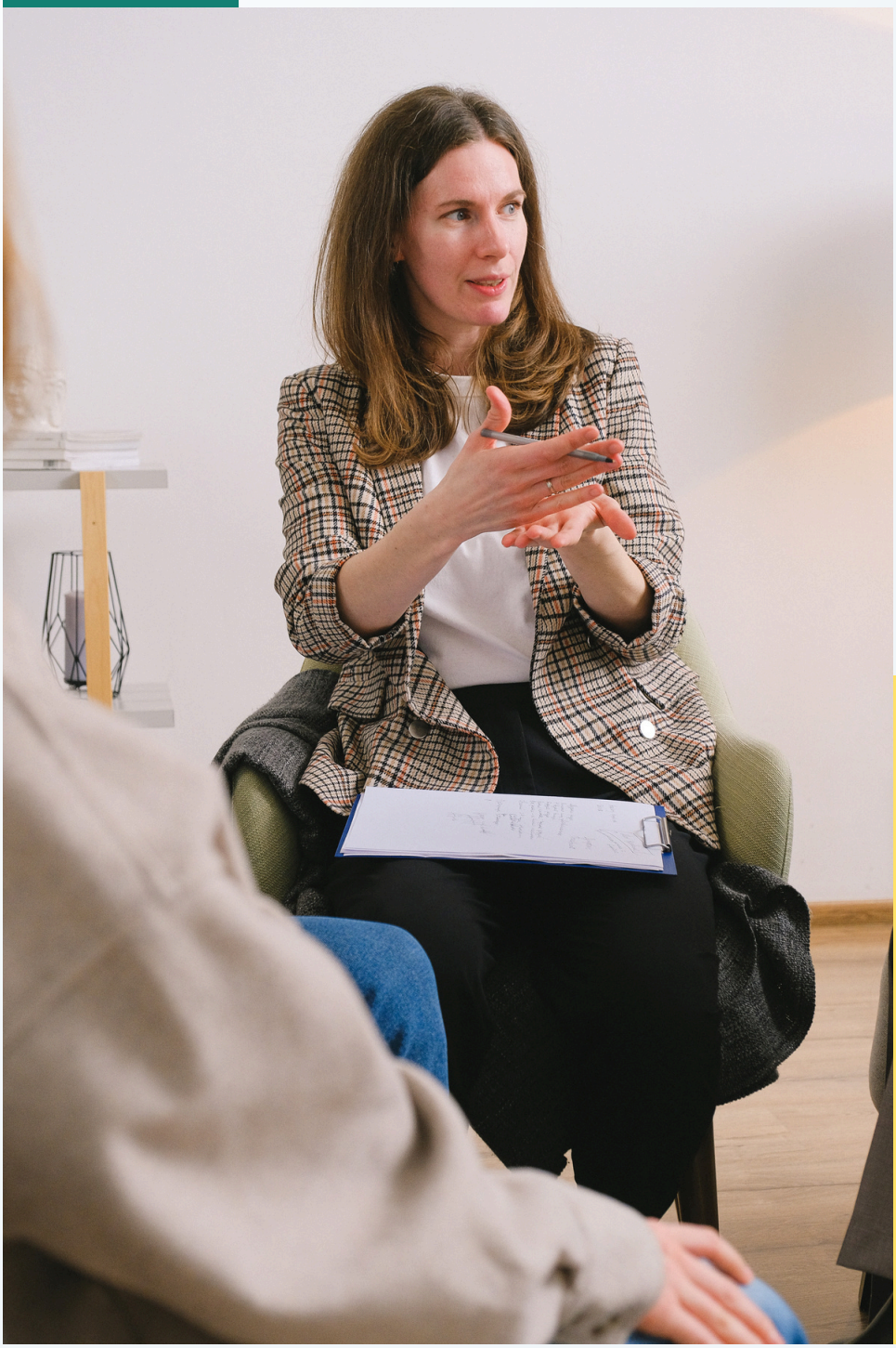
compass



REPLICATION GUIDE

for the Work Discussion Groups Methodology to support reflexivity of care managers

Co-funded by the European Union

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PURPOSE OF THE GUIDE

Why is a replication guide needed?

The replication guide is essential to support the consistent and effective adoption of the Work Discussion Group (WDG) model across diverse health and social care settings. Care managers often face long hours and high-intensity work that impede reflective practice, yet reflection is critical for fostering professional development, resilience, and the successful implementation of person-centered care (PCC).

This guide provides comprehensive support by detailing how WDGs enhance reflective practices, foster professional development, and build resilience among care managers. It equips users with the tools and knowledge to create a structured space for reflection and learning, enabling care managers to better lead and sustain person-centered care (PCC) practices.

ABOUT THE PROJECT

PROJECT MISSION

The project aims to equip care managers with skills to better respond to actual labour market needs, specifically by improving their skills to lead the change towards PCC (person-centred care) approaches in their working contexts and providing guidance to European care managers on how to practically implement person-centered leadership in their everyday work. COMPASS focuses on VET, as it aims to innovate VET practices in the care sector, equipping care managers with skills to better respond to actual labour market needs, it has the potential to be applied in other contexts and to support the creation of synergies among them.

TARGET GROUP

The resources developed by Compass are designed for care managers in elderly care services (residential, semi-residential and home care).
Care managers, meaning professionals having coordination responsibilities towards front-line care workers in residential or home care services, have often been neglected by training and continuous professional development programmes aimed to promote PCC and are an overlooked group when it comes to research about their role and practices (Orellana, 2009).

PROJECT RESULTS

Care Managers as Drivers of PCC: A multi-language, blended learning (meaning a combination of e-learning and face-to-face learning sessions) training package addressed to care managers across Europe.

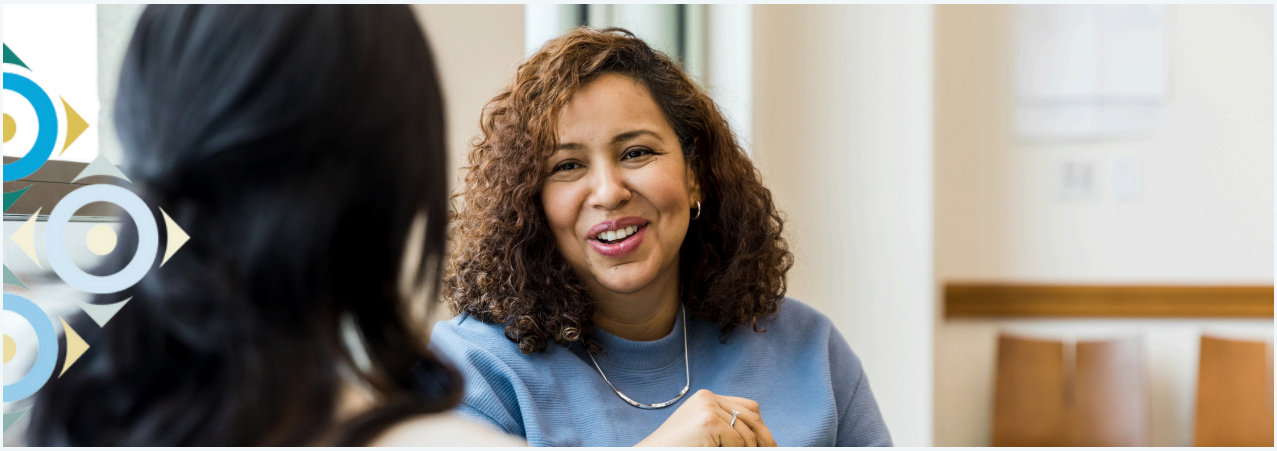
Supporting Reflexivity of Care Managers: A methodology to run online
reflective groups of care managers committed to improve the PCC practices of their organizations, inspired by the “work discussion groups” (WDGs) methodology.

Building and sharing practices: A digital Community of Practice for European care managers committed to improve the PCC practices of their organizations.

INTRODUCTION

According to Gorman (2003), the use of reflective skills in the practice of care managers represents an added value for learning, promoting a critical analysis of the work performed and facilitating the long-term assimilation of learned processes. This type of learning requires a commitment across both personal and professional dimensions (Argyris & Schön, 1974). With this in mind, a working group model based on the Work Group Discussion (WDG) method was developed within the Erasmus+ Compass project. The Compass partnership received ad-hoc training and then proceeded with the adaptation, testing and dissemination of a methodology for running online reflective groups, involving care managers eager to improve Person-Centred Care (PCC) practices in their organisations. Psychoanalytic Work Discussion emerged as a group method aimed at helping professionals confront their defences with respect to the emotional impact of their work, especially when these defences hinder an adequate understanding of needs, opportunities and boundaries in the work context. The aim of the Work Discussion is, in fact, to recapture those emotional experiences that are most difficult to tolerate, thus preparing participants to face the complexity of the helping relationship and all the potential it entails.

In this guide, the methodological framework of reference of the Compass model, which is necessary for replication in other care management contexts, is presented and deepened. The following has been inspired and elaborated from the 2020 text “Osservazione, riflessività e apprendimento nelle professioni d’aiuto. Il metodo della Work Discussion psicoanalitica” (Observation, reflexivity and learning in the helping professions. The Psychoanalytic Work Discussion method) edited by Daniele Morciano, with the collaboration of Psifia members Aurora Polito and Sara Scrimieri for the translation of some essays.



OVERVIEW OF THE WDG METHOD

Any kind of change must be designed and applied with an awareness of the limits of what is possible, i.e. those limits that are part of the organisation and that would prevent practitioners from effective change. Approaches and methods that are not possible may in fact generate resistance to change and frustration.

Psychoanalytic work discussion is one of the methods aimed at developing practitioners' observational and reflective skills on anxieties and defences in the performance of their role. It offers the possibility to creatively transform uncertainties and concerns related to the work being done in opportunities for change for both the user and the practitioner. The basic assumption of this method is that, in order to mitigate the negative effect of defences, it would be necessary to help practitioners recognise them, tolerate them and transform them into useful resources for their work. The perspective of this method is therefore not to stop at the identification and reworking of anxieties at the level of the individual practitioner, but of the wider system. The reflexivity and learning that derive from care experiences can become a valuable resource if this method is included in a process of evaluation of the services or interventions implemented by the organisations of the figures taking part in them, according to an evaluation model that relies on the active participation both of those who work in the front lines (in direct contact with users, patients and beneficiaries), and of those who hold management, coordination and planning responsibilities.

THE EFFECTS OF ANXIETY

Anxiety is an affect, a state of psychic tension that acts mainly at an unconscious level, different from a feeling (linked to a stable relationship with a specific object) or an emotion (immediate reaction to a significant stimulus). It is difficult to rationalise and can occur without a clear reason, or with intertwining motives.
William Halton points out how an excessively control-oriented management culture can generate anxiety in operators, activating defensive mechanisms such as not taking responsibility for preventive decisions. This avoidance behaviour can damage both the quality of life of practitioners and the effectiveness of service and professional performance. For example, fear of reprimands may lead nurses to fail to act even when they feel that a sensible decision would be right.

Anxiety, therefore, fuels a rigid attachment to protocols and procedures, hindering autonomous decision-making and operational flexibility. Anxiety and stress can cause difficulty in making decisions and chronic uncertain, even those of little importance, and lead to disconnection from reality, with poor attention to providing appropriate care and sometimes inappropriate behaviour.
Internal tensions may be directed towards other issues rather than the original cause. According to William Halton, in private settings with a lack of leadership, the absence of control can result in repressive aggression, such as mistreatment of patients.

The work context has been transformed by post-modernity, reducing the link between rational action and professional purpose. The profession is increasingly individualised, imposing greater personal responsibility without adequate support.
Two possible reactions:

- Passively suffering this change as a fate made of loss of protection, sense of abandonment, bewilderment and uncertainty;
- Seizing it as an opportunity for greater freedom and participation in exploring, experimenting and actively contributing to the evolution of knowledge and particles (Beck, 1986).

However, this does not detract from the fact that this type of empowerment, and whatever the response to it, may generate further anxiety in practitioners, weakening the cohesion and alliance between the organisation's staff members and between employees and the organisation, i.e. the social defence that holds the organisation together.

SOCIAL DEFENCES IN CARE ORGANISATIONS

In 1953, psychoanalyst Elliot Jaques defined social defence as an emotional configuration that promotes internal group cohesion and at the same time collaboration with other groups in the same organisation. According to Jaques, all institutions are used by their members as defence mechanisms against anxiety, benefiting from the protective and cohesive effects. Social defences are in fact present in all organisations and individuals need to use them as a means "to preserve their identity and protect themselves from intolerable internal conflict" (Miller, 1976). The British psychoanalyst Isabel Menzies Lyth points out that social defences are not only the sum of the unconscious psychological dynamics of the members of an organisation, but continue to act independently once embedded in structures, systems, cultures and working practices, influencing the thoughts, emotions and behaviour of those who are part of them. Indeed, she states that institutions once established can be extremely difficult to change and contribute to shaping the personality structure of their members, either temporarily or permanently (Menzies Lyth, 1989), but in order to change members, it is first necessary to change institutions (Morciano, 2020). Therefore, it is not possible to consider that change must come only at the individual level, underestimating the effect that the nature and leadership of the organisation can have on the practitioners.

Menzies Lyth experienced a working environment pervaded by high levels of stress and tension, both with patients and between colleagues and superiors, with high drop-out rates and absenteeism from work.

This situation was due to the care culture in the organisation, which was based on two principles

- strict adherence to care procedures
- a pervasive system of monitoring their correct application.

The fear of being reprimanded drove the nurses not to accept even what they felt was common sense in their care work, preventing them from deviating from strict protocols and making even the most trivial decisions.

Despite the fact that the task had been performed, anxious conditions persisted. Menzies Lyth argues that recognising and integrating emotions, including aggressive ones, promotes professional development and patient safety. Obsessive-punitive systems without empathy increase the risk of poor care, neglect and abuse. The collapse of such systems leads to an outbreak of repressed aggression, putting vulnerable patients at risk.

THE PSYCHOANALYTIC APPROACH

A psychoanalytic approach can help to investigate the variety of anxiety experiences in greater depth. There are, for example, some aspects that Mario Perini has tried to bring out through his analysis on 2013 aimed at highlighting certain subjective experiences of carers:

- not being able to grasp the meaning of what one observes (AMBIGUITY)
- not knowing whether and whom to trust (CHALLENGE)
- having to run to keep up with rapid and sudden changes (SPEED)
- not being able to count on something lasting and consistent (FUGACITY or VOLATILITY)
- not being able to keep in mind (IMPENSABILITY)

It is crucial to implement interventions that help professionals manage risks and see the expansion of autonomy as an opportunity for improvement. Organisational models are needed that can contain anxieties, listen to them and transform them into reflection to improve practices and intervention strategies.

One of the pillars on which a functioning organisation is founded is precisely the development of a reflective culture.

In this sense, the Work Discussion method is aimed precisely at training and supporting the development of reflective capacities and practices based on reflexivity in the care professions and their organisations of origin.

THE PSYCHOANALYTIC WORK DISCUSSION METHOD

Psychoanalytic Work Discussion is a method aimed at:

- Helping practitioners to develop the ability to observe, reflect and learn from the experiences of anxiety and defences against it that are activated while carrying out their tasks;
- Supporting innovation practices of services and/or interventions implemented by organizations, following a model that involves both frontline workers and those involved in leadership, coordination, and programming.

The Work Discussion takes place in small groups of homogeneous or mixed professionals with respect to the organisation of origin and/or the field of work. The group meets permanently for a prolonged period, during which each of the participants brings and presents in turn an observation in written form on a work situation regarding the relationship with users/patients, work colleagues and/or other figures involved (staff of one's own organisation or of other organisations with which one interacts, relatives, etc.).

On the basis of the observation presented by one of the members, a group discussion is triggered, facilitated by a conductor. His/her task is to promote a learning experience that starts primarily from the situation reported by the observer/speaker, balancing two types of functions:

- one of a protective/supportive type, aimed at creating a climate of suspension of judgement, dissolving doubts and welcoming fears, encouraging thought and facilitating confrontation
- the other focused on encouragement and stimulation, towards participation as well as the creation of a climate of respect

Internal supervision differs from 'Work Discussion' in that it is a formal control of work with respect to tasks, procedures and regulations. Although supervision can promote a respectful and communicative environment, 'Work Discussion' is characterised by greater methodological robustness. In fact, it allows for a systematic comparison of cases, stimulating participation and the development of critical thinking on habitual patterns of action or expected protocols.

This type of learning becomes possible to the extent that the conductor directs the group's attention towards reflection on the practice, diverting it from the mere accumulation of data or information.

Furthermore, through the presentation of concrete cases it is possible to identify difficulties and failures encountered in one's own work and turn them into starting points for discovering new possibilities for action. For example, participants learn how to emotionally tolerate anxiety-generating work situations by becoming aware of defensive routines rooted in the culture of their own organisation.

Through this method it is possible to develop or enhance a variety of competences:

- learning to tolerate the emotions one feels when reflecting and confronting work situations that generate anxiety (fear, anxiety, suffering, stress, etc.), avoiding defensive reactions and becoming aware when these are triggered;
- accepting that there is no one right way to carry out a task or tackle a problem, but that it is necessary to construct "tailor-made" solutions for the specific situations one is working with, especially when these are particularly complex and refractory to change because of the anxiety experiences they activate;
- self-observing and reflecting on one's own work while it is being carried out, i.e. 'stepping back' into the heart of a situation and considering it from a different perspective;
- arrive at a richer understanding of work situations that takes into account the emotional and unconscious elements that come into play;
- understand psychoanalytic theories and concepts applied in work practice.

Work discussion is a method that offers the possibility to creatively transform uncertainties and concerns related to the work being done in opportunities for change for both the user and the practitioner.

Innovation lies in the capacity for renewal that takes place every time a work discussion is introduced in a work context.

Unique and unrepeatable situations are witnessed, as a creative process is activated and it is never identical to the previous one.

This method is innovative despite already having a long history: WD has developed as a tool for training and professional practice in a variety of contexts since it systematically became part of advanced training courses, at the end of the 60s, at the Tavistock Clinic in London.

The Work Discussion method was created to manage dysfunctional mechanisms related to anxiety, tension and stress in healthcare organisations, especially during innovation processes. These mechanisms derive from highly demanded performances, application of standardised protocols and lack of support, creating psychological and emotional conditions that compromise the quality of care and staff well-being. The WD method addresses the need to identify and address these mechanisms, which are often not consciously recognised, but perceived as technical or practical problems.

That means identifying:

- experiences of anxiety in the helping professions,
- the resulting defensive reactions enacted at the individual and organizational levels
- their counterproductive effect when anxiety levels become excessive, creating resistance to change.

AIMS AND STAGES OF WDG

Psychoanalytic Work Discussion is a method aimed at:

- Helping practitioners to develop the ability to observe, reflect and learn from the experiences of anxiety and defences against it that are activated while carrying out their tasks;
- Supporting innovation practices of services and/or interventions implemented by organizations, following a model that involves both frontline workers and those involved in leadership, coordination, and programming.

From this perspective, WD can help to understand how to encourage practitioners to move from canonical modes of intervention-often structured as defences against anxieties-to new theories that are more in tune with reality and thus more capable of responding to the actual needs of patients.

These meetings don't teach specific strategies of intervention. Group members are encouraged to think and discuss the meanings different work situations can have and to find more appropriate ways to face them.

Work Group Discussions (WGDs) are led by one or two professionals, depending on the need, as in the case of more heterogeneous groups or for a broader division of labour.

The WD method is characterised by the presence of an experienced leader with leadership responsibility, but can also be led by a facilitator or counsellor, resulting in a less structured and more therapeutic WGD.

The aim of the seminar is to sharpen perception and develop intuition, improving understanding of social interactions through unconscious motivations, with a gradual training process to increase sensitivity and awareness.

«Not noticing» is an effect of defence mechanisms from psychic pain perceived in oneself and in others. The process can help participants becoming more capable of dealing with such pain more closely and realizing that there is no expert skilled enough to offer immediate solutions are problems that seminar participants face.

The target groups are care managers in care services (residential, semi-residential and home care). It may be someone with a vocational qualification or a qualification acquired after a BA in social work or nursing who covers a middle-management position in the organization.

The process develops in 3 different stages:

- Observation (participant or not): situations are often chosen based on the specific difficulties they hide, for oneself or for the others involved in the work environment.
- Registration: producing a detailed report of what has been observed.
- Group Reading and Discussion of the report.

OBSERVATION

Observation provides the tools to recognise and understand mental states that are difficult to identify. In Work Discussion groups, free association is used to express impressions, feelings and unprocessed thoughts, which will acquire meaning when brought together.

According to Bion, good observation requires the 'Negative Capability' (ability to stay on a question without seeking answers) and the 'Not Knowing' approach.

WD is a continuous professional development technique that enriches existing understanding by guiding the group towards practical thinking within the organisation.

Sometimes the group is encouraged to "unlearn" instead of learning, so it can be observed that this experience is uncomfortable at first, because of new discovered elements of a working area which the employer was competent in until this moment.

The suggestion is to dive emotionally into the reported experience, instead of activating a more intellectual reflexion on it.

In conclusion, observation includes:

- train oneself to take behaviours into account
- consider verbal and non-verbal interactions
- not interpreting what is reported
- reporting even what seems insignificant at the time
- leaving room for uncertainty
- do not believe you have the answer
- remember that there are various ways of doing things and there is no right way
- listen also emotionally

REGISTRATION

After the observation phase, it is important to transcribe the observed details without allowing too much time to pass. If this is not possible, it is advisable to take notes before writing the complete report. It is essential to respect the sequence of events. Writing down rather than just remembering allows one to grasp the connections between the parts and to stop and reflect, even though it may be difficult at first for participants who are not used to doing this in daily practice.

When writing a registration of what was observed during the seminars, must been taken into account all aspects that may be useful to stimulate reflection among the practitioners. These aspects could include:

- what particularly caught the attention of the group
- the reaction of the members and any actions
- the attitude and behaviour of the group
- any efforts that were made
- what was talked about and how
- any avoidances or feelings of discomfort
- the interaction between the participants

Remind that what seems to be meaningless is nonetheless important to be registered.

GROUP READING AND DISCUSSION OF THE REPORT

In order to facilitate group discussion and foster serenity of sharing, before the group activities start it is important for its members to agree on the confidential nature of the content that will be discussed. Rather than making a formal agreement, it is important to reflect on the sense of maintaining confidentiality. Participants are invited to make sure that nothing that will be shared outside the group will cause embarrassment or be offensive to anyone.

During presentations, it is useful to encourage speakers to share difficulties or concerns to reduce resistance in documenting their work. The discussion of shared cases is a central aspect of WDGs, and moments of free discussion are useful to express doubts, anticipate problems and discuss solutions.

WD group is not a therapeutic group and it is important to stress that there are no magic solutions for every problem. The conductor's function, with the support of other participants, is to help in understanding more deeply the underlying meanings of the observed behaviours and the emotional components involved, thus developing a more effective reflective ability on what is going on below the surface, to better understand how one can intervene.

Other methods different from words or discussion can be proposed, but can only be contemplated to be a stimulus for sharing and expressing thoughts and emotions, which must always be the focus of WGDs. For example, one can think of a picture or a colour and tell the others about it, or present a picture that can be discussed by the group. Writing can be used to write down what comes to mind during the discussion in order to realise the thoughts and emotions and give them order.

CONDUCTION OF THE GROUP*

The relationship between the conductor and group members is central to learning. The leader must help the group to understand the emotional distress communicated by the worker and the client, to overcome defensive responses and to understand how the relationship can positively manage the situation.

The method focuses on understanding the underlying causes of work situations and increasing awareness of emotional experiences that trigger reactions.

During the sessions it is very important to focus on exploring not only one's own experience at personal and emotional level, but also one's role as a practitioner and one's role within the organisation. This is a fundamental step in extending one's awareness of oneself as part of the organisational system and the influences it can have on one's work.

The learning process may initially seem confusing, as no techniques are taught, but it stimulates deeper reflection on practice.

The writing of the work presented is generally sufficient, but the group may feel disturbed as they reconsider what was previously taken for granted.

In order to allow the success of the WDGs, it must be underlined that the objective of the method is to create an environment in which it is possible to free oneself from the pressure of having to perform well and efficiently by working towards the construction of a reflective and non-judgmental approach towards oneself. themselves and towards other members of the group.

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*Bradley, Jonathan (2008) The work discussion seminar. A learning environment. In: Work discussion. Learning from reflective practice in work with children and families. The Tavistock Clinic Series . Karnac Books, London, pp. 22-37. ISBN 1855756447, 9781855756441

Insights gained about unconscious dynamics go beyond the particular presentation and its subject matter and allow members to have a memorable learning experience which can be applied to many other situations. It is moving to witness a moment when insight is gained by the group as a whole. But this is not the only possibility—sometimes one or two members will stand out in terms of their capacity for insight. At other times a member will be left behind and struggle emotionally, leading to a feeling of anxiety in the group as a whole. And, of course, there can be a move against new learning in the whole group which the Seminar Leader has to deal with.

TIPS FOR REPLICATION

Although the core of WDGs is the interaction and the results that are achieved during the group implementation itself, it is also crucial to reflect on the conditions and setting of the group.

The Compass model based on WDG method has been tested and validated for 6 months through 12 seminars every 2 weeks of 2 hours each. An adapted the model has been planned and tested by keeping the same model and involving 2 separate groups which met for 6 months through 6 monthly seminars of 2 hours each.

In both the cases the programme structure was the following:

- First 1-2 meetings dedicated to deepening the proposed method inspired by the WDG method
- Central meetings dedicated to work on cases provided by the presenter (which may also include stimuli such as meaningful videos)
- Subsequent meetings dedicated to the voluntary sharing of cases by the participants
- Last 1-2 meetings dedicated to the restitution and group discussion of the experience

Both models yielded positive results, but to start groups based on the Compass model, it is crucial to consider logistical and organisational aspects, such as scheduling, duration, voluntary participation, group size and confidentiality. Neglecting these aspects could compromise group participation, involvement and sustainability.

TIME MANAGEMENT

One of the decisive factors to be considered is time management, e.g. the time, the days of meetings, the duration of each meeting, the overall duration of the WDG path. The general rule is to choose days and durations that are compatible with the participants' commitments. Not to consider this would risk the involvement and sustainability of participation on a consistent basis.

In this sense, it might be useful to include time for WDG meetings in working hours, as is done generally with supervision, so as to encourage participation. Alternatively, it could be organised before or after work shifts. Depending on the duration of the meetings, it could be considered to hold the WDG during a break, if working hours allow.

The duration of meetings can vary between 30/45 minutes and 2 hours, but ideally should not be less than 1 hour to foster cohesion and mutual trust. If this duration is not possible, WDGs can still be effective if well organised. In the case of shorter meetings, it is useful to plan a higher frequency (weekly or bi-weekly) and involve members in leadership roles. If meetings are less frequent (every three weeks or monthly), it is important that they last at least 1.5-2 hours.

MEETING LOCATION

Groups can meet anywhere, but it is important to consider that some locations may have different meanings and affect the comfort of the members. The composition of the group and the choice of locations can affect the success of the group, so they should be chosen carefully.

VOLUNTARY OR COMPULSORY PARTICIPATION

Participation in WDGs should ideally be on a voluntary basis by staff who are assumed to have grasped the value of this type of activity. This presupposes that managers are able to convey how important the practice of WDGs is and that staff trust the coordinating figures. Indeed, before starting the groups, it might be useful to accompany the staff members of the organisation in acquiring awareness and understanding of the emotional factors and behaviours that affect the provision of care. It is significant in this sense to emphasise that regardless of the results, the aim is to stimulate reflection on the practice in order to try to understand what is actually happening below what can be perceived on the surface.

GROUP SIZE

To be successful, a Work Discussion Group should have a minimum of 4 and a maximum of 10 participants. Large groups make it difficult for each member to actively participate, and the further risk would be loss of motivation and the abandonment of the group. On the other hand, in groups that are too small, members may feel under too much pressure not to be absent or to bring more situations to discuss. The risk of too small a group is in fact the feeling that it is they who serve the group and not the other way around.

RULES FOR RESPECTING CONFIDENTIALITY

At the beginning of a group, it is important to agree on the confidential nature of the content being discussed. Instead of signing a formal confidentiality agreement, it may be more effective to reflect on what it means to respect this principle. It is crucial to avoid sharing information outside the group that could compromise or harm anyone, while encouraging the dissemination of learning in a responsible manner.

In this sense, it might also be useful to explore what participants' fears might be with regard to what might be the repercussions of what is shared (e.g. fear that something might be reported to senior managers or professionals). Participants could be reassured that only general themes that emerge could be shared with managers, without going into the details of individual contributions made. What will be shared with managers could be agreed in advance with the group participants.

WORKING METHODS

Although the recommended method is to have a rotation for presenting cases, it may be necessary to help the person on duty to write their case, describing in detail the concerns and difficulties regarding the work situation. Such accompaniment could promote the exercise and development of reflective skills.

Another working method could be a group discussion on the topics to start with, rather than a precise order of presentations. The group could then start with an open discussion where each person reports on their specific difficulties or concerns at work and then decide as a group which theme or issue to start with.

INPUTS FOR CASE IN CARE FIELD

In order to support the participants to WDGs based on Compass model, facilitators could provide some ideas for the development of the cases to be brought to the group.

Some examples are:

- Ethical dilemmas
- Problems within the staff (e.g., discussions, relationships, communication problems, etc.)
- Relations with relatives of users/patients
- Pre-post-Covid-19 changes
- Staff motivation and engagement
- Autonomy vs. control

These areas could be shared and discussed within the group in order to collect feedbacks and share other ideas.

ANNEX 1 – EXAMPLE OF CASE FOR WDG AND INPUTS FOR DEVELOPMENT

CASE STUDY INSPIRED BY:
THE WORK DISCUSSION SEMINAR- A LEARNING ENVIRONMENT.

JONATHAN BRADLEY*

Case: Dealing with renal failure

A member of the group, a geriatric nurse, presented an account of Eva, a senior lady who had to deal with the terrible consequences of a late diagnosis of meningitis. Not only did she suffer from chronic renal failure, but due to the way the blood supply was withdrawn by the body system, she had to have both legs amputated at the knee, lost finger tops on one hand, and all the fingers on the other hand except her thumb. She had had skin grafts taken from her abdomen and also had surgery to help her pass stools and urine. Despite this, she was able to go to the social centre and perform simple daily tasks, by cultivating relationships with friends and family. I need hardly describe what a profound effect this account had on the Work Discussion Group. There was a sense of incredulity that any person could have had life turned upside down so tragically. As a group (and I include myself) we struggled to be informed about renal failure, learning about the different techniques that are employed to provide kidney function. This search for information provided an opportunity for the group to become 'ordinary learners' at a very stressful time, when it was very difficult to put oneself in the place of the tragic lady condition presented. But this process of educating ourselves was not powerful enough to contain all our feelings. For example, mention was made of one consequence of dialysis, namely that very little liquid is allowed to the patient. In fact, patients have to become accustomed to feeling 'parched' all the time, and they often have severe headaches as the body protests against such a strict regime. Though there was, of course, a world of difference between this account, delivered in a seminar, and the impact of being on a renal ward, nevertheless there was a powerful communication of what it would feel like to have one's water supply restricted in this way.

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*Original citation: Bradley, Jonathan (2008) The work discussion seminar. A learning environment. In: Work discussion. Learning from reflective practice in work with children and families. The Tavistock Clinic Series . Karnac Books, London, pp. 22-37. ISBN 1855756447, 9781855756441

The response was somatic rather than reflective. Small water bottles brought into the Seminar for refreshment (the equivalent of a day's supply for a renal patient) were sought for in bags and felt for reassurance, and there were several journeys to the toilet. Out of the blue, a primitive way of dealing with a painful situation thus took centre stage, the somatic response being the price to be paid for the group's struggle to respond in an attentive and emotionally present way to this painful scenario. As Seminar Leader (conductor), I remember feeling enormous concern for them, and wondered whether they were being asked to cope with too much. Events proved that I was being over anxious on their behalf since, after a brief drinks interlude, there was a determined return to task.

The following is an account of an evening on evening/night duty with Eva. The presenter established, when coming on duty, that Eva had asked if the nurse could watch videos with her during the evening before another serious operation.
A number of duties with other patients had to be carried out before she could go to Eva.

- *Eva got up and we went to the cupboard. I asked her what type of movies she liked. She shrugged in answer. So I randomly picked video titles and suggested them to her for her selection. After a few suggestions Eva asked me what I wanted to watch. I told her that as long as it was not scary I would watch it with her. We finally picked about five movies and returned to her room. Eva chose "Rain Man" to watch and I put that in. She took her prosthetic legs off and scratched her right leg where there was a dressing. I asked her if she was OK and she said she was fine. We watched about 20 minutes and then Eva decided it was boring so I changed it to "Annie Hall" by Woody Allen.*

- *Eva asked if she could have some fruit squash instead of plain water. She was having gut surgery which required that she was not to have food for 24 hours and have clear fluids till 10.30 on the morning of surgery. So, I double checked with the nurse in charge and got her a cup of orange squash. In the time it took me to do that she had decided that this movie was also boring. So we changed the video to "Thelma & Louise". We watched a few minutes of it and the door buzzed.*

- *I returned to Eva who had put her supra-pubic catheter on free drainage as her normal routine. She was scratching her arms and abdomen. I asked if she was OK and she said she was a little itchy. I suggested that it was time to take her medication but she preferred to take them a little later. So we watched the movie. Then she began a conversation.*

Eva: Is it going to hurt, what they'll do tomorrow?

Nurse: I don't know much about the surgery but since it's on your abdomen, I think it will hurt some. But I'm sure you'll get some pain relief, such as morphine.

E: What is morphine?

N: It is a pain relief medicine which we can give in your mouth or via a cannular and you can push a button when you're in pain and receive a dose. It's called a PCA which you control.

E: What about going after?

N: Do you mean when you pass stool?

E: Yes

N: Well, it's going to be a while before you do that but I don't know.

E: But what do you think?

N: Well I think it shouldn't hurt because I don't think they are going to touch anything in that area. I think it's only going to be your stomach they touch

E: When can I eat?

N: I think possibly the day after your surgery.

E: What! I would have been starved for two days. That's not happening. I'll eat. I don't care what anyone says.

At this moment I thought I should back-track and reassure her since I was guessing.

N: Well they are going to handle your bowel which is part of your gut and this will affect when you can eat.

E: But this is about pooing not eating.

N: Well it's all linked from your mouth right to your anus.

E: You know that it is a mile long. A mile long, all in there. She pointed to her stomach.

N: You are right about that. How come the person who 'consented' you did not speak to you about the procedure?

E: The doctor who came was rude and nasty.

N: That's not fair on you. Listen, I'll' say at handover that the surgeon needs to speak to you before the procedure so that you can ask your questions. And one of us can be with you if it helps.

E: OK.

Eva asked me to get her lucky pyjamas. I did, and then asked her to take her medication as her scratching had become more frantic. She sat up and put about eight tablets into her mouth at once, took a drink and swallowed them all.

OBSERVATION OF THE GROUP DISCUSSION

The case is a moving blend of questions that are harrowing in their simplicity and a routine intended to reassure and allow difficult procedures to take place. Many details about hospital life emerged in discussion. Some procedures had to be carried out by the surgeons and this would involve sending a patient away from the Ward. What place would there be for anxieties such as where a scar would be left due to the passing of blood through the dialysis machine? Would it be below the neckline or above the elbow, so that it could be hidden? What to make of the possibly divergent opinions between medical staff, the lady and her relatives? Would it be dangerous to acknowledge that this could be an important issue to discuss, given the life and death quality of the work on the Ward? For example a site on the arm below the elbow was often chosen for the link to the dialysis machine when operating, so that if it became infected, it would still be possible to insert another above the elbow. The price of failure would be savage.

It seemed possible that these simple yet heartbreaking questions were being evaded since the consequences of trying to give an answer would uncover other questions for Eva such as 'How on earth did I lose limbs, continence, the possibility of a sexual life because of a delay in correctly diagnosing a headache?' Enormous efforts were being made to keep Eva alive and motivated to live. There seemed to be a very fragile line between supporting her efforts to emerge from a state of withdrawal from life and allowing her to voice something of her pain and rage at what had happened, with all its dreadful consequences.

It was clear to me that there was enormous tension in the seminar room at times. The group was distressed at being part of a drama of life and death played out behind a scene characterised by a succession of trivia. How could the facts of bilateral amputation, the loss of fingers, the insertion of catheters, and anxiety about the imminent operation be reconciled with the picture of the dedicated lady, or with the apparently insignificant request for orange squash rather than plain water? It seemed gradually to become clear that whilst the members of the group were following the banality of the conversation, they felt filled close to bursting point with the intensity of the tragedy. There was a sense of being asked to bear something apparently missing from the day-to-day exchanges on the ward. Why was there such a disparity between the acutely painful circumstances of the patient and the muted reactions of hospital staff who were dealing in such a matter of fact way with this tragic situation? A similar imbalance seemed to be observable within the seminar itself, particularly in the interchange between the presenter and the rest of the group. Dialogue was difficult for a while, and it seemed that the presenter felt she had to defend the good reputation of the hospital and hold onto a rigid definition of her job.

My dilemma was that whilst I was aware of the impatience, even desperation, of the seminar group for something interpretative to be said to Eva, I felt great sympathy for the plight of her nurse who was clearly troubled by not feeling able to expand her role. In fact I was strongly put in mind of a similar situation I had encountered when carrying out some consultancy work with nurses from a hospital ward on which there were a number of very sick persons and seniors, many of whom did not recover. I was grateful for the way in which this situation came to my mind when I felt quite caught between opposing views, and could see no clear way of taking the discussion forward. I will describe what I found myself recalling.

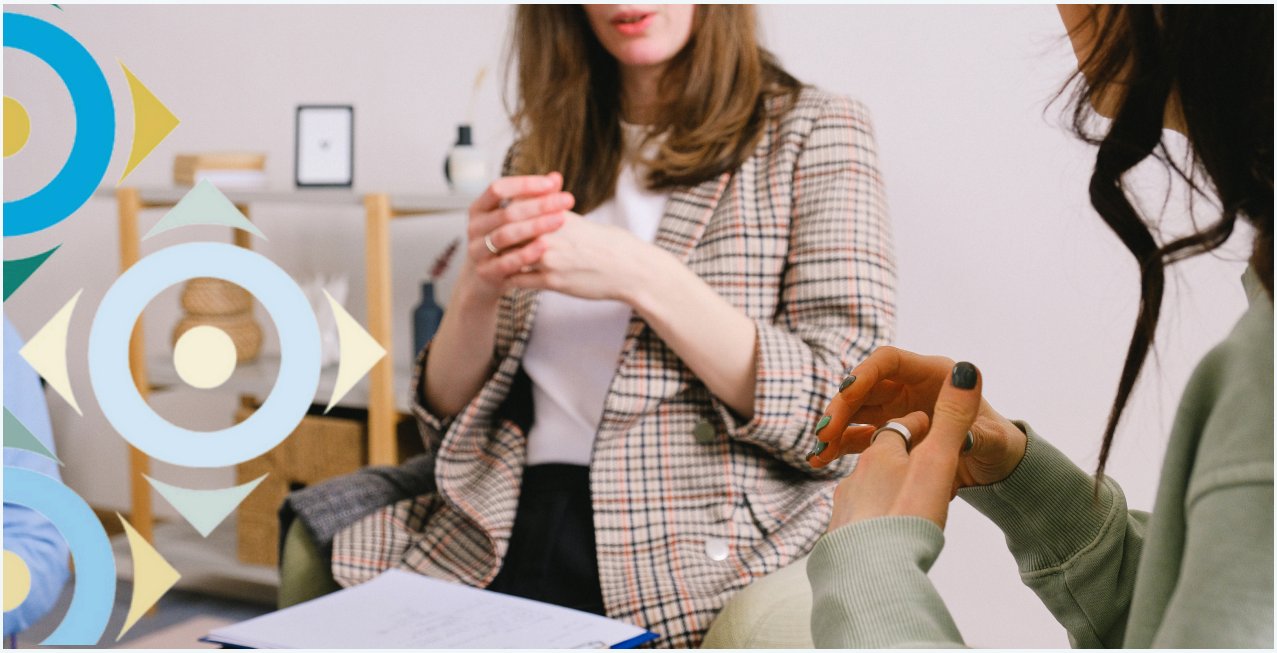
- *My consultation had been arranged by the Medical Consultant who felt that the nurses would be helped by having a regular space to talk and think about the harrowing situations they had to deal with. I was very impressed by the quality of the work being carried out, but, from the beginning it was apparent that there was a feeling of ambivalence in the group. The group could not manage either to attend regularly or describe their work when asked to do so. The presentations were usually verbal and it was stated by a number of presenters they had not felt able to sit down and write down what had happened. They felt that what happened on the ward was dire enough, but to write something down would be to invite unwanted feelings to return whereas all they wanted to do was to forget it.*

- *This was illustrated powerfully by one nurse describing a disturbing time spent with an old man, suffering from the effects of an aggressive cancer. As she sat with him, she found herself hoping that the man would die. The medical staff seemed to have a different viewpoint.*

Indeed the man's deteriorating condition was pushing them to further action as they obtained the relatives' permission to administer a newly developed drug in the hope that it would lead to a halt in the inexorable progress of the cancer. The intervention was not successful, and the man died at 3 o' clock in the morning. The nurse presenting was clearly very upset at the feelings at that time. She went on to say that it was Christmas morning, and she was on duty three hours later. Indeed sometime previously she had volunteered to be Father Christmas and found herself forcing 'Ho, Ho, Ho's' out of her mouth whilst the rest of her was 'in the same place as the man' (her words).

In other words feeling that life had ended. Later that day, to her surprise and subsequent embarrassment, she became extremely irritated with the relatives of another person who had complained to her that one of the hospital's TV sets had very poor reception, and this was ruining their favourite programme. She was so angry with them about what she regarded as selfishness that she could barely wait till the end of her shift, when she was able to do 'kick-boxing' to get it out of her system. When she had finished her account, most of the group nodded their assent. They clearly expected me to dispute the premise that events which are very upsetting need to be got rid of rather than be processed. I felt challenged to defend the decision to convene a meeting about their work, and I felt that unless the defence of it came from within the group itself, this would be the end.

Her words, deeply felt, moved the whole group. Afterwards, I found myself wondering about the different responses to the presentation, one to defend against emotional suffering and the other embracing it as a necessary price for keeping in touch with what mattered, without which one risked being cut off from one's own feelings.



This digression will, I hope, have served to illustrate the situation I encountered in the seminar whilst considering the material from the Renal Unit. The presenter's position was a complex one. One concern was how to manage the routine of death on the ward, and at the same time how to help patients go on with their lives no matter how catastrophic their illness and injuries. As a consequence, a patient's merest indication of a wish to have a future tended to be seized upon.

But what of the response of the seminar group to this scenario? There was a powerful realisation within the group that they were in fact in touch with a quite appropriate sense of sadness and despair, feelings which could not be voiced easily by Eva or the nurses on the ward. It was at this point those terms I had mentioned in discussion such as 'evacuation' 'projection' and 'splitting' took on a very different meaning. The group had experienced something emotionally profound.

They were able to apply psychoanalytic concepts to their understanding in an experiential way. It was quite clear that learning in this way was quite different from merely learning about something, as if it were merely a descriptive process.

The group's realisation of the major forces set loose by such tragedies made it possible for horizons to be broadened and other issues to be considered. It was possible, for example, to consider some larger institutional issues. Did counselling on the ward have to be considered only as a formal referral option or would it be possible to think about the emotional needs of patients in a less formal way and in an everyday context? This question led to thoughtful discussion about what sort of comment might be made on the Ward, and to a greater understanding of the importance of ongoing relationships within the ward setting.

Ultimately, the presenter herself felt sufficiently supported by the Seminar setting to raise the following broad questions about practice:

- **Why does looking after a sick person, senior or young, make it difficult to look beyond the physical needs?**
- **Why is it difficult to organise a team, communicate effectively and listen?**
- **How does one help a person to understand their own mortality?**
- **Are the boundaries of a nurse's role the real obstacle to allowing some thinking/talking beyond the physical problems requiring care?**
- **Is it lack of time or fear of what might be said or revealed that makes it difficult to start talking about the emotional and psychological issues?**

These questions were related to some further reflective points explored in the seminar:

- the effect of working in a high stress, high demand environment
- dealing with life and death everyday
- the difficulty of providing real emotional support, to allow space for patients and relatives
- a setting very focussed on the pathophysiology issues with comparatively little time invested into the psychological or emotional side of the patients' care.
- lack of resources outside the hospital for the continued provision of support once the patient is discharged.

It will be evident how wide-ranging the issues the seminar members could gradually struggle with in response to this particular presentation.

What if participants are reluctant to share personal challenges?

Start by discussing less personal topics or general cases. Build trust over time and reinforce confidentiality to create a safe space where participants feel comfortable sharing

Can WDGs be conducted effectively online?

Yes, online WDGs can be highly effective. Use interactive features like breakout rooms and chat to engage participants and consider pre-session reminders about online etiquette to ensure everyone feels connected.

What should I do if discussions focus too much on solutions instead of reflection?

Gently redirect by reminding participants that WDGs are about exploring underlying emotions and dynamics. Ask questions that prompt reflection on feelings, perspectives, and broader implications rather than direct solutions.

How can continuity between sessions be maintained?

Begin each session with a quick recap of previous discussions or key insights, and encourage participants to think about how they've applied past reflections. This reinforces a continuous learning process.

How can scheduling conflicts be minimized to ensure consistent attendance?

Consider participant availability when setting the schedule, and offer flexible options such as recordings or session notes. If possible, agree on a consistent time to foster routine and commitment.

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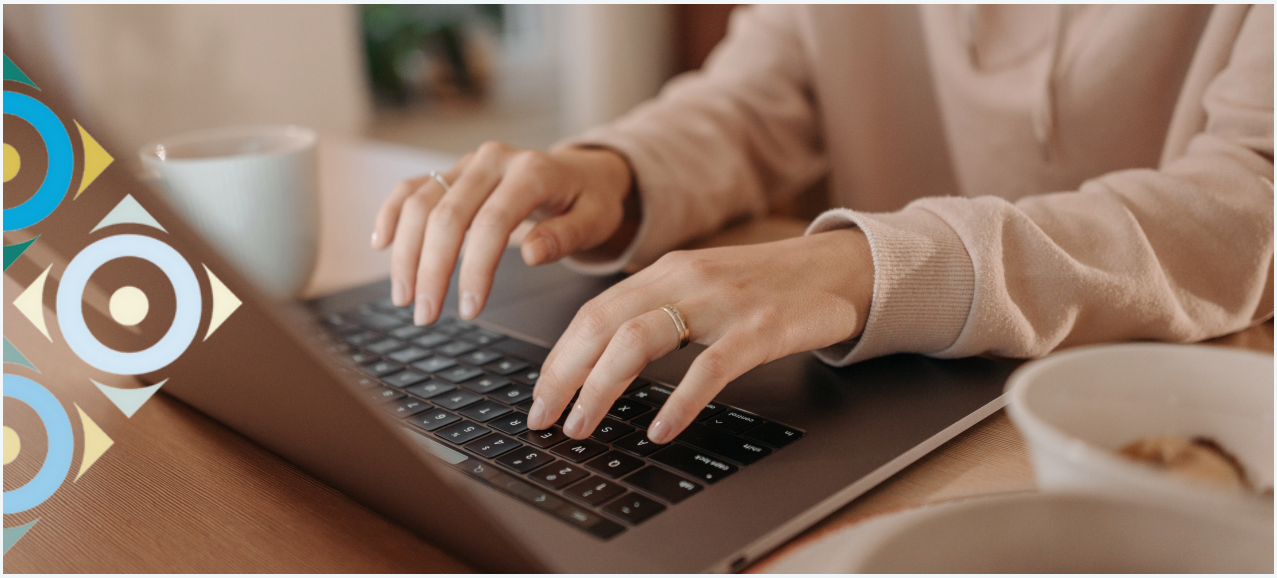
THE MULTI-LANUGAGE BLENDED LEARNING - CARE MANAGERS AS DRIVERS OF PCC

BENEFITS OF WORK DISCUSSION GROUPS

COMMUNITY OF PRACTICE

COMMUNITY OF PRACTICE - SESSION 1 RECORDING



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