Check for updates

DOI: 10.1002/imhj.21790

WILEY

CLINICAL PERSPECTIVE

# Defensive patterns in reflective group supervisions at Child Health Centres

Björn Salomonsson

Department of Women's and Children's Health, Karolinska Institute, Stockholm, Sweden

**Correspondence**
Björn Salomonsson, Department of Women's and Children's Health, Karolinska Institute, Stockholm, Sweden.
Email: Bjorn.Salomonsson@ki.se

**Funding information**
Bertil Wennborg Foundation
Number:

## ABSTRACT

Reflective group supervision with infant healthcare workers has been described in several publications. It aims to enhance their ability to help distressed families, and to comprehend and relieve themselves of the distress that they encounter in such work. The ultimate aim has been formulated as an effort at increasing the professional's reflective function. The present article adds to the literature by applying an ego-psychological perspective on the group process and investigating defensive patterns in such supervisions. This approach includes a critical discussion of the place of the reflective function concept in psychoanalytic metapsychology. The article also suggests a Bionian perspective to account for skewed communicative patterns in groups, so-called *basic assumptions*. Some technical recommendations are provided on the frame in group supervision. They aim to disarm such defenses and facilitate the group participants' possibilities of understanding and thus helping their colleague's problematic relationship with the family. To illustrate the discussion, and to help readers form an image of the supervision process, brief detailed accounts of such work are submitted.

KEYWORDS
Bion, group supervision, infant mental health, nursing, reflective function

## RESUMEN

La supervisión con reflexión en grupo con trabajadores dedicados al cuidado de salud de infantes ha sido descrita en varias publicaciones. La misma busca mejorar su habilidad para ayudar a familias angustiadas, así como comprender y relevarse a sí mismos de la angustia que ellos encuentran en tal ocupación. El objetivo final ha sido formulado como un esfuerzo para incrementar la función de reflexión del profesional. El presente ensayo contribuye a los estudios impresos por medio de aplicar una perspectiva ego-sicológica sobre el proceso de grupo e investigar patrones de defensa en tales supervisiones. Este acercamiento incluye una discusión crítica del lugar que ocupa el concepto de función de reflexión dentro de la metasicología sicoanalítica. Este artículo también sugiere una perspectiva basada en los estudios de Bion para explicar distorsionados patrones comunicativos de grupos, conocidos como suposiciones básicas. Se aportan algunas recomendaciones técnicas acerca del marco en la supervisión en grupo. Su objetivo es desarmar tales defensas y facilitar las posibilidades de comprensión de los participantes en el grupo y, por consiguiente, ayudar a sus colegas en las relaciones problemáticas con la familia. Para ilustrar la discusión, y para ayudar a los lectores a formarse una imagen del proceso de supervisión, se presentan breves recuentos detallados de tal tipo de trabajo.

PALABRAS CLAVES
salud mental infantil, supervisión en grupo, función de reflexión, cuidado, Bion

 © 2019 Michigan Association for Infant Mental Health 

## RÉSUMÉ

La supervision réfléchie en groupe avec les professionnels de la santé mentale du nourrisson a été décrite dans plusieurs publications. Elle se donne pour but d'améliorer leur capacité à aider des familles dans la détresse ainsi qu'à comprendre et à les soulager de la détresse qu'ils ou elles rencontrent dans un tel travail. Le but ultime a été formulé comme étant un effort d'augmenter la fonction de réflexion du professionnel. Cet article s'ajoute aux recherches actuelles en appliquant une perspective égo-psychologique au processus de groupe et en recherchant les patterns défensifs dans de telles supervisions. Cette approche comprend une discussion critique de la place du concept de la fonction de réflexion dans la métapsychologie psychanalytique. Cette étude suggère également une perspective Bionienne afin de représenter les patterns communicatifs biaisés en groupes, ce que l'on appelle les postulats de base. Certaines recommandations techniques sont offertes sur la structure dans la supervision de groupe. Elles ont pour but de désarmer de telles défenses et de faciliter les possibilités de compréhension des participants ou participantes au groupe et donc d'aider la relation problématique de leur collègue avec la famille. Pour illustrer la discussion et afin d'aider les lecteurs à se former une image du processus de supervision, des récits détaillés brefs d'un tel travail sont présentés.

**MOTS CLÉS**

santé mentale du nourrisson, supervision de groupe, fonction réfléchie, soin, Bion

## ZUSAMMENFASSUNG

Die reflexive Gruppensupervision mit Fachleuten aus dem Bereich der Säuglingsgesundheit wurde in mehreren Publikationen beschrieben. Die Supervision zielt darauf ab, ihre Fähigkeit, notleidenden Familien zu helfen, zu verbessern und die Belastung, der sie bei dieser Arbeit ausgesetzt sind, zu verstehen und sich selbst zu entlasten. Als höchstes Ziel wurde das Bestreben formuliert, die reflexive Kompetenz der Fachleute zu erhöhen. Der vorliegende Artikel ergänzt die Literatur, indem er eine ich-psychologische Perspektive auf den Gruppenprozess anwendet und Abwehrmuster in solchen Supervisionen untersucht. Dieser Ansatz beinhaltet eine kritische Diskussion über die Stellung des „Reflecive Functioning"-Konzeptes in der psychoanalytischen Metapsychologie. Der Artikel schlägt auch eine auf Bion basierende Perspektive vor, um verzerrte kommunikative Muster in Gruppen, sogenannte Grundüberzeugungen, zu berücksichtigen. Einige technische Empfehlungen werden im Rahmen der Gruppensupervision gegeben. Sie zielen darauf ab, die Abwehr zu entschärfen und die Gruppenteilnehmer in den Möglichkeiten des Verstehens zu unterstützen und so das problematische Verhältnis ihrer Kollegen zur Familie zu verbessern. Um die Diskussion zu veranschaulichen und den Lesern zu helfen, sich ein Bild vom Supervisionsprozess zu machen, werden kurze, detaillierte Berichte über diese Arbeit vorgelegt.

**STICHWÖRTER**

psychische Gesundheit von Säuglingen, Gruppensupervision, reflexive Funktion, Pflege, Bion

## 抄録

乳児保健ケアワーカーとの内省的な集団スーパーヴィジョンについては、いくつかの出版物に記述されている。それは、苦しみ悩んでいる家族をサポートする彼らの能力を強化し、かつ、そのような仕事の中で出会う自分自身の苦しみを理解し解放することを目的としている。最終目標は、専門家としての内省機能が高まるよう努力することとして構造化することである。本論文は、集団プロセスに自我心理学の視点を取り入れ、そのようなスーパーヴィジョンにおける防衛的なパターンを調査することについての文献として加わる。このアプローチは、精神分析的メタ心理学における内省的機能概念の位置についての重要な討論を含んでいる。本論文ではまた、集団における歪んだコミュニケーションパターンを説明しているビオンの視点、いわゆる基底的想定を示唆している。集団スーパーヴィジョンにおける枠組みについていくつかの技術的な提言がなされてい

10970355, 2019, 4, Downloaded from https://onlinelibrary.wiley.com/doi/10.1002/imhj.21790 by Karolinska Institutet, Wiley Online Library on [20/04/2024]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

る。それらは、これらの防衛を和らげ、同僚の家族に対する問題となる関係性を集団参加者が理解しサポートする可能性を促進することが目的である。討論を説明し、読者がスーパーヴィジョン過程のイメージを形作ることが出来るように、そのような詳細な短い事例を提示する。

キーワード

乳幼児精神保健, 集団スーパーヴィジョン, 内省機能, 世話をすること, ビオン

**摘要**

一些研究論文已經描述了對嬰兒保健工作者的反思性團體監督。它旨在提高保健工作者幫助受困家庭的能力, 以及理解和減輕他們在這種工作中遇到的困難。其最終目標是為提高專業人員的反思功能。本文通過對群體過程應用自我心理學的觀點, 並在此類監督中調查防禦模式, 來增加研究文獻。這種方法包括對精神分析心理學中, 反思功能概念位置的批判性討論。本文還提出 Bionian 的觀點, 來解釋群體中錯誤的交際模式, 即所謂的基本假設。在小組監督框架中提供一些技術建議。其目標是解除這種防禦, 並促進小組參與者的理解, 從而幫助工作者處理與家庭有問題的關係。為了說明論點, 並幫助讀者明白監督過程, 作者提出這些工作的簡要詳細說明

關鍵詞

嬰兒心理健康, 群體監督, 反思功能, 護理, Bion

**ملخص**

تم وصف الاشراف الجماعي التأملي مع العاملين في مجال الرعاية الصحية للرضع في عده منشورات. وهي تهدف إلى تعزيز قدرتهم علي مساعده الأسر المنكوبة ، وفهم المحنة التي تواجههم في هذا العمل والتخفيف من حدتها. وقد تمت صياغة الهدف النهائي كجهد لزيادة الأداء التأملي للمتخصص المهني في مجال صحة الرضع. وتضيف هذه الورقة إلى الأدبيات بتطبيق منظور ذاتي-نفساني علي عملية الجماعة والتحقيق في الأنماط الدفاعية في هذه الأعمال الإشرافية. ويشمل هذا النهج مناقشه نقدية لوضع مفهوم الأداء التأملي في نظريات علم النفس التحليلي. وتقترح الورقة أيضا منظور بيونيان لحساب الأنماط التواصلية المنحرفة في المجموعات ، وما يسمي بالافتراضات الأساسيه. وتقدم بعض التوصيات التقنية بشان اطار الاشراف الجماعي. وهي تهدف إلى نزع سلاح هذه الدفاعات وتيسير إمكانيات المشاركين في الفريق للتفاهم وبالتالي مساعده زميلهم في علاقته الأسرية المضطربة. ولتوضيح المناقشات ، ولمساعده القاريء علي تكوين صورة عن عمليه الاشراف ، تقدم تقارير مفصله موجزة عن هذا العمل.

**الكلمات الرئيسية**

الصحة النفسية للرضع ، الاشراف الجماعي ، الأداء التأملي ، تمريض ، بيون

## 1 | INTRODUCTION

Being in charge of babies and their parents can be taxing for infant healthcare (IHC) professionals. They can feel weighed down by hopelessness, incompetence, and other distressing feelings. Their need of supervision has been emphasized for a long time (Emde, 2009; Osofsky, 2009; Weatherston & Osofsky, 2009), and the effects of *reflective supervision* (RS) have been documented (Amini Virmani & Ontai Lenna, 2010; Frosch, Varwani, Mitchell, Caraccioli, & Willoughby, 2018). One might object that the emotional load of IHC professionals merely copies similar problems in workplaces such as banks, restaurants, and airplanes. These professionals all feel obliged to be nice and smile (Hochschild, 2015) and may revert to *surface acting* or end up in a painful *emotional dissonance* (Hoffman & Bateson, 2001) between personal feelings and behaviors toward customers or patients. However, as many authors on RS (Amini Virmani & Ontai Lenna, 2010; Eaves Simpson, Robinson, & Brown, 2018; Emde, 2009; Frosch et al., 2018; Gilkerson, 2004; Harrison, 2016; Heffron, Reynolds, & Talbot, 2016; O'Rourke, 2011; Osofsky, 2009; Shea, Goldberg, & Weatherston, 2016; Tomlin, Weatherston, & Pavkov, 2014; Weatherston & Osofsky, 2009) have noted, IHC work seems to bring out specific emotional challenges. I will compare their descriptions with my experiences at a Swedish Child Health Centre (CHC), where I work as a psychoanalyst in brief consultations with families with infants and as supervisor of the nursing staff. Departing from the referred authors' accounts, I will investigate some defensive patterns encountered in group supervisions. If we acknowledge and handle them wisely, I argue that we can reach deeper into understanding our supervisees' quandaries. I thus will go beyond some accounts of RS, as in a study by Tomlin et al. (2014) that submitted questions to and collected answers

10970355, 2019, 4, Downloaded from https://onlinelibrary.wiley.com/doi/10.1002/imhj.21790 by Karolinska Institutet, Wiley Online Library on [20/04/2024]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

from RS expert supervisors, and where all items were positively formulated. In contrast, this article investigates negative moments in RS. Second, it provides technical recommendations on the frame in group supervision, which emanate from "Weaving Thoughts" peer-group workshops (Norman & Salomonsson, 2005; Salomonsson, 2012). Third, the nitty-gritty process of supervision is not extensively described in the literature, which can obstruct readers from forming an image of what is going on. A further aim is thus to detail accounts of supervision work. I begin with a vignette.

## 1.1 | Nurse Ingrid's numb discomfort

Ingrid, a midwife at an antenatal clinic, receives an immigrant couple for their first visit. Mother is pregnant with their fourth child. She speaks no Swedish, but her husband speaks English quite well. The first three children were born in their native country, and then he sought asylum in Sweden due to his bisexuality. The wife's relatives kept harassing her due to her husband's sexual disposition, so she and the children joined him in Sweden. He praises the tolerant attitudes to sexual expressions here, but Ingrid feels he is wary of how she reacts to their story.

Ingrid relates in supervision:

> *I really felt ignorant in this area. People have a right to their sexuality if it is based on equality and doesn't harm anybody. Am I stuck in heteronormative prejudices? I'm so unfamiliar with this situation! I feel strongly for the woman. He did help her to come to Sweden and seems eager to be part of parenthood but is she OK with his other sexual relationship(s)? She seems OK but takes up so little space in our conversations. I can't figure out my connection with them! Not good, not bad—and I don't grasp what they want from me and how they, especially* she*, are feeling! He takes up space at her expense, and I don't like that.*

Ingrid is caught in a morass of feelings; vexation, confusion, guilt, discomfort. She is concerned about the woman, vaguely suspicious of the man, but appreciative of his courage in revealing his sexual disposition. She wishes to be "professional and open" and create a good relationship. Yet, she feels obtuse and insensitive in groping about to establish a better contact. Rather than understanding the unspoken emotions and communicative modes in the relationship between the three, she explains her dilemma in terms of her own prejudices and insufficient education in the lesbian, bisexual, transgender, and queer (LBTQ) field. She suspects she is letting the mother down and surrendering to the husband's dominance. She does her job, arranges checkups properly, but feels cut off from herself and from the parents.

The group of five midwives react with a similar mix of discomfort, vows to tolerate the father's bisexuality, annoyance with his attitude, worries about the mother and—worst of all—a malaise that they cannot think. We're approaching an impasse and I suggest:

> ***Me:*** *We're stunned and cannot think. Maybe this is just what you feel, Ingrid?*
>
> ***Ingrid:*** *Yeah, especially when I'm talking with him! I feel little, numb, ignorant. OK, he's got his revenge here in Sweden, where people don't harass him like in his old country. But he* is *arrogant, as when I suggested I'd bring an interpreter next time, so that his wife could take part!* She's *the one who's pregnant, not him! But he said they didn't need an interpreter.*
>
> ***Me:*** *You seem annoyed, are you?*
>
> ***Ingrid:*** *Yes, I notice that now.*
>
> ***Me:*** *So this bisexual man, harassed back home and now a refugee here, gets the upper hand over you, an ethnic Swede. Socially, he's beneath you but in your conversations, you feel beneath him.*
>
> ***Ingrid, with more emotion:*** *Now I also realize this story touches me personally. I'm terribly scared of being cheated by the one I love. With this man, I don't get a grip if he's cheating on her with his male partner.*
>
> ***Me:*** *And you don't find a way of asking him.*
>
> ***Ingrid:*** *Precisely, I'm stunned and stupid.*

The group participants seemed paralyzed in their commitment to help Ingrid. There were some vague comments of empathy with persecuted refugees and commitment to help both parents. The atmosphere was one of helplessness and discombobulation, so I decided to enter in a dialogue with Ingrid, with a second aim of investigating any parallels that went on between her and the group, and between the husband and her. Two sets of skewed communication were spinning, both of them polite and task-oriented on the surface; the group wished to help Ingrid, and she wanted to help the family. Both parties were curious and wished to increase their understanding. Beneath, another current flowed in the opposite direction; its major themes were superiority, inferiority, confusion, and nonunderstanding. This maelstrom stifled reflection in Ingrid and in the group. Empathy became mixed with vexation of unknown origin and cause. The group seemed to defend against unpleasure, whose nature nobody understood, though I guessed it paralleled Ingrid's relationship with the parental

10970355, 2019, 4, Downloaded from https://onlinelibrary.wiley.com/doi/10.1002/imhj.21790 by Karolinska Institutet, Wiley Online Library on [20/04/2024]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

couple. I argue that this and certain other kinds of stalemates that we encounter in RS settings need to be conceptualized as *group defenses*. The better we understand them, the better we can pilot the group when it has run aground. I will soon return to this case to understand it better theoretically, but first I will summarize how U.S. authors on RS conceive of group processes.

## 1.2 | RS: history and practice

Supervision to enhance the reflective capacity of one's work and emotions with patients has been performed with several healthcare professions (Pearce, Phillips, Dawson, & Leggat, 2013). In the infant mental health field, RS was introduced in the 1990s (Fenichel, 1992) to aid professionals challenged by the load and complexity of work with infants and families. They had argued that practitioners across disciplines need time to pause and reflect on clinical situations in which they are involved or entangled. RS is described as a "shared exploration of the emotional content of infant and family work as expressed in relationships between parents and infants, parents and practitioners, and supervisors and practitioners" (Weatherston, Weigand, & Weigand, 2010, p. 23). Such relationships arouse "positive and negative feelings" (Fenichel & Eggbeer, 1991, p. 60) that are examined in supervision, not for therapeutic purposes but because *self-knowledge* is essential for the professional to formulate adequate responses to the family in treatment. Another task is to investigate *parallel processes* in the child–parents–nurse-supervisor relations because they can reveal "positive opportunities for understanding and helping in the wider system of relationship" (Emde, 2009, p. 668)—in the end, the family. Inversely, O'Rourke (2011) noted:

> *The younger the child and the more distressed the dyad, the more likely it is that a worker's early experience stored in the body as unprocessed threat … will be evoked… . This primitive way of relating occurs not only in the parent–infant relationship but also in the parent's and/or the dyad's relationship with the worker. (p. 168)*

If such parallel processes are not acknowledged and analyzed, they risk leading to distress in the professional and, by extension, also to staff conflicts.

Rather than instructing or telling the supervisee what to do, the supervisor needs to wait and listen, "allowing the supervisee to discover solutions, concepts, and perceptions on his own" (Weatherston et al., 2010, p. 24). She or he invites "contemplation rather than imposing solutions" (Weatherston et al., 2010, p. 25) and creates a holding environment (Winnicott, 1960) for the supervisee. The supervisee pursues a deeper understanding of her own inner world, particularly when her predicament with a family represents "reverberations or the reexperiencing of [her] own conflicted past relationships" (Emde, 2009, p. 667). To exemplify, Ingrid realized that her long-standing fear of being cheated had prevented her from probing if something similar was going on in the couple's relationship. Intense affects may emerge in supervision, but if work is successful, it can allow participants to "release, reframe, refocus, and respond" (Harrison, 2016, p. 670) to the emotional challenges they are facing.

To institute RS in *groups* was a natural initiative (Weatherston et al., 2010) because practitioners often work in isolation (Fenichel & Eggbeer, 1991). Another advantage is that workers become "exposed to the wide range of personal responses from other group members" (O'Rourke, 2011, p. 170). As Paré (2016) emphasized, "There are always multiple descriptions or interpretations of any event" (p. 273), and each participant can come up with a facet that adds to the picture. In addition, when predicaments are shared with colleagues, the nurse may feel less lonely and confirmed and empowered (Holm, Lantz, & Severinsson, 1998). "To know that others have experienced similar emotions, and that constructive outcomes are possible, is comforting" (Emde, 2009, p. 667). Group supervisions also contribute to team-building of the staff by creating a "context in which practice is collectively developed and professional identities forged" (Paré, 2016, p. 273).

## 1.3 | RS: Theoretical basis

Theoretical arguments for RS are grounded in attachment research and theory. RS aims to improve participants' *reflective functioning*, *affect regulation*, and *mentalizing capacity* (Fonagy, Gergely, Jurist, & Target, 2002; Fonagy & Target, 2005). Heffron et al. (2016) compared RS group participants to the crowd of blind men who, each from his perspective, try to grasp what an elephant is. "Giving definition to and creating consensus on any unknown is a predictably uncomfortable, turbulent process requiring suspension of premature conclusions and judgment… . These vital attributes exist at the core of a meaningful and productive group reflective supervision process and are essential features of reflective functioning (RF)" (Heffron et al., 2016, p. 629). This is an argument for staying in uncertainty and discomfort to get a more coherent—if not perfect—picture of a knotty clinical case. Thus, *supervisors do not provide truth but suggest reflective practice.* The question is how they achieve this and what the concept RF covers and not covers. Heffron et al. used RF for "operationalizing mentalization, a process by which we understand, interpret, and make meaning of others' behavior in light of the thoughts, feelings, beliefs, wishes, desires, and plans that underlie and motivate that behavior" (p. 630). It is a "developmental achievement arising in the context of secure attachment relationships" (Heffron et al., p. 630).

Heffron et al. (2016) thus planted their definition of RF in a developmental context, which is logical since the concept

10970355, 2019, 4, Downloaded from https://onlinelibrary.wiley.com/doi/10.1002/imhj.21790 by Karolinska Institutet, Wiley Online Library on [20/04/2024]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

arose from such research (Fonagy et al., 1995; Fonagy, Steele, Steele, Moran, & Higgitt, 1991; Slade, 2005). I agree that supervision aims at enhancing the participants' abilities to reflect, but I claim that the RF concept covers insufficiently certain phenomena in a group that obstruct its capacity to forestall those premature conclusions and judgments that Heffron et al. cautioned against. Slade (2005) says mentalization, the ability that RF operationalizes, "refers to *non-defensive* [emphasis added] willingness to engage emotionally, to make meaning of feelings and internal experiences without *becoming overwhelmed or shutting down*" [emphasis added] (p. 271). I agree, but the supervisor's challenge is that group members sometimes do become overwhelmed or defend against engaging emotionally in the presenter's dilemma. How are we to comprehend what happens when RF disintegrates? My question does not challenge the value of RF (including mind-mindedness) in quantifying the transgenerational transmission of attachment (Fonagy, Steele, & Steele, 1991; Fonagy & Target, 2005; Meins et al., 2012; Rosenblum, McDonough, Sameroff, & Muzik, 2008; Slade, Grienenberger, Bernbach, Levy, & Locker, 2005). Rather, it emanates from what I see as *an unclarity of the RF concept's position in psychoanalytic metapsychology.* For example, can the RF concept elucidate those processes that occurred in Ingrid and her group?

To answer these questions, we must first define what the RF concept covers. In Katznelson's (2014) summary, it is "(1) an awareness of the nature of mental states (2) the explicit effort to tease out mental states underlying behaviour (3) the recognition of developmental aspects of mental states and (4) mental states in relation to the interviewer" (p. 108). However, to interpret RF *scores* is not self-evident because although the scale assesses a multidimensional capacity, it ends up in a "unidimensional score" (Choi-Kain & Gunderson, 2008, p. 1133). For two transcripts with an identical unfavorable RF score, one may reflect a "consistently superficial, clichéd, and general understanding of mental states, while the other transcript reflects a highly variable capacity to understand mental states with some moments of antireflectiveness and other moments of marked reflectiveness" (Choi-Kain & Gunderson, 2008, p. 1133).

One can regard RF both as a quantitative measure and as a qualitative construct. In the former view, we can state that Mother A with a high RF understands her child's mental state better than does the low-scoring Mother B. Applying a qualitative perspective, we can investigate the *mechanisms* that impinge on Mother B's or a group's capacity to reflect, when they appear, and why. This would invite an ego-psychological approach by asking: What occurs when more primitive ego-defenses take command? Yet, ego-psychological concepts are not frequent in papers on RF and mentalization. One exception is Slade's (2007) article on reflective parenting programs that aim to diminish "the defenses, specifically projection, projective identification, dissociation, disavowal, and denial … [to be] accompanied by the emergence of higher level ego functions and defenses" (p. 647). Similarly, Fonagy, Steele, Morgan, Steele, and Higgitt (1993) argued that a baby's anxiety may persist due to "the caregiver's defense-driven failure to recognize the circumstantial or physical determinants of his distress" (p. 974). Finally, Bouchard et al. (2008) suggested that different qualities of mentalization (and thereby of RF) may depend on differences in "ego attitudes toward emotional experiences" (p. 48).

Otherwise, it is uncommon to conceive of variations in RF—between or within individuals—in terms of fluctuating ego functions. In my view, once we bring in such concepts, we acquire tools for understanding and remedying those variations, in therapy and in supervision. True, "highly reflective parents rarely deny their own internal experience in relation to parenting, and … they understand that mental states can be ambiguous … and that they can be hidden or disguised" (Slade, 2005, p. 279). Then, what happens when group participants deny their internal experiences and the ambiguity and cloak of emotions? The following section applies a *defense perspective* to Ingrid and the group.

## 1.4 | Combining an ego-psychological and a Bionian framework on Ingrid's case

What prevented the RS participants from helping Ingrid with her discomfort? I will approach the question by combining Freud's theories of early mental functioning and ego defenses with Bion's theory of thinking (1962, 1963, 1965, 1970). It might astonish that I bring in Bion, who was never regarded as a front figure in ego-psychology. True, he seldom relied explicitly on Freud's (1923) structural model. However, as Brown (2011) argued, Bion's model of the $\alpha$-function transforming $\beta$-elements to $\alpha$-elements—within a container/contained relationship like the one between mother and infant—is indeed an ego-psychological construct. The $\alpha$-function is, Brown suggested, "a supraordinate ego function that is responsible for ascribing meaning to experience … [it is] the mechanism underlying the reality principle and also makes thinking possible" (p. 85). This is not far from describing RF, in my view.

Bion (1962) used the letters L, H, and K to denote emotional experiences of Love, Hate, and Knowledge, factors all involved in the $\alpha$-function. Since emotional experiences "cannot be conceived of in isolation from a relationship" (Bion, 1962, p. 42), the letters also refer to interpersonal links or object relationships. His formula "$x$ K $y$" implies that someone, "$x$," is in the process of getting to know another, "$y$," which involves both parties' emotions. Psychotherapy and supervision are manifestations of $x$ K $y$; the therapist/supervisor $x$ is trying to learn about the emotional and intellectual world of the patient/supervisee $y$. Yet, $x$ will

10970355, 2019, 4, Downloaded from https://onlinelibrary.wiley.com/doi/10.1002/imhj.21790 by Karolinska Institutet, Wiley Online Library on [20/04/2024]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

find that the "truth" she or he is searching for, inside *y* as it were, is evanescent because *y* is a human being, not a machine or a lab sample. Therapist/supervisor *x* cannot *possess* knowledge about *y*, only be in the process of getting to know *y* in an emotional relationship. This will elicit frustration and pain in *x*, and I would add in *y* as well. Both parties react as if they had lost an object. This can lead to an "increased dependence on material comfort" (Bion, 1962, p. 11) and, for those involved in therapy or supervision, to rushing to explanations and conclusions.

Bion (1962) built on Freud's (1911) division of mental functioning into the primary and secondary processes. The primary strives for pleasure and ignores any reality contradicting these strivings. Sooner or later, the baby's psychical apparatus must launch the secondary process, which aims to "form a conception of the real circumstances in the external world and to endeavour to make a real alteration in them" (p. 219). Freud adds that the infant—including the care he or she receives from the mother—almost realizes a system that obeys the "fictions" of the primary process. He thus indicates that what we today call the *attachment relationship* is paramount for the baby to develop his or her mental capacities. The screaming baby and the comforting mother in such a relationship have emotions as they try to get to know each other. The baby wants to acquire and retain knowledge (K) about the soothing breast/mother. This involves pain; because the baby is hungry, the breast does not appear instantly, he is angry with it, he has dilapidated his memory of it, and finally, because the breast remains enigmatic and impervious to his efforts at possessing knowledge about it. Similarly, the therapist cannot fulfill the patient's hopes of possessing knowledge about himself but only increase his "*capacity* for suffering even though patient and analyst may hope to decrease pain itself" (Bion, 1963, p. 61). I suggest that this aim can be extended to sustaining emotional pain in RS group members, and it is also here that they may flounder.

When the capacity to suffer pain is overpowered, curbed, or unconsciously attacked in a group or an individual, an anti-K attitude can develop; an "envious assertion of moral superiority" (Bion, 1962, p. 97). Bion (1962, p. 98) denoted it "− K," a term covering the subject's (a) "finding fault with everything," (b) "hatred of any new development in the personality" (Bion, 1962, p. 98), and (c) attempts to arouse a diffuse and nonconstructive guilt in others. If − K is enduring, communications become denuded of meaning. This can happen between therapist and patient, nurse and family, and among group members. "In − K the new idea (or person) is stripped of its value, and the group in turn feels devalued by the new idea" (Bion, 1962, p. 99).

Bion's formulations on − K are not restricted to psychopathology. An everyday example is when we feel uncomfortable at a dinner party because our neighbor is flaunting his recent vacation trip rather than trying to get to know us. We leave the party feeling like a loser, yearning we were more widely traveled. Only later do we intuit his efforts at eliciting our envy. Returning to Ingrid and the father, I speculate that something similar went on between them. An experienced and intelligent nurse got confused, doubting she had the "right" values on LBTQ questions and feeling inferior without knowing why. It is easy to empathize with the man; he is an immigrant father of four children, who knows Swedish insufficiently, expresses his sexuality in nonconformist ways, and fears the nurse will despise him. Yet, our empathy should not dampen our need to understand the relationship he was staging with Ingrid. Rather than addressing his predicaments and sincerely asking Ingrid for help, he retained superiority over her (− K), but lost the possibility of receiving true help from her experience (K). The mechanism seemed to be projective identification, by which Ingrid became the recipient of his unwanted and despised traits. She adopted, figuratively speaking, the role of the scorned immigrant who does not speak Swedish.

## 1.5 | Nurse Kate and the group's flight to facts

Ingrid's case showed how an opaque and discomforting nurse–patient relationship was transferred to the group and forestalled its creativity. The next group supervision example comes from early on in my career. Nurse Kate brings up a boy:

> *Well, it's nothing new, really… . He's 1½ years and biting his parents since many months and now at the nursery, too… . Actually, their first child, a girl, died a few days before expected delivery. Three months later they conceived him, and he was born one day after the day of her death.*

The parents have told Kate that the girl must not be forgotten. They want to talk about her, also during the boy's CHC check-ups. Kate has consented, "but it feels uncomfortable, I never knew the girl!" The group reacts with dismay at this tragic story, even more when Kate adds that the family combined the celebration of the boy's first birthday with the commemoration of the anniversary of the girl's death.

Contrary to the technique I have developed later and will outline in the section on the frame, I initiate the discussion: "Kate told us two stories, one about a biting boy, another about a dead girl. Actually, we don't hear much about his biting but more about the girl; her death must not be forgotten and the parents involve him in this resolve."

At first, the group voices concern about the boy being born into these sad circumstances, and the possible effects on him.

**Anne (in an upset tone):** Will these parents ever be able to see their son in his own right?

**Beatrice:** What's the boy's age?

10970355, 2019, 4, Downloaded from https://onlinelibrary.wiley.com/doi/10.1002/imhj.21790 by Karolinska Institutet, Wiley Online Library on [20/04/2024]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

**Frances (with a firm voice):** What needs to be affirmed here is how *much* the boy is biting. The nursery staff are concerned. What if the parents spent a day with the boy at the nursery, to see with their own eyes what starts his biting?

**Kirsten:** But this might be normal behaviour! I've seen many one-year-olds biting when they start nursery. If everybody calms down, things usually settle by themselves.

**Me:** How might the dead sister impact on the parents' view of their boy? Is her shadow looming behind him so they cannot see him in his own right?

Some nurses hum in confirmation, but do not get explicit. Frances again suggests that the parents should visit the nursery, and maybe Kate could join them.

**Kate (in a slightly dejected tone):** "Yeah, you're right. I'm grateful for your suggestions, especially that I visit the nursery with the boy and the parents."

There were three strands of thought: (a) The biting is the boy's reaction to the parents' unsolved traumatic loss, (b) a hands-on advice of cooperating with the nursery and observe the boy there, and (c) his biting is a normal and passing symptom in a child who recently started nursery. Afterwards, I was dissatisfied with this session. I felt Kate intuited Strand 1 (a) and wanted help with it. But the group, except for Anne, either bypassed it by giving practical advice (b) or by normalizing the symptom (c). I did not have the experience and courage to take up the participants' tendencies to flee into facts, as when Beatrice asked about the boy's age directly after Anne's exclamation about his need to be seen in his own right. The question on age was redundant since Kate had mentioned it. I also assumed it had a defensive purpose of avoiding Anne's disconcerted comment. Frances' advice that Kate visit the nursery and Kirsten's normalization of his biting might be relevant, per se, but they also averted the group's emotional challenge: how to help a pained colleague involved with a family where a child had died, but must remain alive in their memory, and where a boy could only express his emotional turbulence by biting. Kate did not sound convincing when she thanked the group for their advice.

### 1.5.1 | Follow-up and comment

I interviewed Kate some years later about the supervision session.

**Kate:** Looking back, I think of how I felt about the group of staff in those days. When I brought up this case, I felt they reacted in a kind of domineering way. Perhaps I hadn't yet found my place in the group, which makes a huge difference when you ask your colleagues for help and want to feel guided and empowered by them. Sure, I didn't get the kind of advice I was asking for. My problems were more on an emotional level. How should I be with this family? How should I allow the parents to keep their girl alive in their minds—but still urge them to be clear about setting limits for their biting boy?

**Me:** Did you visit the nursery?

**Kate:** In fact, no. I found out a way to talk with the parents about their two kids at a level that I felt was OK. But I did consider how much it meant to them not to forget their first child, the dead girl.

Like myself, Kate was dissatisfied with the session. Her thoughtful comments apràs coup confirmed my suspicion of a missed opportunity of providing substantial help. They also added another factor—how a presenter feels positioned emotionally in his or her group, and if and how this can be addressed. Kate clarifies that she did not merely listen to her colleagues' comments but also filtered them through her unease as a group member, which she did not risk mentioning. I did not discern them, as I was focusing on the group's zigzag groping for "solutions" to her dilemma. Kate's comment raises the subject of *group dynamics* in supervision, a topic I will now address.

## 1.6 | Defensive patterns in groups

The vignette with Ingrid focused on the collective's reactions to her dilemma. Another publication (Salomonsson, 2018) on group supervision has focused on the presenter and the group members as individuals. There, I brought out three major affects tormenting nurses: their anger, guilt, and anxiety of uncertainty. The professional credo states that a nurse must not be angry with a suffering parent or baby. Should this happen, she must defend against it. Guilt can arise once she is angry nevertheless or fails to manage the case well enough. Finally, the fear of those uncertainties that inevitably accompany parent–infant work can lead her to escape the bewilderment by forming or seeking for dead-certain opinions about the case.

If these affects and pertaining conflicts in the individual remain unacknowledged in RS, they can be transposed to negative group processes. I have shown how Kate's colleagues approached the point of agony, retreated, got back again, and invented new ways of escape. I have often observed such defensive patterns in RS groups; *a flight to the surface and to facts, and an avoidance of personal emotional reactions.* Kate's problem was emotional, not practical, but the group could not handle—by an empathic and mentalizing stance toward the family and Kate—the story about the boy's biting and the parents' unmourned child. It was infected with unthinkable anxiety (Winnicott, 1962) and nameless dread (Bion, 1962) among the group members. No wonder it was relieving for them to ask about the boy's age or recommend a visit to the nursery. Their jumping to facts went hand in hand with avoiding threatening emotions.

Sometimes, group members' defensive avoidance of emotional pain can develop into a stifling situation that endangers the group's ability to be of help. Agreeably, such states may be uncommon, and I concede that very often, collegial sharing

10970355, 2019, 4, Downloaded from https://onlinelibrary.wiley.com/doi/10.1002/imhj.21790 by Karolinska Institutet, Wiley Online Library on [20/04/2024]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

can be comforting (Emde, 2009) and make the presenter feel accompanied (Weatherston et al., 2010). Yet, we should not be blind to a group's negative potential; as Enyedy et al. (2003) emphasized, researchers have paid less attention to negative aspects of group supervision such as "between-member problems" (p. 315). In my impression, this also applies to the RS literature. Destructive *intragroup interactions* do exist, as when some nurses take up an opinionated position vis-à-vis the family while others expose its mirror image. For example, some feel sorry for a mother ill-treated by her "terrible husband" while others pique her as being "submissive." Contrasting views on a difficult case are thus projected onto subgroups of nurses. Paré (2016) observed similar phenomena in family therapy group supervisions. Daunted by a case's complexity, participants may

> *steer the task at hand toward diagnosis, or fall back on the familiar refrain "Have you tried … ?"… . The conversation takes on a convergent quality, an implicit vying for the 'correct' interpretation of clients' situations, with privilege frequently granted to those threads originating with the supervisor, or with senior or more "credentialed" practitioners in the room. (p. 276)*

Paré's (2016) examples are equally applicable to RS for nurses, as in Kate's group. Unless detected, acknowledged, and worked through, they can end up in patterns of group functioning that Bion (1961) named *basic assumptions*, which are patterns of thought and communication that cement and obstruct optimal group work. His experiences from group therapy lead him to formulate three assumptions: *Dependence*, *Pairing*, and *Fight-or-Flight*. If unaddressed, they can cause the group's mature functioning to deteriorate. Their driving force is the participants' search for security (Gould, 1997), but the outcome is actually *increased insecurity*; members end up in elitist and idealizing attitudes ("Our clinic is the best"), interrogatory comments to the presenter ("WHY did you ask her that!?"), narrow-minded statements ("Well, adolescent mothers never cause ME any problems"), and requests for authority ("What do YOU suggest, you as supervisor and attachment specialist?"). In short, the participants stop functioning as a work group. Every group risks getting stuck in such mode of thoughts, and then participants will think "too much in terms of *either/or* and to compete for the right to denote what is the right understanding and the right action" (Andersen, 1987, p. 11). The only possible exit is if the supervisor can inspire the group to reflect together on the meaning of, and the reasons for, their polarized positioning (Collens & Van Hout, 2017).

Infant therapists writing on RS have not been so prone to discuss these cautions on group functioning. Grienenberger (2006) argued that therapists working with parents "have a tendency to shift out of the clinical role that defines their work with patients into a more didactic role in which they are seen as expert teachers of child development issues" (p. 670). Perhaps this applies to RS supervisors as well, which may lead them to adopt a more pedagogic attitude. Such a teacher–pupil-like relationship risks masking malignant group patterns which, had they been captured and spoken about in statu nascendi, could have helped exposing the parent–infant case's darker sides. I am thus arguing that supervision should not only provide group members with support, encouragement, pedagogy, and affirmation but also inspire them to approach discomforting facets in themselves, in the group, or in the family.

## 1.7 | Managing the frame

As summarized earlier, RS in a group setting has many advantages, but as Heffron et al. (2016) added and I have argued further, group supervision is also arduous. In contrast to a one-to-one setting,

> *the volume of verbal and nonverbal communication between supervisor and supervisees requires the supervisor at times to hold a broader view and at other times to prioritize and focus on specific elements of the group process to better serve the client families being discussed. (p. 630)*

I agree with their description and their emphasis on *the frame* to maximize emotional safety and productive work in the group. I also join Paré's (2016) suggestion that group supervision should have "specific guidelines and sharing processes" (p. 277) to counter the risks of convergence on purported truths that might not fit for the individual client. This section adds my thoughts and routines regarding the frame and how it can forestall that the group aggregates into dysfunctional communicative patterns that prevent the supervisee from reaching deeper into understanding her dilemma with the family.

### 1.7.1 | The frame

I have formulated the following method.

1. Supervisions take place regularly and in the same room, suitably 1 hr every fortnight. The frame should be kept, or changed, only after mutual agreement. A suitable size is 5 to 7 participants.
2. Anything talked about is handled with respect and professional secrecy.
3. Supervisions focus on patients and the nurses' emotional reactions to them. Issues like working conditions, salaries, organization, or management are taken care of in a separate personnel group, whose leader should *not* be the clinical supervisor.

10970355, 2019, 4, Downloaded from https://onlinelibrary.wiley.com/doi/10.1002/imhj.21790 by Karolinska Institutet, Wiley Online Library on [20/04/2024]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

10970355, 2019, 4, Downloaded from https://onlinelibrary.wiley.com/doi/10.1002/imhj.21790 by Karolinska Institutet, Wiley Online Library on [20/04/2024]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

4. The session begins with the supervisor asking who has a case. The time allotted to each is estimated, and one nurse starts relating her case.
5. The supervisor then invites the group to submit their ideas. Anyone who wants to speak should give a signal. The supervisor summarizes the comments and adds his or her own. Finally, the presenter is asked about her reactions to the discussion.
6. A question-and-answer dialectic or debate between presenter and colleagues is unfavorable. Instead, associating to the material within the group of listeners yields two advantages. They can toss up ideas "in the air" without the presenter arguing for her case, and her listening position diminishes the risk that she feels criticized.
7. Questions of how to handle a case and so on are generally met with a friendly request to continue musing on the presentation. Supervision aims not to teach techniques of handling parents but to fertilize reflection in the group and in the supervisee, for example, on how the family's hassles have been projected into their relationship with the nurse and how she has responded to it.
8. Personal problems and conflicts may surge in the presenter. Indeed, supervision aims to "identify one's responses to clinical material" (Heffron et al., 2016, p. 632) and their private roots. Such situations are treated with respect, and further questions about the presenter's personal history are not recommended. The supervisor must recall that she or he is not doing group therapy.
9. ICH staff seldom feel entitled to supervision. Accordingly, support from the management is essential. In fact, it is part of the frame, since the administration thereby signals that it regards supervision as a necessary component of work, similar to providing appropriate rooms and instruments.

### 1.7.2 | Comments on the frame

Points 1 and 2, on external arrangements and discretion, coincide with the cited RS authors' views (Gilkerson, 2004; Heffron et al., 2016; Weatherston et al., 2010). I assume they also would agree on Point 3, although I have not seen this topic addressed; a supervisee's narrative may unleash complaints on the management, salaries, localities, and so on. Indeed, links may exist between her despair with a family and the groups' unsatisfactory working conditions. The problem is that one cannot be clinical supervisor *and* P-group leader for the same group because the mandates differ; the clinical supervisor is hired to help professionals become more professional whereas the P-leader is employed to solve conflicts within staff or between staff and management. In addition, mixing the two roles can blur the problem under scrutiny—the nurse's difficulties with the family—in that the group clogs into an assumption that her problem is caused by bad management, which arguably cannot be an exhaustive explanation.

Points 4 to 7 are influenced by, but not copied on, the Weaving Thoughts peer-group workshop (Norman & Salomonsson, 2005; Salomonsson, 2012), a format devised by and for psychoanalysts in Stockholm. One analyst is appointed moderator beforehand, and the clinician presents a session in detail, handing out a written transcript, and without submitting antecedents of the case. Participants then associate to the material while neither presenter nor moderator is commenting, until a time agreed upon is reached and the presenter briefly comments on her experiences of the group's work. The method is now practiced among therapists in Europe and the United States. Yet, copying this format to RS groups for nurses would be emotionally challenging and cognitively impoverishing. A parent–infant case presented without further information would strain the nurses' anxiety tolerance and yield fluffy discussions. But its strict frame can well be imported into RS since "structure encourages free expression by delimiting territories of talk, thus creating safety" (Paré, 2016, p. 273). Discouraging colleagues from speaking simultaneously fertilizes the reflective process, so I ask participants to raise their finger if they want to speak. After some embarrassed acclimatization, they generally discover the benefits. Presentations can stimulate participants to debate with one another or the presenter. A gentle request to the presenter not to respond can cause unrest in all. But, if no consensus needs to be achieved and no positions defended in the group, the reflective space is enlarged, and participants feel freer to muse on the material.

Point 8, about personal problems surging in the case discussion, is a difficulty addressed by many authors who, like myself, emphasize the challenge in handling them. First, the working agreement (Proctor, 2010) should clarify from the start the differences between a group for personal problems, staff conflicts, and clinical supervision. Second, as personal issues inevitably emerge, it is important that the supervisor has instituted a frame from the start, whether the one I advocate or another. Finally, as for Point 9, I agree that "work environments that fail to recognize the realities that IMH [infant mental health] professionals face … may create an organizational climate that mirrors conflictual relationships, unpredictability, and a sense of powerless[ness] that client families often feel in their daily lives" (Eaves Simpson et al., 2018, p. 480). If the administration is deaf to the staff's plight and need of supervision, this may increase its "emotional labor" (p. 482) and terminate in burnout reactions.

## 1.8 | Conclusions and clinical relevance

The infant mental health field is flourishing. Epidemiological and clinical studies testify to the importance of intervening early with distressed babies and parents. Treatment programs get started that target populations with special needs. It also is recognized that many reasonably well-functioning

adults can tumble into a crisis when becoming parents—and that they need and benefit from receiving quick help. The aim of integrating psychological help for such families with ordinary infant heathcare is complex and clashes with organizational and professional traditions, parents' embarrassment, and nurses' discomfort with addressing perinatal emotional problems. It is therefore essential to investigate the obstacles among nurses (Kornaros, Nissen, Zwedberg, & Salomonsson, 2018a), parents (Kornaros, Nissen, Zwedberg, & Salomonsson, 2018b), and therapists, to reach out to the many distressed parents and infants.

To increase the quality of infant mental health care, professionals working in primary contact with families or in psychotherapy need attention and training. Many books and papers have been written by parent–infant psychotherapists explicating their methods (for a review, see Salomonsson, 2014, and https://en.wikipedia.org/wiki/Parent-infant_psychotherapy). In contrast, fewer studies have been devoted to developing a tool that is essential to train and develop nurses' capacities to detect and handle emotional distress in families: group supervision. The existing studies emphasize its importance and explain the procedure, with which I am basically in agreement. This article adds to that literature by bringing out the pitfalls that face a presenter and the group in RS. It also enlarges its conceptual basis, from a focus on RF and mentalization to including an ego-psychological and a Bionian framework. With its help, we can recognize more easily and address more openly group defenses that forestall the main purpose of RS—to help the nurse understand and handle her case more optimally.

## ACKNOWLEDGMENTS

I (B.S.) am the sole contributor. I thank Ingrid and Kate for permission to publish supervision extracts. All names are altered. I also thank the Bertil Wennborg Foundation for a grant enabling me to write the article. In addition, I thank Dr. Lawrence J. Brown, Boston, for elucidating discussions on Bion's theories.

## CONFLICTS OF INTEREST

The author declares no conflicts of interest.

## ORCID

*Björn Salomonsson*
https://orcid.org/0000-0003-4747-541X

## REFERENCES

Amini Virmani, E., & Ontai Lenna, L. (2010). Supervision and training in child care: Does reflective supervision foster caregiver insightfulness? *Infant Mental Health Journal*, *31*(1), 16–32.

Andersen, T. (1987). The reflecting team: Dialogue and meta-dialogue in clinical work. *Family Process*, *26*(4), 1–11, 415–428.

Bion, W. R. (1961). *Experiences in groups*. London, United Kingdom: Tavistock.

Bion, W. R. (1962). *Learning from experience*. London, United Kingdom: Karnac Books.

Bion, W. R. (1963). *Elements of psychoanalysis*. London, United Kingdom: Karnac Books.

Bion, W. R. (1965). *Transformations*. London, United Kingdom: Karnac Books.

Bion, W. R. (1970). *Attention and interpretation*. London, United Kingdom: Karnac Books.

Bouchard, M.-A., Target, M., Lecours, S., Fonagy, P., Tremblay, L.-M., Schachter, A., & Stein, H. (2008). Mentalization in adult attachment narratives: Reflective functioning, mental states, and affect elaboration compared. *Psychoanalytic Psychology*, *25*(1), 47–66.

Brown, L. J. (2011). *Intersubjective processes and the unconscious*. London, United Kingdom: Routledge.

Choi-Kain, L. W., & Gunderson, J. G. (2008). Mentalization: Ontogeny, assessment, and application in the treatment of borderline personality disorder. *American Journal of Psychiatry*, *165*(9), 1127–1135.

Collens, P., & Van Hout, F. (2017). Learning in psychotherapy group supervision: Transcending complementarity and the generative potential of group conflict. *British Journal of Psychotherapy*, *33*(2), 177–191.

Eaves Simpson, T., Robinson, J. L., & Brown, E. (2018). Is reflective supervision enough? An exploration of workforce perspectives. *Infant Mental Health Journal*, *39*(4), 478–488.

Emde, R. N. (2009). Facilitating reflective supervision in an early child development center. *Infant Mental Health Journal*, *30*(6), 664–672.

Enyedy, K. C., Arcinue, F., Puri, N. N., Carter, J. W., Goodyear, R. K., & Getzelman, M. A. (2003). Hindering phenomena in group supervision: Implications for practice. *Professional Psychology: Research and Practice*, *34*(3), 312–317.

Fenichel, E. (Ed.). (1992). *Learning through supervision and mentorship to support the development of infants, toddlers, and their families: A sourcebook*. Washington, DC: ZERO TO THREE.

Fenichel, E., & Eggbeer, L. M. (1991). Preparing practitioners to work with infants, toddlers, and their families: Four essential elements of training. *Infants & Young Children*, *4*(2), 56–62.

Fonagy, P., Gergely, G., Jurist, E. L., & Target, M. (2002). *Affect regulation, mentalization, and the development of the self*. New York, NY: Other Press.

Fonagy, P., Steele, H., & Steele, M. (1991). Maternal representations of attachment during pregnancy predict the organization of infant-mother attachment at one year of age. *Child Development*, *62*(5), 891–905.

Fonagy, P., Steele, M., Morgan, G., Steele, H., & Higgitt, A. (1993). Measuring the ghost in the nursery: An empirical study of the relationship between parents' mental representations of childhood experiences and their infants' security of attachment. *Journal of the American Psychoanalytic Association*, *41*(4), 957–989.

Fonagy, P., Steele, M., Steele, H., Leigh, T., Kennedy, R., Mattoon, G., & Target, M. (1995). Attachment, the reflective self, and borderline states. In S. Goldberg & J. Kerr (Eds.), *Attachment research: The state of the art* (pp. 233–278). New York, NY: Analytic Press.

Fonagy, P., Steele, M., Steele, H., Moran, G. S., & Higgitt, A. (1991). The capacity for understanding mental states: The reflective self in parent and child and its significance for security of attachment. *Infant Mental Health Journal*, *12*(3), 201–218.

10970355, 2019, 4, Downloaded from https://onlinelibrary.wiley.com/doi/10.1002/imhj.21790 by Karolinska Institutet, Wiley Online Library on [20/04/2024]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

Fonagy, P., & Target, M. (2005). Bridging the transmission gap: An end to an important mystery of attachment research? *Attachment & Human Development*, *7*(3), 333–343.

Freud, S. (1911). Formulations on the two principles of mental functioning. Standard Edition, Vol. 12, pp. 213–226. London: Hogarth Press.

Freud, S. (1923). The ego and the id. Standard Edition, Vol. 19, pp. 3–66. London: Hogarth Press.

Frosch, C. A., Varwani, Z., Mitchell, J., Caraccioli, C., & Willoughby, M. (2018). Impact of reflective supervision on early childhood interventionists' perceptions of self-efficacy, job satisfaction, and job stress. *Infant Mental Health Journal*, *39*(4), 385–395.

Gilkerson, L. (2004). Irving B. Harris Distinguished Lecture: Reflective supervision in infant–family programs: Adding clinical process to nonclinical settings. *Infant Mental Health Journal*, *25*(5), 424–439.

Gould, L. J. (1997). Correspondences between Bion's basic assumption theory and Klein's developmental positions: An outline. *Free Associations*, *7*, 15–30.

Grienenberger, J. F. (2006). Group process as a holding environment facilitating the development of the parental reflective function: Commentary on the article by Arietta Slade. *Psychoanalytic Inquiry*, *26*(4), 668–675.

Harrison, M. (2016). Release, reframe, refocus, and respond: A practitioner transformation process in a reflective consultation program. *Infant Mental Health Journal*, *37*(6), 670–683.

Heffron, M. C., Reynolds, D., & Talbot, B. (2016). Reflecting together: Reflective functioning as a focus for deepening group supervision. *Infant Mental Health Journal*, *37*(6), 628–639.

Hochschild, A. R. (2015). The managed heart. In A. S. Wharton (Ed.), *Working in America: Continuity, conflict, and change in a new economic era* (pp. 47–54). New York, NY: Routledge.

Hoffman, D. K., & Bateson, J. E. G. (2001). *Essentials of services marketing: Concepts, strategies and cases* (2nd ed.). Orlando, FL: Harcourt College.

Holm, A., Lantz, I., & Severinsson, E. (1998). Nursing students' experiences of the effects of continual process-oriented group supervision. *Journal of Nursing Management*, *6*(2), 105–113.

Katznelson, H. (2014). Reflective functioning: A review. *Clinical Psychology Review*, *34*(2), 107–117.

Kornaros, K., Nissen, E., Zwedberg, S., & Salomonsson, B. (2018a). A hermeneutic study of integrating psychotherapist competence in postnatal child health care: Nurses' perspectives. *BMC Nursing*, *17*(42), 1–10. https://doi.org/10.1186/s12912-018-0311-1

Kornaros, K., Nissen, E., Zwedberg, S., & Salomonsson, B. (2018b). *A hermeneutic study of integrating psychotherapist competence in postnatal child health care: Parents' perspectives*. Manuscript submitted for publication.

Meins, E., Fernyhough, C., de Rosnay, M., Arnott, B., Leekam, S. R., & Turner, M. (2012). Mind-mindedness as a multidimensional construct: Appropriate and nonattuned mind-related comments independently predict infant–mother attachment in a socially diverse sample. *Infancy*, *17*(4), 393–415.

Norman, J., & Salomonsson, B. (2005). "Weaving thoughts': A method for presenting and commenting psychoanalytic case material in a peer group. *International Journal of Psychoanalysis*, *86*(5), 1281–1298.

O'Rourke, P. (2011). The significance of reflective supervision for infant mental health work. *Infant Mental Health Journal*, *32*(2), 165–173.

Osofsky, J. D. (2009). Perspectives on helping traumatized infants, young children, and their families. *Infant Mental Health Journal*, *30*(6), 673–677.

Paré, D. (2016). Creating a space for acknowledgment and generativity in reflective group supervision. *Family Process*, *55*(2), 270–286.

Pearce, P., Phillips, B., Dawson, M., & Leggat, S. G. (2013). Content of clinical supervision sessions for nurses and allied health professionals: A systematic review. *Clinical Governance: An International Journal*, *18*(2), 139–154.

Proctor, B. (2010). Training for the supervision alliance: Attitude, skills and Intention. In J. R. Cutcliffe, K. Hyrkäs, & J. Fowler (Eds.), *Routledge handbook of clinical supervision: Fundamental international themes* (pp. 51–62). London, United Kingdom: Routledge.

Rosenblum, K. L., McDonough, S. C., Sameroff, A. J., & Muzik, M. (2008). Reflection in thought and action: Maternal parenting reflectivity predicts mind-minded comments and interactive behavior. *Infant Mental Health Journal*, *29*(4), 362–376.

Salomonsson, B. (2012). Psychoanalytic case presentations in a Weaving Thoughts group. On countertransference and group dynamics. *International Journal of Psychoanalysis*, *93*(4), 917–937.

Salomonsson, B. (2014). Psychodynamic therapies with infants and parents: A critical review of treatment methods. *Psychodynamic Psychiatry*, *42*(2), 203–234.

Salomonsson, B. (2018). *Nurse group supervision in infant health care: A psychoanalytic argument*. Manuscript submitted for publication.

Shea, S. E., Goldberg, S., & Weatherston, D. J. (2016). A community mental health professional development model for the expansion of reflective practice and supervision: Evaluation of a pilot training series for infant mental health professionals. *Infant Mental Health Journal*, *37*(6), 653–669.

Slade, A. (2005). Parental reflective functioning: An introduction. *Attachment & Human Development*, *7*(3), 269–281.

Slade, A. (2007). Reflective parenting programs: Theory and development. *Psychoanalytic Inquiry*, *26*(4), 640–657.

Slade, A., Grienenberger, J., Bernbach, E., Levy, D., & Locker, A. (2005). Maternal reflective functioning, attachment, and the transmission gap: A preliminary study. *Attachment & Human Development*, *7*(3), 283–298.

Tomlin, A. M., Weatherston, D. J., & Pavkov, T. (2014). Critical components of reflective supervision: Responses from expert supervisors in the field. *Infant Mental Health Journal*, *35*(1), 70–80.

Weatherston, D., & Osofsky, J. D. (2009). Working within the context of relationships: Multidisciplinary, relational, and reflective practice, training, and supervision. *Infant Mental Health Journal*, *30*(6), 573–578.

Weatherston, D., Weigand, R. F., & Weigand, B. (2010). Reflective supervision: Supporting reflection as a cornerstone for competency. *ZERO TO THREE Journal*, *31*(2), 22–30.

Winnicott, D. W. (1960). The theory of the parent-infant relationship. *International Journal of Psychoanalysis*, *41*, 585–595.

Winnicott, D. W. (1962). Ego integration in child development. In M. M. Khan (Ed.), *The maturational processes and the facilitating environment* (pp. 56–63). London, United Kingdom: Hogarth Press.

**How to cite this article:** Salomonsson B. Defensive patterns in reflective group supervisions at Child Health Centres. *Infant Ment Health J*. 2019;40:588–599. https://doi.org/10.1002/imhj.21790

10970355, 2019, 4, Downloaded from https://onlinelibrary.wiley.com/doi/10.1002/imhj.21790 by Karolinska Institutet, Wiley Online Library on [20/04/2024]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License