A Model For Reflective Practice And Structured Supervision

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1. NHS Mental Health Trust Objectives:
Statutory Mental Health Services are increasingly expected to deliver more for less: more cost effective services to increasingly complex clients. This necessitates an increased use of group work in service delivery which is supported by effective group training and supervision. Practitioners have larger case loads and are expected to provide more psychological and psycho-educational interventions. This in turn requires skills in multi-disciplinary team work; psychological formulation and psychological mindedness. Group supervision and reflective practice support skill and knowledge development in all of these areas including; awareness of group process; group facilitation skills; ability to present and discuss clinical work in a multi-disciplinary team and the ability to use feedback in a group setting.

2. Aims Of The Model.
Staff & client containment:
The model seeks to create a safe, structured group setting where staff can be open about their work. Increased staff disclosure increases the available information about patients and thereby improves team understanding. This in turn makes joint formulations easier. It also improves morale and reduces staff burn out.

Staff ability to manage their team role: Staff work in multi-disciplinary teams where they are required to translate their approach to colleagues who may not share their key assumptions. They also need to access other approaches and experiences. The model aims to offer practice in these areas; enabling staff to better understand their habitual patterns and preferences in relating to a multi-disciplinary group.

Capacity to formulate complex cases.
The model aims to increase the capacity of staff to think from multiple perspectives and keep in mind multiple versions of the ‘truth’. It aims to expose staff to their differences and thus increase their tolerance. It seeks to improve formulation through the generation of multiple hypotheses about the causes of patient distress as well as increasing staff empathy. It seeks to capitalize on the wide range of life experience and potential identifications between a staff team and a patient; a staff member who does not empathise with a particular type of patient can hear from someone who does.

Support for recovery model approach.
The model aims to create a learning environment for staff which they can access routinely at work. It mirrors the life-long learning emphasis of the recovery model as a pathway envisaged for patients.

Ability to interpret parallel process.
The model seeks to capture and understand the impact that more disturbed and complex patients have on staff. Maine (1989) describes this process where staff are caught up in a dynamic which leads to burn out and fragmentation of the team. Tier 3 teams are required to work with increasing complexity and co-morbidity; combined
personality disorders and major psychiatric diagnoses. Such patients evoke strong emotional reactions in staff and the model seeks to provide a tool kit for managing and understanding this. Patients who ‘communicate by impact’ will often evoke enactments by staff who feel overwhelmed.

3. Theory

Assumptions.
That patients and staff operate on three levels; conscious, covert and unconscious. Unconscious assumptions and drives are more prevalent for more complex and disturbed patients. These will have an impact on staff, affecting their ability to remain open to the patient. Diagram 1. illustrates how thinking and feeling become disengaged from mental processing and can lead to impulsive behaviours or negative assumptions that block patients in their recovery. E. g. a patient with a history of abuse by a parent finds it difficult to open up in treatment yet is not aware of any negative assumptions about their practitioner.

Diagram 1.

The practitioners’ role is to facilitate the patient to develop their capacity to think and feel when faced with impulses, life events or flash backs. This enables them to stop self defeating patterns. Diagram 2. illustrates how thinking and feelings can become integrated, slowing down action and enabling patients to choose more positive outcomes.
Diagram 2.

Projective Identification describes a process whereby ‘acting out’ by patients forces staff to feel things that rightly belong to the patient. Case example: a patient Sheila feels terrified when a new member joins her therapy group. She has told the therapist that she finds it hard meeting new people. When the new patients arrives, she feels that her fears have been ignored. When the new member asks her her name, she jumps up and starts to throw chairs and plants into the corner of the room and the group and therapist have to evacuate. The staff and group members were made to feel the anxiety and fear of the patient; the therapist later reports how they also felt humiliated that they had to leave the room and were not able to respond to the behaviour. They felt de-skilled in a similar way that the patient felt. In this case, supervision can help staff to unpick the impact of patients and reduce the risk of retaliation by a staff member who feels humiliated.

Enactment is when staff are no longer on task or come out of role or behave out of character due to the impact of a patients disturbance. Supervision aims to reduce this by creating a reflective space. One form of enactment is parallel process; where the practitioners’ behaviour, thoughts and feelings in some way mirror those of their patient.

Case example: A staff member working with a very vulnerable child communicates in such a way that her supervisor offers to help her write up her case report. The supervisor becomes over protective in response to the staff member in the same way that the practitioner had felt towards the client.

One to one supervision creates sight lines where staff and supervisor can reflect on the staff-patient relationship. Diagram 3 illustrates sight lines in blue. The pink arrow shows the impact of assumptions directed at the practitioner and supervisor which changes the
way that both parties react and behave. In other words, the assumptions get ‘under their skin’.

Diagram 3.

Parallel process

Diagram 4.
Group supervision creates more sight lines and more opportunity to spot parallel process. Diagram 4 illustrates this with the increased number of sign lines. The impact of the patient – practitioner relationship is shown by the pink arrow. Here, different elements (pink lines) are picked up by different members of the group. By sharing the load, the group is able to put words to this experience in more detail.

4. Summary of Group Reflection Supervision Model:

- Phase 1. Group share dilemmas & choose one experience to work on.
- Presenter describes material. (10 min)
- Phase 2. Practitioner observes group while group discuss the material (15 min)
- Phase 3. Practitioner shares their observations with group. (15 min)
- Supervisor comments on themes or additional reflections. (5 min)
- Phase 4 Evaluation of the model

Supervisee’s task: phase 1

- Talk for not more than 10 minutes about a dilemma from your work with patients.
- Choose a piece of work that others in the group have not been party to.
- Talk spontaneously without prior preparation.
- Start by giving your reason for choosing this particular presentation; “interesting”, “worrying”, “unusual” etc.
- You are not expected to give comprehensive summary – can omit information if wish.
- Include some description of a live interactional interaction.
- When out of time, take 1 more minute for “what you might regret not having said”.

**Practitioner task: phase 2**
- Don’t interject or respond to questions: allow the group freedom to work on the material.
- Observe how they work; where do they focus, do they omit something?

**Practitioner task: phase 3**
- Tell the group what you noticed and what you learnt from listening to their discussion. Share any parallels between the group interactions and what you recognise in your work with the client.
- Respond to specific issues that have arisen.

**Group's task**

**Phase 1.**
- Listen for facts, thoughts and feelings.
- Only ask questions if these are to clarify facts.

**Phase 2.**
- Explore the material, but not necessarily to ‘solve’ the problem.
- Observe the interactions of the supervision group as generating more information about the patient’s dynamics.
- Increase the level of self disclosure regarding feelings and thoughts that arise in each group member in order to increase available information about the patient.
- Interpretations can be made about the way that the supervisee has worked with their patient if this is used to then better explain the patients inner life.
- Any member of the supervision group can respond to interpretations offered, except the presenter.
- Observe the way that the group is working; watch for parallel process and link back to the patient’s conflicts.

**Group Supervisor’s role: responding to group going ‘off task’**
- Ensure that group stick to the structure and task.
- Redirect comments directed at the supervisee that become too personal: what does this tell us about the patient that colleagues are focussing on the staff member in this way?
- Keep the patient as the focus; not a staff dynamics group.

**Group supervisor’s dual role**:
- Lead from the back; step back from role as specialist; increase participation and reduce dependency on you as having the answers.
- Lead from the front; setting up the structure, keep group on task, sum up at end.
5. Applications
The structure is intended to offer enough containment such that it could also be used for peer supervision groups, larger groups of up to 14 staff, multi-disciplinary teams, reflective practice groups, case discussion groups or training situations. It is not meant to replace clinical supervision groups, which typically work best with smaller numbers of three or four and a group supervisor. However, it could be used as an occasional device for group supervision to offer an alternative perspective or help clarify parallel process where this is interfering with the group’s task.

6. Benefits and Limitations

Benefits:
The collaborative structure mitigates against some negative group dynamics such as competition and rivalry or dependency on an ‘expert’ supervisor. It provides a safe environment where dilemmas can be shared without immediate judgements, as all participants are invited to share their relevant thoughts and associations. The facilitator of the group could be the same person, or it could be a nominated member of a peer group, chosen in rotation. This means that where there is a lack of resources to offer an external supervisor, teams could ‘get something going’ in the meantime. Where a supervisor is new to groups, this structure could serve to enable a safe learning environment for all members of the group.

Limitations:
It is not clear how peer supervision groups manage clinical accountability when there are clinical dilemmas which the group cannot resolve. The model is counter – intuitive; the presented has to sit on their hands once they have described their issue; they may want to cut into the discussion prematurely and the facilitator needs to be confident of their role to stop this.

7. Outcomes
This model has been tried with the Sussex Partnership NHS Foundation Trust Fundamentals in Clinical Supervision Programme in 2009 and 2010. Participants have been generally fed back that they enjoyed using this structure, and this has had a visible effect on levels of participation and motivation during the training. The following are the comments from the 2010 training day:

Feedback re Group Supervision Model. Fundamentals Course 2010

Strengths;
o Creates reflective space with the clear structure acting to reduce anxiety
o Could promote team cohesion
o Increases transparency in team
o Allows shared experience – normalising effect
creates variety
reduced risk of burn out
range of perspectives
creates options for action
a good model for peer s/v
gives a framework for trying something new
encourages reflective thinking
lose the pressure to find the answer
could be used as a vehicle for stability
encourages reflective process
containing safe space
good for reflective practice on wards
good mix of learning – task focussed and not
thinking re feelings
creative
good for MDTs
enlightening

8. Limitations:
could be over exposing if not committed to by all the members
might be difficult to use with fragile teams
changing culture is difficult
shortens space for a) presenting problems b) thinking of solutions
wouldn’t be a replacement for 1:1 supervision
would need to think about governance
need for a protocol to deal with concerns
does it have a name – is it the same as reflective practice
requires degree of cooperation and a leap of faith
might need to start off on safer topics
facilitator needs to make process explicit
would be useful to give opportunity for reflecting on what its like being in the group
need to consider composition of group
important to set it up and explain
may feel unsafe to some people especially at first
not talking in presenter role difficult for some people
need to think about optimum size for different purposes
what would be right mix of prof background – status? Hierarchy?
How would you motivate and inform people about the group?
Too different?
Some people don’t have emotional capacity
Needs CONCENSUS LEADERSHIP & TIME
9. Conclusions:
In an organisation under pressure to reduce costs whilst maintaining staff morale, this model provides an opportunity for staff to collaborate and share their expertise and experiences. In my last role as psychotherapist in a medium secure hospital, I was always surprised by how much I could learn about my practice from nurses who were new to mental health or saw things from a completely different cultural or professional point of view. However, the model does not do everything. If the role of group leader is to be rotated then there will be a need for some group training to support staff facilitator in managing the group dynamics that could de-rail the process.

10. References & Bibliography


Sussex Partnership Fundamentals of Clinical Supervision Course 2010. This programme included a morning introducing and using this model, followed up by an evaluation questionnaire.


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11. About the author.

Howard Edmunds is employed as Principal Adult Psychotherapist & Convenor Of Fundamentals Of Clinical Supervision by Sussex Partnership NHS Foundation Trust. He has facilitated reflective practice groups in a range of mental health settings, including community, voluntary sector and forensic services. He is a Group Analyst and trained in Group Supervision at the Institute of Group Analysis, London.