A systemic supervisory methodology and approach used during COVID times: Collective cut-outs – a gift from the left hand

Joanne Adams | Melissa Baxter

1Visiting Lecturer, Systemic Psychotherapy, DET, Tavistock and Portman Foundation Trust, London, United Kingdom
2Senior Systemic Psychotherapist, City and Hackney CAMHS, East London Foundation Trust, London, United Kingdom

Correspondence
Joanne Adams
Email: jo01adams@yahoo.co.uk

Abstract
This paper sets out to explore the use of a systemic reflexive exercise called “Collective Cut-Outs”, detailing its methodology and usefulness with “frontline” mental health practitioners within supervision and teaching contexts. We draw on the use of storytelling, image, creativity and the usefulness of the left hand (right brain) in clinical mental health contexts and focus on its value in reflexive supervisory groups. We also aim to give voice to the experiences of “frontline” Black Asian Minority Ethnic (BAME) clinicians in an inner-city mental health team during the COVID-19 pandemic. The Collective Cut-Out exercise and its methodology provide a framework to help facilitate reflexive spaces that promote mindful group exercise and the subsequent expression of personal and professional resonance. The subjects of clinical challenge and collective resilience are also brought forth. We offer a case study in the second part of the paper, outlining the use of the exercise in a reflexive group supervisory context. The team in focus have kindly given us, the authors, permission to use their experiences and “cut-outs”. We have either adapted or removed identifiable information from the writing to protect and respect the identity of the team and individuals involved.
**INTRODUCTION**

“Since childhood, I have been enchanted by the fact and the symbolism of the right hand” (left brain) “and the left hand” (right brain) “the one the doer, the other the dreamer... Reaching for knowledge with the right hand is science... The great hypotheses of science are gifts carried in the left hand.” 

*Bruner, 1962, pp. 2.*

We are invited, through the world around us and relationships, to engage in dialogue and relational drama over the course of a lifetime. The stories we hear and tell with each other are internalised to create our inner thoughts, inner–outer conversation and collective ideas, in a recursive, heuristic process.

We (the authors) met during the coronavirus 2019 (COVID-19) pandemic. Our introduction was online and the motivation for our meeting was to find ways to support supervisees in “front-line”1 practice, when working with team stress and a shared sense of isolation, both before and during “lockdown”.

In our following reflections, we focus on the use of an exercise called “Collective Cut-outs” and consider its usefulness in face-to-face (f-to-f) and then online, reflexive supervision. We consider the use of storytelling, through the medium of voice and image, as a generative platform and how the engagement with the “left hand” (right side of the brain) can help in the provision of transformative supervisory practice.

I (Joanne) am a systemic psychotherapist and supervisor working for a Child and Adolescent Mental Health Service (CAMHS) in the National Health Service (NHS), England. I also teach systemic practice. I identify as a White, working-class British female in my 50s of Northern heritage. I have a degree in the arts, and I am a practising artist. I (Melissa) am also a systemic psychotherapist offering reflexive group supervision within an inner-city NHS trust and identify as a White middle-class British female in her 40s, originally from the West Midlands. We recognise that this article is written through the lens of our shared cultures, and with this comes a bias that may overlook other views, interpretations and ideas.
1.1 | Collective Cut-Outs

I (Joanne) had used the “Collective Cut-Out” exercise, initially, with a Child and Adolescent Mental Health Service (CAMHS). This was f-to-f and was created following a wish to respond to individual expressions, and observations, of a sense of team “isolation”. This was “pre-COVID” and an isolation experienced during busy weeks of intense therapeutic meetings with distressed families. The isolation was felt when the quality of the working week had an emphasis of moving through the contact with families and not prioritising the benefits of team reflection and connection. I remember being worried about the team’s mental health and believed there was value in sharing stories of professional struggle and success. It was a worry that if experience was not shared it would hold less “power” (Foucault, 2002) and less collective strength. At the time, I was thinking about the team’s individual ambitions and purpose, and witnessing great practice, but this was not being voiced or heard. I remember thinking that sometimes when working in professional “isolation” we might struggle to envision the collectives that we are part of and their qualities.

This approach was used again, in the early stages of the pandemic, on the Tavistock and Portman Systemic Supervision Course, when eleven students found themselves resigned to bedrooms and remote offices in a bid to continue their studies. They had changed from being a solid f-to-f group, meeting fortnightly, to a group of parts, meeting on screen, and were all experiencing real challenges both personally and professionally. I remember the wish to bring forth “communal resonance” was foremost in the mind, on both occasions.

The exercise was shared with co-author (Melissa) during the pandemic, and then utilised further in “frontline” group supervision. The supervisory dilemma became how to give voice to the daily challenges of ‘frontline’ staff during the pandemic, and their experiences of social injustice highlighted by the Black Lives Matter movement. We will look at this in more detail later in the paper.

2 | IDEAS INFORMING OUR THINKING

2.1 | Use of storytelling

Bruner (2002) referred to the historical use of storytelling to externalise inner turmoil with one’s community. Storytelling would take place in large gatherings, facilitating collective ways through struggle, re-storying with the help of others, and lives would be lived on with new meaning. White and Epston (1990) developed these ideas and created a therapeutic language that moved the “sense of self” and “problems” from inner pathology to outer placing, helping to relinquish individuals from feelings of blame and persecution. White called the process “externalisation”.

White and Epston (1990) spoke of the process of storytelling in therapy as a transformative process, noting firstly the teller of the story, secondly the one who listens and thirdly the audience who witness the narrative craft and offer a potentially transformative response. The process of noting a cognitive move from the first-person perspective (being unaware and involved) to a second-person perspective (involved and observing), and then to a third “meta perspective” (observing/witnessing the system in process and yourself in the system) is in itself a reflexive manoeuvre (Harré & Davies, 1990; Partridge, 2017).

Weingarten (2000) developed further thinking around witnessing, recognising that “voice is contingent on who listens with what attention and attunement” (p. 392). Weingarten’s work led her to develop a “typology of witnessing” that described the different positions taken up while in this
important role; “aware and empowered”, “unaware and empowered”, “aware and disempowered” and lastly “unaware and disempowered”. While bearing witness, the individual takes up varying positions depending on the power and knowledge they hold. The positions can also change over time.

The LUUUUTT model (Figure 1) (Pearce & Pearce, 1990; Pearce, 2012) places the act of storytelling within a Coordinated Management of Meaning (CMM) framework. A supervisor can hold this model in mind for “reflection in and on action” (Schon, 1990) and can use it explicitly with others when co-creating reflexive positions. Pearce (2012) suggested when looking for alternative narratives and better social worlds that an element of wonder and awe can expand imagination and possibility.

2.2 Use of art

Gregory Bateson’s (1972) ideas about relational patterns were influential in the exercise’s creation, and the question of whether this conceptual space “between” could be brought more into view, and played with, within systemic thinking, was considered. Gregory’s daughter Nora Bateson (2016) might refer to this space as the sea of relational activity, where the things we can’t see flow around us in everyday communication and ecological worlds.

In line with these ideas, I (Joanne) found myself being inspired by the approach of Day (2017, 2021), who would present images to supervision students, then sit in silence while inviting the group, the viewer, the audience, to make a connection to the art and, subsequently, the subject and the object in view. There is something in the positions we take, the way we view the other, the way we subjectify and objectify others and relationships that is very nuanced. This led me to enquire “what does art offer reflexive enquiry, and could art help us sit with uncertain nuanced and complex positions?”

I searched for an artist to play with, and Matisse (Spurling, 2009) was one I was drawn to, as his work offered a potential way of making art that felt simple and accessible to a supervisory group. The idea of creating individual shapes that we could place and view as a collective pattern felt like an interesting proposition.
Collective Cut-Outs Exercise

If meeting online, the group are asked to bring with them some coloured paper and scissors. If meeting in person, the group can be provided with these items. The facilitator introduces the exercise by proposing that they (the supervisor) are going to tell the group about an artist called Matisse. The group are then invited to listen to the story and make their own connections with the meanings that the story holds. While telling the story, the facilitator shows images of Matisse’s work. It is a good idea to share with the group Matisse-inspired images (Figure 2) from other groups or ones you have created yourself (to avoid copyright infringement concerns).

Notes for the supervisor

Storytelling can emulate a relational hearth; it can draw people close and can metaphorically warm the heart. A story can dispel or attract its audience. The telling of a story is an important part of the performance of a supervisor and can be offered in the spirit of inviting others to join in, tell stories and listen to the stories of others, while doing this together, creatively and with passion.

The Story of Matisse (adapted from Klein, 2014)

Henri Matisse was a French artist who lived and died between 1869 and 1954. Between the ages of 60 and 85, Matisse developed a technique that he called “painting with scissors”. His work began as maps or templates for larger paintings. He would start with individual cut-out shapes and arrange them onto much larger boards, spending weeks reflecting on the right composition, their pattern and position. Matisse was taking art back to basics in many ways and using an approach that would have been more familiar to young children when creating art for the first-time. Matisse came from a family of tailors and would use family cutting shears when making his pieces. As his health deteriorated and Matisse became more unwell, he continued to produce work from his bed. He called this period his “second life”. Matisse spoke of his wish to represent the colour and vibrancy of life. Even in his difficult days he saw the beauty in life and the need to share this interpretation with others.

Notes for the supervisor:

After reading the story, the facilitator can reflect on parts of the story that may lend themselves to a systemic approach and the idea of individual pieces being part of a “systemic whole”. The facilitator can refer to Bateson’s (1972) theory of mind as a collection of relational interactions and lived experiential patterns rather than just the physical organ of the brain. It can be helpful to speak of the act of positioning (Harré & Van Langenhove, 1990) and repositioning of shapes as being like the ongoing process of reflexivity (Burnham, 2010). The facilitator can wonder if the stories of illness and death raise questions for participants about things we do not know, the more spiritual aspects of life. They could also explore if the beauty and vibrancy of life that Matisse sought to share could be part of the wonder and awe, we experience with each other when adversity is overcome, and the simplicity of life is valued. The facilitator can ask the group what their own resonances are.

The Collective Cut-Outs Exercise (continued)

Next the facilitator asks the group to:

Cut out three shapes that respond to the following prompts:

(Continues)
1. How are you?
2. Think of an experience that you managed this week in your organisation that was challenging?
3. Think of one experience that happened this week in your organisation that you appreciated.

Group instruction:
The group are asked to ‘do the exercise in “isolation”’ (this was a play on the use of the word ‘isolation’ during the pandemic, other words such as “on your own”, or mindfully can be used), while also being asked to pay attention to their thinking and their embodied response as they cut out the shapes. The facilitator can let them know that “they will not be asked to share the content of their thoughts and the experience in mind, just to think and talk about the process of the doing of the exercise, the patterns produced and what future implications may have been evoked”.

The group is given 5–10 minutes on their own to create the shapes, preferably with cameras on.

Notes for the facilitator
Here are some of the theoretical and reflexive considerations underpinning the instructions that are used:

“How are you?” The first prompt was inspired by Vetere (2017), who wrote about how useful it is to recognise a move from the context of the personal to the professional. This construct prompts the facilitator to adopt this “simple” gesture as an “invitational act” that greets others at the door of transition, marking the move between the outside and in. Moving from personal contexts to professional ones. It feels important to mark the “move into” what hopes to be a safe and supportive space.

The second instruction is linked to Minuchin’s (2014) ideas about the helpfulness of the construct of “challenge” when co-creating therapeutic shifts. Minuchin found the construct of challenge as being a conversational marker for the point of change. Pearce (2012) would call this a bifurcation in the dialogue: a place in the relational interaction where there is an opportunity to move things in different future directions.

The third prompt comes from an appreciative stance: “think of an experience at work that you appreciated this week?” This question invites the participants to move from challenge narratives to appreciative ones. By using an appreciative stance, the acts of “an-other” would come to mind, and relational recognition and understanding would come forth. When thinking of an appreciative approach, the spirit and teachings of Lang and McAdam (1997) can be called forth. Lang would inquire in ways that brought forth the positively purposeful in the most traumatic of situations. He did this by always seeing beyond the “systemic stuck-ness”, by finding courageous alternative views of problems and doing this all from a stance of compassion.

The three “simple” instructions may evoke complex feelings and embodied responses. The invitation to be mindful and not concerned about sharing the content of the inner narratives can make it safer to think about some of the more challenging aspects of experience, experiences the participants may feel unable to or unsure about sharing. Importantly, some of the embodied experiences are not necessarily noticed by us, and the group may not have yet acknowledged a connection between body, thought and emotions.
Facilitating group reflections

Following some time in silence for the group to create their shapes the facilitator asks the group to come back together and share their images. They ask the group, whether meeting online or face to face, to share the image that was created in response to the first prompt: How are you? (Time to reflect on the other two prompts will follow).

Space and silence are allowed so that the group can observe each other’s shapes. Online, it is encouraged that people show their images to the screen so that everyone can see the shapes of the others. The facilitator then invites the group to reflect on any patterns. The question “Can anyone see any ‘patterns that connect’ with them or between others?” (Bateson 1972, 2016) is asked. The facilitator prompts the group to start making connections between images, encouraging a reflexive dialogue between the supervisees. They can encourage the group to stand back, either metaphorically or in person, and comment on any patterns and resonance. There is also time given to everyone to speak to their shape and the making of it. The images can be “screen-shot” when meeting online or placed on a wall like a large piece of art and viewed collectively. We like the images to be collated in line with the questions asked, so that we have a triptych of collective art to view and consider.

Additional questions for group reflection:

Is your shape like anyone else’s?

What surprises you when you look at everyone else’s images?

What themes are coming to mind?

What do the collection of shapes tell you about you as a group?

The group share their first shape collectively, and then the second shape and then the third. It feels important to spend time on each of the three themes of “how are you”, “what have been the challenges” and then “the appreciations.” When each prompt has been considered by the group, it can be helpful to think more generally about the process, group reflections and learning.

Group process questions:

What have you noticed while doing this exercise?

What surprised you?

What have you learnt about yourself?

What have you learnt about the others, the group?

How would you like to take what you have learnt forward into future practice and your professional relationships?

Other ways to use the exercise

The exercise can be used in group supervision as an introductory approach, asking a newly forming group to cut out shapes that symbolise how they feel about first meetings, what challenges they see are to come and what future possibilities. The same exercise can be used again in the middle and end of group formation. The shapes over time can be compared as part of the reflexive process.

The exercise can also be used in practice with families with similar questions to those suggested and can be reviewed over time.
For the last year I (Melissa), a fledgling systemic supervisor, have had the privilege to facilitate a reflective space to a team of specialist mental health nurses who work within busy inner-city hospital Accident and Emergency (A&E) departments. For the purpose of this article, the team will be referred to as the Critical Response Team. This Service offers assessment, liaison and onward referrals for the treatment for young people who present at hospital A&E departments due to self-harm or suicidal ideation. The time and care that this team provide for young people is a highly valued and much needed resource for the local community and mental health services. This is a team rich and diverse in race, heritage, age, experience and gender, with the majority identifying themselves within the marginalised Black and Asian population, a demographic recognised as significantly “at risk” during the COVID-19 pandemic.

When the pandemic hit the UK in March 2020, the NHS trust, complying with government guidelines, stopped in-person contact with clients. Clinicians, where possible, began working from their homes providing remote access to therapy, and services ground to a halt for most cases unless they were in crisis. The Critical Response Team did not have the luxury of working from their homes when seeing clients. Their roles required some f-to-f assessments within the crisis-stricken A&E services.

Although offering clients f-to-f assessments, the staff were not able to meet in-person as a team, and the reflective space was offered virtually. This protected hour provided an opportunity to pause and reflect on their individual and collective experiences. All members of the team attended, including the manager, mental health nurses, psychology assistants and administrator. This was a time when the service was expanding to meet the demands of increasing hospital presentations and they were welcoming new colleagues into the team.

The team faced a number of challenges within their role. Alongside a well-documented lack of sufficient personal protective equipment (PPE) to allow them to feel safe in highly contagious hospital departments, there was an additional struggle to sufficiently assess a distressed young client, while both clinician and young person were having to wear face masks. The team were affected by the deaths of colleagues they worked alongside, as well as working with a depleted team as individuals self-isolated with COVID symptoms.

The majority of the team were Black British, the highest risk group in COVID terms. At the time of the session in question, the Critical Response Service was a team of eleven, six identifying
as Black British, one Asian and four of White European heritage. A recognition around the number of deaths within certain groups, disproportionate to the population in England and employment within the NHS, led Cook et al. (2020) to collate data and publish findings in the Health Service Journal. Their report highlighted that, although BAME populations made up 21% of the NHS workforce, 63% of the deaths within this vocation were from the BAME population. A significant number of NHS staff were dying from COVID, and a disproportionate number were from within the BAME population. It is recognised that this population are employed within lower pay banding in the care profession and are more likely to work in higher exposure care environments. Due to being a part of the lower socio-economic groupings, their risk increased as a consequence of lower income, high exposure, multi-family and generational households, and higher rates of comorbidity for issues such as diabetes, renal conditions and cardiovascular disease.

The “frontline” Critical Response Team were managing the impact of being a team at risk of exposure to the COVID virus, as well as the implications of virus transmission. The emergency departments where they worked were under immense pressure, and working within the hospital also had an effect on their personal lives. Although the public offered enthusiastic support by clapping from their doorsteps, there was a different response from flatmates who feared exposure to the virus. Clinicians were also in the difficult position of having to self-isolate from loved ones due to risk factors. While facilitating reflexive supervision, my dilemma was to be able to give voice and witness the struggles and experiences they faced, without increasing anxiety of new colleagues that we wanted to welcome into the group.

Within the group, individuals took up different witnessing positions in relation to the social injustices exposed by COVID, as well as the risks for individuals in the team. Weingarten (2000) (Figure 3) described the different positions adopted when taking on the role of witnessing. She noted that the position of unaware and empowered was the most dangerous of witnessing positions for others and one that supervisors would want to help shift (p. 395). To be in a position of power and being unaware of people’s full stories could result in decisions not being in the

| Aware | Unaware |
|-------|---------|
| **Empowered** |   |
| **Disempowered** |   |

**Figure 3** “A typology of witnessing and the changing of witness positions” adapted from Weingarten (2000) pp.396–397
best interest of others and having negative consequences on relationships. The reflective group provided a space where their individual stories could be told, helping to promote awareness in the team with the hope of helping to bring change into the working culture. Other individuals felt aware yet disempowered to alter their status within the service and from having little choice other than working in the vulnerable position of “frontline” clinician. The aim was to help the team find connection through increased awareness of shared experiences, gaining a collective voice and a sense of empowerment.

Providing a supportive reflective space was also complicated by offering this through a digital medium of telecommunication. In the early days of the pandemic, teletherapy was a developing area in which many British clinicians had limited experience. As a supervisor of the reflective space, I struggled with the limitations that video conferencing offered; individuals in the team expressed this also.

McKenny et al. (2021), in a survey of attitudes and practices of systemic therapists during the pandemic, stated that whilst most of the therapists who participated in the survey felt happy with working online, the findings also highlighted certain difficulties therapists experienced. They struggled translating their therapeutic techniques from f-to-f to teletherapy and felt less able to attend to emotional content. The survey also spoke about the added challenges faced when attending to the therapeutic relationship when meeting clients online. This resonated with my own concerns about providing a “good enough” reflective space, while joining, witnessing, talking and containing the emotions within the team that subsequently emerged.

The LUUUUTT model (Pearce & Pearce, 1990; Pearce, 2012) has been a helpful frame to hold in mind when co-creating a shared narrative with a team who are interacting virtually. Experience of offering group supervision while working online often highlighted the tensions not only between our lived stories and the stories told, but also between the stories perceived by others when team members have only seen each other on screens. Relationships solely based on virtual interactions amplify the untold/unknown/untellable and unheard stories increasing the “mystery” between people. Often tensions that came to light in group supervision during the height of the pandemic arose from the perceived stories people gave each other. The untold stories of clinicians who were having to protect themselves or others by shielding often left their colleagues grasping to make their own meaning as to why their colleagues were not helping with the increased numbers of clients presenting in A&E. Online meetings offer limited opportunities to catch up with colleagues around non-work topics. These conversations naturally occur when working in the same building while passing in the corridor or catching up in the kitchen. Without the “glue” of the “kitchen conversations”, numerous stories remain untold and unknown.

Within the confines of the reflective practice hour, I wanted to give voice to these various stories, to capture their shared narrative, pulling out strengths and resilience both as individuals and a team and give recognition for the challenging work they were undertaking through turbulent times.

2.4 | Giving voice to collective trauma

From the little I (Melissa) knew about Matisse and his transition to using cut-outs as his primary medium when facing constraints of illness, I did recognise the parallels with how mental health teams were working during the pandemic. Our normal strategies for helping clients had disappeared and we needed to think outside of our training and normal ways of working. Most of the work had moved to digital, and colleagues faced being out of their comfort zone and managing
new struggles with engagement, containment and risk, as well as being isolated from supportive colleagues.

Upon learning the prompts in the exercise, I adapted these to fit with the team:

1. Make a cut-out to represent how you are feeling right now. This could be something about your newness, your familiarity or your stress levels due to work and the current climate.
2. Cut out a representation of a difficult work situation in the last couple of weeks.
3. Cut out a representation of your strengths and resilience as a team.

At the time of the session, eight members of the team attended, four identifying as White European females, one Asian male, and three Black British clinicians: two males and one female. Most colleagues were on their own joining virtually. Two were in the same office, socially distanced.

What came forth:

Team members (TM) 1, 2 and 3 choose heart shapes for the first requested cut-out. TM 1 stated that the heart represented how they felt that they were in the right place at the right time in their career. TM 2 had cut a large yellow heart with a jagged space cut out at the top of the heart. This represented how they were really happy to be a part of the team, yet as they had only just joined, the shape that was cut away represented the loss they felt about leaving their old familiar team. TM 3’s heart was a wobbly shape, depicting a period of transition from the Critical Response Team into a new role and highlighting “imposter syndrome”. TM 3 also described their concern of leaving a team at a time during extraordinary circumstances and a team vulnerable to the risks of COVID.

TM 4 presented a large red piece of paper with various shapes cut into and also out of the paper. This represented how he felt lost and isolated in a maze of difference at the moment, struggling to find his way to the stability of the centre. This staff member was in the role of an administrator who had recently joined the team and largely worked at home. He was the only person in the team who was not a mental health nurse. His sense of connection with the rest of the team was hampered by only meeting virtually and not having the opportunity to build relationships by meeting f-to-f. TM 4’s perception of colleagues and their roles, “stories told”, were being influenced by the limitations of online conversations.

TM 5, 6 and 7 chose to cut out three hands of various colours and sizes. TM 5 had decorated her hand with very glittery painted nails. These clinicians spoke about reaching out to each other as a team during this time of crisis and TM 7 wanted to highlight the loss of the physical handovers that they would have during each shift when they would see each other. The glitter nails represented the magical moments of actual in person connection. They spoke of their feelings of isolation from friends/family and team members due to the lockdown. They also voiced their anxieties around transmitting the virus to loved ones due to working within the hospital. There was an emotional recognition around heightened vulnerabilities due to their heritage and health concerns. TM 5 spoke about how they also experienced people being wary of not only coming near them due to being employed in the NHS, but also avoidant of their experiences of working within the hospital.

Although they were separated by distance, their shapes were remarkably similar, as well as their descriptions of current vulnerabilities and struggles, alongside their strengths and resilience as a team. I noted how the hearts and the hands demonstrated embodiment (Fuchs, 2010) of their experience as clinicians within the team and reflected on TM 4 having a very different
experience. I was thoughtful about TM 4’s role and responsibility as an administrator and if this contributed to his felt difference.

The second request was for the individuals to represent a difficult situation in the last couple of weeks. The team came up with some interesting cut-outs. TM 6 used the whole of an A4 sheet of paper cutting into opposite corners. The bottom corner being one clear cut representing the client in crisis coming into the service. On the opposite end they had cut many jagged lines into the paper in various directions showing the complexity of how the client transitioned to other services, once seen by the Critical Response Team. This clinician spoke about the complexity of trying to find the most suitable route and care package for the young person from the myriad of services. The situation felt further hampered by the depleted service provisions during the time of the pandemic and how young people were suffering further due to the limited treatment options.

Similarly, TM 8 cut out a solid rectangle with three triangles cut into the shape. This individual spoke about the struggles they had faced when working within three hospitals. Although they were all mental health services within one Trust, they had different protocols and procedures in the pandemic resulting in daily confusion when working within the role. TM 8 described struggling to get a voice within the hospital setting due to their heritage and professional identity as a mental health nurse. TM 8 spoke about feeling trapped within these systems without an easy solution. TM 2 had cut out a solid rectangle depicting a wall they came up against continually, yet felt that this wall, although daunting, could be climbed and conquered, showing the determination and positivity that represented the characteristics of the team.

For the last request, depicting strength and resilience as a team, they came up with some great shapes. TM 3 cut out a boat with all of the team standing together on the stern riding the uncharted waters they were facing. TM 2, the new manager, cut out shoots of different sizes to depict the energy and new growth resulting from the changes and challenges that the team faced. TM 8 had cut out a balloon and spoke of how she felt that the team were floating above all the challenges, looking down and seeing them but not letting them stop their trajectory. TM 7 had cut out a circle with the middle removed wanting to show that although they are all working in isolation, they were all working as one team together. Lastly, TM 5 had cut out a circle that symbolised a protective eye and talked further about how this was a representation of her sense that being a part of a strong team was a similar protective measure.

At the end of the exercise, I asked the team to send me their cut-outs so that a picture could be created from their shared narrative, for them to keep, they also gave me permission to share the images in this article (Figure 4). I framed the images as a collection, and presented this back to the team.

Although the descriptions of difficult feelings and struggles highlighted the severity of what this team were dealing with daily, the exercise allowed them to bring together their
strengths and resilience and highlighted their appreciation for each other. The session ended with a sense of hopefulness for the future and strengthened bonds between them. It again recalls what Joanne and Bruner (2002) describe as, the process of externalising inner struggles and “isolated” experience in such a way that it creates a greater sense of connection and collective meaning making.

2.5 | Reflections

I (Melissa) had been slightly apprehensive about undertaking an exercise that used the medium of art to externalise the current dilemmas of the team. The group had used creative ways of talking in the past and I had recognised that this medium had allowed the team to open up about difficult things. The move away from words created a safer environment to explore their experiences. I had concerns that this may prove to be difficult over digital means, and that I may struggle to attend to the emotional content. Yet during the exercise, the team were thoughtful and creative with their shapes. Individuals had access to materials in their own home that allowed the shapes to embody the clinician’s personality, enriching the stories lived and stories told, allowing for greater connection.

In the feedback about the exercise, the team highlighted how they were able to express stresses and struggles that felt safe and could be heard by their colleagues without feeling like a burden. The manager also described her joy in experiencing the connection within the team and recognised the benefits of having a reflective space to aid team cohesion. TM 2, as a new member, described the exercise as invaluable, witnessing individuals’ stories enabling a sense of connection and an understanding of the culture of the team that had been hard to achieve when mainly meeting digitally. The witnessing of each other’s stories and the recognition of similarities as well as differences, helped to reduce the sense of isolation that had arisen from working practices as a response to the pandemic.

From my experience of working digitally with teams, I had noticed limitations around the “stories told” and “stories lived” and an amplification of the “unknown, unheard and untold stories”. Reflecting how offering a virtual space impacted the therapeutic relationship, I was curious about how I was being positioned as the facilitator through the limited frame on the screen. I was very aware that I “embodied” (Hardman, 1996) the “safe, White, middle-class, higher paid, working from home” therapist that this team had to step in for when clients of the young people’s mental health service went into crisis. I also felt de-skilled without my short stature, non-threatening, playful nature being so visible to the team, which I rely on to help form a collaborative relationship within the group. I found myself working hard to project a grounded, reflective, containing, appreciative woman who recognised the importance of talking about power, race and discrimination within the structures of the NHS, especially in response to the pandemic and Black Lives Matter. Pendry talks about how race and racism can evoke anxiety due to the sensitivities around the topic, yet goes on to say that, as a supervisor, it is our responsibility to raise the awareness through conversation of social difference and ‘race and racism’ (2017, p. 20). The combined effects of the COVID pandemic and the Black Lives Matter movement brought a renewed focus on widespread racial discrimination, and this pushed me to feel that it was important to linger in conversations around race, power and discrimination with the team through the exercise. The exercise allowed the team to voice the inequalities within their working environment that had been further amplified by the pandemic.
The group exercise gave voice to the emotional distress within the group relating to their social and professional circumstances. Their shared narratives gave rise to the experience of solidarity, renewed energy and perseverance. As the facilitator, I felt privileged to witness such powerful stories, and a felt sense of responsibility as a supervisor to give voice to the struggles faced by marginalised BAME individuals working in the NHS during the pandemic.

3 | CONCLUSION

Doing this activity online, for both of us (authors), brought forth questions about what we take for granted in physicality; experiences such as closeness and implied physical connection, alongside physical subtleties such as nuance and embodied semantics. Yet the embodied act and expression could be dramatised in singular person, online, with group connection being experienced through witnessing others alongside you who were involved in the same activity.

Ideas online benefitted from further verbal description, yet the image also stood alone in its communicative act. On screen, the image could be perceived as part of a screen of screens, a pattern of singular and collective images. The virtual experience connected to the meaning and culture of working in isolation, the benefit of mindfulness when anxious, the holding of uncertainty when uncertain, the not knowing when things would shift. The group’s need to connect and feel validated was present, the wish to find a safe place collectively was present and the drive to find creative and spiritual ways to do this was there. The word spiritual is used in the sense of having another worldly experience that sits on the periphery of understanding and physical grasp. Similar to what Matisse brings into his cut-out pieces and subsequent artistic expression of the world and the inter-related story of the liminality of ill health and end of life experiences: a gift from the left hand.

The story of Matisse lent itself well to organisational contexts, with people in those contexts struggling to feel connected, with teams that were facing untold challenges and sailing out into uncharted waters in uncertain times, with clinicians that felt marginalised and vulnerable.

Maybe it is fair to say that we did not yet have a narrative for the experience of a pandemic and the related collective personal and professional trauma, and within this context we, as professionals, may have struggled to feel entitled to have a voice in a profession where we historically were the ones with the “steady voice” and the “holding hand”. Maybe the element of mystery and creativity (left hand pursuits) enabled the creation of a different type of collective sharing and a space for group mindfulness.

It has been crucial to think of the supervisor’s responsibility to bring forth the “triple loop” of client and personal professional trauma and to connect to wider political and social accounts of injustice and everyday taken-for-granted-ness and, furthermore, to consider that if the experience is denied a voice and/or an audience, it has a lesser social and influential power (Foucault, 2002).

We think the idea about relational patterns (Bateson, 1972, 2016) and the use of image to help show “relational meaning making” and making these more visible and “present” in supervision and therapeutic practice can be helpful. Holding, imagining, re-imagining (Wynner, cited in McKittrick, 2015), recognising, bringing forth the space between and imagining the “patterns at play”. Taking a pause for reflection in busy working days, figuring out the storm and returning to safer ground feels an important process when pausing and returning to “frontline” mental health practice. And lastly, we would like to note the hearts, squiggles and the hands that were predominant in the images, brought forth by the ‘frontline’ clinicians. We imagine these hearts, squiggles and hands being part of a “cycle of significant” experience and connection between patients, young people, individuals, families, “frontline” practitioners, clinicians and supervisors.
ACKNOWLEDGEMENTS
We would like to thank Karen Partridge Course Lead, Systemic Supervision, Tavistock and Portman Foundation Trust for introducing us, the authors, for her continued support and for her “uncanny knack” for seeing potential in creative acts, responsible practice and collective solidarity. We would also like to acknowledge the commitment and adaptability of ‘frontline’ workers in the face of adversity during the pandemic and thank the clinicians who kindly gifted their thoughts and experiences to be documented within this article. The stories they shared gave life to this re-flexive exercise.

CONFLICT OF INTEREST
We have no conflict of interest.

ETHICS
We can confirm that all the practices described meet ethical guidelines, including adherence to professional and legal requirements of the study country.

ORCID
Joanne Adams https://orcid.org/0000-0002-0295-2318

ENDNOTE
1 This article’s use of the word “frontline” is in line with UK government COVID 19 adapted terminology referencing essential workers who continued with face-to-face patient/client/public work during the pandemic.

REFERENCES
Bateson, G. (1972) Steps to an ecology of mind. Chicago and London: The university of Chicago Press.
Bateson, N. (2016) Small arcs of larger circles: framing through other patterns. Axminster, England: Triarchy Press.
Bruner, J. (1962) On knowing essays for the left hand, Expanded edition. Massachusetts, London, England: The Bellknap Press of Harvard University Press Cambridge.
Bruner, J. (2002) Making stories; law, literature, life. Cambridge, Massachusetts, London, England: Harvard University Press.
Burnham, J. (2010) Creating reflexive relationships between practices of systemic supervision and theories of learning and education. In: Burck, C., & Daniel, G. (Eds.) Mirrors and reflections: process of systemic supervision. Chapter 3. London: Karnac Books, pp. 47–49.
Cook, T., & Kursumovic, E., & Lennane, S. (2020) Exclusive deaths of NHS staff from Covid 19. Available at: https://www.hsj.co.uk/exclusive-deaths-of-nhs-staff-from-covid-19-analysed/7027471. For Health Care Leaders HSJ, HSJ Solutions.
Day, E. (2017) Picturing the Graig: a rich portrait of the construction of loss and remembrance in murmurations. Journal of Transformative Systemic Practice, 1(1), 68–79.
Day, E. (2021) Presentation to supervision students. Tavistock and Portman Supervision Course 2020-2021.
Foucault, M. (2002) The archaeology of knowledge (Trans. A. M. Sheridan Smith). London and New York: Routledge.
Fuchs, T. (2010) Phenomenology and psychopathology. In: Schmicking, D. & Gallagher, S. (Eds.) Handbook of phenomenology and cognitive science. Dordrecht: Springer, pp. 547–573. https://doi.org/10.1007/978-90-481-2646-0_28.
Hardman, V. (1996) Embedded and embodied in the therapeutic relationship: understanding the therapist’s use of self systemically. In: Flaskas, C., Mason, B. & Perlesz, A. (Eds.) The therapeutic relationship in systemic therapy. London: Karnac Books.
Harré, R. & Davies, B. (1990) Positioning: the discursive production of selves. *Journal of The Theory of Social Behaviour*, 20(1), 43–63.

Harré, R. & Van Langenhove, L. (Eds.). (1990) *Positioning theory*. Oxford, GB: Blackwell.

Klein, J. (2014) *Looking back: Henri Matisse at Tate Modern*. Jacky Klein explores the revolutionary cut-outs of French artist Henri Matisse, shown at Tate Modern in summer 2014. London. Available at: artfund.org/whats-on/more-to-see-and-do/listicles/video-henri-matisse-at-tate-modern

Lang, P. & McAdam, E. (1997) Narrative-ating: Future dreams in present living. *Human Systems: The Journal of Systemic Consultation and Management*, 8(1), 3–12.

McKenny, R., Galloghly, E., Porter, C.M. & Burbach, F.R. (2021) ‘Living in a Zoom world’: Survey mapping how COVID-19 is changing family therapy practice in the UK. *Journal of Family Therapy*, 43(2), 272–294.

McKittrick, K. (2015) *Sylvia wynter: on being praxis*. Durham and London: Duke University Press.

Minuchin, S. (2014) *The craft of family therapy: challenging certainties*. New York: Routledge.

Partridge, K. (2017) The positioning compass: a tool to facilitate reflexive positioning. *Human Systems: The Journal of Systemic Consultation & Management*, 18, 96–111.

Pearce, K. (2012) *Compassionate communicating, poetry, prose and practices*. London: Lulu Enterprises. www.lulu.com

Pearce, W.B. & Pearce, K.A. (1990) Transcendent storytelling: abilities for systemic practitioners and their clients. *Human Systems*, 9(3–4), 167–185.

Pendry, N. (2017) The construction of racial identity: implications for clinical supervision. In: Bownas, J. & Fredman, G. (Eds.) *Working with embodiment in supervision: a systemic approach*. Oxon: Routledge, pp. 19–33.

Schon, D. (1990) *Educating the reflective practitioner: toward a new design for teaching and learning in the professions*. The Jossey Bass Higher Education Series, 1st edition. London: Wiley.

Spurling, H. (2009) *Matisse: the life*. UK ed: Penguin.

Vetere, A. (2017) *Supervision of family therapy and systemic practice*. New York: Springer.

Weingarten, K. (2000) Witnessing, wonder, and hope in. *Family Process*, 39(4), 389–402.

White, M. & Epston, D. (1990) *Narrative means to therapeutic ends*. New York and London: W.W. Norton & Company.

---

**How to cite this article:** Adams, J, & Baxter, M (2022) A systemic supervisory methodology and approach used during COVID times: Collective cut-outs – a gift from the left hand. *Journal of Family Therapy, 00*:1–16. [https://doi.org/10.1111/1467-6427.12391](https://doi.org/10.1111/1467-6427.12391)