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"CYCLING OVER EVEREST": GROUPWORK WITH DEPRESSED WOMEN

In England, there are fewer and fewer opportunities for social workers to undertake groupwork. The following is a description of an innovative feminist approach involved in adapting psychoanalytic theories, particularly the work of Winnicott, within a groupwork context. The paper describes a typical group session, preceded by an account of some of the main theories and practices informing our work.

Womankind, a women and mental health project, was started in 1986 and is based in Bristol, England. Many of its founders were social workers and this professional link has remained a major influence on our work **(1)**. We have now been running depression groups for the past six years and currently run three weekly groups where we are attempting to develop an approach to meet the needs of women whose history is of depression and disadvantage. This involves exploring whether psychodynamic theories and practices can be usefully adapted and applied, within a feminist framework, to help us to understand the impact of oppression and injustice on women's psychological development and what can be done in terms of practice, from both a personal and political standpoint, to prevent further oppression and to assist women to recover from the pain and defeats already experienced.

Our tentative journey toward psychodynamic theories and practices began with the realisation that a knowledge of women's oppression, and a passion for justice, were not enough. Women were raising issues in our groups at a level where our responses were beginning to feel superficial and unhelpful. For example, whilst it was clear that women gained a great deal from being with one another, the capacity of some women to remember and take in these and other positive experiences remained an ongoing problem. Despite the understanding that women were gaining about the ways that sexism had limited or distorted their experience of themselves and others, and the positive changes they had been able to make in their lives, for some women these changes felt hollow because they did little to alter their depression and their low feeling of self worth in relation to themselves and the future. We had to rethink our view that positive changes in the external world necessarily produced comparable changes in women's internal world: some of the same feelings of deprivation continued to haunt women's experience of themselves, despite our positive affirmations.

To deepen our understanding required looking to those feminist writers involved in exploring other possibilities, including psychoanalytic theory. These included Juliet Mitchell (1974, 1984), Jean Baker Miller (1978), Dorothy Dinnerstein (1978), Nancy Chodorow (1978, 1989), Jane Flax (1981), Carol Gilligan (1982), Luise Eichenbaum and Susie Orbach (1982), Teresa Brennan (1989), Sheila Ernst and Marie Maguire (1987), Jessica Benjamin (1990). However, whilst these writers gave us an important and varied theoretical framework from which to develop our ideas, at times we found it difficult to translate these into a working practice. It was here that we found the writings of Winnicott and Dockar-Drysdale enormously valuable **(2).** A feminist perspective remains central to our work and involves attempting to identify and name the impact of sexism on women's lives, beginning at birth and their welcome into the world as female children, and their ongoing experiences as women. This perspective, including the impact of classism, is described in other papers (Trevithick 1988, 1994).

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The theme of this paper is to outline how we have adapted the work of D. W. Winnicott (1971, 1986a, 1986b, 1987, 1990) and Barbara Dockar-Drysdale (1990) into a groupwork context, together with Bion (1961), in order to address the needs of women suffering from depression **(3).** However, it is important to state at the outset that whilst Winnicott is a major influence on our work, he was not particularly sympathetic to feminism. Nor do his writings adequately cover some subjects important to our exploration, such as the impact of sexism on the emotional development of girls and boys, the issue of gender identity and the construction of masculinity and femininity and the role of the father in the emotional development of the infant, the psychodynamics of domination and submission, and so on. Nevertheless, despite these gaps Winnicott's writings cover many central themes, particularly in relation to depression, and it is here that we continue to draw heavily on his work.

Theoretical framework

Within Winnicott's theoretical framework, the emotional development of the individual can be seen as a journey from dependence to independence, beginning with the *absolute dependence* of the new born baby, where the infant's needs must be met in an almost total way in order for the baby to move on to the next developmental stage, which is one of *relative dependence* where there is the beginnings of less adaptation to the needs of the infant. If all goes well at this stage, a capacity for *independence* begins to develop (Winnicott 1990 p. 84), though this should not be confused with premature self sufficiency, which occurs when individuals are forced into a false independence before they have the emotional resources or maturity to achieve this stage. The final stage is that of *interdependence*, which involves the capacity of the individual to relate to themselves, to others and to their wider environment:

> "Independence is never absolute. The healthy individual does not become isolated, but becomes related to the environment in such a way that the individual and the environment can be said to be interdependent."
>
> (Winnicott 1990 p.84)

Within this developmental process, Winnicott differentiates between two types of failure: that of *privation* and *deprivation*. *Privation* refers to a failure within the infant's environment to facilitate the maturational process at the earliest stages of emotional development, before the infant knows about maternal care. It is the loss of a beginning, whereas *deprivation* is the loss of something that once was but somehow became lost of separated off, resulting in a break in the 'line-of-life' or the 'continuity of being' (Winnicott).

The importance that Winnicott placed on external, cultural and environmental factors in this journey from *absolute dependence* to *interdependence* set him apart from many psychoanalysts. He stressed that it is not only the 'good-enough mother' who brings about the emotional development of the infant but also the facilitating or 'good-enough environment':

> "According to this thesis a good-enough environmental provision in the earliest phase enables the infant to begin to exist, to have experience, to build a personal ego, to ride instincts, and to meet with all the difficulties inherent in life. All this feels real to the infant who becomes able to have a self.."
>
> (Winnicott 1990 p. 304)

Within this 'good-enough environment' lie a range of 'cultural potentialities' which are available for individuals to take up and use, from which they could 'creatively benefit' (Benjamin 1990 p. 37). These 'potentialities' are important because they often bring about

some sense of relief, some transformation, if only temporarily, from the difficulties inherent in life, particularly the anguish involved in feeling isolated and abandoned. In our work, these 'potentialities' may include women being able to call on neighbours for help or being able to utilise the local community facilities, being comforted by a particular person or object, being able to telephone me when troubled, etc. Clearly, in situations of urban decay where communities are being broken up, these 'potentialities' are fewer or more difficult to identify, and this fact must not be forgotten. However, the existence of these `potentialities', though very important, is not in itself enough. How well people can use opportunities without feeling compromised, anxious, unreal, fragmented or exposed in some very important way in part depends on how well, particularly as children, they were carried by their parents or other adults ".. from relating to usage".

'Object-relating' and 'use of the object' are complex concepts and refer to different aspects of experiencing through relating. In 'object-relating', ".. the subject allows certain alterations to the self to take place", whereas within the notion of 'use of the object', ".. object relating is taken for granted". Thus, the 'capacity to use the object' is essentially an inner capability because for an object to be capable of being used, it must be experienced as real (Winnicott 1971 p.88) that is, not as a projection or rooted in an omnipotent struggle for control but as something outside, independent and external. The object must also be capable of surviving attempts to destroy it, so that it is transformed from an object of fantasy (inside) to an object of reality (outside). Destruction and aggression are enlisted in this effort to differentiate and if all goes well, the relatedness will be based on " .. a whole person capable of total relationships with whole persons" (Winnicott 1987 p. 220).

These theories are vitally important within social work and allied professions because they help us understand why some clients cannot take up or use the support or assistance that is on offer: if this support is not *felt* to be real, something tangible and permanent, then it cannot be taken up and utilised. They explain, in part, some of the intense fear and anxiety that some clients experience when seeking help, particularly for clients who have been consistently let down and failed, and highlight how frightening it can be to have to rely on other people or to trust. Some clients have been let down and criticised too often to dare believe that something positive can happen and as a result, may display difficult or unco-operative behaviour which can easily be thought of or pathologised as 'resistant' or as lacking motivation, rather than being seen as an inability to move forward or to make progress because of early failures in the transition from 'relating' to 'using'. This understanding makes the notion of empowerment and participation much more complex issues than they first appear.

Capacity to tolerate a feeling and to experience experiences

The 'depressions' experienced by the women attending our groups range from *near-normal* to *psychotic* in character (Winnicott 1990 p 220). In order to understand where individual women lie within this range, without using psychiatric labels and diagnoses, we have found it helpful to try to identify how women relate to the life experiences they have had. At one end of the range, we work with women who have the capacity to feel, to link and reflect on their experiences, despite the pain and anguish that this evokes. In relation to this cluster of women, for whom spontaneous recovery from depression may be possible, our main task is to be as reliable and consistent in our contact as we can reasonably manage. Our aim is to get alongside women as much as we can, so that by "living an experience together", we can reach a point where ".. the full course of an experience is allowed" (Winnicott 1987 p. 67). For Winnicott, a central theme in this work involves the concept of 'holding':

> ".. it has as its aim not a directing of the individual's life or development, but an enabling of the tendencies which are at work

> within the individual, leading to a natural evolution based on growth. It is emotional growth that has been delayed and perhaps distorted, and under proper conditions the forces that would have led to growth now lead to a disentanglement of the knot".
>
> (Winnicott 1990 p. 228)

By our providing a holding environment and by ".. tolerating the depression until it spontaneously lifts" (Winnicott 1986a p. 77), we hope that some transformation or change may take place. For Hannah Segal, this transformation becomes possible through distress being contained, which she describes in relation to the mother-child relationship in the following way:

> "When an infant has an intolerable anxiety, he (sic) deals with it by projecting it into the mother. The mother's response is to acknowledge the anxiety and do whatever is necessary to relieve the infant's distress. The infant's perception is that he has projected something intolerable into his original object, but the object was capable of containing it and dealing with it. He can then reintroject not only his original anxiety but an anxiety modified by having been contained. He also introjects an object capable of containing and dealing with anxiety. The containment of anxiety by an external object capable of understanding is a beginning of mental stability.
>
> (Segal: quoted in Hinshelwood 1991 p 248)

The containment of anxiety is, in our view, crucial if change is to take place. Where a feature of the depression is a sense of numbness or disassociation, described by Fairbairn as an "attitude of detachment" (1952 p. 6), our main focus may be to help that individual to re-experience some of the original pain or anxiety that became separated off because the feelings could not be contained or tolerated. This process of attempting to hold and contain women's emotions, particularly during periods of uncertainty, forgetfulness, flooding, provides the opportunity for women to 'sort out' and 'work through' the difference between ".. fact and fantasy or outer and inner reality" (Winnicott 1987 p.268) thereby easing some of the impact that these painful, past experiences continue to have, which in turn allows new possibilities to emerge. According to Winnicott, dissociation is an " .. extremely widespread defence mechanism" (1987 p 152).

Feelings of being 'unreal' and 'not whole'

However, this sorting out of fact and fantasy can be difficult for women who do not feel 'whole persons' or who feel split off or unreal to the point that they do not feel that they have had an experience. It is as if each different situation that they encounter at any one time is cocooned in a bubble, set adrift, with no connecting lines or themes to link one experience to another. These difficulties can mean that some of the women we work with are closer to *privation* than *deprivation*. As a result, some find it difficult to relate to others in the group, preferring instead to direct their comments to the group workers: the group dynamic frequently reflects this fragmentation. According to Bion, this inability to relate or to link comes about because the individual has ".. a part-object relationship with himself (sic) as well as with objects not himself" (1959 p 311). A striking characteristic among those women who have difficulty feeling, experiencing or linking is there marked lack of curiosity:

> "The disturbance of the impulse of curiosity on which all learning depends, and the denial of the mechanism by which it seeks expression, makes normal development impossible... The patient appears to have no appreciation of causation and will complain of painful states of mind while persisting in courses of action calculated to produce them."
>
> (Bion 1959 p. 314)

Another noticeable characteristic is a profound sense of compliance - of "fitting in" to whatever is required to the point that some women describe feeling that they have no 'real' personality or that they have not yet started to exist (Winnicott 1971 p. 65). There is a marked a lack of aliveness, a sense of futility and limited ability or inability to recognise need or desire. Some compliance or lack of curiosity is a part of 'normal living' (Winnicott). However, what is different is the degree to which women fail to show any noticeable 'investigative attitude' (Killingmo 1989) and the extent to which they comply and appear empty. Where women demonstrate difficulties in tolerating a feeling or in linking, our task is different and involves attempting to establish meaning. This we do verbally but also through entering the world of symbolisation and transitional phenomena in order to help bring about a regression to an earlier time in their lives, from which they can begin to have experiences and to exist **(4)**.

Establishing meaning

One way that we assist in the establishment of meaning involves a ".. verbalisation of experiences in the immediate present", where we act more as a mirror than someone providing interpretations (Winnicott 1971 p. 118). This point is developed by Killingmo, who distinguishes between two types of therapeutic strategy:

> "(1) revealing meaning and (2) establishing meaning; the first one being primarily relevant in contexts of conflict, the second in contexts of structural deficit. For the purpose of revealing meaning the relevant type of intervention is interpretation, while establishing meaning is brought about by interventions of an affirmative type."
>
> (Killingmo 1989 p. 68)

When working with people with 'structural deficit', whose sense of self appears incomplete or fragmented, Killingmo's 'affirmative interventions' include *objectifying* incidents or feelings to enable them to take some kind of shape or form, so that in time they can be communicated in words and shared with others; *justifying* in order to establish cause and effect so that they can be understood in terms of being "reasonable natural events"; *accepting* in order to establish and convey the vitally important attributes of understanding and acceptance (Killingmo 1989 p. 73). It is hoped that by attempting to meet the fundamental and ".. immediate need for meaningfulness, the ego will be able to raise its level of functioning and adopt an investigating attitude - at least for a while" (Killingmo 1989 p.73).

Putting experiences into words has also proved to be an enormously important process among deprived and disadvantaged groups of people who, perhaps as a result of class, race or gender injustices rather than failures in their emotional development may demonstrate little confidence in their capacity to think or to talk about their thoughts and feelings (Gilligan 1982). Some have been taught to consider themselves "stupid" or "thick" or as "not counting" and have internalised these negative experiences. These blows to the ego make it essential for people from deprived sections of the population to be given positive experiences, and it is here that the interventions identified by Winnicott and Killingmo are particularly important.

In addition to these interventions, we would separate out and add the importance of providing *explanations* about the processes that people are going through both within the group process and, if appropriate, in relation to the world and wider cultural and societal contexts. We see this as an aspect of 'maternal care', though we are careful not to inhibit women's own quest for understanding and meaning. Providing explanations can be seen as one way of attempting to contain anxieties, as well as adapting to women's individual needs , and can be particularly important for those women who, as infants, did not have events or experiences explained to them by their parents, or other adults.

Through attempting to establish meaning, which includes providing positive experiences as a 'memory of care', our hope is that in time these experiences will become assimilated into the ego to form part of the self. However, it is clear that some women do not have an 'internal hook' on to which to hang and store experiences: their sense of self or self esteem is too low to be able to internalise good experiences. This can be seen most clearly when they fail to remember positive experiences that happened in the group in previous weeks: where this is the case, our work needs to begin here. This lack of memory may be due to a range of factors (e.g. medication) but may also indicate that we have not yet been able to pitch our 'affirmative interventions' at a level where meaning could be permanently established or it could be an indicator of *privation* and the fact that there is insufficient emotional foundation on which to lay experiences.

It is not always clear to us why some women have little capacity to store experiences and how this came about, nor whether we can help to create a permanent 'internal hook' so that some integration can begin to take place. Yet despite these doubts, with one or two women we are involved in exploring whether some integration is possible, following the processes described by Barbara Dockar-Drysdale in relation to emotionally deprived children, but relating these to adults:

> We are thinking in terms of a series of processes which must be gone through in order to reach integration. These are experience, realization, symbolization and conceptualization. By this I mean quite simply that a child may have a good experience provided by his (sic) therapist, but that this will be of no value to him until he is able, eventually, to realize it; this is to say, to feel that this good thing really happened to him. Then he must find a way of storing the good thing inside him, which he does by means of symbolizing the experience. Last in the series of processes comes conceptualization, which is understanding intellectually what has happened to him in the course of the experience and being able to think this in words: conceptualization is only of value if it is retrospective - ideas must be the sequel to experience".
>
> (Dockar-Drysdale 1990 p. 98-99)

Transitional Phenomena

As part of our attempts to establish meaning, particularly among women whose experience is more *deprived* than *privated*, we also use symbolisation and transitional phenomena in order for the developmental process to start up again where it has become stuck: here we draw heavily on the work of Barbara Dockar-Drysdale. Our aim is not to fill the gaps or holes in women's emotional development, nor to push them forward prematurely, but to put a bridge across these traumas or 'impingement's' which have brought about a 'break in the line of life' (Winnicott). To achieve this, we use symbolisations as a way of reaching into women's inner reality at an earlier stage in their emotional development. Once we reach this point, we continue to use symbolisations in order to begin to provide ".. a satisfactory experience which must somehow have been missing at the beginning" (Dockar-Drysdale 1990 p 46).

Although most of this transitional work takes place on an individual basis within a counselling relationship, we do use some of the same processes in our groupwork. We mainly do this through 'adaptation to need', which involves setting up a situation where we attempt to meet the unique needs of each individual woman. Sometimes, this may involve making women a particular drink upon arrival at Womankind, or supplying a certain type of biscuit. Other times, it may involve women identifying something that they would like us to give to them. For example, one woman asked me to give her a hankie which she always carries with her, another wears a scarf, one hugs a soft blanket during the group. Another carries and regularly loses a particular stone , using the metaphor of being lost to communicate with us and we reply using the same metaphor. Many carry cards that I and other workers have written to them over the years, one woman has a hug each week, another wants to hear certain words of reassurance, and so forth.

For some, being given objects or gestures in this way can help to bring about a partial or 'localised regression' (Dockar-Drysdale 1990). This is spontaneous, in the sense that it is not a conscious choice, and often takes the form of women feeling very defenceless and childlike. They describe needing someone to take care of them, to feed and clothe them and, most importantly, to explain and interpret the world for them. Sometimes, women in this state retreat to bed, because the effort involved in surviving takes up all their energy or because the world is too bewildering to cope with. However, because the regression is partial, most are still able to undertake the demands made of them in their everyday lives and can manage to get to the group: we pay for taxis if it becomes too difficult to travel.

Once women begin to develop the capacity for storing and reflecting upon experiences, it is hoped that two changes will occur. Firstly, that in time they will use the experience of being *contained* to become the *containers* of their own inner reality. Secondly, once some confidence has been gained and internalised, that their dependency upon the groupworkers, and Womankind, will become less because a different internal order has been created:

> ".. the individual acquires an internal environment .. (and) .. thus becomes able to find new situation-holding experiences, and is able in time to take over the function of the situation-holding person for someone else, without resentment"
>
> (Winnicott 1987 p. 271).

This transition from *contained* to *container* is vitally important for those women who are mothers because it means that they are developing the capacity to be the 'situation-holding person' for their children. However, it must again be stressed that for this to happen requires more than individual endeavour or the capacity to 'use the object'. It also requires an environmental setting that is sensitive to women's needs and capable of providing experiences that are nourishing, fulfilling and energising. Where these external facilitating factors do not exist, women have little choice but to dwell in the isolated and 'false' realm of compliance, premature self sufficiency and secrecy.

GROUPWORK

In order to put our work into context, the following is a description of the cross section of women currently attending our groups and how we see our approach in relation to the groupwork being practiced within social work. The paper then goes on to describe a typical group.

Cross section of women attending our groups

The following breakdown is based on the findings of a pilot study undertaken in 1994. Each group is made up of nine women. Of these twenty-seven women, 4 are black (Afro Caribbean) and 3 come from other ethnic minority groups (all the groupworkers are white women). Their age range spans 22 - 65 years, with half being under thirty. Between them, they have had thirty-six children, of whom fourteen are under ten years old. A small number of women are married but most live alone on benefits: only one woman works part-time in paid employment. Poverty, isolation and loneliness are very real and worrying issues for almost all the women we see.

The majority of women speak of being depressed for many years, some being unable to recall any period when they felt otherwise. Their despair is profound and over half have attempted suicide at some time in their lives: in case of two women, their mothers and a brother actually committed suicide. Interestingly, only about one third of the women we see have been admitted to a psychiatric hospital: more have been treated in day hospitals or day centres. This is significant given the fact that the majority would be classified as suffering from 'severe' or 'enduring' mental health problems: over half have been diagnosed as schizophrenic or as borderline psychotic. (We do not use medical diagnoses, preferring instead to use the word depression because this is how most women describe themselves). Almost all are taking some kind of psychotropic (mood altering) drug, mainly anti-depressants, but also minor and major tranquillisers. An analysis of our referrals revealed that 42% came from General Practitioners (family doctors) and 34% from social workers and other health workers.

Groupwork within social work

There is considerable concern that groupwork is being practiced less than it once was within social work and that where it does exist, it tends to be without a clear theoretical base and to be focused on certain client groups (women and young offenders) rather than available to all (McCaughan 1988). The reasons for this fall-off in groupwork are many: it has proved difficult for some social work academics, managers and practitioners to acknowledge the value and importance of groupwork as a social work method and to take this viewpoint forward; the allocation of resources and priorities within area teams can mitigate against groupwork; some practitioners leave social work courses feeling insufficiently trained, skilled and committed to undertake groupwork; there can be an absence of appropriate supervision and support; there is a question about whether the groupwork theories and practices currently being used are effective in providing support for clients and for bringing about change, and so on. Another reason put forward it that groupwork may require a different more collaborative and participative style of working (McCaughan 1988 p. 86), and this may be difficult to achieve amid the daily pressures and tensions involved in many fieldwork settings, particularly statutory work.

Whilst this may be an accurate description, it places our groupwork approach outside social work because we are pre-occupied with different issues and choose to deal with these in a different way. Although our closest professional links lie with social work, it is difficult to categorise our work because we are drawing our theoretical framework, training and supervision from different sources to those normally available. Some would describe our approach as being closer to "casework in a group" than to "real groupwork" (Kurland & Salmon 1993). However, this issue is less important to us than whether we are being effective in meeting the needs of the women who seek our help: this is very difficult to measure and evaluate.

Central to our work is a belief in the importance of self determination, which for us involves constantly reviewing and modifying our groupwork approach so that by 'adapting to need',

women can begin to find their own way, in their own time, to whatever personal goal(s) they have set themselves. Within this framework, our emphasis is to provide an approach that will meet the needs of a deprived, disadvantaged and depressed cross section of women. In some ways, this pre-occupation has kept us from having to address the tensions and rivalries that continue to exist within groupwork in relation to one-to-one work (sometimes described as casework) and community work. It has also meant that we have failed to challenge creatively the orthodoxy described by authors such as Kurland and Salmon in what they define as "real groupwork" (1993 p.10). Yet we are deeply committed to encouraging the development of a range of different groupwork approaches and believe that unless we can encourage flexibility and experimentation within social work, we run the risk of becoming "territorially defensive", isolated, theoretically adrift and unable to allow for innovation or collaboration in inter-professional initiatives currently under way (Heap 1992).

The role of the groupworkers

Each depression group has three workers: two group leaders and a group co-ordinator, with each undertaking different roles. The group co-ordinator has the centrally important task of ensuring that Womankind provides a setting, a 'transitional space' (Winnicott) that can act as a bridge from which women can begin to explore their thoughts and feelings, "..the chance to remember in .. (their) .. own way and time." (Winnicott 1971 p. xii). The aim is to create a 'good-enough environmental provision', a 'setting that gives confidence', from which women can begin to reveal themselves to themselves. According to Bollas, the existence of a holding environment acts as an 'invitation' for an individual to regress (Bollas 1988 p. 94). The group co-ordinator also provides the continuity between one group and the next by making brief notes each week on the group process and any follow up work required. These notes are then read out when we meet before the group. However, recently we have begun to explore Bion's stance of leaving aside anything that is already known about an individual or the group, in order to keep the focus not on ".. what has happened nor with what is going to happen but with what *is* happening" (Bion 1967 p.272).

During the group, the co-ordinator mainly acts as an observer, though it is often her task to accompany women who leave the group before the end. It is the task of the group leaders to aid communication within the group, which involves enabling members to ".. encompass what is known or become aware of it with acceptance" (Winnicott 1971 p. 102), based on the premise that it is ".. the patient and only the patient who has the answers". In order for group members to feel this acceptance, our approach is one where we play an active part in providing some of the care which, to a large extent, continues to be absent in women's lives. This is based on Winnicott's concept that ".. cure at its root means care" (1986a p.112), where 'care-cure' is seen as part of the concept of holding. Thus, as groupworkers we become:"..

> .. one who responds to need, that is to say, of adaptation, concern and reliability, of cure in the sense of *care* ... This carries no sense of superiority."
>
> (Winnicott 1986a p.116)

As groupworkers, it can sometimes be difficult to maintain this caring, maternal approach, particularly when we are being provoked to retaliate, to be clever or to give up, either because of our own personal histories or as a result of women's need to re-enact earlier failures. Here it is important that we have a theoretical framework from which to understand ourselves and other women's reactions and behaviour. The high priority given to supervision is essential in helping us to bear women's anxieties and to maintain professional boundaries. There is an expectation that all groupworkers will attend as many supervision sessions as possible and that group leaders will be in group or individual therapy themselves.

In order to provide anonymity and to protect confidentiality, the following account is not a description of any one group but an amalgamation. All names have been changed. However, the comments and encounters described actually occurred. Prior to the group session about to be described, there has been a brief meeting between Norma Wilson, the co-leader, Lesley Bradley, the group co-ordinator, and myself to hear a resume of the main issues raised in the group the previous week and to discuss any new developments.

The group

"Here we go again," murmurs Janice, as she drags herself up the stairs behind me, her black boots stamping her misery into every step.
"Why do you come if you hate it so much?" comes a question from someone further down the stairs.
"Because there's nowhere else to go, is there?" snaps Janice, who by now has arrived in the groupwork room and thrown herself on a pile of cushions in the corner.

Joan is next to arrive: she settles herself in the centre of a pile of cushions and kicks her shoes off. She looks comfortable. As much as possible, we have tried to make the groupwork room a warm, soft and soothing place to be. Pastel colours predominate and there is an abundance of cushions of every size. On the walls are paintings and photographs that women have brought in and on the shelves are other symbolic objects - a shell, a box, a little clay figurine, a flower, a teddy bear. The presence of these symbolic objects is important because they indicate that some women are beginning to explore and use the transitional space that Womankind provides.

By now the groupwork room is beginning to fill up as seven of the nine participants settle themselves down for another weekly 1 1/2 hour session of the group. Once this is done, I begin by welcoming everyone and by saying that we have had apologies from Linda and Michelle who cannot come this week. I then ask whether anyone wants to start, perhaps to say something about how they feel about Linda and Michelle being away, how they are feeling now, or how the week has been for them. A silence prevails and I and the other groupworkers use this as an opportunity to sense the mood of the group and its individual members. I pick up a feeling of apprehension and my eyes turn to Janice, who by now has buried her head between her legs, and is gently rocking herself backwards and forwards.

I ask Janice what's the matter, what has happened to make her feel that she did not want to come to the group today? She does not reply except to bury her head even deeper. The room is full of silence and almost in a whisper I ask, "what's happening .. why do you need to hide away today, Janice? Can you put words to your feelings?" She is visibly struggling to find words.
"It's so hard .. so hard to get here .. the journey is too difficult. I feel so scared all the time .. sometimes trying to get to the group feels like cycling over Everest .." She begins to cry, quietly. There is some shuffling in the group: a box of tissues is passed along and acts as a welcome distraction.

In an attempt to give comfort and reassurance, Alice puts her hand on Janice's knee. This produces further tears.
"I think I've made her worse" says Alice, despairingly.
"No Alice", replies Norma, "she just needs to cry, but I'm wondering how you are feeling?"
"Awful ... absolutely terrible. I can't stand this ... all this misery and depression: it's too much. I wasn't as bad as this before I started coming to the group .. I was alright really ..".
"How can you say that?" interrupts Joan, kindly. "You never used to go out, except to the doctors or back and forwards into hospital. How can you say that you were alright?"

"I just had my own pain then, nobody else's .. I can't stand this. It's too much to bear ... all this misery .... " With these words Alice rushes out of the room. Lesley follows to ensure that she has someone with her and that she does not leave the building in a distressed state.

The mood of the group feels worried and startled, prompting Norma to ask how they feel about Alice's departure. The question is met with silence. We know that if left too long, silence can be experienced as persecutory and can fragment the group. Yet despite this, we decide to wait.

Elizabeth, who finds silences difficult, is the first to speak: her voice cuts through the silence like an explosion as she shouts: "I wish I could walk out like that but you've got to keep going, you've got to think positively haven't you? Otherwise no-one will want to know you and you're left with nothing." Her smile is full of apprehension and compliance, as if searching for approval, and my mind drifts back to the previous week where she relayed comments from her clinical psychologist on the importance of positive thinking as a strategy for dealing with her depression.

Another silence prevails. The tension mounts, particularly for Elizabeth, whose shuffling is becoming more pronounced. After a while Norma asks: "Elizabeth, I wonder whether you felt angry at Alice for walking out?"
"No, not really".
"When you say 'not really', what do you mean?"
"I don't know".
"Well then, I'm wondering whether you feel you need to be positive when you come to the group?"
"No, I like coming to the group but I just keep thinking 'why me, why am I always in the wrong, why am I always to blame?' When my husband divorced me, he got everything. I just had a bag of clothes and nothing else. No house, no money, no friends, nothing .... and eight years later, look what I've got .. nothing". Elizabeth cannot yet cry. Instead she expresses her discomfort and pain through repetitive alterations to her charity shop clothes. She appears confused and, sensing this, Norma asks whether Elizabeth would like to say some more about the difficulties she experiences in managing her life and keeping going. She declines the invitation, preferring instead to return to her own thoughts and memories.

In anticipation of the conversation between Elizabeth and Norma continuing, another silence falls on the group. This is broken by a comment from Joan. "Well, if no-one else wants to speak, I'd like to say that I had a better week. I didn't feel so terrified or panicy, though I'm scared that it will come back."
"What will come back?" I ask.
"This feeling that everything is falling apart, that I'm going to fall down a big deep hole and be forgotten .. forever .. left to rot. What I don't understand, and it worries me, is why do I suddenly feel so awful .. so anxious? What happens to make me feel so young, so small .. defenceless .. empty .. frightened .. like something terrible is going to happen but I don't know what. Do you know?" Joan turns to me and indicates that she wants an answer.

I feel uncertain about whether to reply but decide to. "Well, I think that over the past few weeks your defences have not been working as well as they have in the past. This seemed to begin about the time that we closed the group to new women .. is that right?" Joan nods. "Since then, you have seemed very vulnerable and frightened, as if you've tumbled or fallen into another time, an earlier time in you life, and you want someone to take care of you". She beings to cry and I ask if she wants me to stop. She shakes her head. "You've been talking more and more about how tired you are of caring for others and that you want someone to take care of you, to comfort you, to tell you that everything will be alright. My guess is that you have felt these feelings before, perhaps around the time when you were admitted to hospital?" Joan nods and so too do some of the other women in the group. "Maybe one

reason why you feel so awful is because you became aware of your own neediness and your desire to be taken care of and I think that this frightened you. But the fact that you can now feel this neediness is important because it can mean that the developmental process is beginning to start up again ... that you are beginning to sort out and work through some of the deprivation and neglect that you experienced in childhood". She nods again: "I feel I haven't started to live yet. I haven't had a life .. I look alive but I'm dead inside ... dead .... I've tried to be good .. but that's not the same as being alive. Everything feels pointless .. futile .." She begins to sob deeply.

Once again the group is silent. I recall a phone call I had to my home one weekend where I asked Joan if she needed something from me to help her cope during this difficult time. She identified a pillow - a blue pillow and as fate would have it, I found just the right pillow some days after. I am not sure how I knew it to be the right one, but my hunch was confirmed when I gave it to Joan. It now travels wherever she goes and she says it is a source of great comfort.

After some time has passed, Norma asks whether my comments relate to other women's experiences and some begin to tell their own, painful stories.

Tina's comments focus on her experiences of being psychotic in her adolescence and how she now connects this to early childhood experiences of sexual and physical abuse. Her words speak to Janice's experiences of abuse: she is now sitting up, listening intently. Elizabeth follows by describing how she never felt she matched up to her parents' expectations of her. This comment serves to remind Tina and Janice of how much they too felt unwanted and unloved as children. "My dad told me I was a mistake and that's how I've been treated all my life", recalls Tina. Janice nods her understanding. Thinking back on Tina's life, the picture I have is of no-one setting a place for her at the family table. Instead, I see her hanging around - waiting and hoping for some scraps of food, of affection to be thrown her way: she re-enacts this feeling of unimportance in the group and we have to be vigilant not to forget her. My minds drifts to Janice, whom I see as a lost but capable child, who is expected to find her own way home. Though there are signposts and milestones, maps and helpful guides, she does not know how to read or use them. Instead, she is left feeling that life is a huge struggle, like "cycling over Everest", sometimes without pedals.

Another silence: women look lost in their own thoughts, as if grief stricken. My mind drifts to the meaning of the word 'stupid', which originally meant 'numbed with grief'. My preoccupation, and theirs, is disturbed by Alice returning to the group, looking relaxed and calm, followed by Lesley. However, Alice quickly becomes worried by the atmosphere and asks whether she has come back into the group at the wrong time. I reassure her and ask whether she knows why she had to leave the group at that point.
"No, I just had to go."
Catching a sense of lostness, I ask her how it feels to be back.
"I don't know. I don't feel I've arrived back yet".
"Is there anything we can do to help you to get back into the group?"
"No. I just don't feel all here but I'm alright. Can you talk to someone else?"
She is beginning to become agitated, so I decide to leave the issue there.

In the silence that ensues, my thoughts turn to Sheila, who has rarely spoken in the group since she joined over a year ago. Though clearly attentive to what is being said, she has not yet found it possible to entrust her thoughts and feelings to the group. She carries a terrifying fear of "going mad", and much of her life is spent trying to find the right balance in the face of conflicting internal and external pressures. She has great difficulty recognising any feelings, positive or negative, and finds it almost impossible to let anyone get close to her, including her little children. So far, our approach has been to adapt to Sheila's needs as much

as we can, which includes not putting her under any pressure to speak in the group. Our most intense work is undertaken in the counselling sessions which Sheila attends each week.

My thoughts are broken by an angry outburst from Jenny who, turning to me, asks: "Are you going to ask how my week has been ... do you care? Well, it's been absolutely awful and coming here is no help at all. I feel as unwanted here as I feel everywhere else".
"Why do you say that?" I ask.
"You're all the same. I know I ask for it, but you're as bad as all the others who've let me down".
"In what way do you think I have let you down?"
"When I was in hospital, no-one came to see me, not even you. I was just left to sort everything out for myself, yet you went to see Elizabeth when she was admitted .. oh, it doesn't matter. What's done is done. There's no point in talking about it now, so go on to someone else", and with these words, she waves her hand, as if dismissing me. I ask Jenny what would help her to work through her feeling of being abandoned by me but she hears my question as attacking and, as a result, it elicits no response. Although her silence feels uncomfortable, I am aware that once Jenny feels ready, she will find words for her feelings, but that this process cannot be rushed.

In the time remaining, the discussion moves around from one topic to another and as much as they can, women strive to keep some kind of balance between trying to have some time and attention for themselves, whilst also allowing space for other women to speak. Given the degree of depression and deprivation within the group, there is an amazing amount of generosity, tolerance and patience for each woman's individual struggle. Such generosity can be interpreted as a form of self denial, masochism or as an inability to manage negative, envious or rivalrous feelings. It can also be ".. a curious way of mourning and caring for the damaged parts" of themselves (Bollas 1987 p 243), which cannot yet be contacted or communicated. My own view is that a profound fear of criticism and "getting it wrong" also influences whether women will or will not take up the space.

Eventually, an hour and a half has passed and we wind up the group.

After the group

Once this is done, women leave the groupwork room to have coffee and tea in the kitchen. The kitchen then becomes their "own space", a second therapeutic experience. It is here that women make contact with one another, perhaps to arrange to meet during the week or to talk over the telephone. We play no part in these arrangements except occasionally to unravel, within the group, conflicts or misunderstanding that may have arisen. Some women feel uneasy about making social contact in this way and worry that they don't know how to be sociable or that confidentiality may be breached. Some feel tentative because the memory of earlier disappointments and betrayals of trust remain fresh in their minds. Despite these concerns, on the whole most women handle this contact well.

Relating theory to practice

Meanwhile, Lesley, Norma and I meet for the second time to compare observations on the group process, to discuss women's individual contributions and how we ourselves are currently feeling. In terms of countertransference, we attempt to distinguish between feelings that are in response to group members and those emotions which intrude into the work from our own past (Heimann 1950). This is also a time when we attempt to link theory to practice. We begin by noting that for Jenny, I continue to be a 'reliable hate object' (Dockar-Drysdale 1990). Having been taken to the 'point of failure' in the therapeutic alliance by failing to visit

her in hospital, I now stand alongside others from the past who have failed her (Winnicott 1990 p. 258). My task is to withstand and survive Jenny's continued attacks and not to retaliate or abandon her. The issue of hatred, like women's fears and fantasies, is a complex issue which cannot be explored in detail here except to ask what are these feelings being used to convey - as groupworkers, who are we *becoming* and how are we being *used*?

Our work with Joan has provided us with an opportunity to see whether a partial or 'localised regression' is possible and beneficial in a groupwork setting and so far, this appears to be case, particularly where women's primary experience is one of deprivation and not privation. This was the situation for Joan, who thoughout her childhood, was expected to be compliant and to subsume her needs to those of others. A psychotic breakdown after the birth of her first baby, resulted in her admission to hospital, where she was given ECT and since that time, 20 years ago, she has been struggling to recover from recurring severe bouts of depression and to "feel alright about herself".

Her regression took her back to being a young child and revived a neediness that terrified her. She was haunted by a fear, an 'unthinkable anxiety' (Winnicott), which she could not describe in words beyond saying that she felt trapped, as if she had to be on the move for fear of being caught. Our approach was to encourage her to identify what she could cope with and to try to keep her within this range. For depressed women, it can be almost impossible to be still, to 'be' rather than to 'do', particularly when gripped by anxiety. We encouraged her to talk to her family and friends as much as she could, though at times this proved difficult because it exposed her in ways which made her feel vulnerable and frightened. During this period, she was able to 'use' me more, by writing and phoning me at home, which provided her with some of the holding that she needed. Though we could only provide limited help, what was important to Joan, and other women have said the same, was that as much as we could, we were willing to be with her in the dark pit into which she had fallen. She also felt comforted by our efforts to explain what we saw happening to her, which is something that she rarely experienced in childhood, but very much yearned for and needed.

After about four weeks, Joan emerged from this crisis, and since then has continued to explore those parts of herself that became hidden in childhood. According to Winnicott, as long as the individual is located in a 'facilitating environment' from which development is possible, the development process can start up again at any time. Other indicators might be the birth of curiosity or flashes of spontaneous, uninhibited behaviour. For Barbara Dockar-Drysdale, one way to evaluate whether the developmental process has been revived is when an individual is able to identify "the feeling of need and the desire for satisfaction". Joan is in touch with her needs, which are to be herself and to be free of the anxieties and inhibitions that stop her from enjoying life. In this sense she is searching for her true self:

> "The spontaneous gesture is the True Self in action. Only the True Self can be creative and only the True Self can feel real. Whereas a True Self feels real, the existence of a False Self results in a feeling unreal or a sense futility.
>
> The False Self, if successful in its function, hides the True Self, or else finds a way of enabling the True Self to start to live. Such an outcome may be achieved by all manner of means, but we observe most closely those instances in which the sense of things being real or worth while arrives during a treatment".
>
> (Winnicott 1990 p. 148)

Many of the women we work with are reluctant to look at difficult feelings or to allow themselves to have an experience in case they are hurt again. This is particularly true of Janice, Tina and Sheila. Their childhood experiences of abuse have left them, in different

ways, deeply scarred and, as a result, they carry a profound anxiety that they will 'fall apart' or be further traumatised if they are pushed to remember before they feel emotionally ready or prepared (Trevithick 1993). Here again, our task involves being able to reassure, to "hold together the threads of experience" (Winnicott), to contain anxieties, to explain events (where appropriate) and to show a willingness to help. It also involves pitching our interventions at the correct level and then to wait " .. until the patient tells us .. if we make the interpretation out of our own cleverness and experience then the patient must refuse it or destroy it" (Winnicott 1990 p. 182)

Like Joan, Janice is in a state of partial regression and, as a result, is finding it hard to deal with those aspects of her life that require her to be an adult. Nevertheless, she does manage to get herself to the group each week. Janice's reference to "cycling over Everest" is a part of an ongoing communication using metaphors connected to journeys. According to Barbara Dockar-Drysdale, the use of metaphor in this way acts as a safeguard against an individual being further traumatised because if the metaphor is poorly chosen, inappropriate or untimely, it is likely to be experienced as irrelevant or confusing rather than traumatising.

Tina's current difficulties take a different form to those of Janice. Her days are dominated by flashbacks of deeply disturbing scenes, some of which she cannot bear to relate. She also suffers from recurring nightmares where she is being chased, caught and punished in some way. When these flashbacks become too difficult to bear, which often happens at night, she sometimes rings me at home. Containing her anxiety in this way helps her to feel less alone. Her fear of having another breakdown is very profound and leaves us feeling that in addition to the psychotic episode in adolescence, she may have had other breakdowns earlier in her life (Winnicott 1986b).

Our thoughts turn to Alice whose tendency to split means that although she is there in person, she is able to describe very clearly the sense that some part of her is missing from the group. Her own sense of being fragmented is, for the most part, how she experiences the group, which raises questions about what part she and others bring to the group and how these are played out. This in turn raises a more general question about the role of the group in meeting individual needs and how this relates to the ".. interplay between individual needs, group mentality and culture" (Bion 1961 p. 55).

In relation to Elizabeth, we felt that this week, we failed to pitch our interventions at a level that conveyed sufficient understanding and acceptance and, as a result, she was unable to communicate her feelings or to make links. However, some of this difficulty may be due to her poor nutrition or emotional exhaustion. Elizabeth's life is very hard and this fact alone can make communication difficult: "People in pain cannot concentrate" (Klein 1990 p. 40). Surviving from day to day takes up almost all of her physical and emotional energy and on many occasions she has come to the group feeling "ready to throw in the towel". An attempted suicide last year brought home to us the depth of her despair and how pointless life can be when the central, overriding experience is one of isolation and loneliness. Elizabeth is one of a handful of women who could be decribed as having a 'deficit pathology'. Her main purpose in coming to the group is not to work through and sort out painful experiences but to have somewhere to go each week where she will be cared for and nurtured. Whilst this need is legitimate, and forms part of our overall approach, it can create tensions within the group because Elizabeth is often not prepared to discuss her feelings beyond a certain point. Among the groupworkers, her situation causes concern because we are aware that she needs more practical and emotional care than we are currently able to provide. Elizabeth and Alice come across as suffering more from privation and both have been diagnosed as schizophrenic.

With regard to Sheila, we discussed whether we are doing enough to create the opportunity for her to find words. Sheila is 25 years old, has three small sons under seven and lives in a

run-down housing estate in one of the poorest areas of Bristol. For the past year, she has seen someone from Womankind for one-to-one counselling and it is not clear whether this contact interferes with her ability to speak in the group. She feels it does not and insists that she "gets a lot out of coming", even if she cannot speak. Whilst silence can be used as a defence, we are aware that people communicate in different ways and that " .. significant relating and communicating is silent" (Winnicott 1990 p. 184). In addition to Sheila's silence, what is noticeable is her marked lack of curiosity, which is a concern that the school have also identified in relation to her sons. However, in recent months there has been some changes, particularly in her ability to seek help and to share her concerns with others ('use of the object'). For example, Sheila is beginning to have contact with other mothers, and to communicate her worries about the children to their fathers and at the school. These developments may be an indication that Sheila is starting to become the "situation-holding person" for her sons and whilst she finds it frightening to expose her needs, she uses her counselling sessions well to give her support and encouragement. One day, we hope she will be able to use the group in the same way.

Conclusion

At this stage, we are not clear whether our approach is helpful to women whose experience is more *privated* than *deprived*, beyond offering kindness, concern and somewhere to go each week. However, we are clear that one of the greatest difficulties we encounter is in trying to meet the needs of women across this range within the same group. A detailed discussion of this issue goes beyond the scope of this paper except to say that until we adopt different selection procedures, our groupwork approach will always be some kind of a compromise between the needs of women who fall somewhere between 'neurotic' and 'psychotic' forms of depressions, between different manifestations of *deprivation* and *privation* respectively.

By choosing to emphasise how we have applied the writings of Winnicott and Dockar-Drysdale to our groupwork with depressed women, I am aware that I have not covered other crucial issues such as those relating to group dynamics and processes, particularly the use we make of transference and countertranference phenomena, projection, projective identification and other defence mechanisms, how we evaluate the effectiveness of our approach, how we cope with differences across the groups and among the groupworkers, our use of transitional phenomena, the supervision and training we receive, and so forth. Hopefully, some of these issues will be discussed in detail in papers yet to be written.

Instead I have described how we have used and adapted psychoanalytic concepts, particularly the work of Winnicott and Barbara Dockar-Drysdale, in order to develop an approach that is rooted in our feminism and our desire to enable women to relate better to themselves, to other women, to other people, and to their wider environment. If to experience is to exist, then one of our tasks can be to provide experiences within a groupwork setting, a meal, from which women can take in and digest sensations, both good and bad, so that in their emptiness and hunger, they can begin to feed, and to feel filled up.

The emotional starvation I have described is not confined to the women we work with. I believe this problem also exists within social work where many clients have been, for a variety of reasons, deprived of the food and nourishment necessary to live creatively and to move forward. For some, this results in an inability to function without a degree of dependency and support. Although dependency is being discouraged more and more within social work, social workers and their clients are likely to fail in their efforts to make progress if these needs remain unacknowledged and misunderstood. In our work with depressed, deprived and disadvantaged women, who mirror the abilities and difficulties that many social work clients present (Sheppard 1993), it is important that our work starts at the correct point - namely at the point where clients feel 'together' and 'whole' enough to meet and cope with the

difficulties that they are being asked to address. Where people present themselves as being too fragmented and 'untogether' to achieve this, our work needs to start there, which requires learning how to help individuals to pick up the fragments of experience, existence and personhood so that in time, a 'whole person' capable of tolerating a 'whole experience' may eventually emerge. Where this is not possible, and a clear inability to manage the world and its complexities has been acknowledge, particularly by the individual concerned, we feel that as a society it is our moral responsibility to provide a range of alternatives, including residential settings, where vulnerable people can be sheltered from the unmanageable strains and stresses of life.

Groupwork provides an important dimension for understanding that vulnerability because it provides an opportunity to observe how individuals relate to one another, to themselves and to people invested with authority, status and power (in our case, group leaders). Without this knowledge, our understanding of human beings can only be partial. In our experience, groupwork can also provide a very important opportunity from which individuals can begin to describe and identify their personal capabilities and needs. Here we see the group as a base from which people can begin to explore and extend whatever cultural and environmental possibilities that lie within their reach but beyond their vision.

FOOTNOTES

(1) In addition to running three depression groups, Womankind provides a range of services that include some individual counselling, a telephone helpline, an out-of-hours telephone line for evenings and weekends, a befriending scheme based in a local psychiatric hospital, a volunteer programme, placements for social work students, regular talks and training workshops for practitioners working with depressed men and women.

(2) The late Donald Winnicott was a paediatrician, psycho-analyst and twice President of the British Psycho-Analytic Society. Barbara Dockar-Drysdale is a psychotherapist and the founder of the Mulberry Bush School for children needing residential psychotherapeutic care. She was for many years a Consultant Psychotherapist to the Cotswold Community for disturbed and deprived adolescent boys and currently acts as a consultant at Womankind.

(3) In some ways, the task we have set ourselves is similar to that of Bion (1961 p. 143) except that instead of drawing on the work of Klein, as Bion did, we are using the work of Winnicott and Dockar-Drysdale to help us to understand the "emotional life" of the individual and of the group.

(4) It may be helpful to describe in greater detail what is meant by the terms *transitional object* and *symbols* or *symbolisation*. *Symbols* can be both conscious and unconscious. For Rycroft, the latter represent ".. an unconscious substitution of one image, idea, or activity for another .. a private construction .." (Rycroft 1968 p 162-3).

For Winnicott, *transitional objects* (piece of blanket, etc.) mark the infant's ".. progress towards experiencing" (1971 p 6). They act as a *soother* more than a *comforter* because they are ".. more important than the mother, an almost inseparable part of the infant" (Winnicott 1971 p 7):

> ".. when we witness an infant's employment of a transitional object, the first not-me possession, we are witnessing both the child's first use of a

> symbol and the first experience of play .... The use of an object symbolises the union of two now separate things, baby and mother, *at the point in time and space of the initiation of their state of separateness*".
>
> (Winnicott 1971 p 96-7)

Initially, when we ask women to symbolise their past experiences through the use of an object, we do not always know, nor do women themselves know, whether the object will take on the significance of a transitional object - whether it will become "inseparable part" of the woman and carried at all times. Hence, the objects in the groupwork room are primarily symbolisations. As a symbol or a transitional object, the objects (a rabbit, a cushion, stones, panda, paintings, photographs, etc.) it is hoped that they begin a process that involves returning to the individual those sensations, feelings and experiences that have somehow become lost or separated off.

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