USING PSYCHO-DYNAMIC SMALL GROUP WORK IN NURSE EDUCATION: CLOSING

THE THEORY-PRACTICE GAP?
ABSTRACT
This paper illustrates the role of psychodynamic small group work in integrating theory and practice for nursing students. Psychodynamic work with individual patients and in small staff groups is well established in medical and nursing practice. Its use in nursing education is not as widely known. I present material brought to two group supervision sessions by student nurses and discuss this material using the psychodynamic perspective. I illustrate how supervision can assist students to integrate theory and practice. Understanding the theory – practice gap from a psychodynamic perspective may help nurse teachers in their personal tutor work to integrate theoretical and practical learning for students. I argue that reflecting on feelings in small group work with student nurses with a tutor or supervisor who works psychodynamically may help students integrate their theoretical and practical learning.

KEY WORDS
Emotions
Small group supervision
Theory-practice gap
Student nurses
INTRODUCTION
The psychodynamic approach has informed psychiatric nursing practice and medical care (Jackson & Cawley 1992; Lustig 2009; Martindale 2007) in both community and inpatient settings internationally. It has been used in small group teaching in general nursing with student nurses (Fabricius 1991; 1991b; 1995; Franks et al 1994; Gilmartin 2008; de Grave et al 2002) and trained nurses (Ashburner et al 2004; Clifford 1998; Irwin 2006). This body of work shows that small group work can help nurses and doctors work therapeutically through reflection and learning from reflection. There is a small amount of international work (Klitzing 2001) but the concepts of psychodynamic nursing are universal (Peplau 1952/1991) although the policy context in which nursing takes place varies. There is more internationally published work related to psychodynamic medical practice (Lustig 2009). This paper discusses how using a psychodynamic approach in small group work with nursing students may facilitate learning and in particular, assist them to integrate theory and practice.

BACKGROUND
Isabel Menzies-Lyth-Lyth, a psychoanalyst, suggested that nurse-patient relationships change ‘ordinary’ social relationships and that there is a need to manage the intimate and emotional nature of these clinical, ‘non-social’ relationships (Menzies-Lyth 1970). It seems to me that her observation is as accurate today as it was 39 years ago. Learning to work with feelings means that, following Menzies-Lyth, the nurse is aware that as well as the clinical dimension of delivering care, there are also social and emotional processes at work in interactions with patients which affect how we feel (Fabricius 1999). Sometime we are aware of these feelings and can reflect in action – this means we are able to recognise the patient’s feeling and our own responses, and act appropriately. Sometimes we can only reflect on action, i.e. after the event and learn from that reflection to work differently in similar situations in the future. This approach derives from Freud’s theory of psychodynamics or psychoanalysis (Fabricius 1991b; 1995).

In a recent study of clinical leadership for learning, Allan et al (2008) found three conditions should be present for successfully supporting students in their learning in practice: good conceptual and structural links between theory and practice; good mentoring relationships; students needed to be able to negotiate supernumerary status and the expectations of ward staff that they learn through work rather than working under supervision.

In this paper, I suggest that working with feelings is as important now as when Menzies-Lyth first observed nursing practice because the conditions outlined above are frequently not present and students end up feeling unsupported and unable to link theory and practice effectively. I draw on my work as a personal tutor to explore how small group supervision work with students which is psychodynamic can help link theory and practice.

DATA SOURCES
The databases searched to inform this discussion were: BNI; CINAHL; Medline(Ovid) & Medline Pubmed; PsycInfo; IBSS. The inclusion criteria were as follows: English language, peer reviewed, national and international journal papers from 1990 until 2006. Key words used included: psychodynamic nursing; psychodynamic small groups; theory-practice gap; stress; student support.

A psychodynamic approach to emotions is the systematised study and theory of the
psychological forces that underlie human behavior, which emphasises the interplay between unconscious and conscious motivation (http://en.wikipedia.org/wiki/Psychodynamic). The emotions that Menzies-lyth argued are at the heart of the nurse-patient relationship (also suggested by Peplau in her theory of psychodynamic nursing, 1952/1991) are frequently unacknowledged because they are uncomfortable; there is nowhere and no-one with whom the student can discuss these feelings (Fabricius 1991a; 1991b). They remain unconscious but nevertheless active in determining behaviour (Peplau 1952) and Fabricius (1991b) argues that positive and negative feelings need to be acknowledged and utilised to be therapeutic. One principle idea from psychodynamic theory is useful in exploring the effects of emotions on clinical interactions: the unconscious repression of painful emotions

Fabricius (1991b) has described the psychoanalytic perspective as concerned with ‘processes which involve opposing forces and conflicts’ (1991b, pp.135); these opposing forces are emotions in Fabricius’ view. Emotional conflicts arise from the interplay between biology, social conditioning and internal psychic processes unconsciously and consciously (Fabricius 1991b; Mitchell 1974). The unconscious is the site where anti-social emotions are repressed, that is, not made conscious or raised to awareness (Barber 1991; Mitchell 1974). These emotions are most commonly aggressive or sexual and can exert an influence on behaviour especially in times of anxiety or stress while remaining unconscious (Barber 1991; Fabricius 1991b; Ross 1995). For example, consciously, a nurse knows she must be polite to a demanding patient but unconsciously, she may feel anger towards the patient which she represses. Her repressed anger may be obvious in her body language but she is not aware that she is angry. These internal, unconscious conflicts are present in human interactions and, of course, between staff and patients, becoming evident in slips of the tongue, jokes and sarcasm (Ross 1995). A nurse may, on the other hand, consciously be angry with a patient but suppress her anger. This conscious suppression is a different process to repression. The nurse is consciously aware of her feelings although she does not express them (Badcock 1992).

Psychodynamic nursing was first theorised by Peplau in 1952 (1991) to describe nurses working individually with patients and the feelings in the nurse-patient interaction. Peplau argued that such an approach could improve patient outcomes. The form of psychodynamic work more recently developed in nursing education and nursing practice builds on Peplau’s work but has been further informed in the British context by British psychoanalysts, Menzies-Lyth (1971) and Fabricius (1991a; 1991b; 1995). Psychodynamic small group work occurs when a supervisor meets on a regular basis with a group of students (Fabricius 1991a) or trained nurses (Irwin 2006; Ross 1995) to work with feelings which the group brings from practice (Clifford 1998). Working with feelings means that distressful feelings are expressed in a safe environment and thereby contained; the nurse can then unlock the repression or suppression they might be using to help cope with painful feelings which are evoked in practice. Working in this way helps participants tolerate the difficult feelings that are part and parcel of nursing practice (Ross 1995).

Stress has always been a feature of student nurse learning, in particular, the care of dying patients; placement relationships and feelings of incompetence (Parkes 1985). Additionally, following the move to higher education, students’ stress is reported to arise from difficult ward relationships arising from misunderstandings between teachers and
practitioners as to the aim of new curricula (Hamill 2006; Landers 2008) and confusion over the link teacher’s role (Smith & Gray 2001; Allan, Smith, O’Driscoll & Lorentzon 2008; Landers 2008) as well as a theory-practice gap (Allan et al 2008; Cameron 2009; Landers 2008). Indeed, the Leader of the Opposition in the UK (Cameron 2009) has recently criticised existing theoretical courses for nurses. Allan, Smith & Lorentzon (2007) argue that nursing education and clinical practice are structurally uncoupled because of the commissioning and contracting arrangements between institutions of higher education (HEIs) and the National Health Service (NHS) and the location of nurse teachers in HEIs which has increased the theory-practice gap for both teachers and learners. Allan et al (2007) suggest that the theory-practice gap is both structurally reproduced in three ways. Firstly, through the commissioning and contracting arrangements between institutions of higher education (HEIs) and the National Health Service (NHS) (Horrocks 2005; Williams & Taylor 2008). Secondly, through the sharing of students’ learning between practice and HEIs which has highlighted differences between HEIs and practitioners around the nature of learning (Burkitt et al 2000) as well as revealing a discrepancy between these partners over the meaning of fitness for practice (Boogaerts et al 2008). And lastly, through the location of nurse teachers in HEIs (Elliot & Wall 2008; Williams & Taylor 2008) which has increased the theory-practice gap for both teachers and learners.

To support students in their learning and address the confusion over the role of the nurse teacher (Landers 2008; Smith & Gray 2001), both placements and the universities have had to provide support and new roles have emerged. For example, Allan et al (2008) found that a variety of student support interventions are described in curricula documents; they include pastoral support by personal tutors, the role of trust employees such as mentors, placement co-ordinators, practice educators and university wide student support agencies. However there are both differences, in the emphasis that universities place on the type of support offered, and confusion over the exact terms used by different universities to describe the support roles offered to students. Some universities address the issue of the student’s position between practice and the HEI through the provision of online learning opportunities, access to online communities of practice and clear guidance on being a student. However Allan et al’s findings (2007; under review) show that such systems may be in place but students, mentors and staff continue to experience the tensions borne out of the gap between education and practice following the move to higher education. The use of small group psychodynamic work has not been a popular approach in nursing education despite its use in medicine (Martindale 2007) and other fields of nursing (Clifford 1998; Irwin 2006).

DISCUSSION

I am a personal tutor to a group of undergraduate nursing students who have brought the feelings they struggle with to a monthly supervision group over the last year which I run. I am their 2nd personal tutor and they have never worked in this way before. I run the group on psychodynamic lines and I have been supervised throughout this period in group supervision with professionals from other disciplines. Each week the students reflect on their learning in practice by bringing issues from practice to talk about; these issues are related to feelings which the students find uncomfortable and which are often related to caring for dying patients; working as a student as an ‘outsider’ in ward teams...
and feeling incompetent. Another aspect of their learning which students bring is their academic work. At first, I was unhappy about spending time in the supervision discussing academic work; but towards the end of the group’s life I realised that I was reproducing the theory-practice split for students in the group by insisting that they bring on clinical work. It is only on reflection after the penultimate supervision, when discussing their academic work, that I was able to integrate their academic and practical work in my own mind.

I shall use material from two supervision meetings to discuss how small group, psychodynamic work may help close the theory practice gap for students and their nurse supervisors.

**The material**

In the 1st supervision session, all of the five students immediately said they wished to use our supervision to focus on their dissertation (I was also supervising them for their individual dissertations although not marking them). I was somewhat disappointed by this but nevertheless reflected to the group that while our work could focus on feelings, academic work was often stimulated by a problem in practice which itself arose from a feeling about that problem. In that way, we could focus on both academic work and feelings. We spent the rest of this session talking in general terms about their dissertations.

In the 2nd supervision, Phoebe said she had thought of a problem she felt strongly about which might be the focus of her dissertation; this related to an experience she had had while in her palliative care placement. Phoebe had told a psychologist working in the palliative unit that if she, Phoebe were dying, she would be crawling up the walls. The psychologist had suggested that Phoebe needed to talk about this with someone. Amy immediately said that it appeared to her that nurses ‘don’t like to talk about their feelings’. She had been caring for a dying patient with her mentor and had left the room because she had become upset; when she came back, she apologized to her mentor who said ‘Oh that’s okay’ and after a pause, ‘Now let’s get on with xxx’. Amy concluded that nurses find feelings difficult; no-one had asked her about whether she had seen a death, or prepared her for caring for dying patients or dead bodies and her mentor did not take this opportunity to discuss why Amy had been upset. Becky then said she felt that death was ‘draining’ and described a young man dying in intensive care and how the whole team had cried. She finished her description by saying, ‘Now you couldn’t do that all the time could you?’ – perhaps meaning the crying. Sarah immediately added her own example of a woman dying from bleeding oesophagaeal varies and how painful she found this death. ‘There was blood everywhere; we had to clean her up and stop her family coming in. It was too distressing. It was awful’. There was a silence and then I mentioned coping and we talked about how they learnt to cope when faced with difficult clinical situations. Shortly before the end of the supervision, Phoebe said ‘I don’t like doing work as an agency carer because of getting dirty in my own clothes’. Our discussion talked for about five minutes to what purpose a uniform served and then we ended the supervision.

After the 2nd supervision, Phoebe sent me her proposal for her dissertation which is about death anxiety and includes a qualitative research proposal for exploring nurses’ feelings about death anxiety.

**Reflection and learning**

Reading this material again after presenting it to my supervision group, I am struck by
how quickly the experience of death was raised by the students – almost within the 1st five minutes of the 2nd supervision despite their focus in the 1st supervision on academic work. I wonder if they were given permission by me as the group leader to think about theory and practice together when I suggested that a problem in practice might be the start of thinking about their dissertation. Their descriptions and anxiety over death seems to be an example of what Menzies-Lyth (1971) described is at the heart of all nurse-patient relationships – caring for (dying) patients produces anxiety which evokes emotions but these are denied. While at first, I wondered if bringing death as material was extreme, I remembered Taylor (2006) who argues that the task of the National Health Service is to use knowledge to deal with the technical and socio-emotional aspects of illness and damage, birth and death. Nurses encounter death frequently and learn to manage their feelings as Amy’s mentor showed her; in fact, Phoebe’s experience, where the psychologist encouraged her to talk to someone about her feelings, seemed to contrast very much with Amy’s, where her mentor role did not talk about feelings and turned to the nursing work as a distraction. Ross (1995) argues that in certain areas, such as palliative care, primitive unconscious emotions surrounding life and death are aroused constantly. Primitive in this instance means the feelings which are evoked in the *id* deep within the unconscious but rarely acknowledged consciously. Their anxiety is further illustrated by Becky and Sarah’s descriptions of death as ‘draining’ and ‘distressing’.

During the supervision, I felt overwhelmed by their feelings of anxiety and at moments wondered how I would survive the 55 minute supervision session! At the end, I realised that they had all helped each other by listening and offering experiences through sharing; not in a ‘one up-man ship’ way but by quietly reflecting on their shared experiences and feelings. I had an urge to point out this learning but managed not to and was pleased with being able to manage my own feelings; in a way, I mirrored the students’ own learning to manage their feelings. However I had some lingering doubts as to how this supervision helped these students integrate theory and practice. Fabricius (1991b) commented on working with tutors in a psychodynamic small group, that the tutors brought material from their experiences with students which either arose from the students’ experiences with patients or from their academic work. Despite being a member of this group of tutors, I had somehow ‘forgotten’ this acceptance of academic work as material for discussion in the group. I do not remember now if this is because we generally focused on student-patient material. However I find this forgetfulness interesting in the light of the literature on the theory-practice gap and my resistance to integrating theory and practice for my students.
I think my forgetfulness can be understood by framing it within the model of splitting and projection. Splitting can be defined as occurring when the individual unconsciously separates good and bad feelings in situations which evoke powerful feeling (Fabricius 1991b); that is, the individual regresses to an infantile or childlike state when such splitting is routine and an experience the individual learns from (Theodosius 2006). Projection is when the individual locates the painful emotion experienced in another person. – the projection of painful feelings into someone else (Fabricius 1991b). These defence mechanisms act to protect the individual against the ‘primitive’ need and anxiety raised by the awareness of emotions. In their descriptions of their experiences of feeling unprepared for death and dying, there were also comments and criticism about the practice staff, their mentors but also their tutors in college. These students seem to feel that they should be prepared by someone but that this preparation falls between the gap between college (theory) and practice. This situation of blaming the college and/or practice is an example of splitting and projection. The students split the painful, bad feeling (anxiety from not feeling prepared to care for dying patients) from the good feeling (I am a good person) and project the bad feelings into the college or their mentors. It seems to me that my forgetfulness was part of a group split and projection until I was able to reflect on Phoebe’s dissertation and integrate for myself her theoretical and practical learning. On reading her work, I realised that she has processed her feelings and understood them as part of a system which denies death anxiety; much as Menzies-Lyth (1971) understood nurses’ defences against the anxiety of caring for patients as part of the whole system of nursing.

**IMPLICATIONS FOR NURSING**

The theory practice gap can sometimes feel like a fact of nursing life; it exists but of course each of us reproduces it in our teaching (as I have shown) and in our practice (as the material described here shows). I have described how the theory-practice gap is reproduced psychodynamically in the splitting and projection of painful feelings by students and their supervisor. From my experience with psychodynamic, small group work with personal students, I would suggest it is possible to integrate theory and practice for our students and ourselves if we reflect and recognise the split and projection by working psychodynamically. By integrating theory and practice internally, it may be possible to integrate at the structural level also. The implications for nursing from this discussion are that understanding the theory – practice gap from a psychodynamic perspective may help nurse teachers in their personal tutor work to integrate theoretical and practical learning for students. Of course, such work needs training and an acceptance that working with feelings is firstly, possible and secondly, desirable; I say this as resistance to participating in small groups has been well described in the literature (Ashburner et al 2004; Fabricius 1995; Gilmartin 2008).

**CONCLUSIONS**

This paper illustrates the role of psychodynamic small group work in integrating theory and practice for student nurses. I argue that reflecting on feelings in small group work with student nurses with a tutor or supervisor who works psychodynamically may help students integrate their theoretical and practical learning. In the context of continued dissatisfaction with the current education systems both from within the profession and from outside, such an approach may be a way to affect change in learning and practice.
References


Fabricius J (1991a) Learning to work with feelings — a psychodynamic understanding and small group work with junior student nurses. Nurse Education Today 11, 134-42.


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