

UNIVERSITY OF READING
FACULTY OF EDUCATION AND COMMUNITY STUDIES

M.A. DISSERTATION

"THE USE OF SUPERVISION AND CONSULTATION TO DEVELOP A
'REFLECTIVE' PRACTICE WITH AN EMOTIONALLY DISTURBED
CLIENT GROUP IN GROUP CARE ORGANIZATIONS".

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June 1993

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ABSTRACT

This dissertation explores how the use of supervision and consultation can facilitate workers in group care organizations, to develop a particular form of practice with an emotionally disturbed client group.

The thesis suggests that if the worker has a practical theory base from which to understand and manage the strong and sometimes hostile feelings generated by such a client group, he/she is in a better position to provide an appropriate response.

I have called this practice a 'reflective' one, and argue that if group care organizations provide particular forms of supportive structures, workers will be empowered to enhance the treatment task by thoughtful therapeutic intervention.

The dissertation sets this work in a contemporary climate of breakdown and anxiety in residential work with young people, and briefly examines some of the current legislation and reports that attempt to redress this balance.

The work provides introductions to psychoanalytic theories, which help explain the 'roots' of emotional deprivation, and proposes that these ideas can help develop a 'reflective' practice.

Also explored is how supervision, and particularly consultation, facilitate workers to develop forms of self-knowledge that will increase their ability to carry out the demanding task of treatment.

Finally, the dissertation proposes a model on which group care organizations can develop and apply the use of supervision and consultation to therapeutic work with their staff and client groups.

ACKNOWLEDGEMENTS

Firstly I would like to thank Dr. Eric Miller of the Tavistock Institute, for offering his time to answer a series of questions on the role of Consultant to group care organizations, and for feedback on other areas of this dissertation.

My thanks also go to Dr. Alejandro Reyes, Consultant to my own place of work, the Mulberry Bush School, for discussing aspects of the Consultant's role with me, and helping to identify the essential 'ingredients' of consultation.

Special thanks to Adrian Ward, my tutor at Reading University, for allowing me to use some of his unpublished material, and whose clear guidance and advice has made this whole thing possible.

Thanks also to John Whitwell and the Cotswold Community for giving permission to use extracts from an unpublished paper written by Richard Balbernie and Eric Miller in 1984.

Finally, I would like to thank Karen, Sean, Ben and Bobby Diamond for living with my intolerable levels of pre-occupation during the writing of this thesis.

INTRODUCTION

The methodological approach of the thesis is based on a combination of literature research and interview material.

My interest in this area of work started by trying to understand how care workers working with disturbed young people, could creatively use the difficulties encountered in relationships to enhance their work. This developed into an exploration of the concepts of the 'holding' and 'containment' of strong feelings, and being able to 'reflect' these back therapeutically.

My research progressed to identify how supervision and consultation as supportive structures could enhance these processes. My research took this a stage further by meeting and talking with two Consultants involved in the field of group care.

The result of this work has been to provide the reader with introductions to psychoanalytic concepts, and to show how these, supported by the use of consultation, can facilitate the development of a 'reflective' practice.

I have also used comparisons of different models of supervision for residential work, and explored the complimentary and critical aspects of these,

Using the Interviews with Consultants:

To develop the emphasis on consultation, I wrote to two practising Consultants asking for interviews, and was able to present them with a series of questions on the role of the Consultant to group care organizations. My rationale for choosing Dr. Miller and Dr. Reyes was that they both work with residential institutions, and apply a psychodynamic emphasis (see definition page 15) to their consultation styles.

Dr. Miller is an expert on consultation to organizations and their 'primary task' and has published

widely on the process of consultation (e.g. Miller and Gwynne (1972) *A Life Apart*, London: Tavistock Publications). Dr. Reyes is a psychotherapist and Consultant to the Mulberry Bush School.

The pre-set questions I took to them were as follows:

To Dr. Miller I asked:-

- 1) In what ways do you feel consultation can help develop a 'reflective' practice within group care?
- 2) Given that both Consultant and client have their own unconscious processes to deal with, in what ways can the process or outcome of consultation be evaluated?
- 3) How do different 'levels' and types of involvement with organizations affect the nature of the consultancy? I am interested in how different 'distances' from a client group aid 'objectivity'.

To Dr. Reyes I asked the following questions:-

- 1) What is 'quintessential' about consultation?
- 2) How can consultation reduce isolation and 'total institution' phenomena which may lead to abuse?
- 3) In what ways can the Consultant work on aspects of potential prejudice in the organization?

These questions are presented and answered in different forms within the thesis, along with other aspects of material which developed in the course of the conversations.

Their input into the thesis has been invaluable and the information gained from the interviews helped to develop my research. Given my own responsibilities at work, and limited study time, I did not feel it was possible or necessary to further this work by interviewing other Consultants.

Using the Literature:

This dissertation has been developed from an amalgamation of ideas from different literary sources. My primary objective was to bring together these ideas in a personal synthesis, to show how the use of supervision and consultation can help develop a 'reflective' practice based on psychoanalytic ideas.

References to the literature are drawn on directly throughout the thesis. It therefore seems unnecessary to repeat them at this stage. The material ranges from aspects of psychoanalytic theory, to broader issues on residential work.

During my preparatory reading, it became clear that none of the work focused primarily on supervision, consultation and their 'reflective' potential. The various reports examined in Chapter 1, have emphasised the need for such a practice within residential care.

The theme of a 'reflective' understanding is based on the work of Donald A. Schon and his book 'Educating the Reflective Practitioner' (Jossey-Bass 1987). Although Schon acknowledges the use of psychoanalytic ideas (Chapter 9, Learning the Artistry of Psychoanalytic Practice), the book is not primarily aimed at the field of residential or group care. In this sense the dissertation aims to explore the implications of such a practice and apply them to this field.

Chapter Contents:

Chapter 1: Setting the Scene: Recent Legislation as a Response to Anxiety:

This chapter examines some of the most recent reports and legislation, some of which have been produced as a response to crises within residential care. The chapter concentrates on the fact that these reports have clearly shown that supervision and consultation are necessary requirements for such work.

Chapter 2: Developing a Therapeutic Practice Within Group Care:

This chapter explores aspects of Winnicott's theory of early emotional development, which links emotional disturbance with deprivation in the formative experiences of the child. The chapter shows how these ideas can be applied to developing forms of therapeutic intervention within residential child care.

The chapter also defines the meaning of a 'reflective' practice.

Chapter 3: The Worker as 'Container':

Chapter three concentrates on Wilfred Bion's concept of 'container/contained', and the application of this to the worker/client relationship. The chapter shows how an understanding of this theory, and specific unconscious processes, can facilitate the treatment task with an emotionally disturbed client group.

Chapter 4: Supervision and Consultation:

This chapter defines forms, roles and functions of supervision and consultation (and some of the problems within them), that are suited to the needs of group care organizations. The chapter examines how supervision and consultation can help develop a 'reflective' practice.

Chapter 5: Consultation:

This chapter looks at specific issues within the process of consultation which emphasises its importance to residential care. This section is primarily based on interview material.

Chapter 6: Organizational Boundaries in Group Care: The Application of Supervision and Consultation:

This chapter provides a model for applying the complementary tasks of supervision and consultation to organizations where the 'primary task' is the treatment of emotionally disturbed clients. The chapter suggests there are parallels between the use, organization and application of supervision and consultation, and the therapeutic process of the organization.

Summary:

This starts with a summary of the work of the six chapters. It then moves on to discuss the implications of developing supportive structures within group care, and the relationship of these to wider issues of providing integrated services for children and young people.

CHAPTER ONE

SETTING THE SCENE: RECENT LEGISLATION AS A RESPONSE TO ANXIETY

Introduction

This section sets out the ground for the dissertation, by exploring the current state of residential child care, as described in several recent reports. These attempt to provide clear direction in the management of residential work. Some of the reports were produced as responses to crises within this work. The chapter also looks at certain assumptions about residential work and argues that these may hinder creative growth within it.

In the wake of the "Pindown" enquiry (Kahan and Levy 1990), the report "Children in the Public Care" (Utting 1991) was published. In chapter one, section 1.2 it says: There is continuing anxiety about residential child care on several counts:

The number of residents fell sharply during the 1980s, raising questions about its role and- more fundamentally - whether it was needed.

There was an associated loss of a sense of direction, purpose and esteem.

There were gaps and deficiencies in local authority policies and management of residential child care.

The staffing was over-weighted with unqualified and inexperienced people.

A concentration of adolescents among the residents posed problems of control which, if not handled appropriately, led to violence to staff and abuse to other residents.'

The expression of anxiety on all five counts is, I believe, primarily focused on issues of management and control. In an attempt to better this situation the 'Children in the Public Care' report emphasises the need for securing more professionally qualified staff for residential child care. In the recommendations of 'The Children in Public Care' report, (chapter 5), section 16.6 states:

The Department of Health, CCETSW, and the Local Authority Association to establish an Expert Group to report within six months on the Residential Child Care content of qualifying courses.

The Final Report of the expert group was published in June 1992. In section 3, entitled 'History and Urgency', the group report:-

The historical background against which this group has been asked to report is one of repeated failure. Readers will not need reminding in detail of the litany of enquiries and reports which have called for more and better training for residential staff (Barr 1987 lists fifty such reports between 1946 and 1985 alone) and they will be aware of how painfully slow progress has been, (CCETSW (1992) 3.1 p. 8)

Under section 6.2.2, 'The Group Care Curriculum', the group identify particular group care skills. For the purposes of this dissertation, I select the following:-

- (1) Team membership and reflective practice-contributing to a competent establishment.
- (2) Anticipating and handling incidents arising in daily life, including issues of control, and of conflict between e.g. individual and group needs and rights. (ibid p. 18)

The expert group focuses on the particular skills of 'reflective practice' (Chapter Two), and the management of difficult incidents. This dissertation develops ideas for ways of instigating such practices, and argues that without the use of supervision and consultation a 'reflective' practice cannot develop.

Recent reports such as 'The Pindown Experience and the Protection of Children' and 'The Children Act 1989' have recommended and legislated for the need of supervision and consultation.

In volume 4 of 'The Children Act 1989' under 'Guidance and Regulations' the following is written under 'Staff Supervision' (p. 10):-

1.42. All staff should receive individual supervision from their line manager. This

includes those who are not employed as care staff, but, by virtue of the fact that they work in a home, will come into contact with children. All staff will have emotional demands made on them by the children and will be obliged to respond.

1.43. Staff should be afforded the opportunity to express their feelings as 'invoked by the care of children, and be helped to understand these feelings.

This is continued in the section on 'External Consultancy':-

L47. Residential care staff often find the services of an external consultant to the home particularly helpful.

1.48. Homes which employ behavioural or psychotherapeutic methods It is expected that external consultants with specialist expertise in these methods will be engaged to provide additional support to staff and guidance in the treatment of particular children.

In the section on 'Child Abuse in Children's Homes' (pp. 32-35), paragraph 1.91 states:-

It is essential that staff caring for children who have been abused receive specific training and supportive professional supervision. Staff should be made aware of how the experience of being sexually abused affects the way a child relates to adults, so that they can take full account of this in the way they respond. Those responsible for children's homes should also give consideration to the need for external consultancy when staff are caring for children who have been abused or in cases of particular seriousness and complexity.

The most recent of these reports is the 'Warner' report, which is the report of the committee of inquiry into the selection, development and management of staff in children's homes (HMSO 1992). This was established by the Secretary of State for Health after the trial and conviction of Frank Beck in Leicestershire for sexual, and other offences against young people in a children's home. In the summary of recommendations, Recommendation 42 states: -

The Government should require employers to ensure that regular supervision of all staff by line managers takes place at least fortnightly and appropriate remedial or developmental action is agreed, recorded and taken as a result. (ibid p. 191)

and in chapter 8, paragraph 8.7 it states:-

Where links with external professionals are established, *the* standard of work of the home and the outcomes for children are greatly improved. The National Society for the Prevention of Cruelty to children (NSPCC) noted in their evidence that professional support and consultation from outside the home is invaluable in enabling staff to improve the care and development of children. (ibid p. 145)

It is clear from these reports that the use of supervision and consultation are regarded as vital in creating care environments with an ability to support workers involved in a task that may become directionless, and where the task of 'care' for residents and staff is too easily relegated to crisis management.

This dissertation explores the necessity of using supervision and consultation for such services, and moves from a brief look at forms of supervision which facilitate such a task, to a more detailed examination of consultation that will develop the therapeutic potential of such organizations.

Residential Care: A Basic Assumption, and the Management of Anxiety

A central tenet of this thesis is that 'good practice should be available to everyone'. In a time when attitudes about residential care are polarised between authoritarianism and permissiveness, a pragmatic theory base that provides understanding of these dynamics, and provides a working alternative is essential.

The different reports point to a recurring theme; the need for the management of anxiety, and strong feelings in staff. These feelings and the problems associated with them, are inherent in working with disturbed children and adolescents.

The staff of children's homes are especially vulnerable to being treated with contemptuous indifference. Like the therapists, they are made to feel very fully what it is like to be ignored, despised, helpless or even unreal and non-existent.
(Baxter, in Boston and Szur 1983, p. 128)

With such a client group, there is no 'common sense' way of working. Assumptions of 'good common sense' being 'enough', are propagated by suggestions such as, 'if you are nice to children,

they will be nice to you'. These, on the one hand, may infer that young people in care are denied personal liberty, and call for unrestricted self management, or on the other, demand the need for the 'short sharp shock'.

At times when levels of anxiety are heightened, the ability to think clearly is reduced, and such attitudes may become the simplest factors in decision making.

The 'Warner' inquiry into residential child care found that:-

About two-thirds of all the children in homes are considered to be suffering from emotional or behavioural difficulties. This is unsurprising given that about one-third of the children in homes are reported to have been sexually abused. Some children's homes today have high proportions of sexually abused and behaviourally disturbed children with many substance abusers and victims of serious violence within their own families.

(1992, para. 10.4, pp 169-170)

In an issue of 'Community Care', a short article entitled 'Care Staff Subjected to Violence' reported that:-

More than twenty violent incidents were recorded against Bexley Care Staff over three months.

(8 October 1992, p. 4)

Given that two-thirds of children in residential care suffer from emotional and behavioural difficulties, it seems that specialist ways of working, and supportive structures for workers in group care are required.

The government response to these problems reflects the anxiety created by such a client group, For example, Community Care reported:-

The Home Secretary has accused Social Services of failing to lock up young people in their care and prevent them from committing crimes. Kenneth Clarke told last week's Tory Party Conference that some 'persistent' young offenders were being kept in children's homes, only to abscond and re-offend. Proper care for such offenders required restraint, rather than just 'care orders and counselling' The Home Office is to fund the capital cost of 65 new secure places around the country.

(Community Care, 15 October 1992, p. 4)

The need to contain disturbed young people is expressed here as physical containment. Such attitudes maintain a status-quo within residential care by reverting to the need for punitive and penal forms of control. These attitudes can neutralise the possibilities of creative growth within care systems.

This dissertation argues for the application of certain principles drawn from the field of therapeutic child care. These principles are based on psychodynamic concepts, which, as I shall explain, have direct relevance to the management of anxiety and strong feelings.

Summary of Chapter

This chapter has emphasised the precarious context that residential work presently finds itself in, i.e. anxiety about the management and containment of young people who at times appear to be 'out of control', and the mismanagement of certain residential establishments.

Most of the literature mentioned has been produced to help guide development of such work into a 'safer' and more accountable practice.

Consequently, the reports conclude that supervision and consultation are necessary to monitor and evaluate an understanding of the residential task, to assist the personal and professional development of staff, and to help develop their skills in relation to the task.

These conclusions also have direct implications for clear direction in unit management, staff development and teamwork.

However, the reports do not analyse the complexities of the tasks of supervision and consultation in relation to the dynamics of treatment within residential child care. This dissertation addresses this specific issue.

The chapter also points to assumptions and ideologies which may counter change and growth in residential care. The concept of 'containment' is a crucial issue, the following chapter puts forward a rationale for containment meaning the emotional holding of disturbance which also implies a potential for change and growth in the client.

CHAPTER TWO

DEVELOPING A THERAPEUTIC PRACTICE WITHIN GROUP CARE

Introduction

This chapter uses psychodynamic principles to develop and explain a particular way of working within residential care with disturbed clients.

A psychodynamic approach implies recognition of the psychological forces motivating human behaviour and the importance of feelings in the client's life and in the worker/client relationship. (Hornby 1973 in ed. Lishman 1991, p. 49)

Psychoanalytic theory offers other ideas about the use of 'containment' and 'holding'. The theories most relevant to these processes were developed by two British Psychoanalysts, W.R. Bion and D.W. Winnicott.

This chapter explores Winnicott's theory of early emotional development and its application to developing therapeutic ideas within group care. The various meanings and the concept of a 'reflective' practice are also defined.

The next section implies a form of gender stereotyping, in 'reality' parental roles may be more flexible.

A Psychoanalytic Theory Base of Early Emotional Development

This theory is based on the work of Klein, Winnicott and Dockar-Drysdale. Donald Winnicott developed the concept of the 'holding environment', which in its prototype describes the emotional bond between mother and baby, and was later extended to the organization of therapeutic environments, that aimed to provide such 'holding' for emotionally disturbed people. Briefly, the theory is as follows:-

Within its formative months the baby is in an early developmental stage, bonded with the mother and has not yet achieved individuality, or 'unit status'. The baby is wholly dependent on, and undifferentiated from the mother. The baby's instinctual drives are for the fulfilment of basic needs, and these drives invoke raw, primitive emotions, which at this stage the baby has no ability to contain.

The mother in a state of 'primary maternal preoccupation' (Winnicott) instinctually understands the needs of the baby, and as long as this process of meeting the baby's primary needs is 'good enough' (Winnicott) the baby will be receiving the environmental provision it needs to emotionally evolve.

This process allows the personality to develop and 'integrate'. From this separateness, or 'unit status', a sense of 'I AM' is achieved. This foundation leads in later life to the ability for further emotional and intellectual growth and the capability of forming appropriately trusting relationships.

However, if this relationship or 'primary experience' is badly disrupted, the child cannot achieve integration, (the process by which parts are combined into a whole) (Rycroft 1988) and have a secure experience of 'self'. Consequently it may remain in an 'unintegrated' state. If this happens:-

Their development will be 'false' or 'arrested', underlain by a tremendous incapacity for relationships, by terror and confusion and by the danger at any moment that the fragmented core which ought to be the self will give way to chaos.
(Cross in ed. Fees 1990, p. 94)

In unintegrated children then:-

The ego boundary which enables the mature individual to separate his internal drives, impulses, feelings and fantasies from the external world of relations with other people has not yet developed, he does not yet distinguish between inside and outside, between his feelings and their causes.

In this state of fusion and confusion, his experience tends to be either of having the other person or the whole world inside him - the omnipotent fantasy or alternatively of being swallowed up by the other. He may oscillate between these positions.
(Miller, Balbernie 1984, p. 1)

To be engaged in working with an 'unintegrated' client group then, requires the development of

particular skills in dealing with the continuous barrage of apparently meaningless and destructive behaviour.

These emotional reactions are likely to be very strong and, whether we be therapists or substitute parents, we are likely to find aroused in ourselves defences which are not dissimilar to those of the deprived children. We require to be vigilant that our receptivity is not being impaired by these defences and that we too are not drawn into playing a part in the 'cycle of deprivation' despite our firmest intentions to offer a relationship which provides a path out of this cycle.

(Hoxter, in Boston and Szur 1983, p. 126)

This statement that 'our receptivity is not being impaired by these defences' is an important one. It is through these processes of being subjected to intense emotional disturbance that the worker's ability to understand and emotionally 'hold' the client may become blurred. Consequently, the individual or team may lose sight of their 'primary task'.

(The term 'primary task' from here on means 'the task the enterprise must perform in order to survive') (in Menzies-Lyth 1988, p. 222).

A practical example of this term could be that if the 'primary task' of a children's home is to 'care for children', then it must attempt to maintain this work despite obstacles. If, because of external pressures, it simply becomes a 'warehouse' for difficult children, it will inevitably lose its direction, lose sight of its 'primary task' and consequently its reason and ability for existing will be endangered.

It is my proposition that the development of a 'reflective' practice supported by the use of supervision and consultation, will help the workers understand the disturbance they work with, and enable them to remain 'on task' within the group care setting.

Defining Group Care

Before continuing with an exploration of how Winnicott's ideas, and the concept of integration and unintegration can promote good practice in residential care, it will be useful to define some of the

parameters of this term.

The term 'residential child care' has no direct association with the 'therapeutic' theory base I have described, although people working within this field would rightly argue that their engagement with children has therapeutic effects.

The term 'therapeutic child care' implies a specific field, which as I have discussed, has concepts such as 'primary experience' and the emotional 'holding' of disturbed people at its core.

I would like to propose that these concepts have a contribution to make to all forms of residential child care and day care for children.

I quote from the expert group formed for the 'Children in the Public Care' document. Paragraph 3.3 states:-

The group has therefore adopted the term 'group care' to refer as a homogeneous whole to the broad range of residential and day care work with all user groups. We take the view, following Fulcher and Ainsworth (1981), CCETSW (1986) and others, that there is enough in common in the work of teams in all these settings to constitute a 'domain of practice' within social work.
(ibid, p. 8)

From here on then, this dissertation adopts the term 'group care' to apply to the differing forms of residential child care.

My proposition is that the use of the ideas drawn from psychoanalytic literature, which have been applied to forms of therapeutic child care would seem to have a role in the development of 'group care'.

The following section briefly explores some of the applications of these concepts to group care, and shows the complexities of this work, opposing the 'anyone can do it' assumption. These examples call for professional discipline, and high levels of consciousness and attentiveness. Uninformed intuitions are clearly not enough.

Therapeutic Ideas Within Group Care: Complexities of the Task

Beedell (1970) identifies three components of therapeutic residential provision:-

- 1) Holding provision.
- 2) Nurturing provision.
- 3) Therapeutic 'integrity provision' which:-

'positively encourages the development of healthy individuals by adapting sensitively to them and by deliberate attempts at healing where hurt and damage have occurred'.
(1970, p. 79)

This form of group care with a severely emotionally deprived young client group (many of whom may be 'unintegrated') relies on the development of relationships between clients and staff, which, with time, may allow the beginnings of trust and caring to grow.

Ultimately, through the processes described above, the client's resistances to change and growth are reduced. To do this, the idea of 'milieu' therapy is useful, this uses the contacts and routines of daily living and learning to establish such relationships. The task in many ways is one of 're-education', in which the emphasis is on the positive and safe nature of care, education and recreation.

In such an environment there will be opportunities for living, learning, and playing, alongside adult role models, who may eventually be 'introjected' (this term can be briefly defined as identifying with and internalising another person) by the clients as a 'safe' person/s. This difficult and lengthy task will also rely on the individual and group of staff challenging and interrupting unacceptable behaviour.

As Arthur Barron writes:-

The work of the child care staff in the living group is to give the boys and girls experiences of emotional living which will help them to understand themselves and others and to move onto family life, friendships, sexual partnership and parenthood.
(In ed. Fees 1990, p. 27)

Barron uses the term 'living experience therapy', and writes of the group worker's role:-

Living experience therapy relies on the establishment of, and skilful use of working relationships. From the moment he or she steps into the establishment, the main worker has consciously to set about the task of providing the child with his emotional and other needs. This requires a continuous state of Winnicott's 'maternal preoccupation' with the child.
(ibid, p. 28)

Similarly, Berry (1975) writes of the fine tuning required when working with aspects of difficult behaviour and elements of communication within this behaviour:-

Acceptance involves meeting squarely the painful feelings underlying 'unacceptable behaviour' and thus relieving them gradually without the need for fight or flight. Similarly, ventilation of feeling and insight giving are not of great value in themselves alone; their relevance depends on how the feeling is received (and on *how insight* is given) by the worker.
(Berry 1975, p. 79)

Juliet Berry uses the term insight to describe the worker's perception of what the client makes him/her feel, and suggests a thoughtful response to this makes for good practice. The terms insight and intuition describe these processes well. However, I would prefer to use the idea of a 'reflective' practice as it indicates the reciprocal nature of such communications.

Some meanings of the term 'reflection':

The word 'reflection' and the idea of a 'reflective' practice have several meanings, some of which may overlap. I will define here some of the most relevant forms of the term 'reflective' practice.

(These definitions are based on unpublished notes by Adrian Ward, July 1990, with permission of the author).

1) Individual Reflection on the Self:

Boud et al (1985), use the following definition:-

'Those intellectual and affective activities in which individuals engage

to explore their experiences in order to lead to new understandings and appreciations'.

This seems to be a key definition. This suggests the idea of a worker being prepared to learn about him or herself in relation to others, within the experience of the group care environment. This gives credence to that environment itself being a creative and supportive one.

2)'Reflecting Back' to another:

This implies telling somebody what you have heard them saying, in order to check your own understanding and help them be clear about what they are saying, e.g. 'What I hear you saying is this Is this what you really mean?'

3)'The Reflection Process in Casework Supervision' (Mattinson 1975):

The phenomenon by which workers bring into supervision unconscious material, which relates to their own reaction to the transference that they are experiencing from their clients (see later definition of transference).

This is the equivalent phenomena in group settings, by which people wittingly/unwittingly become actors in each others working out of fantasy and anxiety (Hinshelwood). This is a complex and powerful phenomenon and the focus of much diagnostic and interventive effort in 'therapeutic community' work. This involves the realisation, verbalisation and ultimate resolution of what has or is being enacted.

4)'The 'Matching Principle': Aiming to Facilitate Reflection:

The proposition that the model of supervision/consultation should reflect or match the mode of practice:- e.g. that supervision of group work should be conducted in a group (see Hawkins and Shohet 1989), or that supervision of group care work should incorporate elements of individual work, working alongside, and group discussion, to match the various modes of practice involved (Stevens).

These five definitions of reflective practice combine to cover what I believe to be the most relevant to individual and group work. During the course of this dissertation the use of the term 'reflective'

practice may infer that one or any combination of these definitions (or others) may be potentially developed or in operation.

For example, in chapters two and three, 1, 2, 3 and 4 are particularly relevant, in chapters four and five, the 'matching principle' is emphasised.

Summary of Chapter

This chapter has explored Winnicott's theory of early emotional development and shown its application to developing therapeutic practices in group care, particularly residential child care.

The chapter has also defined different ideas involved in the concept of a 'reflective' practice.

For a further understanding of these ideas, it will be useful to explore some of the unconscious processes that occur within them. The psychoanalytic concepts of transference, counter-transference, and projective identification are particularly useful. To define counter-transference it is first necessary to define transference.

CHAPTER THREE

THE WORKER AS 'CONTAINER'

Introduction

This chapter explores the unconscious processes of transference, counter-transference and projective identification, and shows how a knowledge of these, along with Bion's concept of container/contained, can help develop a 'reflective' practice applicable to group care organizations.

Transference, Counter-transference and Projective Identification

Janet Mattinson uses the following definition of transference:-

The experiencing of feelings, drives, attitudes, fantasies and defences towards a person in the present which do not befit that person but are a repetition of reactions originating in regard to significant persons of early childhood, unconsciously displaced on to figures in the present.
(in Mattinson 1975, p. 33)

Mattinson goes on to describe counter-transference as:

The reaction to the transference. (ibid, p. 36)

More recently, and, I believe, a more precise definition is:-

The therapist's emotional response to the patient's transference.
(Prodgers 1991, p. 392)

Applied to group care then, we could say that the worker's feelings about a client's strongly emotive communication, may say something about the client's present emotional state. (This is not to say that all the worker's feelings are necessarily based on a counter-transference response).

Beedell (1970) writing about transference and counter-transference, claims three reasons why these unconscious dynamics are likely to be enacted within group care:-

- 1) The residential worker is in direct contact with the child over a great proportion of his life space.
- 2) The residential worker is functionally closer to the parents in necessarily providing a large part of 'parenting'.

The child is to some extent separated from his home base and often resentful and pained by this so that he is likely to transfer some of his angry feelings towards his 'absent' parents or to those nearest to him, i.e. the residential staff.
(Beedell 1970, p. 141)

In 1950 Paula Heimann published a paper entitled 'On Counter-transference' in the International Journal of Psychoanalysis (1950, 51). She proposed that the emotional response of the therapist to the patient gave clues to the internal world of the patient's 'object relations' (how the 'subject' (person) relates to another 'object' (person) and the relationship between them, this may be based on an 'internal' or 'external' perception), and commented:-

The analyst's counter-transference is an important instrument of research into the patient's unconscious.
(In Preston-Shoot and Agass 1990, p. 37)

Caseament (1985) divides counter-transference reactions into two types; the personal and the diagnostic. According to Preston-Shoot and Agass (1990):-

Personal counter-transference is close to Freud's original meaning and describes those reactions which are determined by the worker's own personal history and current emotional experience.(ibid 1990, p. 38)

Diagnostic counter-transference they suggest is:-

A reaction which is actively aroused in the worker by the client's projections, so that a worker who is sufficiently sensitive will be able to tune into the particular object relationship which is being projected and 'diagnose' what it is.
(ibid, p. 38)

In 1956, Roger Money-Kyrie produced a paper for the International Journal of Psychoanalysis

(1956 Vol. 37), entitled 'Normal Counter-transference and some of its Deviations'. On the concept of 'normal' counter-transference, Money-Kyrle started his research with the role of the therapist and wrote:-

Concern for the patient's welfare comes, I think, from the fusions of two other basic drives; the reparative, which counteracts the latent destructiveness in all of us, and the parental.
(in ed. Meltzer 1978, p. 331)

and placed the emotional response of the therapist in a self-diagnostic position:-

So in some degree, the patient must stand for the damaged objects of the analyst's unconscious fantasy, which are still endangered by aggression and still in need of care and reparation.(ibid)

On the analyst's personal unconscious reaction to the patient, he writes:-

But it is with the unconscious child in the patient that the analyst is most concerned; and because this child so often treats the analyst as parent, the analyst's unconscious can hardly fail to respond in some degree by regarding the patient as his child.
(ibid)

Money-Kyrle identified counter-transference as an oscillation between what is introjected and projected in the analytic relationship:-

As the patient speaks, the analyst will, as it were, become introjectively identified with him and having understood him will re-project him and interpret I think the analyst is most aware of projective phase in which the patient is the representative of a former immature or ill part of himself which he can now understand and treat by interpretation

Meanwhile the patient is receiving effective interpretations, which can help him respond with further associations that can be understood. As long as the analyst understands them, this relationship - which I will call the normal one, persists the analyst's counter-transference feelings will be confined to that sense of empathy with the patient on which his insight is based.
(ibid, p. 332)

This interactive process has links with Melanie Klein's concept of projective identification. Klein describes this as one of the defence mechanisms active in the 'paranoid-schizoid phase' of normal

early emotional development. The infant splits off the 'hated' (it follows that positive aspects are also projected) parts of the self and projects them onto the mother, so that she becomes identified with them.

This process of projection is maintained in a modified form throughout a person's life, but it may become more apparent when working with clients who may be emotionally arrested at early stages of development. Such a client group may project 'bad' or unacceptable parts of themselves onto staff members, and apply pressure for them to experience the projection as 'real', or act it out impulsively. This is not necessarily a negative phenomena, Wilfred Bion put the case that projective identification by the child, and introjective identification by the parent are both parts of the process of normal development.

Within group care with a disturbed client group, these processes will be an inevitable part of treatment, and it is important that workers are able to reflect on such phenomena, and understand them.

Projective identification is then, an important aspect of such interactions. Rycroft defines projective identification as:-

The process by which a person imagines himself to be inside some object external to himself.(1988, p. 67)

Another aspect of projective identification is that it can be used to get someone to 'act out' for you:-

This process can easily propel workers into an unconscious collusion with their clients unless they are able to tune into their own emotional reactions and use their counter-transference diagnostically.
(Preston Shoot and Agass 1990, p. 39)

Preston-Shoot and Agass place an understanding of projective identification within the worker's diagnostic counter-transference:-

The importance of projective identification is that it attempts to describe, metaphorically, how disavowed aspects of a client's emotional state can be directly and unconsciously communicated to the worker, and how that communication can evoke responses in the worker which may provide vital counter-transference clues to the client's inner world of object relationships.
(ibid, p. 42)

Three Examples

This section looks at practical applications of the theories of counter-transference and projective identification. If the disturbance of the client can be understood by using the diagnostic aspects of counter-transference, it can be 'reflected back' allowing for further understanding and emotional growth.

Example 1: Counter-transference Within Psychotherapy

The following example is drawn from work by a trained child psychotherapist, and gives an impression of the strength of feeling that can be created within therapy by counter-transference phenomena. The first account by Anne Alvarez describes a therapy session with a twelve year old boy:-

He began a frenzy of destructiveness unleashed mostly on the room and the furniture, only rarely on me. Gradually the hallucinations and cogwheels left him, the aggression towards the room diminished and he began to concentrate his destructive efforts more on me and my person. But the cruelty and torture were not physical, they were mental. I had to watch him pry faeces out of his bottom and shove them up his nose. He glared into my face when he did this, and I did watch. I felt appalled, disgusted and absolutely hopeless. Once, when I was thinking to myself 'There is no hope for you Richard' but not knowing what to say, he sang, 'Cape of No-Hope, Cape of No-Hope'. I think he was projecting hopelessness into me but mostly of what Money-Kyrle calls a desperate motive rather than a destructive one. I had not sorted out these differentiations in these years, but I did make myself watch him, and so perhaps to an extent he did feel I contained some of his hopelessness for him. (1983, p. 13)

The projection of feelings from the child to the therapist can be seen clearly here, and the difficulties of managing the counter-transference, even for a trained therapist are apparent. The severe emotional pressure that Alvarez is subjected to is managed by a personal understanding of the concepts of projection and counter-transference. This child is similar to many within group care. For workers then, there is a need for a high level of self-awareness. The following case study from group care gives a similar example of this process.

Example 2: Counter-transference in Group Care

The following example is taken from an account of the treatment of 'Warren' at 'Peper Harow'. In this case Warren's placement ended because staff were unable to safely contain him.

Recently, a young boy whose terrifying, sadistic behaviour towards others was about to culminate in his suspension, disappeared to the art room and idly drew the picture uppermost in his mind. The picture, in red ink, was of a wolf-like head with a dagger plunged through its neck, and with tears of blood spurting from its eyes. It was the nearest he could come to describing the confused fantasies, which in turn expressed his own fear of his uncontrolled metamorphosis into a dangerous 'wolf', his sorrow at such an identity, and his supposition that such a beast had to be destroyed. If that very limited selection of his complex feelings could be explored, many further issues would emerge from them alone. They could concern his ambivalence about his wanting to live or die; be about his ability to confuse himself with his victims and would question whether he could only feel significant when making others feel afraid of him.

At one level of awareness, expressed through his drawing, Warren was actually communicating about his inner world. Yet, his compulsive and repeatedly sadistic behaviour towards others seemed unceasing and intolerable So, once more, he was about to be driven away by those he had frightened too often.
(Rose, in ed. Fees 1990, p. 81)

Here we can see that the strength of feelings that Warren created in the staff group were not at this point in time able to be successfully contained. In keeping with the definition of counter-transference it could be said that here the staff team as 'therapist' were unable to cope with the emotional response to the patient (Warren). By being unable to firstly contain their feelings, and then reflect them back, the potential for helping Warren work through his disturbance was reduced, and led to the ending of Warren's treatment. Interestingly, it would seem that in hindsight, the writing up of these events allowed a counter-transference response to develop.

Example 3: A Psychoanalysts Account of Projective Identification in a Group Care Setting R.D.

Hinshelwood writes an account of a staff meeting which starts in the following way:-

The general impression of disorder was intense. In the course of pouring out coffee one of the members of the team, Rose, had to go to the kitchen for some milk. On returning she complained that the kitchen staff had been disobliging and unorganised! Sheila then recalled that was not the only case of that happening recently. Thelma said that she knew that one of the domestic staff in the

kitchen was leaving at the end of the week. By this time the character of the staff meeting had changed completely. There was a unified concentration on the topic The efficiency of the group could hardly have been greater. Possible tension and difficulties which might have beset the kitchen staff were isolated and discussed.(Hinshelwood 1987, p. 69)

Hinshelwood writes of this meeting:-

The interest in the trouble in the kitchen was not primarily intended to deal with the kitchen trouble, but with the problem in the troubled staff. This was a projective identification. The staff continued to identify the troubled feelings but they no longer had to own them.(ibid, p. 70)

It would seem that a complex task may require complex concepts to support it. Winnicott's ideas give a theory base for understanding early emotional development, and the problems created when emotional holding is insufficient. The examples of counter-transference and projective identification, give an impression of some of the unconscious processes at play within interpersonal relationships, and may facilitate workers understanding of certain forms of individual and group behaviour within group care.

The following theory offers ways of containing such disturbance, and is also based on the early mother/child relationship,

A Psychoanalytic Theory Base - Bion's Concept of 'Container/Contained'

In 'Learning from Experience' (1962), Wilfred Bion used the concept of a container, and containment, to describe the process by which a baby projects feelings of anxiety (as well as positive feelings) into the mother, who is able to receive them, be preoccupied with and contain them, and then return them to the baby in a modified and more manageable form. The ability to contain these feelings will depend on the state of mind Bion described as 'Maternal Reverie'. This requires the mother to deal with, and reflect on the projections.

Bion developed the idea from Melanie Klein, that a baby's original capacity for primitive thought, arises from the experience of separation from the mother's breast. The baby's first experience of loss and pain, comes from this experience of the absence of the breast 'inside it'. This can only happen in the interaction between baby and care giver. Bion calls this process 'containment'. Bion created the concept of the baby developing a capacity for 'alpha function', which, he describes, produces formative psychic development and structuring. This becomes 'instilled' in the baby. Defining alpha function Bion writes:-

It seemed convenient to suppose an alpha-function to convert sense data into alpha elements and thus provide the psyche with material for dream thoughts and hence the capacity to be conscious or unconscious.(in Brookes 1991, p. 134)

Bion's ideas converge with Winnicott's as both argue that it is through the experience of separateness that the infant starts on the path to individuality.

For Bion, the mother's task is to bring the real breast to meet with the infant's preconception of it, so that the baby experiences a 'realisation'. This account is similar to Winnicott's use of 'transitional space' in which the baby develops a creative interplay between the reality and fantasy of the breast, which ultimately helps it develop a sense of itself as a boundary between inner and outer worlds.

According to Bion, then, psychic structuring only really develops with the absence of the breast. This first experience of separation and loss is a challenge to the baby's omnipotence. The infant's solution to the problem of 'no breast inside', is to project the experience into the mother, according to Brookes:-

A mother with an inner world in which experiences can be contained, symbolised, dreamed and thought about, (in other words, in which there is alpha-function) is able to contain her experience of 'no breast inside' within this inner world by means of a process which Bion calls her 'maternal reverie.

The baby's experience is then held in the maternal psyche, where experience has long been made to make sense - presumably by every sort of psychic processing from the most primitive splitting to the most mature working through. Maternal reverie is a psychic realm where thoughts have been generated and necessitated thinking, and therefore psychic structure; and after a sojourn there, the infant's projection is transformed and can be re-introjected composed of completely different 'elements'.(Brookes 1991, p. 135)

Bion's theory suggests that at the beginning of the baby's life, there is no potential for alpha function, the baby can only develop a psychic life in relation to the mother. The process of containment between mother and baby, therefore, facilitates psychic growth and development.

The application of the Theory to Group Care Settings

This prototype has been applied to the formation of other relationships, e.g. between worker and client:-

Applied to a worker-client relationship, Bion's model of the container/contained relationship of mother *and* infant suggests the following definitions of 'containment'. First, containment must refer to a situation in which painful feelings, associated with unconscious fantasy, are conveyed to a worker by a client through an unconscious process of projective identification; this can be used by the worker as counter-transference information In order to help with his pain and symptoms, the worker cultivates psychic awareness of her counter-transference feelings and their possible means for her client, and links them with his past. They both seek consciously and unconsciously to make the fantasy apparent in their relationship, where it can be *seen*, tolerated and thought about. For example, when a social worker has a painful experience of attack by an angry client, and is left feeling a failure, the client may unconsciously be communicating to the worker something of his own experience of personal failure, and his feelings about it. (Brookes 1991, p. 136)

As I have previously discussed, the emotional disturbance absorbed by workers in group care, needs a safe 'container'. A worker trained, or helped to think, and to respond to counter-transference phenomena is in a better position to hold and reflect back the feelings of the client.

The concepts of containment and counter-transference then, become vital tools for those engaged with an emotionally damaged client group. So, as the baby feels the mother contain its psychic pain in the experience of 'no breast', similarly,

The painful experience is therapeutically contained in that the worker holds it in a structured psyche where some of his/her own feelings have been worked through. She/he thinks about it, and tries not to respond unconsciously to the client's projections by acting out.
(ibid, p. 137)

What does the worker have to do? She must be able to feel and then think consciously about what the client is communicating unconsciously. She must ask: What are my counter-transference feelings? How are they being expressed in the relationship between us? How could they link to my client's present and past? Client and worker may have to wait some time before the painful unconscious 'thought' (analogue of the infantile experience of 'no breast inside') becomes apparent between them and can be talked about.
(ibid)

For a further discussion on the development of containment it is necessary to think beyond the skill

of the worker. To be supported and trained properly the worker must be in a system that encourages and develops the discipline of a 'reflective' practice. This structure must ultimately be a containing one for the worker, where he/she can have his/her professional needs met, in order to meet the needs of the client.

In a stressful and difficult holding situation a worker must feel that the holding environment of the agency is reasonably supportive before she can create a 'thinking space' (Oliver-Bellasis and Vincent 1990) in which to contain the client. Without holding in Winnicott's sense there can be no containment in Bion's sense.
(ibid)

These concepts translate directly to the worker's task within group care. For the individual worker and the team as 'therapist', an understanding of the processes of emotional containment, internal diagnosis and 'reflecting back', are critical components of effective therapeutic work.

Summary of Chapter

This chapter has covered aspects of the psychoanalytic theories of Klein and Bion. I have suggested that these are relevant for an understanding, and treatment of, emotional disturbance.

I have concentrated on developing Bion's concept of container/contained, and argued that this theoretical position along with a knowledge of the unconscious processes of counter-transference and projective identification, can help to develop a 'reflective' practice to facilitate the treatment task. Examples of these processes have been presented.

The next chapter explores some roles and functions of supervision and consultation, and looks at these in relation to issues of power, prejudice and dependency. It also looks at models of supervision which are relevant to group care.

CHAPTER FOUR

SUPERVISION AND CONSULTATION

Introduction

This chapter explores issues within supervision and consultation. In order to develop this process I felt it was important to clarify my ideas by gaining some direct insight.

Consequently, I asked two practising Consultants, Dr. Eric Miller of the Tavistock Institute, and Dr. Alejandro Reyes, a psychotherapist and paediatrician, for feedback on some of the issues. I also asked them a series of questions, some of which have been used in this section. Both Dr. Miller and Dr. Reyes have experience of working in group care settings using a psychodynamic approach (see previous definition).

Supervision and Consultation, Definitions, Role and Function

There is general agreement between most writers that Supervision has three main functions:-

- a) Managerial
- b) Supportive
- c) Educational

This view is shared, for example, by Brown (1984), and Hawkins and Shohet (1989). For the purpose of this dissertation the following definition by James Atherton is useful:-

The process of talking to someone else involved in the same system about what one is doing in order to do it better.
(1986, p. 3)

This places the role of supervision within the 'boundary' of the organization.

In contrast to this, the role of the Consultant in this dissertation is that of the model of 'external staff Consultant' (Millard 1992). This differentiation of 'internal' and 'external' roles is important, for reasons explained later in the thesis.

Within the literature on consultation, this differentiation is sometimes blurred. For example, I would agree with Millard (1992) that Hinshelwood (1979) uses the term 'external supervisor', to describe a role which, as it is external to the organization, should be regarded as consultation.

The following definition of consultation takes into account this 'external' nature, it is by Lippett (1959):-

Consultation, like supervision is a general label for many variations of relationship. The general definition of consultation assumes that:

- the consultation relation is a voluntary relationship between; a professional helper (a consultant) and help needing (client);
- in which the consultant is attempting to give help to the client in the solving of some current or potential problem;
- and the relationship is seen as temporary by both parties:
- also, the consultant is not part of any hierarchical power system in which the client is located. (in Blake and Mouton 1986, pp 7-8)

Brown (1984) uses the following table to highlight the main task and role differences:

Supervision	Consultancy
Compulsory	Voluntary
Supervisee accountable to supervisor (usually line manager)	Freely entered voluntary relationship
Supervisor from same profession	Consultant may be from same or related profession
Agenda chosen by supervisor and supervisee	Agenda chosen by consultee

Supervisor is not selected by supervisee, but by role in the organization	Consultant selected by consultee on the basis of having the relevant knowledge and skills
Decision-making is a shared responsibility	Responsibility for decisions rests with the consultee
Continuous activity	Time limited contract
A 'free' service	Sometimes a fee-paying service, or on some negotiated basis

Both Lippett and Brown claim that there are differences in the power relationships between Consultants and Consultees and Supervisors with Supervisees. These power relationships are based on the different roles and 'contracts' that both Supervisors and Consultants have with their client group. The following section explores issues of power as well as prejudice and dependency within supervision and consultation.

Issues of Power, Dependency and Prejudice within Supervision and Consultation

Ward (1993) draws attention to three key issues in group care work. These are:-

- 4) Power
- 5) Prejudice
- 6) Dependency

This chapter examines these issues within supervision and consultation.

1) Power:

- a) Potential 'Power' Problems - Limitations of Supervision and Differences of these in Relation to Consultation

Within the functions set out above, supervision has a particular role in the organization's hierarchy. The Supervisor is usually a line manager to the Supervisee, thus there is a direct, 'managerial' function. Does this potential aspect of direct 'authority' within the relationship affect the supportive aspects of it?

During my discussion with Dr. Miller we talked about this aspect of supervision. He explained that there was a clear managerial function within supervision which literally implied overseeing the work of the worker by a senior member of staff. Using a comparison he explained that the function of supervision within industry was the same as that in the 'caring professions'.

Within industry, for example, the 'foreman' may oversee the work of the worker to make sure the job is done properly. An obstacle within the 'caring professions' is that this direct managerial function may become blurred, and consequently the power relationship is confused. This distorts issues of management and support for the worker, which may create an ambiguity of role that could be experienced as 'uncontaining' to the worker.

D.W. Millard writes of this difference of power relationships between supervision and consultancy:-

Most institutions have a staff hierarchy within which all staff have regular supervision with their seniors whether or not external consultancy occurs. Thus, the kind of consultancy discussed in this paper is not a power relationship having any responsibility for the appointment grading, promotion or dismissal of staff members.(1992, p. 88)

The question that follows is, do these differences of relationship affect the use and outcome of both supervision and consultation to the user group? Supervision has been described as being largely about containment of anxiety

(see Hinshelwood 1979, p. 210), as we have seen, it is also about staff development. Workers in group care organizations are also on a journey to eventual departure, and the organization may have profound ambivalence about this, just as workers do about the integration and maturation of the child (I am suggesting here that workers' own dependency needs are unconsciously met in worker/client relationships).

Perhaps this suggests one of the differences in dynamic between supervision and consultation - Consultants may tend to be less possessive than Supervisors, because they are less influenced by anxiety about the impact on the organization of experienced workers moving on. Workers may recognise this difference and respond differently to Consultants, creating both positive and negative effects in the 'matrix' of the organization. this problem may be heightened by the shortage of highly skilled and experienced workers within group care.

Another aspect of the potential 'limitations' of supervision worth exploring here, is that supervision

often starts off with a clear task, but can become more difficult with time. When a new worker joins an organization there is a clear supervision role such as explaining the way the place is run, what sort of clients are helped, how they are helped, who does what job, etc., in short, all the basic knowledge the new person needs can be brought into the supervision session and be worked through systematically, (this is the 'educative' function). This means the Supervisor being responsible for the 'norms' of the organization.

However, within a period of time, the team leader supervising the worker often needs to help the worker take several 'quantum leaps' ahead because of the immediate necessities of the demanding nature of the work.

I believe that at this stage the power relationship between Supervisor and Supervisee changes from a managerial, supportive and 'nurturing' role into one approaching professional dependency, where the new worker has to respond with elements of becoming an active and dependable part of the team.

At this stage the emotional 'distance' between the Supervisor and Supervisee changes (and therefore the power relationship). At the beginning, before being both emotionally involved in the work, the newness of the situation allows for a distance between the two. In this second phase, this distance is reduced by the day to day realities of the work. Consequently, the 'clinical' aspects of supervision are reduced.

This may be overcome to an extent with a change of Supervisor at a specific time for the new worker. For example, if another team operates within the same workplace, it may be possible for another team leader or experienced worker to supervise the new person, giving a fresh 'external' objective' view on his or her progress and concerns.

Because of the Consultant's emotional distance from the worker, consultation may not so easily fall into this trap.

Power Relations within Consultation

In my interview with Dr. Miller, we talked about issues of power and dependency within

consultation. His view was that each organization can be seen as a 'political system' in terms of power relations. The fee paid to the Consultant will inevitably create power for the Consultant. The prevailing hierarchical system of the organization creates the power structure. The Consultant coming into the organization is a new element in this dynamic. Consequently, the prevailing 'order' is in some ways disrupted. The Consultant's entry will create different alliances between people and crystallise others.

In this respect, the Consultant must remain aware of how he/she is used within this process, to be aligned with or against, and to attempt to understand the meaning of these processes in the present system. By understanding this 'culture' of the organization, the Consultant is in a better position to bring about the change required. Within this context the term 'culture' has a specific meaning:-

We believe that there are important belief systems (or meaning systems) which influence the way the individual sees reality and chooses to act. There are also belief systems in the organization - the organizational culture (Marshall and Maclean 1985) - which influence the way people behave in roles. There are both important personal belief systems (such as beliefs about morality and achievement) and important organizational beliefs (the organizational culture, such as loyalty, competition and risk) which come to bear on the individual and influence the way he or she sees relationships. Each belief system is supported by a history of events which have confirmed or disconfirmed the beliefs. (Campbell, Draper, Huffington 1991, p. 9)

Consequently, the more the Consultant understands the processes of the organization, the potential for change is increased:-

A systemic consultation explores the meaning of change for the organization as it is reflected in the way newly perceived differences and similarities will affect relationships. The exploration moves from *the* culture of the organization downwards to the individual, and from the individual upward to the culture. Through this process, individuals experience themselves re-connected to the organization in a different way. This leads to seeing problems and obstacles in a different light, which leads to new strategies for solving problems; and the organization moves on with renewed vigour. (Campbell, Draper, Huffington 1991, p. 14)

These ideas are explored further in chapter five, which concentrates solely on the use of consultation.

During my meeting with Dr. Miller, he talked about some of his experiences of how dependency can be an issue within the consultation process. His view was that there will be different types of transference onto the Consultant, depending on the age and gender of him or her.

Dependency on the Consultant is therefore an inevitable phase of the process. Dr. Miller explained that different forms of dependency will be in operation at different stages of the consultation. These phases are the 'immature' or infantile dependency, and the 'mature' state. An example of an 'immature' state of dependency for an adult could be described as the use of a doctor during illness, here there will be handing over of the care of the person to the doctor's expertise. An example of a 'mature' state of dependency for an adult could be seeking the use of a solicitor's legal expertise because the adult has only a limited knowledge of a specific professional field.

Within a consultation there will be a phase where immature dependency is prevalent. This may be apparent when the client group expects *the* Consultant to have 'magical' solutions to problems. Dr. Miller regarded awareness of this stage as important. He spoke about experiences of Consultants who found the 'dependency' phase difficult and wanted to quickly 'get past it'. In Dr. Miller's view, the Consultant must allow this phase to be worked through. Out of this stage then develops a 'weaning' or 'transitional' phase where the client becomes gradually less dependent on the Consultant and more able to develop independent problem solving skills. this process ultimately leads to the Consultant's potential 'redundancy'.

In this respect, acknowledgement of dependency is vital in group care consultation (and supervision where the same processes occur), where the process of moving from dependency to independence in the staff group, reflects the same maturational processes within the client group.

Various writers have written on aspects of prejudice within group care, e.g. Coulshed (1990) tackles problems of sex discrimination and sexism in the workplace, Dominelli (1989) concentrates on developing anti-racist social work.

Within the organization, issues of prejudice should be worked on in supervision. However, the external nature of consultation gives it a particular perspective. My own question to Dr. Reyes was:

In what ways can the Consultant work on aspects of potential prejudice in the organization?

Dr. Reyes felt that firstly, it was important to understand the root causes of prejudice (I will use this term to cover racial, disability, age, sexual orientation and sex discrimination).

In this sense, prejudice is a basic defence mechanism. A 'fragile' self may adopt a projective system to disavow the painful negative aspects of this self, and project them onto another 'object' with an apparent and therefore 'alien' difference.

Within group care organizations, where clients may have such fragile 'selves', and workers can have their personal beliefs and feelings brought to the surface through emotive exchanges, issues of prejudice will inevitably be present.

Prejudice is also inextricably tied in with issues of power. In this sense, discrimination can be described as having the power to act on prejudice. The externalities of the Consultant provides an 'opening' into the prevailing power structure, allowing for regulation, criticism and monitoring of it.

The 'culture' (see previous definition) of the group care organization is a crucial issue here. A system that does not allow for differentiation of space (physical and emotional), and is not clear about its organizational boundaries, 'philosophy' or value system, is more at prey to issues of prejudice, propagated by the anxieties of the power structure which fails to 'hold' these boundaries and values. (Examples of such cultures would be the 'macho' one which might undermine the self-image and esteem of female clients and staff, or where there was collusion by staff around the conscious polarisation of racial difference).

The Consultant's external perspective puts him/her in a position to see these problems developing in the system, and provide the conditions that will allow for change, or ultimately by appealing to external agencies for further action.

These ideas are developed further in the later section on Consultation as a means of monitoring and protecting organizations from developing into abusive systems.

SUPERVISION

Introduction

Having defined some of the functions of supervision and consultancy, and having placed their roles as internal and external to the organization, I would like to proceed with an exploration of some models of supervision which seem particularly relevant to group care organizations, where there may be a proportion of the residents who are emotionally disturbed.

I will give a brief outline of four different models of supervision developed for group care. It is not the task of this dissertation to point to the 'right' one, but rather give some examples of relevant models developed over the last fifteen years, and, where applicable, show the arguments against them.

Four Models of Supervision of Group Care

1) George Wright has written several articles on supervision for such organizations; the first of these reviewed here is 'A Model of Supervision for Residential Staff' (1978).

Wright draws up a list of factors characterising residential social work when drawing up a model of supervision. These are correlated with the primary task of the organization:-

1. Ascertain if the aims and objectives of the unit are being achieved.
2. Ensure the staff know and understand the aims and objectives of the unit. Wright suggests that:-

If supervisors alleviate stress, rather than increase it and do not present themselves as the source of all wisdom and knowledge but as humans with human weaknesses, a fruitful relationship is likely to develop. (ibid, p. 22)

He concludes:-

The aims of supervision should be to ensure that the most appropriate service is provided for clients by developing the maximum potential of staff and the unit. (ibid)

In another article 'The Right Way to Staff Supervision' (1980), Wright identifies three key areas for this model:-

Supervision should be practised within hierarchical role relationships.

Supervision should be a formal exercise happening within designated times.

Supervision should always be one to one.

A critical response to this article was written by Robin Douglas and Chris Payne (1980). Douglas and Payne argue that it is neither realistic nor advisable that Supervisors in senior positions should be able to meet all the supervision needs of staff, and that the three functions of supervision - managing, teaching and supporting - are unlikely to be exercised in hierarchical models.

They suggest that this would increase dependency rather than promote independence. Their criticism of the 'formal meeting' aspect is based on a belief that the content and objectives of supervision should take precedent over the arrangements; they point out that 'line supervision', e.g. evaluating a problem after it has arisen rather than waiting for a formal meeting, is of value in developing workers' performance in relation to the task. On the idea of supervision being one to one, they point out the benefits of forms of group supervision.

2) In his paper 'Staff Support Systems in the Residential Treatment of Adolescents' (1985), Peter Hodgkinson suggests that staff support should have three main areas:

A regular group forum.

Individual Supervision.

In-service training.

I will concentrate on (a) a regular group forum. Hodgkinson argues that to be effective, a staff support group must function in a task related way. If this is to be achieved, it is essential that there is a commonly held, firm acceptance within the organization about the purpose, focus and organizational format of the group. If not, the group may function maladaptively, shut off from reality, become paranoid and be preoccupied with hidden agendas of leadership, etc., (i.e. function

according to what Bion calls 'basic assumptions').

Hodgkinson proposes two forms of such groups, model 1 is a meeting of the whole staff group with the unit leader as facilitator, where the whole group works on its problems. Model 2 involves the use of an external Consultant.

3) Peter Hawkins developed a more holistic and psychodynamic approach to supervision in his article 'Mapping it Out' (1982). This approach to supervision was further developed with Robin Shohet in their 1989 book 'Supervision in the Helping Professions' (see chapter six 'A Process Model of Supervision'). Hawkins's original paper identified three main areas to be dealt with in supervision:-

- Management issues (including organizational and administrative tasks).
- Work with clients.
- The work life of the individual being supervised.

Hawkins integrated the different areas into a diagram of three overlapping circles. Diagram 1:

As the three circles interlock, four more areas are created. He suggests that "these territories become particularly interesting as they are where conflicts occur between different work demands" (p. 17).

Of the four interfaces he writes that (a) "is the area where the staff member can explore himself as part of the management and organizational context of the work"; (b) is the area in which the staff member can explore his reaction to clients, and interaction with clients. This is also where the staff member's counter-transference will be worked on. Area (c) points to the need for the supervision to "help the Supervisee integrate these two areas and not see them as separate endeavours, competing for his attention" (ibid). The overall balance (d) "is concerned with how the worker integrates the different aspects of work".

The diagram is then extended to take in the larger systems of the organization and its relationship with outside agencies. This is a systemic approach. Hawkins goes on to explain an elaborate use of the map, whereby using two different coloured pens over a series of supervision sessions, the Supervisor and Supervisee can mark on the map which areas have been covered, and which neglected. This process can be used to chart the course of the supervisory relationship. Hawkins points out two disadvantages; firstly the map can only give a two-dimensional account of a multi-

dimensional process, and secondly, it cannot take into account modes on non-verbal communication which occur in supervision.

4) Within group care organizations, there will, to greater or lesser degrees, be an element of anxiety within the atmosphere of the place. The uncertainty associated with such a potentially impulsive and volatile client group, will inevitably be stressful for workers. As Cohen and Schneider write:-

Since these staff are working in a psychiatric facility with disturbed patients, they often find themselves in situations of feeling insecure or where their security of self becomes threatened. These types of situations of uncertainty force the individual to return and search after the defences of mirroring and idealisation that are already known internally from their earliest perceptions of the development and enhancement of one's self. (1992, p. 111)

Cohen and Schneider contend that within such situations staff:-

are in need of continuous supervision in order for them to contain their own feelings which become aroused from work in such an intensive setting. (ibid 1992, p. 109)

The type of supervision regarded as most relevant to this form of work is supervision on the 'self', as Cohen and Schneider put it:-

These counsellors need to first understand themselves: their ways of responding, their own emotional areas, their fears and sensitivities, their self-image, etc. No matter how much we can help them to learn, they will respond on their own internal conflicts and issues. Therefore, the kind of supervision needed is of a different type - the kind that enables the counsellor to look at his 'self'. (ibid, p. 112)

Analysing the component parts of this form of supervision, Cohen and Schneider break them down into two functions:-

- the management of the milieu and the patients within it
- the intra-psychic factors that impinge upon the counsellor with regard to his feelings. (ibid, p. 114)

Cohen and Schneider suggest two different experiences of supervision, a group form to cover management issues, and an individual form to deal with specific personal issues/problems.

A Brief Comparison of the Four Models

There are clearly positive aspects and shared areas of agreement in all of the four models. The aims of Wright's model, i.e. tying the use of supervision to the 'primary task' of the organization would, I believe, be recognised by the others. However, Douglas and Paynes's criticisms of the model itself are also valid. There would seem to be an overlap of agreement between Hodgkinson's and Cohen and Schneider's models, in that they both suggest a mutually supportive use of both individual and group supervision. It may be that Hawkins's model could influence and develop the range and depth of the work covered in the individual models of these two.

It would seem that the more the workers in such organizations understand their own unconscious processes and group dynamics, the better they will be able to perform their primary task.

The capacity of staff to question their assumptions, to learn and grow, is directly correlated with the capacity of the residents to learn and change. (Miller 1989, p. 39)

Summary of Chapter

This chapter started by defining supervision and consultation and looking at their different roles and functions. I then identified three key issues in group care, those of power, dependency and prejudice, and through interview material explored how these can affect the supervisory and consultative process. The chapter finishes with a review of four different models of supervision for residential care and a brief comparison of them.

CHAPTER FIVE

CONSULTATION

Introduction

Having explored the use of different forms of supervision within group care, I will now move on to concentrate on the importance of consultation.

As we have previously seen, there are potential limitations within supervision, (I identified these as ambivalence about workers 'maturation', 'professional' dependency, and lack of 'perspective', i.e. being part of the organization's dynamics). My research then moved on to find out what the 'essence' of consultation is, and in what ways it can help develop a 'reflective' practice.

This section examines aspects of 'systemic' consultation. Systemic consultation differs from other forms of consultancy in that it takes into account the totality of the organization, looking at how the 'internal' component parts are working together, and the relationship of these parts to the whole. It also explores the relationship of the organization to its external environment.

Given that group care is about change and growth, systemic consultation provides a 'matching principle' as it is concerned with change and growth in the organization:-

We were aware that in developing our approach to systems consultation, we have drawn on a variety of ideas from other people in the field of systems thinking and consultation, as well as contributing many ideas of our own. We realise that the final blend represents an amalgam, so we decided to choose a name for it.

We chose the name 'Development Consultation'. 'Development' reflects our basic belief that organizations are going through a continual process of moving from one-developmental stage to another. Each stage is characterised by the way the organization responds to feedback from its environment.(Campbell, Draper, Huffington 1991, p. 2)

This section uses further material gained from interviews with Dr. Miller and Dr. Reyes.

Questions and Material Gained from the Interviews

1)The 'Essential' Aspects of Consultation

Firstly, I asked Dr. Reyes: What is 'quintessential' about consultancy? Dr. Reyes explained that Consultants and Supervisors have different relationships with their clients (workers or colleagues) based on different 'distances' from them. For example, the Supervisor has a 'normative' relationship with the Supervisee, based on a responsibility for the 'norms' of the organization, His/her role is to keep the Supervisee within these norms.

The Consultant is more 'free', i.e. not bound by the norms of the organization, although he would take into account the prevailing needs of the worker/s, he would have less problem 'expanding the mind' of him or her. The Consultant is external to the worker, and therefore has a different 'perspective'. In this respect it is externality that is the key to consultancy.

Dr. Reyes's own experience of working in group care settings fell into two modes of consultation. Firstly, workers would discuss individual casework with children with him. In the 'individual' mode, he explained that his role was like that of a 'parent' with a distance from the worker/child 'dyadic' relationship.

During this work, he felt he was able to allow workers to talk through, and make sense of their experiences within the consultation, and pointed out (similarly to the discussion on dependency), that young staff would often see his role tied to the management, and therefore power structure of the organization.

The second form of consultancy he explained, was the 'systems' approach. With this approach he would look at the links and interfaces of the child/worker/organization matrix. From this perspective he was in a position to be critical of the organization and suggest changes or modifications of it.

Similarly, during my interview with Dr. Miller, we talked around the subject of 'distance' within consultation. On the point of 'distance' from the client, Dr. Miller's view was that 'distance' gave the Consultant the sanction to withdraw or disassociate, he gave an example of being a Consultant to a

company and resigning because of the management wanting to involve him in an unethical decision.

2) The Consultant as 'Observing Ego'

I asked Dr. Miller the question: In what way can consultation help develop a 'reflective' practice within group care? Dr. Miller's view was that the idea of having different 'perspectives' on the organization was a useful one.

Moving 'perspective' from seeing how the organization is relating to its wider environment, to looking at what is happening on the inside, helped develop a systemic view of the organization. He explained that a useful role for the Consultant was that of the 'observing ego'. In terms of this developing a 'reflective' practice, he felt that if people could develop their own practice of being the 'observer ego', this could develop a critical perspective in the organization.

Campbell, Draper and Huffington (1991), also regard the 'observer position' as a basic concept of systemic consultation:-

We find that when members of an organization take part in a systemic consultation, they not only see new connections between change and stability, similarities and differences, the individual and the system, but they see their own position differently. They see themselves connected to the organization in ways they had not appreciated before.

This is an observer's position relative to their own behaviour in the organization. Although one cannot observe oneself, this term refers to the process whereby the individual reflects on the relationship between his own beliefs and his own behaviour - this self-reflective position being a prelude to any change based on a model of systemic awareness.(ibid, p. 14)

Dr. Miller explained that developing the 'observing ego' role meant stepping back from the individuals in the organization and allowing them to see themselves as 'citizens' of the organization. This temporarily makes hierarchies 'transparent', and thus the processes of the organization are clearer.

This can create a 'reflecting space' or 'reflective ego' within the organization. By constantly moving

'perspective' the Consultant facilitates this process, and a self reflective position is developed for the workers. The workers in this respect, will always meet the Consultant on the 'boundary' he/she is presently working from.

3) Consultation to the 'Task' - A Systemic Approach

Dr. Miller explained his form of consultancy as 'consultation to the task', in this he would see the 'client as task'. His first point of the actual consultancy process would then be to look at the 'primary task' of the organization, once this has been clarified a rule of thumb would be that any deviation from this task would be subject to the critical functions of the consultancy process.

Within this form, the staff are seen as the 'workers of task', and the 'boundary' or 'interface' of the group and the task is the area of analysis and work for the Consultant. The task is then restoring the staff at this interface to effective working roles and relationships, so that any dysfunction is repaired and the most effective way of maintaining the primary task continues.

To understand this interface, Dr. Miller talked of having first to understand the 'technology' of the organization. Within group care this 'technology' would be the way the staff worked with their client group. Dr. Miller explained that the staff group would be facilitated to ask questions such as: What is happening to us as a staff group?, and: Does what is happening in the organization affect or reflect this? Here the task is to see the organization as a collection of potentially related individuals, and restoration of inter-personal relationships aligned with the primary task as the main issues. In this respect 'containment' alone is not enough, this form of consultancy aims for task restoration.

Dr. Miller talked of the differences between 'narrow process' consultation and 'organizational' consultation. The 'narrow process' Consultant looks only at the group process. The 'organizational' Consultant works systemically, looking at the process, task, the relationship of the organization with its environment, and then the overall relationship between these areas.

Diagrammatically it could be put:-

Process Consultant} group process

Organizational Consultant} process + task + relationship with environment} overall relationship.

Within this form of consultation, Dr. Miller felt that as well as examining the transference in operation onto him (in an organization the transference will often give clues to the culture and resistances of the organization), he could also offer the client different conceptual frameworks. These could develop the worker's capacity to think and create a more reflective culture within the organization.

Having defined 'externality' as the 'essence' of consultation, and looked at ways in which systemic consultancy can help develop a reflective practice, I would like to proceed with a current issue of how consultancy can help to protect forms of abuse occurring in group care organizations.

4) Consultation as a Monitor of Potentially Abusive Regimes

This is presently a preoccupation for anyone engaged in residential work. Whether *they be* staff, or involved as referring agencies. Recently the 'Pindown' controversy, and the Leicestershire Inquiry have pointed to how systems of abuse have developed and remained undetected.

The 'Warner' report (1992) points out in section 1.3, page 1, that:-

Because children's homes are often regarded as closed institutions we have examined as part of the management arrangements the overall system of checks and balances that ensure external contact and involvement with homes and the ability of children to make their concerns known outside homes

and

inadequate staff appraisal and supervision; lack of accountability; little monitoring or oversight of homes; inadequate complaints procedures; the 'closed' nature of a home with few links to the outside world, are all too common features of the homes where things have gone wrong.(ibid, p. 8)

The reports produced for the enquiries have called for systems of supervision of consultation to help regulate and monitor the safety of workers and clients in such institutions.

I asked Dr. Reyes how consultation could prevent the phenomena of the 'closed' system where isolation and the development of a 'total institution' could lead to abuse. Dr. Reyes said that the Consultant's role in this case is providing an 'opening' to the outside world. This maintains an 'open' system. By its external nature this opening will mean a loss of control to the prevailing controlling power.

The external input decreases the possibility of control and allows potential freedom for anyone within it. In this respect justice, validation and feeling are external inputs.

As well as the examples of 'Pindown' in Staffordshire, and the abusive regime created by Beck in Leicestershire, other 'external' examples of 'closed' systems are totalitarian states where these external 'inputs' are not allowed. Another example of a 'closed' system would be parts of Southern Italy, where an individual might appeal to the police to stop the Mafia, only to find that they are part of it.

These cases are bigger examples of the microcosm of group care, but the same principles apply. The Consultant can then provide a regulatory role and monitor the organization.

The authority structure and the idea of dependency in the organization can also be taken into account here. Moving from a centralised authority structure to a decentralised one will decrease the possibility of 'total' control and help the individual workers break off dependency on central authority figures and develop an independence and their own personalised 'live' authority. The Consultant can help the individual workers to gain understanding of these processes within the different stages of consultation.

Summary of Chapter

This chapter has examined the 'quintessential' nature of consultation. The concepts of 'distance', 'perspective' and 'externality' were identified as essential 'ingredients', these were recurring themes in both sets of interviews.

The chapter explains how these concepts can facilitate a 'reflective' practice.

The chapter also shows how a form of consultancy that concentrates on 'restoring staff to effective working roles', can offer group care organizations a clear way of maintaining their 'primary task' and monitor against the development of potentially abusive systems.

The next chapter examines how the application of supervision and consultation within clear organizational boundaries provide a precondition for effective therapeutic work.

CHAPTER SIX

ORGANIZATIONAL BOUNDARIES WITHIN GROUP CARE: THE APPLICATION OF SUPERVISION AND CONSULTATION

Introduction

This chapter explores the use of organizational boundaries in group care settings, particularly where there is concern for the treatment of emotionally disturbed residents.

The chapter proposes that the use of supervision and consultancy can help such organizations identify problems and thus create emotional evolution for workers and clients.

Given the previous definition of 'unintegration', organizationally, the group care task is to provide an environment where the child can begin to form his/her own ego boundary, in order to be able to make appropriate distinctions between his/her inner world and 'objective' reality.

The term 'objectivity' is here on, used to mean:

Essentially the clarification of one's own subjectivity. (Miller 1976, p. 365)

Miller and Balbernie (1984) explain that to carry out this therapeutic task the organization has to carry out two 'contradictory' tasks: to contain; and to provide for separation.

In many group care organizations the residents are emotionally 'contained' by workers who provide different forms of structured boundaries. I would like to clarify here, that in this sense, containment means emotional holding through preoccupation with the client in the mind of the worker. There are young people for whom, at times, this form of containment will not feel 'enough', hence the necessity to use periods of physical holding when other forms of communication have failed.

The 'first' boundary may be a child being cared for (on behalf of the organization) by a 'key' or 'focal' worker. In the day to day living situation this worker may be subjected to intense emotional pressure.

If this first 'boundary' is breached by the disturbance of the child, (an example of this could be the child's 'focal' worker feeling 'worn out') a second boundary, that of the team leader or senior manager comes into play. The 'final' boundary will inevitably be the authority of the organization itself. Thus, the different 'levels' of boundaries act as 'shock absorbers' (Miller, Balbernie 1984) to the child's disturbance.

The different levels of boundary management create for the client a 'negotiating space' (ibid) between the boundaries where limits can be tested. This physical and emotional space allows for close containment to meet a child's primary needs, but must be flexible enough to allow for separation, and the consequent ego development of the child. In this way he/she may experience and manage the complexities of separation and choice.

The use of allowing for differing degrees of containment and separation is part of the therapeutic process that allows the child to develop a capacity for developing relationships and managing transactions across these boundaries, eventually to the 'outside' world. The treatment task was defined in an unpublished paper by A.K. Rice as:-

To strengthen the capacity of the young delinquent to take a more mature and sophisticated responsibility for his own behaviour, to take more conscious and rational authority for his own decisions about when to conform and when to deviate, what to accept and what to reject. In short, to help him control the relations between himself and the environment.(Rice 1968 in Miller 1989)

We concluded then that the task was to enable him to recognise options and make realistic choices for himself, accepting that he might even choose to be delinquent. But if he did so, it would be a decision taken on his own authority in full recognition of what he was doing. (1984, p. 1)

The 'shock absorber' form of boundary management is not, however, a one way system from the child to the outside world; if the staff task is to help the clients 'manage' themselves, there is a need for the organization's management to facilitate the work of the staff, in the same way as staff do this for the client group.

There is an equivalent tension between separation and containment (between staff and management) and an equivalent negotiating space within that tension is worked through. That space and that tension are necessary to enable staff to hold onto their boundaries, so that they can continue to manage themselves in relation to the boys.(ibid, p. 3)

It is my proposition that the use of supervision and consultancy are vital resources for the holding of these boundaries, and allowing workers to maintain their primary task. In 'Towards an Organizational Model for the Treatment of Adolescents' (1989), Miller describes the boundary structure as a 'series of membranes' but points out that 'the membrane analogy is an 'over-simplification" (ibid, p. 35).

The membranes in the Cotswold Community are not sheets of rubber; they are human beings struggling to manage themselves in immensely demanding roles, which constantly require them to make difficult professional and personal judgements about when to contain and whether they can / and when to promote separation, when to respond to demands for dependency and when to resist them. The oscillations of the disturbed boy threaten the integrity of the ego functioning of the staff, who may themselves get pulled into polarised positions: of either authoritarianism or over permissiveness, of either loving or hating, without being able to hold onto a realistic ambivalence.

The hatred, however, is often expressed, The fact that most boys have had an upbringing in which they have been emotionally deprived and physically abused inhibits staff from acknowledging even to themselves the anger that the boys' behaviour sometimes evokes.

Sometimes, as we have seen, staff insist that a violent boy must be discharged on the grounds that they can no longer contain his increasingly murderous attacks on them. Perhaps the other side of this coin is that they can no longer contain their murderous impulses towards the boy.(ibid, p. 36)

Within this emotional 'melting pot' the need to be 'objective' about what unconscious dynamics are being acted out / played out I worked through, and by whom, is a major concern.

It is here that supervision and consultation, help to make sense of these dynamics and enable the organization to remain 'on task'. Otherwise the organization may become engulfed with the anxieties that resonate through the daily world of workers and clients.

As an example of such breakdown in a therapeutic community, I refer to Janzing (1991) who describes how patients' anxieties 'comprise fears within staff groups' (ibid, p. 7) and explains how this may lead to a breakdown in 'surface' (organizational) structure. This leads to the staff group acting out various forms of anxiety that are potentially present (in differing degrees) in both the patient and staff groups.

Similarly, De Haan (1991) describes a scenario in which the process of 'fusion' in the staff team of a therapeutic community mirror some of the emotional disorders of the patient group. (In this paper, it is the retirement of the community's leader that acts as a catalyst to the process). As Eric Miller writes:-

It is important to keep the dynamics of the institution at all levels under constant review. What are the boys projecting into staff, and vice versa? Is the necessary tension between containment and separation being maintained, or has it given way to a culture control? This necessary culture of continuous self-examination is supported by the use of external consultants who can, as it were, hold a mirror to the organization as a whole or to part of it. (Miller 1989, pp. 36-37)

When the staff of the group care organization are preoccupied with their task, then, the ability to remain 'objective' about the matrix of dynamics may be blurred and confused. The Consultant is in a position to provide feedback and ideas that may help the staff understand the dynamics they are involved in, and consequently allow for further evolution.

The staff in residential settings are unable to deal with strong emotions by isolation or insulation. Indeed, they may be the victims of it, finding themselves and their problems as marginalised as their client's. The residential establishment may, therefore, impose considerable stress on staff, and 'absences, illness or high staff turnover may be the result. The Consultant, someone with a reputation coming from the outside world but sharing the staff difficulties, is in a strong position to reduce these stresses and this may be the best justification for his or her work.(Tantam p. V in (ed.) Silveira 1991)

Inner and Outer Worlds: Parallels Between Organization for Supervision and Consultation and Therapeutic Process

To further the discussion on the use of consultation and supervision as aids to the primary task of group care organizations, I would like to progress with a hypothesis of parallel objectives between the organizational boundaries which help the client develop distinctions between his or her inner and outer worlds, and the use of supervision and consultation.

The following diagram may represent two different dynamics within an organization, firstly as a

series of containing boundaries around the client, and secondly as the 'emotional development' of the client moving from the inner circle as a small, dependent, or partial 'self' to the outer circle as an independent 'social' self.

Diagram 2:

ORGANIZATIONAL BOUNDARY

In terms of the containing boundaries, each person around the child must be aware of how their function is related to the space between them and the nearest inner or outer circle. As John Whitwell writes:-

If a person has not developed the capacity to distinguish what is 'inside' himself and what is outside, and to control the boundary between them, then he needs to be somewhere where there are clearly defined and simple boundaries in the external environment. The less developed are the former, then the stronger, more clearly defined and less complex must be the latter. In the residential community everyone must be clear who is inside and outside what, otherwise chaos and breakdown ensues. In working with disturbed people there has always to be a clear definition with regard to individuals, groups and systems and their boundaries.(1984, p. 24)

Returning to the 'parallel' action idea, within this model, the place of the Supervisor and Consultant must always belong to an outer or external space, vis a vis the Supervisee or Consultee. Consequently, the Supervisee/Consultee also needs a space of 'autonomy'.

As previously described, for the client, the continual testing of boundaries and creating negotiating space between boundaries, allows him/her to internalise the ability to contain and to separate. Through this treatment process the client is able to develop ego functioning by having primary needs met, and at the same time separating out from dependency relationships to independence and reality testing.

It might be that there are similar psychological benefits to both the staff and client groups from this model, in that, the external spaces create an important level 'beyond' the here and now, where healthy fantasies or the 'sane' bits of everybody's self, can be safely put. The other side of this is,

however, that the fantasy of such external spaces may also be terrifying.

Within many forms of group care it is the totality of *the* environment (milieu or planned environment therapy) that facilitates the treatment process. Supervision and consultation may be regarded as consciously planned aspects of this environment, and like the boundaries, act as 'shock absorbers' or containers for the anxiety of the organization.

It is my proposition that supervision is developed within the boundary of the organization, and is consequently subject to the dynamics of it. Diagram 3 shows the relationship of the Supervisor to the Supervisee, 'contained' within the organizational boundary.

Diagram 3:

(The arrow represents the reciprocal interaction within supervision).

In the case of consultation, the organization uses the service of the Consultant, who comes from the outside, to provide a specific service for it. Consultancy is used as an external 'objective' assessment of the dynamics and is, therefore, not directly subject to them.

Diagram 4:

(The arrows represent the interaction across the boundary between the Consultant and organization).

Supervision could be said to represent attempts to understand the internal dynamics of the organization, and being in the organization it reflects the inner world of the organization. Consultancy coming from the outside represents an 'objective' external assessment of the dynamics - and represents the outer world/external environment of the organization. (In this sense it may provide a 'reality testing' function).

Diagram 5:

ORGANIZATIONAL BOUNDARY

If the two are brought together (Diagram 5) we can see that the use of consultancy and supervision can provide an on-going review of the internal and external aspects of the organization. Consequently, the 'health' of the organization is regularly assessed.

My proposition is that both supervision and consultation, by providing the potential for a reflective practice, facilitate the work of group care workers, and this has a correlation with the client's capacity to emotionally evolve. The correlation is 'real' in that both workers and clients are part of a therapeutic process, and accordingly, neither supervision nor consultation is sufficient alone, they must complement each other. This link between the development of the staff and client groups is suggested by Berry:-

Since these warring internal elements are exactly the same as those which are in conflict with colleagues and inmates, the experience of the Consultant continuing to try to help in spite of obstacles does simultaneously begin to ease relationships all round in the daily caring situation.(1975, p. 137)

Summary of Chapter

Chapter six proposes that one way of effectively providing containment and treatment for emotionally disturbed clients is by developing a clear system of 'boundary management' around the client, these 'boundaries' may act as 'shock absorbers' to the disturbance of the client.

This model implies that each person involved with this task is clear about his/her responsibilities and those of the person on the next 'boundary'.

The chapter also proposes that supervision and consultation act respectively as internal and external monitors of the dynamics of the organization, to ensure that staff are getting the support they need, and that the therapeutic task is being maintained.

The chapter concludes that the 'mental health' of the organization is kept in check by the supervisory and consultative functions, and that ultimately both staff and clients are involved in versions of the same therapeutic process.

CONCLUDING CHAPTER

SUMMARY

Chapter 1:

This chapter explored some of the most recent reports and legislation (e.g. 'Pindown', The Children Act 1989, and the 'Warner' report), many of these reports were produced as a response to anxiety about different forms of breakdown in the residential care system.

The reports all conclude that supervision and consultation are necessary for the future development of residential care.

The chapter looks at certain prevalent assumptions and ideologies that may hinder the development of creative growth in the field of residential care. I propose that the need for a particular form of 'containment' meaning 'emotional holding' rather than incarceration, can lead to change and growth for the disturbed client.

Chapter 2:

The theme of 'containment' is further developed in this chapter. Aspects of Winnicott's theory are explored. These are based on the formative experiences of the mother/infant relationship, consequently they also create the possibility for healing people who have been emotionally damaged at this primary stage.

The concept of developing a 'reflective' practice for group care workers is introduced in this chapter, and some definitions of 'reflective' practice are given.

The psychodynamic concepts of transference, counter-transference and projective identification are defined, and examples are given of how an understanding of these unconscious processes can develop the capacity of workers to understand complex interactions within relationships, and respond therapeutically to them, I have chosen Bion's concept of 'container/contained' as a prototype for this treatment process, and shown how the application of this theory can have

therapeutic effects.

Chapter 4:

This chapter examines definitions, roles and functions of supervision and consultation. It explores the use of these in relation to three key issues within group care - power, prejudice and dependency.

The section on supervision gives four examples of models of supervision which are relevant to group care, and looks at brief comparisons and criticisms of them.

Chapter 5:

The chapter then moves on to focus on the use of consultation and identifies the 'essence' of consultation as externality. This section shows how the external nature of the Consultant's role provides a distance from, and perspective on, the dynamics of the organization. In this respect the chapter shows how consultation can help develop a 'reflective' practice by creating 'spaces' for reflection in the organization.

This chapter concentrates on an application of the uses of supervision and consultation to group care organizations. It proposes that by developing a clear system of 'boundary' management a supportive, containing and therapeutic structure is created for both workers and clients. The chapter suggests that such a structure is a pre-requisite for therapeutic work.

The chapter proposes that these boundaries are based on each worker being clear of his/her task, this will create the conditions in which emotional growth can take place for the client.

The chapter concludes that supervision and consultation act as internal and external monitors of this facilitating structure, which is inevitably affected at all levels by the disturbance it works with. Supervision and consultation ensure that staff get the support they need, and that the primary task is maintained.

The chapter concludes that in this respect, both workers and clients are involved in versions of the same developmental therapeutic process.

CONCLUSION

This dissertation has concentrated on the development of the therapeutic potential of group care organizations through the use of supervision and, in particular, consultation. I have suggested that these facilitate the primary task by staff support, clarifying management roles, increasing communication and enabling a 'reflective' practice to be used by workers.

The thesis has concentrated largely on aspects of the 'internal' world of organizations. In chapter five, through interviews with Dr. Miller and Dr. Reyes, the 'external' nature of consultation was identified. I would like, therefore, to finish with some implications drawn from the thesis, that have relevance to the wider world of group care management and policy making.

In her book 'The Power to Care for Children's Homes', Norma Baldwin argues that a prerequisite for effective work in children's homes is a supportive 'parent' authority. This, she suggests, empowers the staff of the home to have control over their own internal policy making and admissions. She states that this is achieved through 'open' communication, she identifies this as meaning and trusting and reliable informal link to formal structures.

Group care organizations then, should help their clients as part of an integrated range of services for children and young people. 'External' development of such services will mean:-

The programmes needed will be corporate local authority, health and voluntary sector programmes rather than simply Social Services department programmes (Baldwin 1990, p. 181)

and of the organizations themselves, Baldwin writes:-

A multi-faceted organization is required, which will have varied and overlapping specialisms: specialism based on geographical areas need to exist alongside other specialisms for particular consumer groups or particular types of problems. (ibid, p. 183)

Developing a range of specialist support systems requires particular forms of expertise, thus the need for both supervision and consultation to monitor, educate, and provide appropriate regulation of such work is vital. The provision of these services, and a proactive attitude towards their use, is ultimately the responsibility of 'parent' authorities.

This thesis has emphasised the importance of a structure that provides supervision and consultation to enable group care workers to carry out a specialist therapeutic task with their clients.

A structure which recognises and deals with conflicts of interest, for example between different groups of workers, between parents and children, between the agency's need to save money and a client's need for scarce resources, is necessary. (ibid, p. 183)

Unfortunately this structure is presently an ideal one. If we are to develop genuine caring and healing systems for emotionally damaged young people, then all group care workers should be afforded the right to supportive supervision and consultation. As previously mentioned, the 'Warner' report has recently supported this position.

The practice of residential care can only be as effective, however, as the policies, resources and organizational arrangements for child care services on which it depends. The power of residential workers to provide resident centred care cannot be separated from wider questions about the resources children and their families need if they are to lead personally fulfilling and socially responsible lives.(ibid, p. 187)

It remains to be seen whether those who hold the real power to provide care in our society will listen to these arguments.

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Prepared for the Internet by Rachael Thompson
September 2009