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> That I would not give a name to this series of encounters and that the patients and staff —in calling it Groupgroup—would is perhaps the signifying matter. This series of meetings lasted for several years and proved a marvelous training field for many of the staff, especially when, as in later years, it was followed by a seminar given by myself and Dr. Schindelheim. One day an anorectic patient left the meeting for a visit to her "individual doctor." After some interpretation of the sort described in this paper, first one, then several, and finally all of the people there went upstairs to fetch the patient back. They asked that her individual doctor come with her, but he declined. Still, they somehow managed not to allow him to "lead" the remainder of the group. The young woman in question professed herself to be "fed up" with having fifty people troop after her, but that was as may be.
>
> The great issue in work with chronic patients (and people in training) is how to shape the work to fit an hour and how to work with a floating population. One conducts each session as if it were the first and the last.

A group composed of medical students on their psychiatry rotation and psychiatric in- and day-hospital patients has been in session for almost 5 years now. To it have gradually been added the therapists of the treatment groups for the patients and other residents and staff interested in group therapy. The group numbers upwards of forty, with about fifteen being medical students. It meets once weekly for 50 minutes.

The idea arose while we (the training staff) were considering the problems of giving medical students a feel for psychiatry. (The medical students, in their third year, spend 6 weeks in their rotation through psychiatry.) Some medical students manage their rotation by keeping—passionately —a pencil's length away from patients. They docket, ticket, note, record, interrogate and prescribe, much as if they were observing laboratory creatures in a maze.

Others surrender to an acute case of medical students' disease. Everything they discover, everything about which they hear seems all too true of them. Of course not all students position themselves so that (as in the first posture) they cannot see the trees for the forest or (as in the

second) the forest for their frightened preoccupation with the trees. But of most it can fairly be said that the tension involved makes very nearly impossible a warm but accurate perspective, a cool but compassionate regard, both to patients and to themselves in relation to patients.

Ruminating on that condition, we rapidly realized that much the same could be said of patients with respect to such other "nonpatient" people as doctors. Patients either fail to discern differences or they deny similarities—often both, simultaneously. This realization took us away from such familiar teaching methods as having medical students observe or "record" patient groups. There, only the students get educated (if such observations made under the influence of overwhelming internal commotion or, equally difficult, *no* internal commotion, could be called education).

The other alternative, of having patients observe or record a medical student group, also seemed in many ways difficult. We imagined medical students would find the arrangement rather overwhelming. Too few patients could observe, and the same issues of commotion applied. No one cared to take on the problem of keeping the patient-observers from actively participating. And so on.

In the end we saw that the matter of commotion in both groups *was* the issue they had in common. That was the element that deflected and distorted discovery.

Presently, therefore, an item appeared on the weekly schedules for both patients and students: "Mondays 1:40 p.m. Day Room—Group."

The day room is a large ungainly chamber in which chairs sprawl, tables stand about where left by previous arts and craft users, and air conditioners occlude audition. In short, it is a sort of multipurpose room so many hospitals have and hope soon to replace, and have had and have hoped to replace for years. An arrangement of people sitting in a circle and speaking so that they can easily be heard is not to be found. Rather, people sit in concentric circles on plastic pillowed couches and "easy" chairs that in one corner surround a coffee table littered with ashtrays. Everyone looks

nervous. Everyone looks as if he or she were trying to look at ease. Were it not for the shining nameplates adorning the medical students and their slimmer-fitting clothing and the funnels of cigarette smoke spuming from the patients, expressions would go far to suggest there is a human condition in common.

Following are excerpts from three sessions.

SESSION ONE

P: …so you have to come to the hospital and there's nothing to do, so you ask for like a pool table or something… and nothing, etc.

P 2: They don't care.

[Silence]

P: I asked, what's her name, you know? And she gives me some crap. You know? About how [*inaudible*].

P 2: What's it to them? It's always the same old shit, etc.

Ψ: It is good to have someone to blame.

P: Who's he?

P 2: I don't know. He didn't say.

P 3: What'd he say?

P 2: I don't know. Something about blame.

P: What's he say? I ain't blaming nobody. I'm just saying they don't do nothing.

P 3: Ignore him. Anyway, he won't say who he is.

Ψ: I am being blamed for thinking I am being blamed. [*Silence*] I get the idea that when people feel in danger of feeling at fault, it is good to find someone else to blame.

P 2: You must feel bad because you are blaming us!

P 3: Don't let's get into that. I didn't come here to discuss blame. I came here to meet them [*looking at the medical students*]. They have succeeded in life, and we haven't: so I thought we could learn from them. But they haven't said a damn thing.

Ψ: When people feel helpless, it is good to find someone to blame.

P 3: Shut up. I'm talking to them.

M.S.: It's hard for us too—I don't know what to say. Could you—you know—sort of say what we… I…

Ψ: When people don't know what to do and feel bad, it is a relief to find someone to blame.

M.S. 2: I don't know if you know this, but all we got was a schedule saying Group 1:40-2:30. We don't know what this is for. We don't know what we are supposed to do. Any more, I guess, than you do.

Ψ: Although people appear to believe they don't know what to do, what they do do is behave as if blame were a very useful thing to do in this group.

P: Him and his blame!

P 2: It's the exact same with us! The sheet—you know? Says like Art or Group Therapy, says just Group!

[Here everyone looks very cheerful and alert. Many laugh.]

Ψ: What a good atmosphere! What a good feeling! Do you notice how everyone's spirits rise when it is clear that not only is there someone to blame but everyone agrees there is the *same* someone to blame?

[Silence]

M.S.: That's true, that's really true. I've noticed when I can't do something or feel I can't—afraid—I look around for some excuse, something to blame it on—until I realize that if it's going to get done, *I* just have to do it anyway.

[Silence]

Ψ: So, now we have the questions: Does helplessness make us want to blame, or does blaming make us helpless? Is it that I am helpless because you are letting me down, or, *because* I want to feel you are letting me down, I feel helpless?

SESSION TWO

(Seven weeks later; hence, a new set of medical students. Some new patients, some patients previously present.)

[Silence]

P: This is worse than Community Meeting. At least there, there is something to talk about.

P 2: That doesn't make talking about anything worth it. Community Meeting sucks.

P 3: What's the purpose of this meeting, anyway?

P 4: You think you're going to get an answer? They never answer, like (P 2) said about Community Meeting. It's this way in every group.

P: So why did you come?

P 3: To see if they [*gesturing toward the medical students*] had something to contribute. Evidently they don't.

M.S.: There are lots of groups?

P: Oh, yes. Community Meeting. Therapy Group, Art Group, etc.

M.S.: And they're *all* like this?

P 2: Yes. Either they don't talk or they twist what you say.

M.S.: Why do you suppose that is?

P 2: How are we supposed to know?

[Silence]

M.S. 2: But no one talks in any of the meetings?

Ψ: Insofar as people believe the needed information is elsewhere than in themselves, the interview technique would appear to make great good sense.

P: Where do you believe the answers lie?

Ψ: Since you believe good answers are in me, you interview me.

[Silence]

P: Well, what am I supposed to do?

Ψ: Since you believe good answers are in me, you interview me.

P 2: You see, that's the way all the groups are.

M.S. 3: How many groups do you attend?

Ψ: It seems a very nice idea that the really valuable information is outside one's own grasp and in someone else's possession.

P: I agree. We never act as if we have the answers to our own problems.

P 2: Well, if we did, would we be stuck in this dump? Do you think you have all the answers?

P: Not all. No one does.

P 2: Well, he thinks he does. Do you think you do?

M.S. 3: No.

P 2: No one thinks we have all the answers except you. Who are you, anyway?

Ψ: I am being interviewed in the belief that I have valuable answers. But I am supposed to be the only one who thinks so. People who think they may have useful information get in trouble here today.

P: See, he won't even tell you who he is. He wouldn't even answer your question.

P 2: Why won't you tell me who you are? Why won't you answer my question?

Ψ: People are getting the goods on me. I am being revealed as a person who has what it takes, but won't give it.

P: I think he's right. What does it matter who he is? We have answers. It's just that we won't use them.

P 2: Well, if you have all those terrific answers, what are they?

Ψ: One can't believe one has usable information and be very popular. The only good idea is that the useful information is elsewhere and has yet to be discovered. That way we can feel better about feeling so stuck.

P: Last time you were here…

P 2: I don't remember; he was here before?

P: I remember him.

P 2: When?

Ψ: Interviewing!

P 2: Fuck off!

Ψ: Take that for thinking you have an answer.

P: Last time he was here he said that blaming others made us feel helpless because we were expecting them to do what we were afraid to.

P 3: Oh yes, I remember!

M.S.: It sounds like he is saying more or less the same thing.

Ψ: No interviewing this time around.

P: Do you think he's right?

M.S. 2: Do you?

Ψ: It would be sad to think that ordinary answers inside of oneself were the best one could get.

P: I agree.

P 3: Right on!

Ψ: So if we all agreed there were better answers elsewhere, we could feel better, even if not getting them kept us stuck. But watch out if you think your inside information, bad as it is, is good enough to go on.

P: See, he even says himself that his inside answers stink!

M.S.: No, I think I see what he means…

[Silence]

SESSION THREE

Most people present appear to have been present several times before. Fifty or sixty people are alertly silent.)

Ψ: The door is the Breast. It is left open in the hope that there is more and better to come. My own Breast, like those of the others' here, is deemed insufficient—on this everyone agrees. This agreement is expressed in the silence. The motto of this group might be: "Only suckers take what they can get!"

P: How are you getting along after your operation, Millie?

M.S.: What sort of procedure did you have?

[Further discussion falters; silence]

Ψ: The silence has become the Breast. It is left open in hopes that something more and better can come from it than what we have had so far.

P: You and your fucking "breast."

Ψ: My Breast has been discovered to be capable of sexual intercourse; perhaps the thought of it having had sexual intercourse makes the grounds for its refusal or for it being bitten to shreds.

P: (This is Millie) If my husband knew I would have to listen to this kind of talk, he would take me out of here.

M.S.: She has a point there.

Millie: My husband doesn't approve of talking dirty.

[Nods all around]

Ψ: It is a relief, perhaps, to think of a couple where there are not filthy doings going on, instead of myself and someone where there might be.

1st M.S.: Don't you and Dr. S. meet after this meeting to discuss it?

Dr. S.: Caught in the act!

[Much laughter]

Ψ: The feeling of being left out of a sexual couple is painful: Why am I left out? What will it take for me to be included? Where will I get what it takes? The door becomes a breast that might be there. The silence might be the cupboard where what it takes is stored. But if we use up the silence, if we close the door, what will be left to hope for?

M.S.: Oh, if you want the door closed… [*Closes it*]

P: I don't think that is what he meant. I think he was saying that we are afraid we'll never get enough of what it takes to be loved and that we are scared to use up what we have.

(This now becomes a matter of wide discussion; those present appear to need to sort out their positions on this and reach a consensus.)

P: This is a good hospital; they take very good care of you here.

P: What is it like for you people—the doctors, I mean?

M.S.: [*Consults others with eye searches*] Very good. The training is excellent. But this group is, well, weird. We heard of it from other guys in our class. The say you go in feeling like a med student and uh… um….

P: It's the sex—all the time. Too much. I want to forget about it, see, but they won't let it drop. I mean, I can't think with it always going on! Who can think? Makes you crazy, sex all the time.

*5th M.S.:*I agree. He doesn't have to continually use sexual metaphors. I find it offensive. Why is the door a breast?

M.S.: The knob!

[Much laughter and foot stamping]

M.S.: No, but I mean seriously.…

Ψ: [to Dr. S.] I think it is so difficult for children when they feel that something in the air that tells them that either or both the parents are up to something, that they want to get together at least among themselves.…

Dr. S.: Yes, I felt lonely when they [*nodding to M.S. 5 and P 5*] were having it off together. I found myself looking around for someone for myself—

P: —Dr. S. is lonely!

P: Dr. S. is frustrated!! [Much laughter, "Poor Dr. S., "etc.—nervously on the part of the medical students, with whom Dr. S. works in a group of their own.]

P: It's a good thing you are in this group. He will give you a nice big bosom so you can find some nice girl for yourself.

M.S.: With a knob on it!

M.S.: On her!

[More laughter]

Ψ: By talking directly to you I appear to have stimulated thoughts of us as a homosexual couple and thought that homosexual love might be the way out of feeling left out. There are now two problems. One is to find you a nice person so that you will stop having intercourse with me. The other is which person in the couple keeps the knob and which gives it up.

P: Snob? Did you say snob?

Ψ: When Dr. S. or I don't have intercourse except in words with the other members of this group, we are naturally felt to be snobs.

DISCUSSION

As group sessions are, these are rich with meaning. Perhaps more, certainly other, than what we chose to pick up on might have been selected by other workers. A few words concerning the reasons for the choices we made might therefore be in order.

Already likely to be evident is why we chose not to focus upon individuals. Our purpose, of course, was to discover (so as to uncover) the bonds that people form when as fellow beings they confront the difficulties that are here in a group. By displaying the similarities that were revealed, we hoped to give flex to the distance between patient and student, leaving each free to assert whatever

qualities he or she felt widened or closed that distance.

In the early years, before it had become clear how very much most people could make use of, we stayed closer to interpretations that made conscious sense: I would talk of the door without adverting to its symbolic representation of, say, the Breast. This was a concession to the staff, who attended these meetings and who were guided by their own hopes of maintaining a social alliance between themselves and their patients. As time went on, however, I was more and more persuaded that people sometimes need precisely those interpretations that don't make "sense"; and, moreover, that giving these in a group gave to them a resonant "sense" that devolved from the experience of hearing such ideas with people who were also working with and against them much as one is oneself. (The "knob" in the latter session is an example; already its meaning as both penis and as breast when cognate with penis is becoming evident.)

The reader will judge whether such interpretations can be said to have variously reached the people present—whether, for example, the reposition of hope by the patients in their hospitalization and by the students in their training and by both in leaving the (a) door open was properly inferred and communicated.

My own impression is that it was a matter of subsets, and that by the end of the group experience both of these subsets felt a curious and compelling fellow-feeling, each with the other. But each saw something, too, about their differences. Each, I think, came in touch with the private aspects of themselves that *all* felt when, inevitably, deeply alone in public.