Reflective essay on teamwork

This essay will critically reflect on the process of teamwork, change management and leadership; all issues pertinent to the role of the SCPHN. Barr and Dowding (2008) assert the necessity for leaders to critically reflect effectively, in order to raise their awareness and effect change where needed. Densten and Gray (2001) support this view, adding that leadership development depends on active reflection.

A peer learning group (PLG) of five was formed; their goal to identify an area for change within their practice, justified by available evidence, and to formulate a plan of implementation. Our group was a mix of School Health and District Nurse SCPHN students, which made it more difficult to identify a common change initiative. However, our group overcame this obstacle and identified low staff morale in the workplace as an area to consider for change. A literature search revealed this to be a feasible initiative. The work of the PLG was to be delivered to an audience of peers through a presentation. We aptly named our team “ The Motivators”.

Sullivan & Garland (2010) distinguish groups from teams and discuss the concept of how groups are transformed into teams, and the necessity for a thorough understanding of this process for effective team leadership and management. Morhman et al (1995) define a team as a group of individuals working together to produce a product or service for which they are all mutually accountable. They have a shared goal and are interdependent in it’s accomplishment, their interactions producing the collective result. It is argued that groups differ in that they perform their tasks independently of each other and sometimes also competitively (Sullivan & Garland, 2010).

It has been proffered that working in small teams is conducive to effective learning and involves collaboration and co-operation (Will, 1997). Conversely, Topping (2005) adopts a cynical stance by implying that the application of peer learning strategies by educational establishments is simply gathering together a group of individuals and hoping for the best. Co-operative learning is said to reinforce learning amongst group members through discussion and peer review, while collaborative learning is socially constructed knowledge assuming the negotiation of the individuals different perspectives (Will, 1997). In order to achieve a goal it is essential that teams work cooperatively (Sullivan & Garland, 2010). Further, Clements et al (1997) cite collaboration as the foundation of a healthy team and together with effective communication is key to producing high quality results. Parker (2008) suggests that working collaboratively requires a clear objective and a consensus of opinion when decision making; DFES (2004) reiterate the aspect of shared responsibility in collaborative working.

My own PLG worked both collaboratively and co-operatively, facilitated and evidenced by: a readiness to assume roles within the team, maintaining communication links, regular meetings and the sharing of information resources and ideas. The perspective offered by Slavin (1996) is that of social cohesion; peers helping each other because they want each to succeed. This idea is applicable to my PLG as our presentation was assessed as a joint effort. Sullivan & Garland (2010) maintain that strong group cohesiveness fosters greater personal support and cooperation amongst the group, which again was evident in our group. However, Slavin (1996) acknowledges the constraints of learning in this manner as each team

member has limited time/exposure to the other members learning topic. Because our group had different timetables we experienced difficulties meeting up, however we overcame this by maintaining contact via e mail. Oliver (2006) acknowledges the complications that can arise in team-work and Eisenhardt (1997) stresses the need for stability when aspiring to produce optimum performance.

Tuckman, (1965) offered a model comprising four stages, advocating this as the ideal group- decision making process. Adair (2004) purports it to be a problem solving toolkit.

Forming: this did not present us with a problem as we all knew each other. From forming as a group we evolved quickly into:

Storming: this stage enabled the team to grow. We identified an area for change, which was limited by our mixed professional group, and planned our immediate work schedule. We completed a SWOT analysis to identify the strengths and weaknesses we envisaged in implementing the change. No one was immediately willing to take on the mantle of leader so we unanimously elected the person who had initially proposed the change initiative. We exchanged contact details, agreed a time plan and arranged our next meeting.

Norming: is said to occur when the team has developed trust and are working toward a common goal (Adair, 2004). At this time it is likely that some members will forgo their own ideas in order to progress the team function. In this stage all members assume responsibility for the success of the team goal. I was fortunate to belong to a group that worked well

together and were well motivated. Due to this degree of co operation we passed through to the final phase quickly:

Performing: At this stage we worked cooperatively on delegated tasks maintaining contact frequently between meetings. We offered each other support and encouragement throughout the process and our team leader encouraged contact and mutual support.

Action learning (AL) has been defined as a continual process of learning and reflection which is supported by colleagues with the ultimate aim of accomplishing a goal (McGill & Beaty, 2001). It has a bottom up approach and is said to promote innovation rather than simply change (Pryjmachuk, 1996). In essence this is what our group did; by coming together to focus on the issues of individual group members and reflecting on them, the group were enabled to proceed with their planned action. Pedlar (2008) describes AL as an approach to problem solving whereby individuals are enabled to develop and form relationships that contrive to enhance the change process. The relationship between research and innovation was highlighted by Lord Darzi (2007).

Most organisations are concerned with effective team working and it is accepted that factors affecting team performance are multi-faceted (McGill & Beaty, 2001). Empirical studies suggest the validity of Belbin’s Self - Perception Inventory (SPI) (Aritzeta et al, 2005). Belbin (1981) developed the SPI to identify the behavioural characteristics of individuals within a team, thus enabling the creation of effectively functioning teams through a creative and appropriate mix (Broucek & Randell, 1996). An Observers’

Assessment (OA) which was later introduced has further increased validity (Belbin, 1994). . Although the tool has received criticism (Furnham et al, 1993), Belbin's defence was that the tool was not intended as a psychometric instrument (Belbin, 1993b). Our group used a version of the tool (Foundation of Nursing Leadership, 2011) as a learning experience to identify our roles within the team. I emerged as ' Supporter' and ' Questioner' in equal measure closely followed by ' Finisher' (Appendix). In Belbin's SPI this would equate to Team worker, Monitor Evaluator and Completer-Finisher. A supporter of Belbin theory suggests that greater control is achieved through the ability to forecast team attitudes (Fisher et al, 2000). I was surprised at how accurate this was for myself although I would not entirely agree. Although we didn't use the SPI to assess the characteristics of our team prior to beginning the project, it was an interesting and informative task to undertake. It happened that we had a mix of characteristics within our team which perhaps accounted for our collaborative cooperation. However, it has been argued that Maslow's ' Hierarchy of Needs' Model favours the management of organisational dynamics as it maintains motivation through the desire to achieve (Burnes, 2004).

The current re-design of the health service requires a willingness and ability to adapt to change (Institute for Innovation and Improvement, 2011). Efforts to contrive change are unanimously said to be fraught with challenges (Parkin, 1997; MacFarlane et al, 2002), although McWilliam and Ward-Griffin, 2006; Darzi, 2007) argue that healthcare workers have both the mandate and the potential to lead and effect change initiatives. One of the major

challenges to change is seen as resistance, which is said to have both positive and negative effects and to be expected by managers implementing change (Sullivan &Garland, 2010). Waddell and Sohal (1998) insist that resistance to change should be utilised and viewed as evaluative material to reassess the proposed change. Pederit (2000) found resistance to reveal valid concerns about proposed change worthy of reconsideration.

Bovey and Hede (2001) argue that resisting change is a natural human behaviour and unavoidable. Fisher & Savage (1999) identify through Personal Construct Theory, a model of personal change – The Transition Curve – (Appendix), which identifies a process individuals may go through in the transition period of change. Similarly, the stages of grief identified by Kübler Ross (1969) (Appendix) are also applied to the process of change, although Connor (1998) adapted the sequence in his ‘ Cycle of Negative Response’ as he argued the emotions involved in change are less intense. Change is recognised as unsettling so it is logical that the change agent be a settling influence. A theory Y style of management is thought to aid change through it’s liberating and developmental aspects; McGregor espoused the theory that control, achievement and improvement are accomplished through enabling, empowering and giving responsibility (Appendix).

There appears to be a lack of distinction between resistance and conflict in some of the literature (Parkin, 2009). Parkin differentiates the two by stating the more aggressive and emotional nature of conflict. Our PLG was fortunate in not encountering any conflict at all; DiPaola and Hoy (2001) suggest that large, diverse groups have a greater potential for conflict through the wider differences in objectives and perspectives. As our group was small with

common interests and goals, areas for conflict should be minimal. Chuang et al (2004) supports this when arguing that the shared values of nurses promotes greater tolerance and respect, although it has been said that as a group, nurses are apt to avoid conflict to the detriment of effective change implementation (Valentine, 2001). However, Anderson (2005) argues the limitless potential for conflict amongst any group, small or large.

Historically, conflict has been viewed as having a negative impact due to the tensions it creates (Medina et al, 2005) but it has also been asserted that conflict can also benefit team performance (Jehn, 1995). McAdam (2005) suggests that conflict can be both constructive, leading to innovative results or destructive, which hinders innovation. It therefore follows that conflict is better managed rather than resolved. Bruce and Wyman (1998) suggest conflict can be channelled by good management into creativity and positive outcomes. It is important that learning opportunities are not missed through avoiding conflict (Fagan, 1985). Working through conflict can create enhanced understanding, increased motivation and lead to more effective working (Sullivan and Garland, 2010). Crawley and Graham (2002) describe the benefits of healthy conflict as culminating in providing a driver for change.

Nicholson (2011) asserts that leaders can create conditions to either hinder or aid innovation and Bruhn (2004) reiterates this when arguing that leaders set the limits of success by how they manage change. Innovation is currently the popular term within healthcare organisations, implying change with a positive thrust (Parkin, 2009), Pryjmachuk (1996) also supports this reasoning when stating that innovations are seen as welcome, while change

is not. Reid (2009) stated the legal obligation on Strategic Health Authorities to promote innovation. Conversely, research suggests change in whatever form remains unpopular, causing stress and conflict (Stewart & O'Donnell, 2007). The literature abounds with a multiplicity of change strategies ranging from the dictatorial approach of ' controlling' to those which embrace the ' involving paradigm' (Dunphy and Bryant, 1996: 692).

The ' Motivators' identified Lewin's (1951) three step approach to change management as an appropriate model to manage the identified change. The model has been dismissed as outdated and simplistic (Dawson, 1994), but according to Burnes (2004) criticism is based on a narrow interpretation of the model. The model should be viewed alongside the other elements of the planned approach: Field Theory; Group Dynamics and Action Research, which combine to create a robust model (Burnes, 2004b; Darwin et al, 2002) and involves:

Unfreezing: is said to refer to reducing the behaviours that maintain the present situation and recognition of the need for change to effect improvement (Goppee & Galloway, 2009). Good communication is a vital element at this stage; good practice would ensure those likely to be affected by the change agree, or at least are cognisant of the need for change (Kotter and Cohen, 2002; Curtis and White, 2002). Involving people in all aspects of the planning and implementation of the change discourages resistance (Curtis and White, 2002). A Gantt chart was developed as a tool to provide a timeframe/schedule for implementing and evaluating the proposed change as advocated by Borril et al (2001) (Appendix).

Moving: The Gantt chart would provide a framework for revision and review of the change. It would be advisable to check that all those involved with the change are clear and informed about the change and that all other professionals involved are fully aware (Goppee and Galloway, 2009).

Refreezing: refers to the stage when the change has been accepted both emotionally and intellectually by colleagues. The change should be stabilised and reinforced through mechanisms of support such as policy and resources, as appropriate (Goppee and Galloway, 2009). Evaluation of the change is essential; evidence dictates that successful, well performing teams are characterised by the use of measurement in supporting improvement (Darzi, 2008). The use of measurement, benchmarking, and audit are recommended as a means of guiding local improvement and innovation (NHS, 2008., Care Quality Commission, 2009,. DH, 2008). Pre and post change data collection is also considered a valuable means of evaluating a change (DH, 2009; Cooper and Benjamin, 2004).

For change to actually happen requires effective leadership (Darzi, 2009). As SCPHN’s, cultivation of leadership skills is deemed essential to effecting change; NHS (2011) assert that leadership capacity and capability can be cultivated and is a core expectation of practicing professionals (Darzi, 2009). Hogan et al (1994) would refute this, stating the ‘ trait’ theory of leadership whereby people are born leaders with inherent leadership characteristics which cannot be learned. Borrill and West (2001) identify leadership as critical in developing effective team working and should maximise the benefits and minimise the weaknesses within the team. Transactional leadership has been commonly used in healthcare (Curtin, 2001), mainly as

it lends itself to achieving targets. It is equated by some as being managerial in its style (Finkleman, 2006) with the focus being task and organisation orientated, with sparse attention to the needs of the followers. Conversely, transformational leadership is said to be universally applicable (Bass et al, 1987) inspiring followers to disregard their personal interests for the good of the group or organisation.

We identified the transformational approach as the most appropriate one for both our team and in leading the change in the workplace, as this visionary style actively encourages and embraces innovation and change (Curtin, 2001). Bass (1998) also considers transformational leadership empowering, motivating colleagues to reach and perform to their maximum potential. Conversely Transactional leadership is thought to be inappropriate when teams are demoralised, demotivated or stressed (Stordeur, 2001)

NOTES FOR CONCLUSION

Nurses in the present working climate have to accept necessary changes Not only should they accept changes as they take place, but should also be constantly reviewing working practices and being proactive in implementing changes as and when necessary. If this does not happen, nurses will have to deal with the fallout of changes imposed on nursing by others

Overall, although management skills are important and necessary, the future requires leadership to provide the dynamics essential to challenge and lead organisations into an era where management of rapid change is the necessary key for future survival. Nursing leaders are ideally positioned to influence these changes and to play a major role in facilitating the changes

Transforming Community Services: dh 2009 Ambition, Action, Achievement

Transforming Services for Children, Young People and their Families

Developing and supporting people to design, deliver and lead high quality community services

Actions to consider in developing a ‘ social movement approach’ to change owned and lead by local services and practitioners

Transformational change happens when those delivering care are motivated and inspired to do things differently.

The Next Stage Review emphasised the need for a high quality workforce to deliver high quality care and introduced the healthcare professional for the 21st century being ‘ practitioner, partner, leader’. Contributors to the programme have built on the concept of practitioner, partner, leader to develop attributes for community practitioners that will generate radical improvement.

Many good initiatives flounder because insufficient attention is paid to the staff themselves and the actions needed to create the climate in which the desired attributes can ensure success. Organisations implementing change will want to consider how they promote such attributes in their own workforce, and the action needed on a number of fronts. How staff are educated and trained, managed and led, how services are commissioned and regulated, and how performance is monitored, can all contribute to the creation of a positive, enabling culture in which staff constantly strive to

improve safety, effectiveness and experience of care. Conversely, the same factors can mitigate against empowerment, motivation and personal accountability, reducing the likelihood of success.

Social movement

A group of people with a common ideology who try together to achieve certain general goals; features include:

- Energy
- Mass
- Pace
- Momentum
- Passion
- Commitment
- Spread
- Sustainability

References

ADAIR, J. (2004) The Concise Adair on Leadership London: Thoroughgood.

ANDERSON, E. (2005) Approaches to conflict resolution. British Medical Journal Vol. 331 (7512) pp. 334-336.

ARITZETA, A., SWAILES, S. and SENIOR, B. (2005) Research Memorandum. Team Roles: psychometric evidence, construct validity and team building. Centre for Management and Organisational Learning Business School: University of Hull

BARR, J. & DOWDING, L. (2008) Leadership in Healthcare. London: Sage

BASS, B. (1998) Leadership and performance beyond expectations New York: Free Press

BASS, B., WALDMAN, D., AVOLIO, B. and BEBB, M. (1987) Transformational leadership and the falling dominoes effect. Group and organisation studies Vol. 12. (1) pp. 73-87

BELBIN, M. (1981) Management Teams: Why they Succeed or Fail. London: Heinemann

BELBIN, M. (1994) Team Roles at Work Oxford: Heinemann

BELBIN, M. (1993) A reply to the Belbin team-role self-perception inventory by Furnham, Steele and Pendleton . Journal of Occupational and Organisational Psychology Vol. 66 (3) pp. 47-52

BORRILL, C. and WEST, M. (2001) Developing Team Working in Health Care: a guide for managers. Birmingham: Aston University for Health Service Organisation Research. Available at: www1. aston. ac. uk/aston-business-school/research/centres/ihse/publications Accessed on: 02/03/2011

BOVEY, W. and HEDE, A. (2001) Resistance to organisational change: the role of cognitive and affective processes. Leadership and Organisational Development Journal. Vol. 22 pp. 372-383

BROUCEK, W. and RANDELL, G. (1996) An assessment of the construct validity of the Belbin Self-Perception Inventory and Observer’s Assessment from the perspective of the five factor model. Journal of Occupational and Organizational Psychology December 1st 1996.

BRUCE, R. and WYMAN, S. (1998) Changing Organisations: Practicing Action Training and Research. Kent: Sage

BRUHN, J. (2004) Leaders Who Create Change and Those who Manage it. How Leaders Limit Success. The Health Care Manager Vol 23 (2) pp. 132-140

BURNES, B. (2004) Kurt Lewin and the Planned Approach to Change: A Re-appraisal Journal of Management Studies Vol. 41 (6) pp. 977-1002

CARE QUALITY COMMISSION (2009) Engagement in clinical audits. Available at:

www. cqc. org. uk/periodicreview/nationalcommitmentsandpriorities2009/10/acuteandspecialisttrusts/nationalpriorities/engagementinclinicalaudits. cfm accessed on 19/03/2011

CHUANG, Y., CHURCH, R. and ZIKIC, J. (2004) Organisational culture, group diversity and intra-group conflict. Team Performance Management Vol. 10 (1-2) pp. 26-34

CONNOR, D. (1998) Managing at the speed of change: how resilient managers succeed and prosper where others fail. Chichester: John Wiley & Sons.

COOPER, J. and BENJAMIN, M. (2004) Clinical audit in practice. Nursing Standard Vol. 18 (28) pp. 47-53

CRAWLEY, J. and GRAHAM, K. (2002) Mediation for managers: Resolving conflict and rebuilding relationships at work. London: Nicholas Bealey

CURTIN, L. (2001) Guest editorial: EQ is more important now than ever before. Seminars for Nurse Managers Vol. 9 (4) pp. 203-205

CURTIS, E. and WHITE, P. (2002) Resistance to change: Causes and solutions. Nursing Management Vol. 8 (10) pp. 15-21

DARWIN, J., JOHNSON, P. and McAULEY, J. (2002) Developing Strategies for Change Harlow: Prentice Hall.

DARZI, PROFESSOR LORD. (2007) Our NHS our Future – NHS Next Stage Review: Interim Report. London: Department of Health

DARZI, PROFESSOR LORD. (2008) High quality care for all : NHS Next Stage Review final report. Available at: www. dh. gov. uk/en/Publicationsandstatistics/ accessed on 03/03/2011

DAWSON, P. (1994) Organisational Change: A Processual Approach. London: Paul Chapman

DENSTEN, I. & GRAY, J. (2001) Leadership development and reflection: what is the connection? International Journal of Educational Management Vol 15 (3) pp. 119-124

DFES see DEPARTMENT FOR EDUCATION AND SKILLS (2004) Every Child matters: A Change for Children. The Stationary Office.

DH see DEPARTMENT of HEALTH (2009) What is clinical audit? Available at: www. dh. gov. uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_107462. pdf accessed on 03/03/2011

DiPAOLA, M and HOY, W. (2001) Formalization, conflict, and change: constructive and destructive consequences in schools. The International Journal of Nursing Management Vol. 15 (5) pp. 238-244.

DUNPHY, D, and BRYANT, B. (1996) Teams: panaceas or prescriptions for improved performance? Human relations. Vol 49 (5) pp. 677-698

EISENHARDT, E. (1997) cited in FISHERS, S., MacROSSEN, W. and SEMPLE, J. (2000) Control and Belbins Team Roles. Personal Review Vol 30 (5) 578-588

FAGAN, M. (1985) Interpersonal conflict among staff of Community mental health centers Vol. 12 (3) pp. 192-204

FINKELMAN, A. (2006) Leadership and Management in Nursing. New Jersey: Pearson Education Ltd.

FISHER, J. and SAVAGE, J. (eds), (1999) Beyond Experimentation Into Meaning Farnborough: EPCA Publications

FISHER, S., MacROSSEN, W. and SEMPLE, J. (2000) Control and Belbins Team Roles. Personal Review Vol. 30 (5) 578-588

FURNHAM, A., STEELE, H., PENDLETON, D. (1993) A psychometric assessment of the Belbin Team Role Self-Perception Inventory. Journal of Occupational and Organisational Psychology Vol. 66 (3) pp. 245-257

GOPPEE, N. and GALLOWAY, J. (2009) Leadership and Management in Healthcare. London: Sage

HOGAN, R., CURPHY, G. and HOGAN, J. (1994) What do we know about leadership? American Psychologist Vol. 49. pp. 493-504

NHS INSTITUTE FOR INNOVATION AND IMPROVEMENT (2011) Available at: www. institute. nhs. uk accessed on 18/02/2011

JEHN, K. (1995) A multi-method examination of the benefits and detriments of intra-group conflict. Administrative Science Quarterly Vol. 40 (2) pp. 256-282.

KANTER, R., STEIN, B. and JICK, T. (1992) The challenge of organizational

change. New York: The Free Press. Available at: www. pluspulse. nl/pdf/EAWOP resistance. pdf accessed on 26/02/2011

KOTTER, J. and COHEN, D. (2002) The Heart of Change: Real life stories of how people change their organisations. Boston: Harvard Business School

KÜBLER-ROSS, E. (1969) On Death & Dying Available at: www. businessballs. com/elisabeth_kubler_ross_five_stages_of_grief. htm accessed on 20/02/2011

LEWIN, K. (1947/1997) Frontiers in group dynamics. In: Resolving Social Conflicts Field Theory in Social Science. Washington DC American Psychological Association pp. 301-336

LEWIN, K. (1951) Field Theory in Social Science: Selected Theoretical Papers. New York: Harper Row

MacFARLANE, F., GANTLEY, M. and MURREY, E. (2002) The CeMENT project: a case study in change management. Medical Teacher vol 24 (3) pp. 320-326

McADAM, R. (2005) A multi-level theory of innovation implementation: Normative

evaluation, legitimisation and conflict. European Journal of Innovation Management Vol. 8 (3) 373-388.

McGILL, I. & BEATY, L. (2001) Action Learning: A guide for professional, management and educational development. Revised 2nd ed. London: Kogan Page

McWILLIAM, C. and WARD-GRIFFIN, C. (2006) Implementing organisational change in health and social services. Journal of Organisational Change Management vol 19 (2) pp. 119-135

MEDINA, F. MUNDUATE, L., DORADO, M., MARTINEZ, I. and GUERRA, J. (2005) Types of intra-group conflict and effective reactions. Journal of Managerial Psychology Vol. 20 (3-4) pp. 219-230

MORHMAN, S., COHEN, S. and MORHMAN, A. (1995) Designing Team-Based Organisations San Francisco: Jossey-Bass

DH see DEPARTMENT of HEALTH (2008) National Clinical Audit AdvisoryGroup. Available at:

webarchive. nationalarchives. gov. uk+/www. dh. gov. uk/en/Publichealth/Patients accessed on 03/03/2011

NHS CLINICAL GOVERNANCE SUPPORT TEAM (2008) What is Clinical Governance? Available at: http://webarchive. nationalarchives. gov. uk/20081112112652/cgsupport. nhs. uk/ accessed on: 03/03/2011

NICHOLSON, D. Chief Executive of the NHS (2011) Institute for innovation and Improvement Available at: www. institute. nhs. uk/building_capability/general/building_capability. html accessed on 19/02/2011

PARKER, M. (2008) Team Players and Team Work: New Strategies for the Competitive Enterprise 2nd ed. USA: John Wiley

PARKIN, P. (2009) Managing Change in Healthcare Using Action Research. London: Sage.

PEDLER, M. (2008) Action Learning for Managers 2nd ed. Cornwall: Godwen

PIDERIT, S. (2000) Rethinking resistance and recognising ambivalence: a multidimentional view of attitudes toward an organisational change. Academy of Management Review. Vol. 25. pp. 783-795

PRYJMACHUK, S. (1996) Pragmatism and change: some implications for nurses, nurse managers and nursing. Journal of Nursing Management (4) pp. 201-205

ROLFE, G. FRESHWATER, D. & JASPER, M. (2001) Critical Reflection in Nursing and the Helping Professions: a Users Guide. Basingstoke, Palgrave Macmillan.

SLAVIN, R. (1996) Research on cooperative learning and achievement: What we know, what we need to know. Contemporary Educational Psychology (21) pp. 43-69.

SULLIVAN, E. and GARLAND, G. (2010) Practical Leadership and Management in Nursing. Essex: Pearson Education Ltd.

STEWART, J. & O'DONNELL, M. (2007) Implementing change in a public agency – leadership, learning and organisational resilience International Journal of Public Sector Management. Vol. 20 (3) pp. 239-251.

STORDEUR, S., D'HOORE, W. and VANDENBERGHE, C. (2001) Leadership, organisational stress, and emotional exhaustion among hospital nursing staff. Journal of Advanced Nursing Vol. 35 (4) pp. 533-542

TOPPING, K. (2005) Trends in Peer Learning. Educational Psychology Vol. 25 (6) pp. 631-645.

TUCKMAN, B. (1965) Developmental sequence in small groups. Psychological Bulletin Vol. 63 (6) pp. 384-99. Available at: www. mph. ufl. edu/events/seminar/Tuckman1965DevelopmentalSequence. pdf accessed on 27/02/2011

VALENTINE, P. (2001) A gender perspective on conflict management strategies of nurses. Journal of Nursing Scholarship. Vol. 33 (1) pp. 69-74.

WADDLE, D. and SOHAL, A. (1998) Resistance: a constructive tool for change management. Management Decision Vol 36 p543

WILL, M. (1997) Group Learning in Workshops New Directions for Adult and Continuing Education. No. 76. Winter 1997.

Appendix 5

Five stages of grief – Elisabeth Kübler Ross

1 – Denial

Denial is a conscious or unconscious refusal to accept facts, information, reality, etc., relating to the situation concerned. It’s a defence mechanism and perfectly natural. Some people can become locked in this stage when dealing with a traumatic change that can be ignored. Death of course is not particularly easy to avoid or evade indefinitely.

2 – Anger

Anger can manifest in different ways. People dealing with emotional upset can be angry with themselves, and/or with others, especially those close to them. Knowing this helps keep detached and non-judgemental when experiencing the anger of someone who is very upset.

3 – Bargaining

Traditionally the bargaining stage for people facing death can involve attempting to bargain with whatever God the person believes in. People facing less serious trauma can bargain or seek to negotiate a compromise. For example “ Can we still be friends?..” when facing a break-up. Bargaining rarely provides a sustainable solution, especially if it’s a matter of life or death.

4 – Depression

Also referred to as preparatory grieving. In a way it’s the dress rehearsal or the practice run for the ‘ aftermath’ although this stage means different things depending on whom it involves. It’s a sort of acceptance with

emotional attachment. It’s natural to feel sadness and regret, fear, uncertainty, etc. It shows that the person has at least begun to accept the reality.

5 – Acceptance

Again this stage definitely varies according to the person’s situation, although broadly it is an indication that there is some emotional detachment and objectivity. People dying can enter this stage a long time before the people they leave behind, who must necessarily pass through their own individual stages of dealing with the grief.

Based on the Grief Cycle model first published in On Death & Dying, Elisabeth Kübler-Ross, 1969. Interpretation by Alan Chapman 2006-2009.