Personal reflections on case discussion group nursing essay

It seems an almost impossible task to me to be able to encapsulate all my reflections on the past year of our CDG in this report. At this point in writing I am wondering whether this thought is a reflection of feeling overwhelmed by my memories of the past year. Therefore, I have decided to break up certain aspects of the group in order to help me make sense of my experiences and reflect on what was learnt.

Diversity and difference within the group

There are seven trainee members in our group (one male and six females) and we had a male facilitator. We quickly noticed the abundance of similarities between members of the group. All the trainee members of our group live in London and we all had our adult mental health placement in the same trust in London. Interestingly, we also discovered that our facilitator was based in London on his clinical days and lived in the same area as two of the trainees in the group. All the trainee members are also relatively close in age (25-32 years). Our group members come from a range of social and cultural backgrounds, which was illustrated when we completed cultural genograms in one CDG session. One could consider our group to be racially, ethnically and culturally diverse, with members coming from a variety of different social economic backgrounds, countries and cultural influences. Several of our group members had also spent a number years living in African and Asian continents and some speak a number of different languages.

Structure of the group

Reflecting back I realise the way in which our sessions were structured was very original and added a depth to our experience of the Case Discussion

group (CDG). Each week two trainees would present a case to the rest of the group, with one presentation lasting slightly longer than the other (depending on whether it was a major or minor case). Many of the cases that our group members presented were not individual client cases, but more systemic situations which we were struggling with. Once the trainee had presented their case they left the group and sat in a different part of the room. This left the remaining group members to discuss their ideas about the case in the style of a ‘ reflecting circle’.

I found this experience invaluable as it as it gave me insight into how it must feel to have a reflecting team with you when working as a therapist. Reflecting teams have been used since the 1980’s (Anderson, 1987) and are now to be considered a form of therapy in itself. The primary focus of the reflecting team is to generate ‘ multiple perspectives’ (White & Epston, 1990) for the therapist and client.

‘ Without the generation of alternate knowledges, people are perhaps “ stuck” or “ standing still” and cannot move forward with their lives’ (Dawson et al, 2003; p2).

Indeed, when I presented a client who was very stuck in her unusual beliefs, I realised that I too was stuck in how I was working with her. Listening to the other trainees discuss her case made me realise that I needed to be more flexible in my approach to working with her and think creatively.

What was interesting was how incredibly frustrating it felt being sat away from the group and being unable to verbally ‘ defend’ aspects of your work. This made me reflect on how clients may feel when decisions about their

care are made without them being present. For example, I was recently invited to attend an Assertive Outreach team meeting which involved sixteen other mental health professionals. The purpose was to review a young man who had complex mental health problems and was not complying with his medication routine. It was only at the end of the meeting that I asked why he had not been invited and it became clear that no-one had taken responsibility for communicating with him so he had not even been asked. Reflecting back on this had made me strongly aware of the need to work collaboratively with clients, particularly with regards to keeping them informed about decisions or changes in their care.

The group process

The model which I feel best encapsulates the process of our CDG is Manors' phase-model of group development:

Figure 1 – Model of group development (Manor, 2000)

Forming the group and engagement phase

Authority crisis and the empowerment phase

Intimacy crisis and the mutuality phase

Separation crisis and the termination phase

In the first few CDG sessions we were primarily concerned with defining the purpose of the group (i. e. what is the group for?), allocating roles (e. g. chair and scribe responsibilities) and defining the leadership position of the facilitator (i. e. Will he tell us what to do?). This is defined as phase 1 in the

model and seems to be a perfect account of the confusing and somewhat frustrating formation period of the group. Each of the subsequent stages of the group involves a ‘ crisis period’. The second crisis (authority) seems similar to the ‘ storming’ stage in Tuckman and Jensen’s model of group development (1965) which I identified as a relevant model in my PBL reflective account. In our early CDG sessions there was a power struggle between the facilitator and the trainee group members, in as much as the facilitator seemed to make suggestions in the sessions (e. g. styles of presentation for the PBL, topics we should cover) which were opposite to the ideas we had produced.

“ I felt that he was a bit patronising towards us today, he seemed to go against every suggestion that ****** made” (3rd CDG session entry)

Reflecting back on this entry I wonder whether we ousted him in an attempt to make our cohesion as a ‘ trainee group’ stronger. I also wonder whether we subsequently attempted to create ‘ a group away from the group’, by arranging social outings for our CDG trainee members and discussing the CDG sessions on the train journey home. Admittedly there were two strong characters in our group who led these discussions and some who just sat there quietly. It is only with hindsight that I realise we were experiencing an authority crisis and our way of regaining power was to reform and bond as a trainee group.

The next phase in Manor’s model is concerned with the intimacy of the group and their ability to open up personal conversations. For our CDG I don’t think this happened until about 7 months in. Until this time we were very

restrained as a group in discussing personal issues and I noticed we never discussed our own feelings in the CDG sessions. Our strong use of humour may have also been a defence for ‘ protecting’ the group from reaching this phase. I recall one of the stronger members of the group joking that we ‘ were not a group who need to cry over things’. I think it was comments like this that made us feel cohesive as a group; however it also meant at times I felt unable to disclose my true feelings about an issue for fear of going against the essence of our group. Interestingly, this recently changed when we completed personal cultural genograms in a CDG session. This was a pinnacle point in our group process as it seemed to break all the intimacy boundaries we had created and allowed certain members to express their feelings of frustration when discussing certain cases or clinical situations. Our relationship with the facilitator also changed after this point and became more mutual.

A major advantage of this model is that it accounts for the group changes over time, particularly with regards to the ending of our group. Reading about the final separation crisis and termination phase reminded me of our last CDG session in July to which only three trainees were present. I recall a strong sense of fear and despair in the session, and we spent over half of the session talking about the initial problems of the group. This is referred to as re-capitulation in the model and is seen as an attempt to prolong the life of the group.

Given that we knew the group was not truly ending, why did we go through the process of separation crisis?

Despite knowing there would be a continuation of our group in the second year of training I think we struggled with being ‘ separated’ from our facilitator. This made me think about how clients must feel when they are about to finish a therapeutic group and the anxiety it must generate. Yalom eloquently describes the benefits from this crisis:

‘ Learning that I must take ultimate responsibility for the way I live my life no matter how much guidance and support I get from others’ (Yalom, 1995; p88)

With hindsight it is clear that experiencing the termination of a group process is one of the most valuable stages as it essentially installs a sense of hope and facilitates a handover of responsibility. Understanding this model has been an important learning stage for me as I have been able to use my personal learning of the CDG process and transfer it to my clinical work with groups. At present I am just finishing with three recovery groups for clients on inpatient wards and have used Manor’s model to help them understand their own group dynamics.

Personal and Professional Development

Personally, I really valued the opportunity to learn about the different models that other group members were working with as it has helped me broaden my clinical approach. Our facilitator brought systemic thinking to our sessions, which essentially shaped the discussions we had about clinical cases. Given that most of our lectures and placements were guided by a CBT approach, it felt new and somewhat daunting to be asked questions from a systemic perspective. In my first case presentation regarding a lady who had

been emotionally and physically abused as a teenager. I recall the facilitator opening up a discussion with the other trainees about her attachments and role in the family structure. It was fascinating listening to how this changed the content of the conversation. At first I noticed that the other trainees were trying to ‘ problem-solve’ my case, but this immediately changed and they were generating more thoughtful and curious conversation which delved into areas I had not even considered. It made me realise the value of thinking about and understanding systems as part of the therapeutic process. Indeed, I have since discovered the benefit of using systemic tools such as Genograms and ecomaps when helping clients talk about and make links to their past.

Interestingly, I was initially quite resistant to thinking in a systemic way and realise I was ‘ clutching’ on to the model which was used in my placement. Writing this report has made me wonder whether the resistance I showed is a parallel to the resistance often present in multi-disciplinary teams when change is imminent. For example, the service where my placement is has recently adopted the Recovery model (Repper & Perkins, 2003) as a framework for mental health care delivery. After attending many of their team meetings I realised just how defensive many of the team members felt about this, and they constructed it ‘ as just another new fad in the system’. It made me realise how resistance can be important in telling us something about the underlying feelings and fears people hold. Similarly, there is evidence to suggest that the role many Psychologists and therapists hold in teams stirs resistance from other health care professionals. Hook (2001) discusses the fear which some staff have regarding the notion of

psychological processes, as it can be perceived as a threat to their knowledge. Hook (2001) describes this as ‘ mind science’ versus ‘ brain science’. True enough; the issue of Psychologists’ integration in teams is one which attracts much attention in current health policy literature:

“ Stakeholders showed an overwhelming preference for the integration of psychologists within teams but only if psychologists retained their unique identity and contribution (e. g. offering an authoritative and constructive counter-balance to the ‘ medical model’)” (Department of Health, 2007; p2)

With the fast-changing climate of the NHS I realise that the roles of health care professionals are continually adapting and I wonder how resistance and institutional defences will be part of that. These are issues which evolved for me after reflecting on the CDG process, and ones which I will continue to grapple with throughout my training.

Another valuable experience for me was learning more about diversity issues and how they can affect the therapeutic relationship. This topic arose after we spent two CDG sessions completing cultural genograms individually and then presented them to the rest of the group. Not only was this an introduction to a useful clinical tool, but it enabled me to think about what culture really means and how it is different to ethnicity and race. These terms had caused great confusion in our initial group discussion about culture, and I did not even realise that they meant different things until our facilitator kindly defined them for us.

Thinking about my own cultural identity also made me aware and sensitive to my clients' different cultural affiliations. Indeed, Hardy & Laszloffy (1995) argues that:

" Trainees are rarely challenged to examine how their respective cultural identities influence understanding and acceptance of those who are both culturally similar and dissimilar" (Hardy & Laszloffy, 1995, p227)

Most of my current clients come from very different backgrounds to me and some have strong religious attachments which influence the way they understand and cope with their mental health difficulty. After completing the genogram in our CDG I reflected in my supervision sessions on how areas of difference may interplay with the therapeutic relationship. For example, one client I was seeing described herself as a contemporary Christian and her faith meant she constructed her mental health difficulty to be a punishment from God. After reflecting on this in supervision, I realised that there was a big difference in our religious affiliations (I would consider myself to be an atheist), which was affecting my acceptance of her construction. Once I understood this our sessions suddenly shifted and we were able to progress with her treatment. Furthermore, I now routinely acknowledge any areas of difference when I first see a client individually and feel this had always had a positive impact on the therapeutic alliance.

On a more personal level, writing this account has enabled me to think about what role I played in the group and what this tells me about my role as a professional in training. As I am writing I am aware that it has been easier for me to write about the group process than think about my own involvement

and contributions to it. Upon closer inspection I am curious as to whether my narrative of the group process reflects the position of ‘ the follower’. This role has been well-documented in leadership literature, and the title encapsulates a person who can sometimes be pushed aside by others with regards to leadership decisions (Dvir & Shamir, 2003). Certainly my behaviour in the CDG this year fits with this description, and has made me think about how I present myself to my professional network. Whilst this is useful for me to realise, it also feels slightly uncomfortable to acknowledge this, as acknowledgement for me means action should be taken. I refer here to the eloquent words from Bolton (2001):

“ Reflection is not a cosy process of quiet contemplation. It is an active, dynamic, often threatening process which demands total involvement of the self and a commitment to action. In reflective practice there is nowhere to hide”.

In many ways the characteristics of ‘ the follower’ mirrors that in Yalom’s (2005) description of the silent client in group therapy. Yalom stipulates that such clients trigger feelings of frustration in other group members but can also be valuable for the group as, ‘ silence is never silent’ (Yalom, 2005). Yalom (2005) asserts that you can find meaning in the ‘ here-and-now’ of their behaviour which informs you about their way of relating with others in the outside world. Learning this made me think about a client whom I used to see who was ‘ silent’ for much of our sessions. I wonder now whether her silence was the most useful piece of information that was available to me, yet I did not recognise that at the time. This is something I will make a conscious effort to think about in future clinical work.

Final thoughts

One of my final thoughts is around the name chosen to represent the group experience. I wonder whether it would be more fitting to call the groups, ‘ Reflective Practice Groups’ rather than ‘ Case Discussion Groups’? The latter name projects an expectation of a more formal and typical structure to the group where one would expect presentation and discussion to be the crux of it. In fact, my experience of the CDG sessions challenges this expectation as the actual time spent focusing on cases was minimal. I personally think that ‘ Reflective Practice’ incorporates thinking about other areas of clinical work which are important and may impact upon our work with clients. For example, thinking systemically about working with staff or critically about organisational stress and the effects this has on clinical work. Reflecting back I realise such issues are pertinent to our development as first years and the groups would be a perfect opportunity to explore and contain them. By changing the name of the groups it would embrace such explorations and consequently add a reflective element to our practice which simply cannot be satisfied by supervision alone.

Finally I feel that the group has added an expansive dimension to my thinking as a trainee psychologist. My expectations of the CDG were continually challenged by my actual experience of it. I found that it enabled me to be more open, more honest and far more curious in my clinical work, and for that I am extremely grateful.