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Experiential learning: the development of communication skills in a group therapy setting

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This paper describes the implementation of a teaching programme designed to develop the psycho-therapeutic skills of student nurses in a group therapy setting during a psychiatric nursing module. The teaching programme was designed and carried out by the authors who functioned in a dual role as both classroom teacher and clinical teacher (supervisor). The experiential approach described is seen as being an effective method of introducing students to psychotherapeutic skills, whilst at the same time clearly demonstrating one potential aspect of the psychiatric nurse's role to the students. The rationale for this programme was the view that experiential teaching both in class and in the clinical situation is the most effective way to help learners acquire those skills (Reynolds 1982, Ellis & Watson 1985, Reynolds & Cormack 1985). The outcome of the teaching programme was evaluated by the learners and teachers involved in the therapy. It is proposed that the teaching methods described in this paper facilitated the successful teaching of group psycho-therapeutic skills, and the learners' perception of the psychiatric nurse's role, which Powell (1982) describes as being fundamentally different from that of nurses working in non-psychiatric disciplines.

THE LEARNERS' CLASSROOM EXPERIENCE

Prior to clinical practice, the learners were introduced to the theories of group dynamics, with particular emphasis on verbal and non verbal communication. The teaching methods used were small group discussion followed by role modelling, group simulations and therapeutic games. The theory of group dynamics was kept to a minimum, due to the small amount of available classroom time (12 h). Specifically, theory content focused upon the structure of groups, the therapeutic value of groups and the therapist's qualities (organisational and leadership behaviours). Firstly, supervisors didactically taught the learner the former's accumulated clinical and theoretical knowledge concerning effective therapeutic behaviours which facilitate group process. This was followed by experiential teaching (three 2 h sessions of group work) involving games and followed by discussion. The games were closely related to the skills being taught (see Fig. 1), and discussion focused upon the learners thoughts (cognition) and feelings (affect) encountered during group interaction.

A wide range of thoughts and feelings were verbalised by the students at this time, providing them with an insight into the stress and

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This is an exercise to help a person improve his ability to communicate and interact with others.

Aims Reduce social isolation
Establish eye contact
Improve concentration
Encourage self-expression

Procedure Two people stand facing one another. First they make eye contact and try to maintain it throughout the remainder of the exercise. Then, one of them (the leader) moves a part or parts of his body very slowly and his partner (the follower) tries to mirror the motion exactly. The pair switch roles several times and then they attempt to continue moving and reflecting each other's moves with neither one of them consciously leading.

Remocker & Storch (1982)

Fig 1 *Mirrors*

difficulties often encountered by therapists and clients during group therapy. In addition, by experiencing support from peers, and universality (the experience of not being alone) the students were able to experientially learn about the therapeutic value of group therapy.

THE LEARNERS' CLINICAL EXPERIENCE

Reynolds (1985) defined clinical teaching as a ward-based patient-centred activity which lends itself easily to an experiential approach using modelling, practice and constructive feedback. Bandura (1977) expressed the view that in order to acquire behaviour and comprehend theory, learners must have a role model to imitate and a supportive supervisor, and this was the rationale applied to the clinical experience. Learners and their supervisor, together with ward staff, were involved in all aspects of the group therapy from the selection of patients and planning, through to evaluation both of the group and of themselves.

SELECTION OF PATIENTS FOR GROUP THERAPY

Selection of patients for group therapy should consider the needs of learners rather than the needs of the ward, because inexperienced learners may damage nurse–patient relationships if they are given responsibility for patients who have serious difficulty with interpersonal contact too early. Neeson et al (1984) suggest that this may result in students experiencing loss of self efficacy (self confidence) and as a consequence, a negative experience for the patient may result. That rationale was central to the selection of group members. In addition, only those whom it was felt would benefit from group therapy were asked to participate.

Patients were assessed individually to determine their suitability and several criteria were used the first of which was nursing staff's perception of the patients' problems. Examples included maladaptive expression of negative affect (such as hostility) or problems with close interpersonal contacts, which may result from reality problems (such as delusional ideation). Secondly, the patient's perception of his needs and difficulties were considered (subjective data). Finally, the patient's motivation towards and expectations from group therapy were taken into account. Prior to selection, patients were provided with information about group therapy. The importance of making a commitment and the potential value of group therapy were discussed at that time.

An opportunity was provided for the patient to ask questions and to decide whether he would like to join the group. Ernst et al (1981) believe this kind of introduction to therapy encourages the patient to view it positively, understand its aims and be aware of his role as a group member. Although research findings on the suitability of patients for psychotherapy are inconsistent and often contradictory, many therapists have attempted to identify indicators of unsuitability for therapy. Examples include extreme mental disorganisation (severe delusions or hallucinations, or marked confusion) and factors relating to personality, intelligence and educational attainment (Bloch 1982). For these reasons it was considered inappropriate to include those who were severely depressed, profoundly psychotic or mentally handicapped. As previously stated, the aims of the group

Table 1
Aims of group experience

Patients	Learners
To give support and advice to patients in a group setting	To provide a controlled yet realistic environment where learners can observe and practice interpersonal skills
To provide patients with a channel of communication to staff and a support system for each other	To demonstrate the role of the psychiatric nurse as a therapist
To provide a safe environment for the discussion and acting out of thoughts, feelings and behaviours	To promote meaningful empathic involvement with patients
To encourage patients to take some responsibility for their own health	To assist learners to assess patients' mental states and evaluate care, effectively
To maintain patients in reality	

were both treatment-orientated and educationally based (see Table 1).

The pre-clinical discussion

Immediately prior to the group therapy session, a pre-group discussion was held, involving learners, supervisors and ward staff. Some clinical data from the previous session were presented and the content of the group therapy session planned. Participants reviewed their roles as therapists and possible responses to problematic situations were discussed, e.g., how to respond within the group if a patient was unwilling or unable to speak, or how to react if a patient walked out of the group. Clinical data such as observations and assessments of particular patients were also highlighted and objectives were formulated for those patients by the learners, their supervisors and ward staff.

Initially, all learners voiced anxieties to a greater or lesser degree, specifically related to their lack of experience and self efficacy. Subsequent experience of supervised practice resulted in a marked reduction of these feelings, and the learners looked less to their supervisor for support and guidance, and were sufficiently motivated and innovative in their outlook to put forward their own ideas for facilitating group interaction.

The group therapy session

Although the groups in both long stay and acute wards focussed mainly on improving patients' communication skills, group aims included other problematic areas such as short term memory deficit, poor concentration, and a lack of trust or self-awareness.

Group therapy commenced with one or two warm-up or introductory games, of about 10 minutes duration – this was intended to relax all group members, patients, learners and staff. The rest of the session was given over to discussion. Initially we felt this discussion required to be structured so an agenda was drawn up designed to encourage patients to participate in the group without feeling threatened. Bloch (1982) advises that the group should not be pressured into believing they must 'confess' or proclaim their innermost thoughts, therefore exercises such as the Balloon Debate in acute groups, or Likes and Dislikes (see Fig. 2) in the long stay groups were found to be appropriate.

As the groups developed it was noted that these exercises were not required. Patients progressed to the point where they felt able to

This is an exercise in public speaking, and a group that is just beginning to enjoy a sense of cohesiveness will benefit most from this exericse.

Aims Encourage self-expression
Decrease muddled thinking
Improve decision making

Procedure The group imagines that they are seated in the basket of a hot air balloon which is sinking. Although each of them is a famous person, the only way to save the balloon is to lighten it. Thus, all but one of the passengers must jump overboard. In a short speech, each person puts forward the reasons why he should be the one to be saved. Voting is based on the content of the speech, and the person with the most votes is the winner.

Remocker & Storch (1982)

Fig 2 Balloon debate

discuss their problems within the group with relative ease. For example, one patient voiced fears which she had had for several years, but felt unable to discuss with anyone before. In fact, although we had anticipated problems of motivation and participation with the non-acute group of patients, it proved remarkably easy for them to progress to a less structured discussion. The value of a structured session therefore, benefited both the learners and the patients initially as it allowed for a 'settling in' and 'familiarisation' period, but to have continued with this too long may have stifled the natural development and progress of the group. To lighten the mood and to relieve any tensions which may have arisen from the unstructured discussion, each group session was terminated by an appropriate game such as Group Yell, Mirrors, or Group Squeeze (see Fig. 3). These games facilitated laughter and relaxation, and this we always found to be the most beneficial way to terminate the group therapy.

Aims	Release tension, warm-up, trust building
Procedure	The group huddles together in a crouching position. The leader begins a low hum. As the group beings to rise slowly, the sound level also rises, so that at the end, everyone leaps into the air and shouts at the same time.
Variations	Add specific words or sounds chosen by the group in advance.

Brandes & Phillips (1979)

Fig 3 Group yell

The post clinical discussion

This had two component parts: an unstructured discussion and a more structured phase which focussed upon the learners' self evaluation and supervisors' feedback. During the unstructured phase, all members of staff participating in the group session were involved (supervisor, learners and normally a trained nurse member of the ward team). Topics for discussion included goal achievement, group cohesion and individual patient's responses and progress. For continuity of group sessions, noting the above information was found to be helpful. The observations and comments made were related to previously identified nursing needs and to group dynamics which facilitated the learners' ability to comprehend and apply their theory within a patient-centred, problem solving framework. For example, patients' behaviour was often discussed within an operant or behavioural therapy explanation system.

The self-evaluation chart (SEC)

The SEC, devised by the authors, was used by the learner to evaluate her performance (see Fig. 4). This evaluation formed the basis for the structured phase of the post-group discussion. Each learner criticised her own performance within the group; her thoughts, feelings and behaviours during the session were explored. This highlighted the perception of her own strengths and weaknesses. The supervisor then completed an assessment form (Fig. 5). His observations were discussed with the learner, and constructive criticism, praise and encouragement were provided at that time.

The assessment tools are intended to provide a focus for post-clinical conferences; they do not necessarily have reliability or predictive validity. However, the authors believe that the tools possess face validity, in the sense that the content – the items in the tools – are representative of the questions which need to be asked in respect of the learners' aims. It is felt however, that these tools are fairly crude and represent an initial attempt to identify behaviours and attitudes which are considered to be therapeutic.

Initially, some learners asked too many direct questions during the group therapy sessions, which may have been due to their inexperience. This was often extremely threatening to patients, and resulted in a limited verbal response from them. Generally, students were encouraged to explore their own strengths and weaknesses, and direct negative criticism from the supervisor was seldom used. Reynolds & Cormack (1985) suggest that this form of counselling by the supervisor increases

Communication — Self Evaluation Chart

To be completed as soon as possible following a group therapy session. Do not discuss your performance with other colleagues in the group until you have completed this assessment.

Please tick as appropriate

Non verbal communication YES NO

1. Did you utilise eye contact appropriately?
2. Was your posture open and relaxed?
3. Did you facilitate postural echo?
4. Did your facial expression convey:
   a) understanding
   b) sympathy
   c) empathy?
5. Did you use gestures to aid verbal interaction? (examples pointing, shrugging shoulders, nodding or shaking head)
6. Was there a comfortable distance between you and others?
7. Was there an opportunity to use touch to express your feelings?

Verbal communication YES NO

8. Was your voice clear and distinct?
9. Was the tone appropriate?
10. Did you ask questions?
11. Did you give:
    a) information
    b) explanation
    c) reassurance
    d) advice
    e) comfort?
12. Did you focus on areas of concern?
13. Did you clarify points not understood?
14. Did you address:
    a) individual patients
    b) individual staff
    c) the group?

Validity YES NO

15. Did you emphasise important points?
16. Did you use reflection?
17. Did you give others time to speak?
18. Did you allow others time to answer questions?
19. Did you actively listen to others?
20. Did you tolerate silence?

Environment YES NO

21. Was the group setting:
    a) comfortable
    b) without distraction
    c) relaxed?

Feelings YES NO

22. Did you feel:
    a) relaxed
    b) confident
    c) secure?
23. Do you feel you communicated well within the group?

If you wish to make any other point then please do so.

Please return to your clinical teacher.

Comments: Date:

Fig 4 The self evaluation chart (SEC)

Therapeutic groups and Communication Skill Assessment Form

0=Never
1=Rarely (once or twice)
2=Occasionally (4 or 5 times)
3=Often (more than 5 times)

Observe nurse for a 15 minute period half-way through the session.

1. *Non verbal communication*				
Establish and maintain eye contact	0	1	2	3
Displays open relaxed posture	0	1	2	3
Uses touch empathically	0	1	2	3
Changes facial expression empathically	0	1	2	3
Uses hand/arm gestures	0	1	2	3
2. *Vocal communication*				
Speaks clearly	0	1	2	3
Changes tone for emphasis	0	1	2	3
3. *Did nurse use statements which were:*				
Information giving	0	1	2	3
Information seeking	0	1	2	3
Clarifying	0	1	2	3
Focussing on important points	0	1	2	3
Supportive	0	1	2	3
Empathic	0	1	2	3
Argumentative	0	1	2	3
Confrontive	0	1	2	3
Unrelated	0	1	2	3
Did nurse:				
Listen attentively	0	1	2	3
Use direct closed questions	0	1	2	3
Use indirect open questions	0	1	2	3
Use reflection	0	1	2	3
Use silence	0	1	2	3
Use non-words (mm, ah)	0	1	2	3
Give feedback where necessary	0	1	2	3
Ask for feedback	0	1	2	3
Did nurse:				
Monopolise	0	1	2	3
Use value judgements	0	1	2	3
Interrupt	0	1	2	3
Change subject	0	1	2	3

Scores:

Fig 5 Therapeutic groups and communication skill assessment form

the learner's self awareness of her communication skills and deficits. At first, learners viewed their performance more negatively than the supervisor's assessment, perhaps due to strong feelings of anxiety and low self efficacy. However, as their experience increased and self confidence improved they tended to view their behaviour more positively and perceived an improvement in their own performance. The supervisors' assessment forms also demonstrated a steady change in the students' response over the 13-week experience, with some learners demonstrating exceptional ability in a wide range of interpersonal skills, such as active listening, empathy, warmth and genuineness.

It is proposed that the teacher–learner relationship was strengthened and enhanced by the use of the experiential methods described. Many factors must be considered as important in establishing and maintaining this relationship, for example:

- the shared goals of both learner and supervisor during clinical practice
- the shared experience of both learner and supervisor during group therapy and clinical conferences
- the personal and individual nature of the supervisor–learner relationship, when the supervisor shares a great deal of himself, his personality and his communication style during group therapy sessions. This facilitates trust, and results in the student giving something of herself in return.

Smyth (1985) states that self evaluation by both teacher and student is bound to elevate and strengthen their relationship, providing that the student feels understood and can receive help. Though experiential techniques blurr the boundaries between supervisor and learner this can only benefit both participants by creating a less formal yet secure teaching–learning climate.

CONCLUSION

An experiential teaching programme, as described here, has many advantages over the traditional didactic approach to teaching psychiatric nursing, both for the teacher and the learner. Frequent practice in the clinical area allows teachers to maintain their psychotherapeutic skills, and participate in current nursing strategies. It also provides the learner with an experienced and skilled role model. The frequent contact between supervisor and

student during the teaching programme described, appeared to assist the development of the teacher–learner relationship. Learners readily accepted constructive criticism, and were able to verbalise their thoughts by active questioning and participation in discussions during group therapy and clinical conferences. The supervisors were able to closely observe and assess the development of the learners' skills, and provide continuous and immediate feedback.

It is the authors' view that the support given to the students by the teacher was a central component of the teaching programme described, as it provided the learners with the opportunity and the confidence to practice and attain a high level of psycho-therapeutic skills in the group situation. At the outset, our aim was to teach learners interpersonal skills. We believe that this was achieved, however, what surprised us most was the learners' attitudes, their enthusiasm, initiative and motivation matched their genuine desire to be involved in the therapeutic care of patients. We believe that this type of teaching method enables them to more fully develop their potential as therapists.

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