A Model For Reflective Practice And Peer Supervision Groups
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1. NHS Mental Health Trust Objectives:

1. Context.
Mental health services are required to respond to increasing complex expectations of service delivery. Government policy papers, such as New Ways of Working, Borderline

Personality Disorder; no longer a diagnosis of exclusion, Under One Roof, The Recovery Model, Better By Design, all set ambitious targets to deliver a more integrated, multi-disciplinary service which is more *psychologically minded* and responsive to patients needs. The term 'psychological minded' has been used to describe a reflective approach to mental health treatments, including the use of formulation, reflective practice groups and a more participative approach to multi-disciplinary working, with leadership according to expertise. This shift requires staff to be more collaborative and open to other viewpoints; to present and discuss work in a multi-disciplinary team; to translate ones own favoured approach for others and to be open to constructive criticism. Funding cuts also place pressure to increase the use of group treatments, including psycho-education. Staff unfamiliar with group facilitation will increasingly be asked to adapt their approach.

2. Aims Of The Model.
Staff & client containment:
We sought to offer a reflective space where staff can discuss dilemmas in their work; to increase both staff support and levels of staff disclosure when discussing patients. Firstly, support helps staff remain open to their patients. Secondly increased staff disclosure about the problems them experience with patients increases the available information and team understanding.   This in turn makes formulation easier. It also reduces staff anxiety and stress.

Staff ability to manage their team role: Staff work in multi-disciplinary teams where they are required to explain 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.

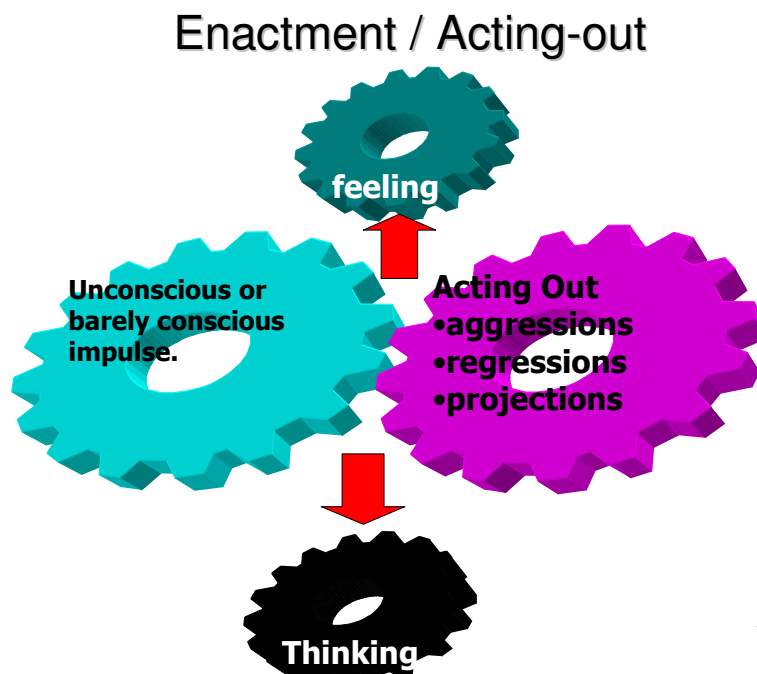**Ability to interpret parallel process.**

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. Unconcious 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.

Enactment / Acting-out

feeling

Unconscious or barely conscious impulse.

Acting Out
•**aggressions**
•**regressions**
•**projections**

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Thinking

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.

a. Problem solving : feeling and thinking integrated.

Un-conscious

or barely conscious impulse.

Thinking   and

reflection

Action

Experienced

feelings
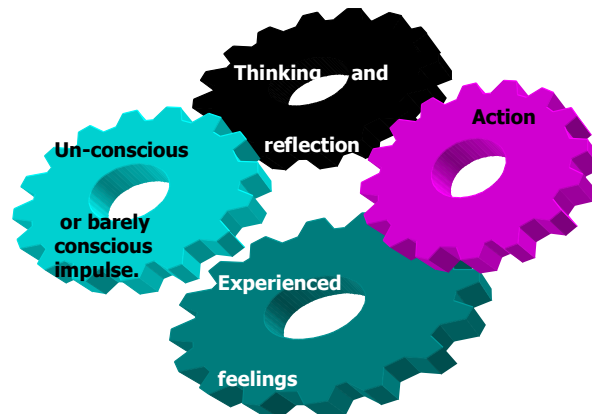
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Diagram 2.

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 practioner and supervisor which changes the way that both parties react and behave. In other words, the assumptions get ' under their skin'.
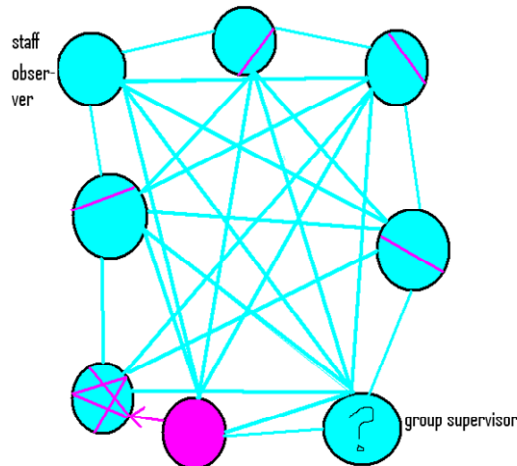
Diagram 3.

Parallel process

staff

supervisor

Patient

staff
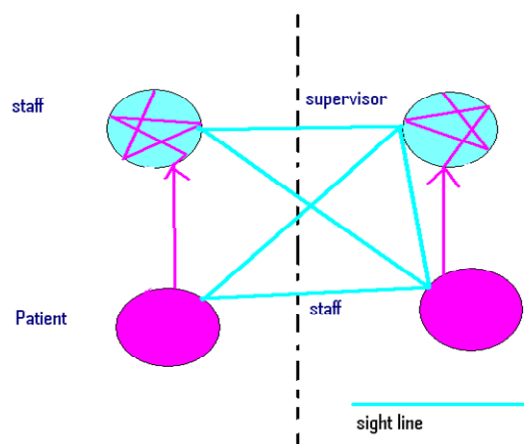
sight line

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Diagram 4.

Group reflection model:
Group as supervisor

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 containment such that it could be applied to 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.

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 4/5/2010
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
- o   creates variety
- o   reduced risk of burn out
- o   range of perspectives
- o   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.

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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 facilitatrf 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.