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Guide to Patient-Staff Large Group Meetings: A Sociotherapeutic Approach

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Large group meetings of patients and staff are common in most mental hospital treatment units and in partial-hospital or day-care programs for patients with psychiatric, social, developmental, and addictive disorders. These meetings, usually led by nursing staff, other professionals, and sometimes by the unit chief, are often called "community meetings." Their purposes and methods are seldom carefully thought through, and staff are seldom trained in how to contribute and use these meetings. This article presents a *sociotherapeutic approach,* a particular way to conceptualize and conduct these meetings, holding the understanding of current working relations between staff and patients as their primary task. Advantages of a *sociotherapeutic approach* are discussed in terms of a hierarchy of administrative and clinical objectives applicable to a wide range of organizations and programs. Guidelines for conducting large group meetings are discussed, and the importance of consistent leadership working within a well-conceptualized frame is emphasized.

The use of large group meetings of patients clinical papers on the large group includes and staff has a long history within mental hospitals. These have been commonly known as. "community meetings," referring to the patients and the staff as a community usually as an integral part of a *milieu* treatment program. Rationales and methods derived from work done in England during World War II by Maxwell Jones (1965), Wilfred Bion (1959), and S. H. Foulkes (1990) have been most influential. At that time, the need to care for large numbers of patients stimulated important innovations in the care and treatment of patients with mental illnesses. Lionel Kreeger's (1975) collection of important papers by Tom Main, Patrick deMare, and Pierre Turquet discussing theory and a variety of applications of clinical work mostly in Great Britain. Primarily guided by psychoanalytic theory and clinical experience, the multiple aims and agendas represented in these reports are not well differentiated, and guidelines for using large group meetings of patients and staff in contemporary treatment settings outside those generally classified as "milieu therapy" are not systematically presented.

More recent work in the United States by Munich, Carsky, and Appelbaum (1985), Klein (1981), and Klein and Brown (1987) derives from a broader theoretical base, representing some integration of group dynamics, psychoanalytic, and social systems theories. These papers place the meetings more clearly in particular treatment settings and also provide some leadership guidance. Edelson's (1970a, 1970b) two books, *Sociotherapy and Psychotherapy* and *The Practice of Sociotherapy,* stand out as the most theoretically rigorous and clinically sophisticated expositions of large patient-staff community meetings. Edelson made extensive use of Talcott Parsons's theory of action and applied it to a series of detailed reports and comprehensive analyses of the life and process of a series of community meetings at a well-known psychiatric treatment center in the United States. At the present time, the use of large group meetings is being pursued most vigorously in Great Britain by Malcolm Pines and other group analysts trained in a tradition founded by Foulkes (1990). An unpublished paper by Gerhard Wilke (1998) reporting large group work that was done at the Group-Analytic Society Symposium in Copenhagen in 1996 provides a good review of the British work as well as the analysis of a series of large group sessions. This body of work does not, however, discuss the use of large group sessions in mental health settings common now in the United States.

The model presented in this article owes much to all of the above-mentioned ideas and writing and is based on many years of conducting, supervising, and consulting to patient-staff meetings in many different settings (Lip-ar, 1968; Lipgar & Martin, 1988). Group relations conference work in the A. K. Rice Tavistock tradition has also been influential (Lipgar, 1998; Rice, 1965). This article is meant to link this rich tradition of clinical and theoretical work with the practical problems of conducting large patient-staff meetings in contemporary treatment settings.

Typically, large group meetings include patients who present a wide range of impairments, disorders, and illnesses and staff in many different designated work roles. Furthermore, both patient and staff subgroups usually include other demographic differences such as age, gender, race, ethnicity, socioeconomic status, religion, marital status, and sexual orientation. Whether the patient population is chronically or acutely ill and homogeneous or heterogeneous and whether the patient-care program is organized in accordance with milieu treatment philosophy (long term or short term), the approach outlined here provides guidelines for conducting patient-staff meetings that can contribute substantially to the safety, coherence, and effectiveness of programs in a variety of organizational and administrative settings.

Regardless of the setting, each program can be understood to consist of these two major groups (patients and staff) who need, in some measure, to interact and work collaboratively. Staff essentially has the role of delivering services, and patients essentially have the role of making use of these services. A sociotherapeutic approach aims to advance the capacities of both groups to understand their own and each other's roles and their interdependency.

Purposes of Large Patient-Staff Meetings

To prepare administrators and staff to make these meetings a regular part of the program, the distinctive goals of these meetings should be reviewed and discussed. Not only is such preparation part of staff development, but it is also needed to justify scheduling such a labor-intensive activity on a regular basis.

A list of goals can include the following:

(a) to foster staff's and patients' insight into the condition and dynamics of the ward, unit, or program as a working organization;

(b) to demonstrate staff's leadership and competence as a team of professionals working in open session (responding to and managing conflict, disorganized thinking, impulsive or deviant behaviors, disappointments, and frustrations with caring, fair-minded, and helpful behaviors that contribute to safety and coherence of the unit as a working treatment environment);

(c) to promote staffs ability to work together across discipline and organizational lines by working in the meeting on the common task of understanding the current condition of how patients and staff are working and living together (to promote interdisciplinary collaboration and problem solving on behalf of patient care);

(d) to provide patients rehabilitative and habilitative, therapeutic, and developmental stimulation and exercise by exploring in open session their experiences and concerns as patients at this particular time, in this particular program;

(e) to reduce incidents of violence, destructive acting out, disorganized and deviant behaviors, and depressive or dependent regressions by promoting verbal expressions and explorations of tensions and the use of discussion in dealing with stress and conflict;

(f) to develop, reinforce, and maintain positive therapeutic and social values for both patients and staff; and

(g) to clarify the legal and social constraints within which the unit functions as well as the options and initiatives available for improving the effectiveness of the working relations among patients and between patients and staff.

In this list of purposes, the primary task is to learn more about how patients and staff are working and living together (the working dynamics of the administrative unit or treatment program) and not the treatment of the patients per se. This group-as-a-whole, psychosocial systems focus is a deliberate choice, differentiated clearly from other important components of the unit's program that focus on other objectives. Coherent and useful meetings require clarity of purpose and goals that are feasible and relevant (Kernberg, 1979; Lipgar, 1968). The primary task gives focus to the meetings and has important implications for how the meeting is led.

By approaching the meetings from a socio*therapeutic* vantage point, patient-staff meetings can serve both administrative and treatment aims, the two "masters" often experienced in conflict and in competition for resources. Administration must concern itself with consistency of policy and fairness across a diverse population, and therapists must concern themselves with individual differences and individual needs. Reconciling the resulting tensions and coordinating the relevant efforts is not the task of the patient-staff meeting alone, but it is a unique venue for discovering symptoms of intergroup dysfunction and for clarifying the issues.

Patient welfare requires that both administrative and therapeutic objectives be integrated. Pavilions, units, or patient-care programs as working groups are the psychosocial context within which patient-care and treatment objectives are pursued, and effective functioning of these social systems requires thoughtful, skillful, and constant nurturing and maintenance. When well led, patient-staff meetings can contribute significantly to the social system's capacity to contain, balance, and coordinate conflicting values, interests, and needs.

It is the one occasion in a unit's program in which patients and staff can both see how privileges and restrictions concerning, for instance, radio and television time, use of public telephones, smoking, or possession of such items as a Walkman (with wired earphones) may affect different parts of the unit in different ways. It is also the one time when reasons for the procedures and policies can be explained, objections heard, and improvements sought. Furthermore, understanding and accepting such matters as the need for particular suicide precautions, patient rights according to law, and the way in which discharges can be discussed with clinical treatment teams without resorting to le gal procedures are often better achieved when discussed openly with questions and answers being shared by patients and staff. Similarly, open discussion of differences in treatment plans and ward privileges (issues that affect patients' feelings and behaviors at a group level but that staff usually attempt to manage with patients individually) can be very conducive to better working relations between patients and staff. These meetings, however, to be effective must be well led.

Patient-Staff Meetings in an Organizational Context

Before discussing further how to conduct these meetings, it is useful to prepare a conceptual frame or outline of the essential work common to most patient-care or treatment units. The work that most programs must accomplish can be outlined in terms of a hierarchy of certain basic and critical tasks around which the work group must order and coordinate its efforts and resources. Consider the relevance of the following set of tasks as a framework for any program:

1. Safety for patients and staff. Problems of patient-to-patient and patient-to-staff assaults are of increasing concern in patient-care facilities. Leadership and good milieu management are important in the reduction and management of aggressive acting out (Canatsey & Roper, 1997; Carmel & Hunter, 1993; Katz & Kirkland, 1990; Kleepsies, 1998). Large group meetings of patients and staff can reinforce social norms, reduce tensions, and support other program efforts to reduce violence and use of restraints (Bensley, Nelson, & Kaufman, 1995; Flannery, Hanson, Penk, & Flannery, 1996; Herrera & Lawson, 1987).

2. Evaluation and diagnosis of patients' conditions and needs. A large group simulates important aspects of social life outside the treatment setting, and patients' behavior in this setting provides staff with data about patients' conditions and needs unavailable in other parts of the program. Patients often demonstrate capacities not otherwise apparent or, conversely, deficiencies in managing their impulses and organizing their thoughts that were not apparent in face-to-face interviews.

3. Treatment, rehabilitation, and habilitation. Depending on the purposes of the unit's program and the particular condition of the patient, the large group can provide some evidence of patients' progress and support the treatment or rehabilitation plans for individual patients. A regressed, depressed, and even disorganized patient can gain encouragement and reassurance, sometimes directly by an interchange in the meeting and often indirectly on the basis of observation of other patients in the meeting.

4. "Linking," connecting, or reconnecting patients to appropriate treatment and support agencies, hospitals, family, community groups, and other resources. Although such work is primarily assigned to social workers, information and the experiences of other patients may emerge in the large group meetings that can reinforce the efforts of the social worker in dyadic sessions.

5. Fiscal accountability. Are patients getting their "money's worth," and who is "footing the bill"? Economic reality and discussion of feelings about such economic matters are often the only path open for patient-staff dialogue. In any case, in the public forum of the large group, frankness about such issues may be more useful and less shaming than a psychological discussion of dependency and the accompanying interpretations directed at individuals' personality and character.

6. Training and staff development. By working together in regularly scheduled patient-staff meetings, taking up the challenge of learning how to participate in and contributing to the coherence and productivity of these open large group discussions, learning to include and address patients' concerns about the unit's functioning and their relationships in the unit, staff can learn a common language appropriate for the particular patient population, develop a shared view of therapeutic values, and reinvest in the program.

If the leaders or conductors of the meetings keep these overarching organizational and program tasks in mind, the meetings are more likely to contribute to both patient welfare and program stability. By keeping in mind such a list of the program tasks, it should be easier for the staff to participate during the meeting in ways that support ego functioning of both patients and staff. Coherent meetings are more likely if the leadership provides a clear sense of who "we" are and why "we" are meeting here and now. Success of patient-staff meetings can be assessed in terms of how well the meetings support and promote the accomplishment of these essential tasks.

Sociotherapy and Psychotherapy

Although the primary task of these sociotherapeutic meetings is not therapy for the patients, these meetings can illuminate and support treatment goals. Well-managed, open discussion of such incidents as a patient cutting him- or herself or of another becoming disorganized and violent during the night not only can lead to staff and patients both becoming more responsible with regard to each other's safety but also can demonstrate empathic concern for the individual in ways that promote the patient's personal work in individual or small-group therapy sessions.

Clinical examples of large group discussions affecting personal therapeutic changes in individual patients are included in several chapters in Kreeger's *(1975)* collection (cf. chapter 6 by J. S. Whiteley and chapter 7 by R. Springmann). Whiteley (1975) in England, Winer and Ornstein *(1994)* and Winer and Lewis *(1984)* in the United States also discuss how psychotherapeutic work can be accomplished even in large groups by interpreting group tensions and group themes. Both make reference to group-as-a-whole work developed in small-group settings by Bion *(1959),* Foulkes *(1990),* and Whitaker and Lieberman *(1964).* Whitely, in particular, views

the large group also as a medium for therapy, calling it *sociotherapy*. His use of *sociotherapy,* however, refers primarily to the treatment of patients' pathology rather than to the treatment of the social system that is the context for this and other tasks.

Although psychotherapy may be pursued in such settings, the small group is, in my experience, the more appropriate and more widely accepted venue for psychotherapy efforts within inpatient programs. The psychotherapeutic work that can take place in the large group is usually cited to encourage and support the continuation of these labor-intensive, but commonly held, large group meetings. Although these reports are often dramatic or compelling, they tend to blur the boundary between *sociotherapy* and *psychotherapy*. In doing so, something essential is lost. In my view, clarity of purpose, commitment to a feasible and relevant task, and attention to distinctions are important factors in the achievement of positive outcomes.

The psychotherapeutic work that Winer and Orstein (1994) and others trained primarily in psychanalysis seek to accomplish in large groups requires special training to interpret patients' collective transference reactions and object relations. There are risks involved in making such interpretations, especially in large group settings. In taking this approach (the treatment of patients) in the large group sessions, even more extensive and specialized training (and retraining) of staff is required than is required for the application of the sociotherapeutic approach outlined here. Given the heterogeneity of patients, particularly in terms of psychological functions (common in most treatment settings), the interpretation of patient behavior, even in terms of group-as-a-whole themes, seems to me especially risky and usually counterproductive.

Patients and staff working together on issues of common concern, relying primarily on clarifying meanings rather than on exploring covert meanings, is more likely to make the meetings feasible and relevant. Such sociotherapeutic meetings can have significant therapeutic effects. However, the patients are not, in this approach, the object of treatment-the unit is. There are, depending on the leadership, direct habilitative and rehabilitative benefits for the patients and significant indirect benefits, but the distinctive and primary aim is simply to talk together about current common concerns (intraunit and intergroup issues).

These meetings are open, allowing for free and open discussion, that should lead to operational coherence and to adaptive insights and resolutions affecting how services are delivered. Better patient participation in treatment and better treatment outcomes result. The meetings foster essentially therapeutic processes; both discovery and recovery, ventilation, and adaptive problem-solving occur. Discussion and interpretation of overt behavior and covert attitudes are included. The unit or program, however, and not the patients, as individuals or even as a group, is the object of study.

Leadership in Large Patient-Staff Meetings

Because face-to-face contact is difficult, large groups can be regressive and chaotic, exposing both patients and staff to primitive processes and regressive behaviors. To mitigate such risks, it is helpful to keep in mind and apply a reality framework of adaptive tasks for which the contributions of all members of the unit, according to their role responsibilities and capabilities, are necessary. This task-oriented, group-as-a-whole systems perspective can have a containing effect on the psychotic processes within large group meetings (Rice, 1965).

If, on the other hand, in preparing and in conducting these meetings, treatment of patient pathology is put first, several problems may be aggravated. By putting the emphasis on treatment of individuals, there is increased risk of having the meeting captured or monopolized by one or two "difficult" patients, often to the frustration of many other patients and of staff. It becomes more likely, then, that staff and patients become locked into a public display of patient pathology and staff limitations in correcting it. This can be frustrating, embarrassing, and worse, not only for the "target" patient but also for those watching the futile reenactment of some interpersonal or social "madness."

Organizing the meeting to achieve particular or generic psychotherapeutic goals for individual patients may expose both patients and staff in ways that may aggravate covert processes and resistances that make the meetings more difficult and frustrating. Instead, by organizing the staff's leadership functions toward the psychosocial goals of understanding the unit or program as a working organization and of understanding how patients and staff are getting along with each other in doing the work of the program, ego resources are mobilized and the primitive processes can be better contained.

Seeking an understanding of the group as a whole is a distinctive task that joins staff and patients. Conducting the large group meetings in this way fosters acknowledgment of interdependency and interrelatedness that cannot be accomplished in other aspects of the program. During large patient-staff group meetings, aspects of the common circumstance are made manifest in ways essential to the reinstatement, inculcation, or maintenance of basic human values on which achievement of specific prograin objectives depend.

Given the diversity of the patient populations on most units today--diversity, not only in terms of their psychiatric condition and psychological and social problems but also in terms of their different personal histories, socioeconomic, racial, and ethnic

backgrounds--careful preparation, as well as skill, is required to make these meetings relevant, useful, and productive. Attention should be directed toward promoting teamwork and cohesiveness. Individual differences not only with respect to different affiliations and feelings about demographic differences but also with regard to different treatment plans, which present obstacles to teamwork and cohesiveness, can and should be explored. Their exploration in the large group often requires the ability to translate confused and disorganized messages, to comprehend and clarify disparate points of view, and to be able to discuss individual treatment needs in a matter-of-fact way without violating patients' rights to privacy. Some issues involving intense interpersonal conflicts will need further discussion and disposition by designated staff, committees, or other parts of the program. The working assumption here is that all members of a social system, regardless of manifest and experienced differences, are needed to work on the task of exploring and understanding the current conditions within the unit. When this work proceeds in an integrative way, leaders and followers discover and assume responsibility for their overt and covert contributions to the work. For this to happen, all parties need to have their experiences and observations presented or represented. Otherwise, reasonable and creative efforts to overcome obstacles cannot be mobilized, and learning is thwarted.

The distinctiveness of the large group of patients and staff is that it is a large group. It is exactly its uniqueness in terms of size and the interrelated diversity that should be enhanced and exploited. The feasible and relevant task that justifies such a gathering of patients and staff is the work of discussing the question "How we are working and living together how is the unit working"? Although responsibility for managing the unit and the delivery of services rests with the staff and not with the patients, this responsibility cannot be carried out without insight into intragroup relations as critical to enhancing working relationships between staff and patients.

Staff, holding the responsibility to deliver services in safety, and patients, holding the responsibility to make use of the hospital or program, have to interact and collaborate across the boundary of their different roles and have to maintain and increase communication for either party to gain satisfaction. The patient-staff meeting has the unique and primary purpose of discussing together "How are we getting along how is our interdependency working today?" There is no other occasion when such a question can meaningfully be addressed-that is, when so much data relevant to meaningful inquiry and assessment can be gathered. It is in the large discussion group that the interplay, intergroup tensions, and intraunit tensions among components of the unit as a living organization can be studied.

Solutions to system and organizational issues are more likely to be found when both leaders and followers have access to the relevant data. Responsible administrators and clinicians must be interested in, attentive to, prepared to learn from, and trained to react constructively to the fund of rich information available in these large group meetings. Benefits depend, of course, on certain skills in the staff to conduct, participate in, and learn from the meetings.

Conducting Large Patient-Staff Meetings

Considerable preparation and training are required to make these large group meetings successful. Staff should be prepared to provide consistency of purpose, practice, and procedure over a period of time. Consistency in leadership role functioning is more important than consistency in personnel. It is usually a good practice to have a team of two or three staff ready as designated leaders over a 6-month period.

In addition to having designated leaders committed to the meetings' purposes and potential, it is useful to have at least 15 min for these conductors to gather impressions and ideas from staff before each meeting. Those designated as leaders that day should enter the meeting with some knowledge of recent and special events or problems, such as a patient may have just received bad news from home, another may have been placed in restraints during the night, a social worker or nurse may have called in sick, an accident in the kitchen may have disrupted food service, and so forth. What events and issues are prominent at the moment, what recent interactions among patients, among staff, between patients and staff, what news and rumors are currently of concern to patients and staff about each other and about their relationship to the hospital system overall? Such questions can quickly be surveyed before the meeting begins.

All patients should be encouraged to attend, only those who are so psychologically disorganized or dysfunctional that they are unable to respond to verbal directions and verbal limit setting should be excused or their attendance may be limited to time periods appropriate to their psychological functioning. If a staff member can be assigned to sit next to patients whose functioning is seriously impaired, then such support often enables a patient to participate (at least to be present) who would otherwise have to be excluded. Attendance for some patients can be limited to specific short time periods, and their time in the meetings can be increased as their condition improves.

All staff should attend, or at least each part of the staff should be represented. The night shift, for instance, should formally be represented by some nursing or mental health personnel; the occupational therapist, social work, psychiatry, psychology vocational rehabilitation services, and so forth should be present or represented. Accomplishing work on the meeting's primary task-gaining

insight into how the group as a whole is functioning and how subgroups within the unit are living and working to-ether require such participation.

These meetings open with only two or three sentences of simple introduction, orienting all participants to the primary purpose in language that is easily and quickly understood. This opening statement may include such orienting information as the day's date and how long the meeting will last. Depending on the population of patients, other orienting comments may be appropriate such as restating not only the primary task but also the boundary rules or behavioral norms for the meeting-the discussion is open to all, speak one at a time, and, if the discussion needs more order, the leader may ask people to raise their hands to be recognized before speaking. It is preferable to keep announcements of such rules to a minimum and to emphasize the positive. Indicate what behaviors will help the meeting and provide guidance for what can be discussed and what would be a contribution. For example, "We want to hear what the unit is like for you today. What have you noticed that would be important for us all to hear about today?"

The following set of guidelines for conducting these large patient-staff group meetings is derived from approximately 40 years' experience, the last 20 including coconsulting and coleading with John B. Martin (Lipgar & Martin, 1988):

1. Provide enough structure to enable people to stay in the meeting and enter into the discussion, but not so much that it stifles the free flow of ideas.

2. Demonstrate and reinforce the benefits of cooperation during the meeting itself by valuing each person's efforts and by identifying common interests.

3. Demonstrate and reinforce the benefits of talking things out, of talking in ways that enable others to understand the current circumstances and concerns within the unit as a community-a working group of patients and staff whose differences can be identified and contained and who share important goals.

4. Promote understanding of the realistic similarities and differences between parts of the unit as a whole, accept competing interests among subgroups as natural, as something worth talking about openly, in a direct and matter-of-fact way.

5. Direct attention and inquiry to understanding the relations among subgroups and their interdependence-referring interpersonal conflicts, usually, but not always, for further discussion and resolution after the meeting with specific staff.

6. Promote awareness, clarification, and discussion of the different roles and responsibilities within the unit.

7. Promote the realization of and appreciation for the actual, functional interdependencies among the people on the unit.

8. Inquire into and clarify group as a whole, system issues without losing interest in and respect for individual differences and individual needs.

9. Encourage people to speak from their own experience and observations.

10. Build insight into the tensions of intraunit, intergroup, and organizational and group life within the program unit.

These leadership guidelines are intended to maintain balance between too much and too little structure; between too much management and exercise of authority by staff and too little; between too much dependency on staff and too little; between too much talk about television rules, curfews, cigarettes, water temperature in the showers, air temperature, and food; and too much "psychologizing." Talking about daily living concerns should be encouraged and respected and may need at times to remain at a concrete level. These manifest concerns can enable both patients and staff to build an understanding of group themes and issues of common concern. These manifest concerns can also be interpreted and their symbolic and metaphorical meanings considered at times that seem appropriate.

Unconscious attitudes among both patients and staff, toward staff, toward the program, and toward patients will of course be present. Expression of feelings, fantasies, rumors, and attitudes can at times be encouraged and interpreted. These meetings are benefited most, however, by the coordinating and integrating competence of the best ego functioning of all members. The quality of the meetings is especially dependent on the capacity of the designated leaders to make sense out of the details and to see the "forest for the trees."

Although coherence and "sense making" are essential, so is the climate of acceptance, respect, and inclusion. Leadership should seek to maintain cohesiveness and comfort. It is important to encourage and maintain an openness to diverse ideas and to a wide range of

emotional expressiveness. The challenge is to include and manage the psychotic and primitive processes, not simply to suppress, deny, or avoid it. This takes skill, experience, and personal poise.

To provide open yet coherent leadership also requires authorization and support from above in the administration, from one's colleagues, and from the patients as well. It is important for the leaders to understand and help the group to understand that the large patient-staff group meeting is not the same as a democratic or parliamentary gathering of citizens, nor is it a problem-solving committee, nor even a large group therapy session intended to explore and resolve personal psychiatric or emotional problems. It is a gathering of patients and staff taking place within a hospital or agency program to discuss their different roles and responsibilities specific to this time and place. A "town meeting" would be among citizens whose rights and obligations as citizens are constitutionally equal. These large group meetings of patients and staff are between citizens and among equals in the broad sense, but under these particular circumstances, the citizens have particular work relations to illuminate, interdependencies to understand, and collaborations to achieve.

Each large group meeting must, in a sense, be sufficient unto itself-simply, an opportunity to join together to learn about "us" as a social unit, how are "we" feeling and functioning today. It should be of importance to take the time to hear each other out about how people in their staff and patient roles are currently feeling about being and working together. The usefulness of this should become apparent to the participants as they engage regularly in the practice. Learning in and from the discussion is a shared achievement because learning, in this sense, requires hearing from each other and listening.

Ongoing Problems in Conducting Large Meetings

The boundaries of these meetings in terms of task, time, space, and membership will require continual effort by designated staff leaders. There are recurring tensions and dynamics that will challenge the framework, focus, and effectiveness of these meetings.

Among the pressures to disrupt the meetings are not only those that emanate from the patients' various pathological conditions, organic as well as functional impairments, but there are also group and organizational pressures. Staff members at different times may feel that the meetings cause disruptions among the patients and make them harder to manage. Management may at times question the relative value of expending staff time in this particular way--other parts of the unit's program may seem to have priority. Often, the matter of securing or scheduling a large and appropriate space to meet can be a seriously disruptive factor, a real challenge to the meeting as a consistent part of the program. Questions of ethics and protecting patient privacy-patient rights to confidentiality-may also challenge the continuation of these meetings.

To protect the meetings' usefulness for both administrative aims and patients' needs, it is essential to maintain clarity about the feasible purposes for which the meetings are designed. This means focusing on the meeting as a forum for discussion and dialogue-for self-study of the unit as a working group made up of diverse segments often in conflict. Furthermore, it is essential that members of the staff make use of what they hear and learn in the meetings. This means that the staff not only must review the large group meeting in its own postmeeting session, but appropriate members of the staff must also take actions relevant to the discussions of issues and problems that emerge in the large group sessions.

This latter is no easy task, and it requires leadership on the part of the unit chief and other staff members. Without meaningful postmeeting follow through, the large group discussions will wither, their vitality and usefulness will atrophy. There are many other difficulties that occur during the course of conducting such patient-staff community meetings. Development of an understanding of the central and feasible purpose of the meeting is an ongoing problem because staff members as well as patients have their own idea about what people should be able to accomplish in a large group setting. Leaders must be patient and consistent in how they shepherd the participants into a greater mutual awareness of each other's viewpoints. By patiently mediating between and among often disparate and discordant points of view, leaders nurture the meetings' mission as a forum for discourse and learning

Summary

Large group meetings provide opportunities for free expression that can provide administrative and clinical staff with insight into group-as-a-whole, system, and intergroup problems and into psychosocial tensions as well as operational and practical problems. These meetings can also support ego functioning for both staff and patients by providing orientation to institutional and interpersonal reality, by stimulating and reactivating capacities to relate to social objects, by introducing and supporting therapeutic norms, and by demonstrating the capacity of the hospital unit to serve as an active, intuitive, and responsive "container" in Bion's (1962) sense or as a "good enough mother" in Winnicott's (1965) sense. Risks of patients' acting out, violence, and malingering, and staff burnout and acting out can be reduced.

The technical and psychological problems of conducting such large group discussions require leadership training, experience, and skill. Special preparation of staff and patients is also required. Brief premeeting staff reconnaissance or "canvasing" is recommended as well as staff postmeeting review sessions. Staff postmeeting sessions should attend to implications of the events of the meeting for staff role behaviors and must go beyond a psychological review of the interactions of the meeting itself. Follow through actions on specific problem issues and implementation of insights are essential.

Consistent use of the large group discussions for the primary purpose of clarifying how patients and staff are working and living together is more than an exercise in communication, it is a way to increase safety and treatment effectiveness.

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