

The Patient as Participant in Supervision

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In my work as psychotherapist in psychiatric care, I have met patients and their families in diverse situations. I will focus on an experience I had as supervisor on a psychiatric in-patient ward; a difficult situation where the patient's participation was important in resolving the impasse we had reached. This experience changed my perspective as well as my way of doing supervision. A few words should be said about the background and the context.

Context

The unit is a ward with twelve beds. Patients can be admitted there for a variety of psychiatric reasons, no condition is excluded. The ward, together with the out-patient clinic, has the overall responsibility for all needs of psychiatric help within the local community. In meeting with patients and their families, I am oriented towards a language systems perspective. This includes the notion that our psychological realities are co-constructions, influenced by participants in the ongoing conversation. I think that there is no one true reality or story, waiting to be "uncovered" or explained. There might be one story more dominant than another and my undertaking is to create possibilities for a more open dialogue between these stories. A polyphonic perspective, the idea that there may be "several subjective voices" simultaneously needing to be heard (Bakhtin, 1984) is applicable during the treatment meetingⁱ. I value treatment meetings with participation of patients and their relatives or other people who have significance for the patient in the situation. Equally important in my theoretical perspective is the reflecting team.ⁱⁱ

Also, from Western Lapland, in Finland, I have "borrowed" the idea that you should not talk about the patient or his/her network unless these people are present and participating in the conversation.ⁱⁱⁱ I am very much in favor of that approach but have not used it in the context of supervision. The traditional way of supervision, as I understand it, and as related to the staff at our general in-patient ward, could be defined along with Gerald Caplan's terminology as alternating between the two categories:

- client-centered case consultation
- consultee-centered case consultation^{iv}

In these supervision sessions the patient is not present, only me as supervisor and the staff members.

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The contrast between the treatment meetings and family talks, where the patient naturally was present, and the patient's "natural" absence in the supervisory situation, started coming back to me like a recurring toothache. In my inner dialogue the idea of the patient taking part in supervision was evoking many obstacles and few possibilities. The opportunity to invite the patient to a supervision session came when I found myself at an impasse and needed help from outside.

An Idea

What constituted the impasse? In our supervision a picture emerged that the staff had divided into two groups in relationship to a patient. My effort to get the groups to listen to each other had not been successful. Not an

unusual situation for a supervisor, however, this time it was more frustrating for me than before. I walked around carrying two contradictory monologues in my mind, both starting to sound like definite truths. Intellectually I saw that both perspectives had something to tell, the problem was that no one was ready to listen. Someone has said “the propaganda starts where the dialogue ends” which described this situation. It was evident that the staff groups misunderstood each other and the dialogue broke down.

The patient, noticing the different discussions going on in different closed rooms, developed an even more destructive behavior in relationship to the staff. As defined by the *DSM IV* the patient exhibited manic behaviors meeting the criteria for a diagnosis of manic-depressive psychosis. She periodically and forcefully tested hospital rules and staff boundaries. In this situation I suggested that we should change the supervision setting. We would invite the patient and work as a reflecting team. After a few days hesitation, both patient and staff agreed to give it a try.

Practice

Who participated? Usually the teams had supervision separately, each in their own group. This day we asked representatives from each team to participate in a joint supervision group, also including the patient and one of her two contact persons on the ward. So, the participants included the patient and one of her contact persons on the ward. Also people representing the two staff groups at the ward, two from each “camp” and me, totaling seven people.

What was the structure of the meeting? Beforehand we had agreed that I was going to start by interviewing representatives from the two staff groups. The patient and her contact person would be in a listening position; not talking to us, sitting in the same room but a little to the side. I asked the interviewees to talk from a personal perspective about their own experiences in relation to the patient. I asked them to talk from two different perspectives:

- dilemmas/difficulties
- resources/possibilities

As they were talking, one at a time, I asked questions encouraging them to be clear and specific. I also jotted down some of their wordings on a large pad of paper, making it easier for all to follow the conversation. After this the patient and the contact person had the opportunity to reflect on what we had discussed in the interview. The interview group, including myself, remained silent. Then, the staff group and I reflected on their discussion. Finally the patient

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and the contact person got a second chance to comment on our

reflections. Before I closed down the meeting we all talked about the question: What was it like to do this: good/bad?

What happened?

A few short remarks:

Initially, having arrived in the room, Lena, the female patient, said: “Oh, are there so many people who will talk about me?... I think I will stay for five minutes...” I told her that she was free to leave the situation if it put too much of a strain on her. She stayed for the entire sixty-five minutes! She stayed even though the staff members were open with their reflections about difficulties and possibilities. Or, was it *because* they talked about her openly in her presence and not behind closed doors?

Before we started, I turned to the patient and her contact person, saying that there were many different thoughts and ideas about how, and if, we could be of any help to her. I said that, in spite of the differences, I was convinced that each one wanted to be of help to her, but for the moment we did not exactly know how.

Then, What Happened?

It was interesting to see how the participants in this new setting generated a new dialogue. Gradually, it became possible for the different opinions and experiences to exist openly, in the same room. The two staff groups started to listen to the viewpoint of the other group in a new way. When they talked with each other, sharing experiences, they used different words than before. For example: Instead of saying [about the patient] “...she is all mad and crazy, look at the way she is screaming towards us,” came this: “I became angry and felt hurt when she was spitting at me and

calling me a bitch.” Or instead of saying: “they [meaning the other staff group] never put any limits to her behavior, only we do.” They now could say: “when we have different limits in relation to Lena and what she is allowed to do, it is getting worse for everybody, for you, for us and for Lena.”

Evaluation and Comments

The patient was able to stay with us through the meeting. How come? When I asked her afterwards she said two things: she learned things she did not know before, and, she recognized things, like someone really cared about her, although the situation was difficult and that someone else had annoyed her a couple of times. In addition, I think that her initial nervousness turned into curiosity and a wish to comment and make reflections.

When I asked two staff members who took part in the meeting for their comments, among other things they said:

- The supervision became more constructive, it didn't go astray as much [Christina, nurse]
- You as supervisor didn't end up in one of the two “camps” that had developed. [Naimi, mental health worker]
- To be more open, in the presence of the patient, is a matter of training for us as staff members [Christina, nurse]
- It became obvious that everyone had a responsibility for the situation, and was trying to do something about it. All who participated heard the same thing. [Christina, nurse]
- In the role of contact person you can feel very lonely, so it was very good for me, not only for the patient, to hear that people did care for both of us. [Naimi, mental health worker]
- But... in some situations of severe deadlock all staff members need to meet each other. In this situation only a few participated... is there a risk that what we achieve does not get anchored in the whole staff group? [Christina, nurse]

In earlier supervision situations I had not been able to get the different groups to listen to each other – what made it happen this time? My own ideas about what contributed to the change coincide to some extent with the comments above:

- The presence and participation of the patient
- In this open talk the staff groups used a different language, less intrusive and offensive and yet not ignoring difficult issues.
- Staff members allowed themselves to be more openly uncertain; less convinced that they knew the truth.
- Staff members' responses to my questions focused on their behavior in relation to the patient, not the other way around.
- Among these responses were experiences that got verbalized for the first time. This also bears upon the patient's reflections.
- Another kind of listening was possible.
- Mutually, the view of the other changed from more observing to more participating.
- We all moved from a monological talk to a more dialogical talk

Harry Goolishian (Anderson & Goolishian, 1988) and Gregory Bateson (1972) among others said that “You cannot change other people; you can only change yourself and your relationship to others”. That is what I think happened here. A sentence from Martin Buber also came to my mind: “In a true dialogue, each member has to contribute with himself – fully”^{vi} Possibly, something along that line also took place? The presence and participation of the patient led to a change we would not have accomplished without her. I think of the “resurrection” of the broken dialogue between the staff groups and between the staff and the patient.

Was this openness humiliating for the patient? When I asked her she did not think so. She later agreed to take part in another meeting with the same structure, during her stay at the ward. Here I am obviously making a choice, based on an ideological stance, I listen more to what *she really is saying* in her evaluation rather than trying to figure out what she is *not* saying. For several years I have come across literature where therapists have underlined the importance of listening more to the “voice” of the patient in evaluation of therapy.^{vi} This reading has come to underline my choice to listen to what people are saying, and to give up the option of interpreting their words on another level, as often is done unless you make the choice to listen to what is actually said.

Was there something in this way of applying the reflecting team that could have made the situation abusive for the patient? My experience is that comments and reflections that tend to be normative, without people asking for that,

make them stop listening. Michael White (1999) describes this as a risk when using a reflecting team. He calls this *statement of judgment*,^{vii} In order to meet with this risk he “instructs” the patient/family to notice if there are evaluations or judgments of their life in the reflections they hear. If so, he wants them to comment on that.

I see that as an important remark. Sometimes I have experienced normative judgments coming more from staff/therapists being familiar with the reflecting team as a method, than from “beginners”. What I mean is that when some staff members got use to the new way of working with the reflection processes, they forgot that uncertainty was not something to “overcome” and be less uncertain, instead of remembering that uncertainty, in the meaning of let a question/a reflection to be “hanging in the air”, was a way to invite others to raise their voices and that way facilitate the re-building of a dialogue.

Finally, have we practiced this changed supervision context several times at the ward and with other patients? Yes, although the traditional supervision situation tends to be more common. The changed context has not been applied to any specific group of patients. That which has made me consider this way of working tends to be situations where I as a supervisor have seen signs of staff members dividing into separate groups in relation to a patient, and have seen an escalation of destructive communicative behavior.

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My task as a supervisor has then primarily been to introduce and keep the structure of the meeting in order to make the situation perceptible and to some extent predictable for participants. I would like to encourage those of you who have supervision assignments and have

good experiences from reflecting team work, to try this way of doing supervision. It helped me to understand that even as a supervisor you can talk about and share difficult situations with your supervisees and include the patient. It can be rewarding for the patient as well as for staff and supervisor. In our work it has sometimes been evident that the presence and participation of the patient was a prerequisite for us to resolve an impasse.

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Endnotes

ⁱ Treatment meeting is defined as in the psychiatric clinic of Keropudas, Finland: A meeting where the structure and the content of the treatment is *defined* and *planned*, together with those who are concerned. These meetings can simultaneously function as a therapeutic forum and a treatment planning situation.

ⁱⁱ I refer to the way of working introduced and in several ways developed by Professor Tom Andersen in Tromsø, Norway. (Andersen, 1990, 1995, 1997).

ⁱⁱⁱ The work is extensively presented in Swedish in Jaakko Seikkula's book *Öppna samtal*. See also Seikkula et al (1995).

^{iv} Caplan notes additional forms of supervision. Here I mention the ones most often used at the psychiatric in-patient ward in Skellefteå.

^v Martin Buber does not directly refer to psychotherapy when he talks about "a genuine conversation". I make this connection here because I think that we have a challenge to develop the therapeutic conversation to an even more equal and mutual situation than what is common in psychiatry today. This includes being more personal, without being private, in relation to the patient and his/her network. (The quote is translated from the Swedish version of his book *Between man and man*).

^{vi} Three examples:

Anderson, Harlene (1997) *Conversation, Language and Possibilities*.

Miller, Scott et al (1997) *Escape from Babel*.

London, Sylvia et al (1998) *Clients' Voices: a collection of Clients' Accounts*.

^{vii} White, Michael (1999) Reflecting team work as definitional ceremony revisited.

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