its inner and outer boundaries. As they try to connect, group members negotiate the permeability of the boundaries between them, looking for a level of permeability that will enable fruitful communication yet leave them feeling safe enough (Pines 1990). This process changes members' willingness to see others; to see the world around; and to be seen. Or should I say, it changes their willingness to influence others and to be touched by them. It is dangerous in a place like a hospital, where death and madness are so present.

Some of the people who enter this space try to remain untouched and seal their boundaries. A staff member may believe that he observes patients yet be totally unaware of being seen by them. A patient can try to hide his secrets, unaware of the fact that some of his hallucinatory behavior is seen by others - as if he can really blind himself in order not to see that which is unbearable. A staff member can be blind to unhelpful or damaging aspects of his work. A patient may not recognise his devastating condition and his dependence on his therapists and the hospital's authorities. A manager can be blind to his constricting influence or the limits of his power. Reasons for this behaviour include compassion fatigue and burnout, differing world views about society, social arrangements and human relations, and about health, illness and therapy. And, of course, the social unconscious which affects them all (Hopper 2024).

Let me share an example from my work. The hospital I work in, "Mazor", is located in northern Israel. The population in this area is diverse. Both staff and patients include Jewish, Muslim, Christian and Druse people. Many of the patients and staff lead traditional family lives in the villages of the Galilee while others live in modern cities and there are many immigrants as well as Israeli born people. There are at least three different mother tongues - Hebrew, Arabic and Russian. Many people are religious and dress accordingly. All these people live and work together. Sometimes that which is acceptable to one subgroup is totally unacceptable to another. Questions of acceptability touch nearly every subject, from questions concerning gender diversity or suicide to questions about trust in authorities and transparency. A huge effort is needed to find a common language, which is not always possible.

Naomi was a 20-year old woman, hospitalized in an open department which I directed. She was in a depressive state, after trying to commit suicide. It followed a decision she made to change her gender, which was not accepted by her family and community and she was rejected by them. When she entered the ward, Naomi asked us to call her Noam, a male name, and to address her in male language. In both Hebrew and Arabic, many words take different gender-based forms. Looking at him, we saw a gentle, attractive young woman with a short haircut and a bound chest, moving around with a light feminine walk. We had a staff of 30 who treated 35 patients. Naomi's request to be addressed as a man challenged the core beliefs of many of them, especially because of the connection between the suicide attempt and the rejection by the family.

My initial position as the director of the department was that Naomi's request should be respected. I told the staff to call him Noam and to relate to him as male. Soon some staff members protested and refused to comply. "Who do you think you are? You have no right to ask us to call her Noam", they said. "She is a female. It is written in her ID and you must follow that". In the medical file, some nurses continued to write Naomi. In the list of patients located at the nurse's station, the name was changed several times from Naomi to Noam and back. Some found solutions such as not calling Noam by any name or using only gender-neutral verbs when addressing him. “You are not doing your job", a young doctor told me furiously. "We are professionals, and the professional community is clear in accepting gender diversity. Personal beliefs are not relevant. You, as director,

must demand from everyone to address him as a man." Others attacked him, asking "Who are you to demand that?”

The tension was everywhere. Staff members argued loudly in front of patients. Some called Noam Naomi just to protest while others ignored him. Not only were patients aware of this tension, but there was tension within their cohort. Suspicions developed between professional sectors and bitter debates ensued. It was in the corridors, the nurses' station, staff meetings, everywhere. It was hard to be there, hard to work.

I was surprised. I didn't expect such a strong reaction. I had to calm things down and provide a space to process all of this. I hoped that our weekly staff supervision groups and community meetings in which patients and staff met would help with that. But many of those who protested against addressing Naomi as male, refused to participate. Most of those who attended the groups were more accepting toward the subject. Some of them expressed understanding of the difficulties of those resisting it. Especially helpful was a remark from a psychologist: "How can we demand of a person who sees a woman, that he call her a man? It is really bewildering, and it is an attack on perception itself." It helped me soften my voice towards those who refused to address Naomi as a male.

When I finally convinced a resisting staff member to join the supervision group he didn't say a word. I tried to encourage him to speak, and when he finally spoke, he said he didn’t like such groups. "I grew up in a communist country and I don't trust such processes. You have no right to force me to be part of that. You think you are promoting openness and trust, but you are unrespectful and even controlling toward people like me, who prefer to keep their thoughts to themselves and hold opinions different from yours." It had never occurred to me that while I perceived my attitude to be open and promoting acceptance, others perceived it as controlling. I really believed that with time, people would see that my ideas were valuable and accept them. I have learned that it is impossible in an environment that is so diverse and reflects a diverse society. There will always be people who value the establishment of clear boundaries and others who challenge social order instead of negotiating with it. There will always be

people who will mainly see group processes as an effort to control them. I had to accept that.

Noam stayed at the department for two months. On his last day, in a community meeting, he was asked by another patient about his feelings during his stay. He replied that he saw the difficulties the staff had. He heard the discussions and saw the tension but he also saw the effort to find a way to be with him and respect him. This was much more than he expected to get outside. It also helped him understand the difficulties of his environment and the struggles which awaited him. This was a surprising "happy ending" for me. The Drama that the staff "played" in front of him and other patients, expressing societal tensions on the department's stage was helpful!

Discussion:

Naomi/Noam's presence brought to the department the conflict he had with his orthodox environment, including his rejection and his inability to find a solution other than suicide. His presence and the request to be accepted as a male challenged core beliefs of people who worked in the department and it was stressful for all of them. His suicide attempt made it even harder, as feelings of rejection could easily become matters of life and death.

The department was divided into those who supported Noam's request to be addressed as male and those who opposed it. As I supported it and asked staff members to address him as he had requested, it soon became a challenge to my authority, including my group analytic/therapeutic community ideas and my belief that I was promoting openness and the acceptance of difference. It deepened a split between the functions of treatment, care and control with people taking opposing sides. Many staff members behaved as if patients were not there, as if they did not observe their conflicts or were affected by them. It deepened the polarization between staff and patients, between those with more power and those who were subjected to the power of the staff.

The group work done in the department facilitated a change, but the changes that took place were partial and varied - many refused to participate in these changes and did not

attend. Yet, it provided a space for processing that enabled milder tones to emerge, in the spirit of live and let live. Being there helped me and others to see that for some staff members (and patients as well) accepting gender fluidity was far too much. It really contradicted the values of their culture. Accepting their position and choices led me (and others) to voice my preference but not demand it. As people felt more accepted, they could live with the perception of those who did accept gender fluidity. All along, the staff group became more inclusive, and conflicts lessened.

I believe feeling the change in the department atmosphere helped the person who opposed my group analytic attitude to join the supervision group and speak. He was suspicious of both the group and myself, yet had the courage to challenge me and I could listen to him and change my position. I really gave up my wish to turn the whole department into a group analytic/therapeutic community space. He helped me understand that this was impossible. I no longer expected everyone to join the groups. I found that even when only part of the larger group joins it, it has its effect. Paradoxically, this understanding made the department, including its patients, more communicative, more accepting and in a way, more group analytic.

These changes made it possible for Noam to use his observations of the staff to his benefit. Instead of meeting a sealed wall of rejection (as he met in his original environment) he could now look through a window and see a nuanced environment that represented society. This softened him and enabled him to accept rejecting voices, since he saw with his own eyes that there were other voices and that people could influence each other and change. This was hopeful for him, as he could now imagine new possibilities and a different future.

People who enter a psychiatric hospital are faced with questions concerning the validity of human perception, freedom of choice, the value of life and the value of categories by which matters as fundamental as gender, are marked out. This includes patients and staff. They witness madness, loss and unbearable pain. Workers meet the limits of their ability to help others, to ease pain or prevent suicide. It is a huge effort to stand there with their eyes open and their minds clear, which Hinshelwood likens to "thinking under fire" (Hinshelwood, 2001). There is a pull toward basic assumptions' mentality (Bion,

1961; Hopper, 2009). Two poles are unconsciously created amongst the workers, in an effort to deny the possibility of failure. Some behave as if they can contain everything while others believe they can really control madness and unaccepted behavior. These beliefs echo in patients' expectations. A whole spectrum of possibilities exists between these poles.

The organization of boundaries differ between these two poles. At the pole of acceptance, people perceive the hospital's milieu as radically different from the world, as if the surrounding walls can block the outer world's non acceptance of diversity. At the pole of control, the demands of society cross the wall as if it is not there. It only blocks the madness within. At both poles workers are blind to the needs of other colleagues and believe that the dynamics amongst them are not seen by patients.

The therapeutic value of the milieu resides in its movement between deep polarization and a richer spectrum of possibilities. This movement results in a change in the perception of the boundaries within the department and between the department and the external world, instead of sealing one's boundaries against a breach or blurring them, windows are opened in the walls (Pines, 1990). These windows let one be seen and influenced by others, by the group they are part of and by society at large while feeling safe enough. Then, there is no longer a need to have total control over madness nor to be a perfect container of it. It becomes safe to let patients see oneself and the way one changes. And, as shown in the vignette, it proves helpful for them,

This is possible if in the spirit of the therapeutic community, an effort is made to maintain reflective group spaces in which the people in the department, including the leading figure, can observe and accept the limits of their powers (Novakovic, 2011; Peleg, 2017). Here they can see the unavoidable influence of the surrounding society and how the positions that individuals take are inseparable from the environments they come from (Hopper, 2024). They can gain a willingness to accept that whatever they do is partial. This is especially true of the department's manager, his willingness to change and be seen as open to the attitudes of others.

It is this work that enables the department as a whole to move towards a working group mentality, towards cohesion and differentiation. A discourse about polarization around gender fluidity led to a discourse concerning attitudes toward the department's culture. This led to a development of a more nuanced view of power relations in the department, acceptance of difference and willingness to be influenced by others. It is a state of mutual recognition and acceptance (Benjamin, 2004). As polarity diminishes, both staff and patients can imagine new possibilities and have a freer choice of where to position themselves. This can bring hope.

I would like to thank John Schlapobersky, Robi Friedman and Robert Grossmark for their valuable comments on the manuscript. Special thanks to Alona, my wife, for our thoughtful discussions of the text.

References:

Bion, W.R. (1961) Experiences in Groups and Other Papers. London: Tavistoc

Benjamin, J. (2004). Beyond doer and done to: An intersubjective view of thirdness. The Psychoanalytic Quarterly, 73, 5–46. 8

Bott-Spillius E (2013) Asylum and society. In: Bell D and Novakovic A (eds) Living on the border. Psychotic processes in the individual, the couple and the group. London: Karnac, pp. 171–193

Foulkes, S. H., & Anthony, E. J. (1965). Group psychotherapy, the psychoanalytic approach. London: Karnac.

Hinshelwood RD (2001). Thinking about instituions: Mileux and madness. London and Philadelphia: Jessika Kingsley Publishers.

Hopper E (2009), The Theory of the basic assumption of incohesion: aggregation/massification or (BA)I:A/M. British Journal of Psychotherapy: 25(2); 143-294

Hopper E (ed) (2024), The tripartite matrix in the developing theory and expanding practice of group analysis. London and New York: Routledge.

Main, T. F. (1977). The Concept of the Therapeutic Community: Variations and Vicissitudes. Group Analysis 10 (2): 2–16.

Novakovic A (2011) Community meetings on acute psychiatric wards: rationale for group specialist input for staff teams in the acute care services. Group Analysis 44(1): 52–67.

Pines M (1990) Group analytic psychotherapy and the borderline patient. In: Roth BE, Stone WN and Kibel H (eds) The difficult patient in group: Group psychotherapy with borderline and narcissistic disorders. Madisson and Connecticut: International universities press, pp 31-44

Peleg I (2017) Co-Constructing a common language: Aspects of a group supervision for the multi-disciplinary staff of a psychiatric ward. In: Doron Y and Friedman R (eds) Group Analysis in the land of milk and honey. London: Karnac, pp. 249 263.

Schlapobersky, J. (1994). The language of the group. In D. Brown & L. Zinkin L. (Ed.), The psyche and the social world. London: Jessica Kingsley.

Whiteley, S. (2004). The Evolution of the Therapeutic Community. Psychiatric Quarterly 75 (3).