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Disentangling dynamics: group sensitivity and supervision

G. WINSHIP¹ MA Dip Gp Psych RMN ENB 616 & S. HARDY² MSc BA(Hons) DPNS RMN RGN RNT

¹Psychotherapy Department, 53–55 Argyle Road, Reading, UK & ²Queens Building, University of East Anglia, Norwich, UK

Correspondence:

G. Winship

Psychotherapy Department

53–55 Argyle Road

Reading RG1 7YL

UK

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In order to contextualize Altschul's interest in group dynamics we present a brief history of staff group work approaches in the UK and USA. Using case examples, the work of staff group sensitivity and group supervision is described. The difficulties of working in staff groups are highlighted and the antipathy towards group practice is discussed. It is argued that learning about conflict resolution in staff groups prepares nurses for dealing with conflicts in clinical practice. The case for re-invigorating interest in group theory and practice is presented. In presenting our reflections on staff group work, we hope not only to re-ignite the type of interest in groups that inspired Altschul but also to represent the case that it is ill conceived to attempt the work of mental health nursing without recourse to the supervisory resources of group theory, practice and support. It is through group feedback that mental health nurses and other health professionals can extend their learning about interpersonal relations, achieve quality standardization through peer feedback and reflect on practice in truly collaborative ways (Schon 1983).

Keywords: group dynamics, sensitivity, staff support, supervision groups

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The golden age of groups

Altschul's (1972) study of interaction patterns in acute psychiatric wards changed the way in which nursing research and practice evolved. She was among the first wave of UK nurse researchers who attempted to observe, describe and understand the nurse–patient relationship and disentangle some of the complex dynamics of the helping alliance. In particular, Altschul (1964) found that group discussion among staff was an essential tool in fostering understanding as well as presenting an opportunity for on-going co-operative education.

Altschul's interest arose out of the proliferation of group study in the middle part of the twentieth century. Interest in group approaches derived especially from the work and influence of Wilfred Bion, Michael Foulkes and Tom Main and their early experiments with groups at Northfield Hospital, Birmingham, towards the end of the

Second World War treating shell shocked soldiers (Hardy & Winship 1997). At the same time as these early Northfield experiments, Maxwell Jones was carrying out experimental group therapy with traumatized soldiers at the Mill Hill Hospital in North London. Mill Hill was the temporary asylum for patients and staff evacuated from the Maudsley during the Second World War and it was at Mill Hill that Annie Altschul first learned about group therapy.

After the war Tom Main, who had also worked at Northfield, went on to develop group work at the Cassel Therapeutic Community in Richmond. Main began to work with the nursing staff in small groups examining clinical material. It is clear from Main's (1957) account of the processes of these groups that the nursing staff used the group meetings to vent their feelings about both the patients and each other. He found that the nursing staff harboured feelings of resentment with a tendency

to blame others for clinical failures. The group was a space for working through these uncomfortable feelings where the work could be more realistically appraised and resentments could be safely discharged (Barnes 1968).

Group approaches had something of a hey day during the 1960s with increasing interest in their application in a variety of mental health and psychological settings (Altschul 1964). This was a time when the therapeutic community (TC) ideology also proliferated extending the concept of socially orientated therapy. From the late 1950s the psychoanalyst Michael Balint established supervisory and support groups for General Practitioners (GPs) and during the 1960s these were popularly sort after training experiences. These 'Balint Groups', as they became known, enabled GPs to work together in processing their experiences of difficult patients and develop psychological and psychotherapeutic counselling skills.

Following his war time experiences at Northfield, Wilfred Bion encapsulated his ideas in his seminal work *Experiences in Groups* (Bion 1961) which laid the foundations for the development of a specialist field of organizational and group consultation at the Tavistock in London. It was from this base that Isobel Menzies Lyth (Menzies 1960) carried out her famous study of nursing. Group and organizational work has developed an enduring tradition at the Tavistock Institute, London (Obholzer & Roberts 1994).

Formal training group work in the USA can be traced originally to the work of Kurt Lewin and social psychologists in the industrial field dating from the late 1940s. The term Training Group (T group) was applied to dynamic staff group meetings aimed at encouraging verbalization of feelings and exploration of intra group tension and group dynamics (de Mare & Kreeger 1974). The aim of early T groups was to foster staff relations that were more conducive to efficient industrial work output. Yalom (1975) charted the development of T groups in the human relations laboratories in the 1950s. The evolution of encounter groups as spaces for feedback, honesty and participant observation among staff teams in the US peaked during the 1960s where 'milieu therapy' enjoyed a surge of interest comparable to the TC ideology in the UK.

However, by the late 1970s group approaches came increasingly under fire. The popular modalities of treatment began to shift significantly away from psychosocial, group or collective approaches to more individually based paradigms such as cognitive or behavioural work (Winship 1998). This shift was not surprising and occurred against the backdrop of an overarching political climate which de-emphasized sociality, indeed, society

was said by some to not exist. In this antisocial climate, not only were staff and patient group approaches viewed with suspicion within a management culture fearful of collective protest, but staff themselves turned away from the difficulty of being face to face with each other in group settings.

Reflecting on the intolerable

Harvey (1992), a NHS manager from Birmingham, aired a widely held perception of staff support groups that they were an unnecessary expenditure of time and that they were the cause of distress rather than a means of alleviation. He further argued that staff groups did not help staff sort out issues like role ambiguity and interpersonal prejudice but rather they had an invidious function in helping staff tolerate the intolerable.

Anyone who has spent time working in staff or patient groups will probably have to agree that the experience of being in a group is often difficult, if not distressing. The idea that staff support groups help nurses tolerate the intolerable might even be an understatement. One might assert that groups have an inherent function in helping nurses survive the unsurvivable. However, survival should not be underestimated, indeed, that groups can promote survival and tolerance would seem to be an elemental argument in favour of *having* staff groups and not being without them.

The feelings and dynamics aroused in staff group settings are complex and the wish to extinguish them is understandable. There is often an unrealistic expectation that a group is going to have some magical solution. The aftermath of this idealistic optimism is usually disappointment. The work of a staff group is a gradual process, there are no short-cut solutions and there are occasions when the group may be more insensitive than sensitive. For example, a well established staff support group in a busy psychiatric unit had met on a weekly basis for several years. There were occasions in the history of the group when an external facilitator had been employed but mostly the group was, for all intents and purpose, unfacilitated externally. The group was originally established as a space for reflection and free floating discussion. The open agenda was unstructured insofar as there were no preset topics. However, the group was consistently framed; it happened at the same time and same place every week, almost without fail (only two exceptional weeks in a period of five years).

The group was often light and jolly, though the unstructured nature of the group often created anxiety. The group was imbued with interpersonal tension and hierarchical conflicts and there were times when the

group sat in silence for protracted periods, sometimes for up to half an hour. On some occasions this silence was felt by some staff to be a kind of meditation time, a quiet space for reflection away from the busy hub-bub of demanding patients. At other times the silence was felt to be a frozen chill of unspoken anger, rage sadness and hurt. Even for the most inveterate of optimistic staff, there were times when the group was inescapably excruciating and difficult to bear as conflicts surfaced and harsh words were shared. Group attendance was an explicit expectation and staff would go out of their way to find a plausible excuse to be somewhere else at the time of the group, volunteering to be the one who stayed out of the group to keep an eye on the patients for instance. However, such manoeuvrings did not preclude occasions when staff felt disappointed at not being able to attend the group. There appeared to be a core belief within the multi disciplinary team about the intrinsic value of the group which kept it alive.

The love-hate relationship that the staff had with the group was not dissimilar, in some of the members' minds, to other weekly staff support groups elsewhere. The group seemed to function in part as a therapeutic experience as the staff were able to use the space to talk about personal issues, and part educational and training. Insofar as there was a parallel process between staff running therapy groups for patients (the predominant therapeutic modality on the unit) and experiencing for themselves what it was like to be a group member, the group was an exposing experience where the staff could not so easily hide behind the mantle of 'therapist'. In the absence of a personal experience of group therapy, the weekly staff group was the closest to the experience of being a patient in a group that the staff were likely to get.

This group was therefore, in part, meant to be a refraction of how it was for the patients in their three times weekly small psychotherapy groups, an experiential learning forum as well as a supportive and therapeutic experience. Like the patient groups there were intimate moments of palpable support, where grief and loss were shared, where it felt safe enough to cry together. On other occasions it felt dangerous to speak as the group reverberated with scapegoating, subgrouping, sabotage and clumsy insensitivity. The realization that the staff group could be dysfunctional, not unlike the patient group, was both scary and illuminating. Principally, the challenge was to find the creative resolutions to the problems of delinquency and destruction in groups which, in turn, could be utilized in working with the same conflicts in the patient group.

The group was often referred to as a 'support group' but one of the staff nurses complained that the title of the

group was anomalous to its nature; that in a group that purported to be supportive she experienced very little *support*. She set about doing a piece of research asking the staff to calibrate what percentage of the group they found to be supportive. The results demonstrated that indeed, on average, the staff found only 10% of the group as supportive. The feeling was that if only 10% of the group was supportive then what was the other 90% about? It was decided to change the name of the group from 'staff support group' to 'staff *sensitivity* group', the idea being that the groups aim was not just to be supportive but rather a group where group members could be sensitive to what was happening to colleagues, themselves and their patients, and learn about the other 90% of the experience of being in the group.

One foot in hell

To call a staff group a *support group* would appear to risk creating disappointment. The problem with impressing the concept of support is that it rarely happens inside the group itself. The measure of efficiency of a staff sensitivity group is not necessarily the amount of support that happens inside the group but the amount of support that happens elsewhere outside of the group. The idea that support begins and ends in the group is a false premise for a group. It should be said that the real work of support begins when the group ends.

Subjective experience from working in many milieux with and without staff groups is that the general level of support that occurs in units which have a weekly staff sensitivity group is higher than in those units which do not. The sensitivity group can act as a place where ill feeling can be discharged and one might think of the staff group as a 'palace of ill feeling' as Janzing (1991) noted in his work with groups in Holland. He said how staff often felt as though they had *one foot in hell*, the common fear being that somehow conflict would lead to destruction and collapse. Janzing further noted that some groups tended to idealize their teamwork without the where-withal to acknowledge the other side of the brilliant coin, a process of idealization that resulted in a burdensome anxiety about tolerating the reality of conflict. The outcome of this idealization was a closed ill-functioning system where healthy fragmentation was unable to exist in order to balance the danger of over closeness.

There is often confusion about the purpose of staff sensitivity groups and whether or not the group is allowed to talk about patients. Working with very disturbed patients has a sizeable impact on staff members and very often staff cope with traumatic incidents. The need to talk about patients is therefore both

legitimate and necessary. The idea that the staff group is a place where staff talk about themselves seems a dangerous prohibition of the crucial work of staff talking together about how the patients make them feel. There is a subtlety of emphasis here, but disentangling the patients' problems should, if possible, be left to the task of clinical supervision.

The staff sensitivity group may be a place for staff to talk about what is happening in their life outside of work. There is clearly a therapeutic component to its function and it is often uncomfortable for staff to relinquish their role as therapist. On the whole the main focus of the group should be about what is happening between members of the team. If we were to put a percentage on how much of the material pertains to work and how much pertains to personal issues outside of work, in a well functioning group we would venture to say that the group would focus about 5–15% of the time on issues beyond work and the rest would be concerned with issues within the group and workplace. Of course this varies, for instance if a member of staff has experienced a major life event they might need to spend some time talking through their feelings. But run-of-mill, if the group as a whole is spending too much of its energy talking about issues beyond the group, then something is probably going awry and the group is flying from its task of professional self examination. At the other end of the spectrum, some people give absolutely nothing away about themselves, and this may also be of some cause for concern.

The process might be described as an on-going team building exercise. The tension expressed in the group helps to clear the air. This is not to say that staff should let go and lose control or rage and shout at each other, rather that interpersonal conflicts are talked about in an open and frank manner, thus freeing up the staff to be sensitive to each other during the rest of the week. The real business of support therefore is not something that is limited to the hour or hour and a half that staff meet in the group, rather the real task of support is one which is on-going through the whole working week, beginning when the staff group ends.

Fostering group relations among staff may go some way to adumbrating the most common causes of burn-out. Data from a specialist in-patient unit treating nurses and other sick health care professionals suggests that serious mental health breakdown is precipitated by isolation and feelings of shame causing a reluctance to share problems (Hardy *et al.* 1998). The promotion of formal group networks therefore has a dual aim: the parallel of therapeutic staff support and improved quality of patient care.

Supervision groups

It is sometimes difficult to draw a clear distinction between individual therapy and clinical supervision, that is to say, the process of individual supervision might run a close line to personal therapy. The same might be said of a group supervision where there is a crossover between clinical supervision issues which are discussed in the group and staff sensitivity issues (Wright 1988). For example, in a group supervision session the staff were talking about how one of the patients was prone to bouts of hysterical laughter. The female staff felt frustrated and annoyed with the patient and one of them reported that she wished to 'slap' the patient. The male staff on the other hand felt more tolerant of the patient and appeared quite indifferent to the female staff's reaction. There followed a heated discussion where the males were accused of not pulling their weight with this patient. The supervisor asked about the patient's history and the staff recounted that the patient had reported memories of his uncontrollable laughter from the age of 11. He also recalled at this time being beaten by his mother: 'if you don't laugh you'll cry' he had said. Meanwhile his father, who was an alcoholic, took little or no responsibility for discipline in the home. As this jigsaw of material was pieced together it became apparent that the staff were unknowingly enacting some of the patient's family dynamics. The male staff seemed to be playing the role of indifferent father and the female staff were seemingly in the role of irritated and beating mother.

The supervision space in the above example oscillated between a sensitivity group and clinical supervision where one informed the other. It was necessary in the group for the male and female staff to talk about their tensions in their working relationships before the countertransference material could be untangled. It would seem important not to make brute limits between sensitivity and supervisory group work. It is a question of balance and for the most part individual and group supervision aims to keep the patient at the centre of the supervisor and supervised's relationship without losing sight of the staff's own personal or group dynamics. Pedder (1986) argues that within the remit of psycho-dynamic supervision there is a necessary crossover between supervision as education and supervision as therapy and that there might be occasions when it is necessary to focus more on the personal development of the supervised. In his experience, the more senior and experienced the supervised, the less like therapy the supervision process needs to be. He recommends that the start of a supervision session needs to be open ended enough to allow space for the supervised to bring personal material into the session.

A more structured beginning may well help focus the session on the clinical material that needs to be examined, but as Pedder argues, this structuring might well compromise the tutorial and pastoral function of the supervision process.

One well known model of supervision is Patrick Casement's (1985), where he emphasizes the need for the supervisee to develop an 'internal supervisor'. The aim is to help guide practitioners in the presence of their patients, that is to say, helping the process of 'thinking-on-the-spot' or developing a capacity for 'reflection-in-action' (Schon 1983). Casement points out that this is not a model of an 'internalized supervisor', that is to say, the impeding process of thinking about what the supervisor would say or do, rather the concept is more of an autonomous process of dialogue with oneself. The group supervision setting would seem to be well suited to this process of developing the internal capacities of practitioner to develop the capacity to think on the spot, where an over-reliance on the supervisor is adumbrated by peer learning and feedback in the group. Group supervision enables participants to stand in a third position relative to the supervisor-supervised role, an objective position which may help the group of supervisees to develop their own 'internal supervisor' (Crick 1991). However, the group supervision process has the added dimension of peer competitiveness and therefore requires the supervisor to have an understanding and experience of working with group dynamics.

While much emphasis is placed on peer learning in the supervision group, it is the reflective role of the group leader/supervisor that may be instrumental in maintaining coherence in the group in the face of disruptive polemical feelings such as love and hate (Sternberg 1994). What constitutes a helpful supervision group is one where a culture of enquiry is maintained. Where interpersonal tension becomes over heated in the group, learning may be thwarted. Sternberg (1994) suggests that the group supervisor should not interpret the group's transference towards them but remain an active listener, observing what happens in the group and then feeding back their experience of the group. This reflective role may cause some initial frustration in the group where there is a desire for the facilitator to somehow have the answers to the problems that the staff bring to the group.

This dynamic was noticeable in a weekly supervision group set up in an extremely busy acute in-patient unit. Many staff were complaining of feeling unsupported in their work with patients. The weekly supervision group was started at a time when two of the charge nurses were leaving to travel and take a break from nursing. The group found it very difficult to allow themselves time

away from the hectic ward activity or give themselves time to sit and think about the loss of two prominent members of the team and what this would mean for the patients.

One of the earlier sessions started with the ward staff calling out to each other and dragging each other into chairs, laughing at the obvious reticence to attend. One of the female members asked if she could leave the group to eat lunch, as she thought that would be a better use of her time. Several others pronounced that similarly they wished to leave the group to each lunch. They looked to the facilitator for permission but the facilitator refrained from agreeing or prohibiting the request. The staff got up and left the room. One nurse remained on the edge of his chair, apologizing for his colleagues behaviour but wanting to leave himself, which he then did. The group facilitator was left alone in the room.

This group appeared to be 'mirroring' the problems of working with acutely disturbed patients who were reluctant recipients of care and treatment. The difficulties of staying or going seemed also to be a mirror dynamic enactment of the two senior charge nurses leaving. The facilitator was made to feel the sense of abandonment that pervaded the unit at that time. The facilitator also had a sense that the group was acting out the way in which the staff team controlled unsafe psychotic behaviour from patients (by controlling the patient through physical restraint and with medication, then quickly abandoning the patient afterwards). The disquiet and feelings of unsafety in the unit could not be verbalized and so were enacted for the facilitator to observe and experience. In the following sessions the facilitator was able to bring some of these dynamics to the groups attention.

Ostensibly, when clinical material is presented in supervision, the task is to attempt to unfold the experience of the staff, rather than simply accept the material content at face value. The process is one that often features conflict and anxiety between group members. Unravelling this conflict may help bring about some understanding of the patient, that is to say, it is possible to see the patient's inner worlds 'mirrored' in the discussions and transactions of the staff in the group supervision setting as in both of the vignettes above (Kutter 1993).

The importance of recognizing these enactments laid the foundations for a new synthesis in the minds of the staff, thereby offering the potential of a new experience for the patient of a collaborative team who might be able to contain what is intolerable for the patient. A failure to understand the dynamics that might underpin splits and tensions in the staff team may unknowingly lead the staff into acting in a negative, punitive or inconsistent role.

The patient's disturbance is often too painful to think about, and therefore can not be held in mind. The conflicts and anxieties of the patient become undifferentiated from the anxieties and conflicts in the staff team, as above. De-coding the patient's disturbance is aided by a group process where the variety of responses among the staff can be examined and pieced together. Here the group becomes a tool for understanding the patient, whereby the patient's disturbance can be seen in the staff group. The deciphering of the subjective experience is a process akin to de-coding a dream.

Conclusion

Through the process of group sensitivity and supervision some semblance of understanding can be brought to patient and staff dynamics. In the work of disentangling these dynamics the aggregate experience of the group is helpful where many heads are better than one. When working with difficult patients, the sharing of experiences also enables staff to realize that they are not alone in their feelings and the distress they feel. In this way the resources of the group are the means by which a sense of milieu containment may be achieved.

The aim of group work is to think in a collaborative way in order to identify the impediments to thinking which may otherwise remain unconscious and likely to exert more disturbance. Dartington (1993) has described how nurses may 'collude in their unthinkingness' (p. 22) where the emotional response to a patient may be understood in terms of Winnicott's (1949) notion of hate in the countertransference. Quite simply, difficult emotions that remain unconscious may block clear thinking. Group supervision provides a space to begin to bring into consciousness those emotions. The role of facilitating a supervision group involves making full use of the resources and creativity of the group (Pedder 1986), engendering an environment that enables staff to feel more capable of thinking in action in their clinical practice, where healthy sharing takes the place of reluctant shame. Staff conflict in this ethos can be understood as clinically relevant and necessary in terms of the supervision process that helps staff to identify what belongs to the staff and what belongs to the patient. Not all staff conflict can be, nor should be, put down to the experience of working with the patient, for staff have their own interpersonal conflicts to work through. The combination of group and clinical supervision should be a prerequisite to a well functioning team.

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