Introduction

Barbara Dockar-Drysdale (Pip) presented this paper in 1973 at a conference, "The Evolving of Caring Systems" at the University of Dundee. She shared the platform with Richard Balbernie, Professor Ben Morris and Anthea Hay. Pip wrote this at a point when the Cotswold Community's therapeutic culture was becoming established following the transformation from an Approved School.

Staff Consultation in an Evolving Care System

B. E. Dockar-Drysdale

This paper is an attempt to describe an on-going project. Our task was to set up a therapeutic structure within an existing management structure. We would hope that the structure will be strong enough to support staff through considerable change, to reach a new position.

The workers concerned are the usual mixture of different personalities and skills, and are trained or untrained. It seems to me that this sort of therapeutic structure could be set up in most caring institutions.

I have recently reached a tentative realization which seems to throw considerable light on problems which I have only partially understood in the course of my work as a consultant. I work in two therapeutic institutions: one for children of primary school age – the Mulberry Bush – and one for adolescent boys – The Cotswold Community. I think of this realization of mine as 'The theory of the impossible task', the 'theory' being the basic assumption that people cannot change except in superficial ways, an idea subscribed to by families, institutions and managing bodies. There is plenty of encouragement for those who engage in the task of changing or helping delinquent and difficult children. Child care workers are praised and admired as unselfish, dedicated people making great sacrifices in order to devote themselves to a hopeless but worthy cause. This encouraging, praising attitude continues through all sorts of crises, breakdowns and failures, but changes to anxiety and suspicion, should any success attend the struggles of the people involved in this kind of work.

The theory of the impossible task is to be found among child care workers themselves, who will work with devotion, accept instruction and advice, learn theory and so on, but do not in fact believe that their efforts will lead to results. Some people actually choose this kind of work just because they believe it to be impossible – like climbers assailing a peak which they believe to be unconquerable.

Long ago, I remember, there was a student at the Mulberry Bush who could not manage a play group of three disturbed children. She left us after a few weeks, and when we next had news of her, she was working for an organization aimed at achieving world peace. I also remember, to give another instance, the young wife of a new member of staff at the Cotswold telling me 'But this way of working is not *possible.*'

This basic assumption was one of the many obstacles which I encountered when I started to work as a consultant in the Cotswold; not that I recognized the nature of the obstacle at the time, I only knew that I was being made to feel 'helpless and hopeless' and that there was more than one barrier between myself and the workers in the place – realization came later.

Another obstacle lay in the survival of what I ultimately termed 'the Dinosaurs' – a subculture of institutionalisation based on the past hierarchical structure, which was giving place to a therapeutic community. There were many adults and boys who believed that the change was momentary and that the old order would be restored before long. The Dinosaur was made up of all the bits of institutionalisation remaining in the people living in the place. For example, the attitude to night care remained entrenched in the past (when there was a night watchman), change being fiercely resisted for a long time. One could say that there was a deep relief in a return to the 'institutional womb'.

The third realization which helped me to understand the problems a bit better was what I called 'the fallacy of a delusional equilibrium'. This was another basic assumption on the part of many people in the place, which implied that by keeping things calm and smooth on top, the chaos below the surface need not be reached. Breakdown in this false equilibrium was projected on to any likely scapegoat.

When I started work four years ago, the first fundamental changes had been brought about already. I am going to quote a brief unpublished report which I wrote concerning my work during this early period in the Cotswold.

> 'Initially we saw my tasks to be (firstly) the provision of ego support in order to facilitate ego functioning in integrated children; (secondly) the containment of unintegrated children with provision of primary experience with which to build the self and achieve integration. These two tasks were to be carried out through work with both staff and boys. It was assumed that unintegrated children would form a small minority group in the place: this group would need, a soon as possible, to be insulated in order to receive appropriate treatment. The mixture of integrated and unintegrated boys was recognised as undesirable.
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> In the event, I was assigned to a house, St David's, consisting of very deprived and disturbed boys; this group was not yet separated in any way from the rest of the Community, but was self-selective in terms of gross disturbance as a common factor. I talked with the boys and with the staff individually, until the staff themselves asked for group meetings with me. These staff groups became the nucleus of my work in the Community. My sessions with boys could – with their permission – be used to help staff to gain insight and to understand the need for teamwork in order to provide experience. These individual sessions were – and remain – of necessity brief – twenty to thirty minutes. I have found that where residential workers are themselves carrying out a therapeutic programme, sessions with individual boys have what I call a 'key' function, helping to open and deepen channels of communication between boys and workers.
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> St David's became presently the unit for unintegrated boys known as 'The Cottage'. Once this kind of insulation had been established, my task became more

precise. By discussing weekly 'happenings' chosen by the Cottage team, I was able to help them to provide primary experience, through individual adaptation to need, based on early dependence and involving localized regression within a relationship in a firmly structured containing environment. In this way, the team came to realize how disciplined any real therapeutic work must be, and the danger of collusion and the need for confrontation of a non-punitive kind. The team did good work, although naturally making many mistakes which with adequate support they could face. The development of an ego culture in the Cottage minimized authoritarian attitudes at one extreme, and sub-cultures at the other. The establishment of open communication between staff and boys reduced acting out; and the insulation and containment of this group of unintegrated boys enabled ego growth and strengthening in other groups within the Community.

For various reasons it was decided after a time that I should work in a similar consultant-tutor role in the remaining three house teams. My weekly discussion groups evolved into seminars, with learning based on the group experiences during the current week. Each group seminar lasts for forty-five minutes, with periods of from twenty to thirty minutes available as before for key sessions with boys, usually at their own request and tutorials with team members – often the heads of houses. I have a close liaison with the head of group living, who plans my day's work each week, and with whom I discuss my work in detail each Wednesday evening on the telephone, after my return home. I have also meetings with Mike Jinks, the head of education. I meet Richard Balbernie frequently, and discuss problems and recommendations with him, both at the Cotswold and by telephone.

The development of a system of need assessment ahs enabled us to chart all houses on a basis of integrated or unintegrated: and if unintegrated, to chart the specific syndrome of deprivation (see my paper for the Home Office course at Bournemouth, 1970). From this "inside diagnosis" we are now in a position to plan treatment on a foundation of need, and to select with some certainty those boys to whom we can offer help. The work on need assessment is also enabling the staff to conceptualize and communicate what they are doing; and recently teams have begun to carry out these assessments themselves, checking results with me, so that we can plan treatment programmes in an exact way.'

In order to understand the nature of the task facing a consultant, in this particular set of circumstances, it seems important to clarify the nature of a classification such as I have just mentioned, that is, into integrated and unintegrated. I shall now quote from my own work.[1]

'Winnicott and others have postulated a primary state of unity of the mother and her baby.[2] In thinking about emotional deprivation I find it necessary to take as a starting point this state of unity at the very beginning of a baby's life. Freud wrote: "For just as the mother originally satisfied all the needs of the foetus through her own body, so now, after it's birth she continues to do so, though partly through other means.

1 Dockar-Drysdale, B. E. (1968) *'Therapy in Child Care'* London. Longman.

2 Winnicott, D. W. (1958) *'Collected Papers'* London Tavistock.

There is much more continuity between intra-uterine life and earliest infancy than the impressive caesura of the act of birth allows us to believe."[3] In the course of normal development the separating out of mother and a baby is a long and gradual process; at the completion of this the baby exists for the first time as a separate individual, absolutely dependent on the mother, but no longer emotionally part of her. If integration of the personality is to take place usually by the end of the first year of life the evolution of this process must not be interrupted. Interruption of this essential process which mothers and babies work through together in their own time and in their own way, is in my view the trauma which lies at the root of the various types of cases of emotional deprivation referred to us.

> The point at which traumatic interruption has taken place determines the nature of the survival mechanisms used by the child: the primitive nature of these mechanisms does not prevent them from being used in a highly complex manner. Winnicott has said: "All the rest of mental illness (other than psychoneurosis) belongs to the build-up of the personality in earliest childhood and in infancy, along with the environmental provision that fails or succeeds in its function of facilitating the maturational processes of the individual. In other words, mental illness that is not psychoneurosis has importance for the social worker because it concerns not so much the individual's organized defences as the individual's failure to attain ego-strength or the personality integration that enables defences to form".[4] The emotionally deprived child is pre-neurotic, unable to experience guilt or anxiety, and functioning at various primitive stages of development. For a neurotic child there may have been inadequate continuity between the intra-uterine and postnatal phases, but nevertheless he has enough protective and protected environment to make it possible or him to build a separate personality structure, capable of integrating good and bad experiences and his responses to them, rather than being helplessly buffeted by them. He is thus able, having reached integration because of "good enough infant care" (Winnicott)[5] to embark on the long voyage of secondary experience.'

When we first classified all the boys in the Cotswold on the basis of integration as individuals, we found that seventy-five per cent of our population turned out to be unintegrated: this was a rough-and-ready emergency classification, using the presence of panic and disruption as the factors determining whether or not a boy was to be considered integrated. A unit for the integrated twenty-five per cent was set up, which accepted boys who achieved integration as the result of treatment within the Community; and those a very few who on referral seemed to be integrated. Obviously my work with the staff of the unit for integrated boys (Boulderstone) was very different to discussions with teams in other units.

Initially, as I have indicated, subject matter for team discussion groups depended entirely on what they themselves surfaced. I felt that they were under such stress that my chief value at first must be as a safety valve in what was a crisis culture. There was mass acting-out in all units, and subculture among staff as well as boys.

3 Freud, S. (1926) *'Inhibitions, Symptoms and Anxiety'* London, Hogarth

4 Winnicott, D. W. (1963) *'The Mentally Ill in Your Caseload'* in 'New Thinking for Changing Needs', Association of Social Workers

5 Winnicott, D. W. (1958) *'Collected Papers'* London, Tavistock

Workers, both in groups and individually, selected communication to impart to me in a way which made it very difficult to be of any use. The fallacy of the delusional equilibrium, already mentioned, was much in evidence: information concerning the various units gave the impression of a smooth-running, well established organization, only disturbed by the not-to-be-explained phenomena of acting out, which could not be denied. So I did what I could with the limited resources at my disposal, often bored and frustrated, but hoping that as workers came to know and trust me, more urgent reality could begin to be communicated.

In fact, the process of classifying as 'integrated' or 'unintegrated' did much to open up dialogue. In order to answer the questions 'Does this boy panic?' and 'Does he disrupt?' workers started to ask themselves new questions about boys and about themselves. In order to make use of this development I evolved a technique which I call 'need assessment'. The use of this kind of technique seems to me to be essential in focussing, as it does, the attention of the whole group including the consultant on the primary task – in our case, the provision of primary experience.

> 'On the basis that anti-task, acting-out, and subcultures of all kinds tend to spring from a breakdown in real communication, it would seem of the utmost importance to keep all lines of communication open – between members of the team, between grown ups and children, and between the consultant and all others in the place. The making of a need assessment involves the whole staff group of a residential unit, working with the consultant, and pooling resources in order to evaluate need. Often insights are reached in the making of these assessments which are not only of value to the child under consideration, but also to the treatment team themselves, throwing light on problems of delusional counter-transference – splitting mechanisms for example – but in a way which is tolerable because it is indirect and shared. Such an approach seems to me to give child care workers a proper professional position in the scheme of things – the consultant being entirely dependent on the material brought forward by the unit team (see my paper on "Need Assessment").[6]
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> The questions asked in the need assessment are those which I have asked myself in attempting to analyse a context profile, which is a method of reporting by the team on experience with one child during a week (I have written about this technique elsewhere).[7]
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> I have tried to approach the problem of meeting the child's needs – whatever these may be – by classification (rather than by considering his symptoms). I have so far used this form of need assessment in both the Cotswold and the Bush. I think that it would always be necessary for a senior worker to lead such a group discussion; asking and explaining the questions, and recording the answers. There can be no 'yes' or 'no' answers: all replies must be based on actual experiences with the child.
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> We have found that this kind of need assessment helps us in planning for the

6 Dockar-Drysdale, B. E. *'Consultation in Child Care'* London, Longman, to be published this year.

7 Dockar-Drysdale, B. E. (1968) *'Therapy in Child Care'* London, Longman.

child's management and care. A need assessment in no way replaces other assessments (case history, intellectual ability, and so on). I find it a valuable addition to other information.

The questions can only be answered for the first time by a group of people who are living with the child, and have been doing so for at least three weeks or a month: they must understand that this is a first need assessment – that there will be others necessary in order to meet the child's evolving needs. I think that only a group of resident workers can draw on the kind of experience essential to this type of assessment.' [8]

One individual can make this sort of assessment. An assessment when completed forms a basis for a treatment programme. The other less obvious use of need assessments is the introduction of important concepts to staff, *always in a practical context,* so that workers quite easily become accustomed to considering boys in this rather exact and disciplined way, and to applying the concepts to *themselves* as well as to the boys.

The assessments are of course repeated at intervals and are always available for reference. The material required is from personal experience, so that pseudo-objectivity in the form of observation 'out there' is avoided.

I shall now quote from a paper which has not yet been published.

'The questions may seem odd at first, but they do seem to obtain the kind of information necessary. Workers quickly become accustomed to this approach, which is still at a 'workshop' stage. A need assessment usually needs an hour of group work to complete.

Classification Is this boy integrated as a person, or is he unintegrated? To judge this, one should ask oneself.

(a) Does he panic? By panic, I mean a state of unthinkable anxiety – almost a physical condition. (Many so-called 'temper tantrums' are panics.)

(b) Does he disrupt? By this, I mean does he disrupt a group activity or a happening between two other people.

It would appear, from evidence so far, that the presence of panic and disruption fairly frequently in a child's life justify us in considering him, for the present, as being unintegrated.

If he seems to be unintegrated, go on to the next question.

1. What is the *syndrome of deprivation?* This can be judged by answers to the following questions. What is the state of feelings in this boy in regard to

8 Dockar-Drysdale, B. E. '*Consultation in Child Care*' London, Longman, to be published later this year.

(a) personal guilt. This refers to concern; to what one could call healthy guilt – not a fear of being punished or found out, but an acceptance of personal responsibility for harm done to others, of a kind which can lead to making reparation.

(b) dependence on people or a person

(c) merger. This is the way in which some children become merged with one other or with a group (a typically delinquent phenomenon).

(d) empathy. I like to think of this as being a capacity to imagine what it must feel like to be in someone else's shoes, while remaining in one's own.

(e) stress. How does this child deal with feelings of stress?

(f) communication. Does he *really* communicate, or does he just chatter in a stereotyped way?

(g) identification. Does he, for example, seem to model himself on a grown up he admires, or on another child? - be careful not to confuse this with merger.

(h) depression. Is he sometimes very depressed, or is he indifferent, or always apparently cheerful? Is he at times deeply sad? There is a kind of state of low level of consciousness – just 'ticking over' – sometimes seen in deprived children, which I call 'hibernation' and which should not be confused with depression.

(i) aggression. – Verbal and physical.

2. What is his *capacity for play?*

(a) narcissistic. Does he play a lot alone with pleasure?

(b) transitional. Does he, for example, make use of a transitional object?

(c) pre-oedipal. Does he usually like to play with one other, usually a grown up?

(d) oedipal. Does he play with more than one grown up at a time?

(e) post-oedipal. Does he play with other children, is he able to keep rules, and so on? (See "Play" in "Therapy in Child Care").

3. What is his *capacity for learning* – in every sort of learning situation? Does he learn from experience?

4. What is his *capacity for self preservation?* i.e. is he accident prone? Does he take care of himself and his belongings? Does he seem to value himself?' [9]

As the unit teams became accustomed to using need assessments, there was a considerable opening up of communication especially because, for the first time, people began to take some share of responsibility for boys' acting out. I felt it was safe to say – and say again – that all acting out results from breakdown in communication. The exception to this statement can be found in symbolic acting out in relation to an adult. This is acting out *towards* communication, and can turn up in the course of treatment. The distinction is clear because this special acting out is always directed to a known and trusted person, whereas acting out which is broken down communication is quite anonymous and concerns unknown people.

The realization of this fact produced an almost intolerable level of anxiety among the workers; but honesty, courage and determination led them to investigate with me boys' acting out is that in most cases we could actually find the point at which communication broke down. This particular realization came with others, in such a way that workers began to accept professional and personal responsibility for crisis situations. They began to consider ways in which acting out and violence could be anticipated and often prevented or at least be localized.

People working with unintegrated children and adolescents have to carry a much heavier load of tension and anxiety than those who are trying to help neurotic, integrated youngsters. Workers at the Cotswold are constantly exposed to the full blast of primary processes – they are in touch with what *should* be in the unconscious but which, without ego development, is present at a conscious level in all its primitive violence (Winnicott used to describe this as 'dreaming awake'). The danger – apart from the actual violent acting out – is that this primitive material can pick up wavelengths in the unconscious of the workers – this is what can lead to collusive pairing, which is damaging in the extreme to boy and adult. For these reasons it is essential that workers should become as conscious as possible about themselves, so that they and the boys are less at risk and more free to concentrate on the primary task. Some time ago there was an outburst of acting out by certain boys, and in the course of sorting out the causes, the following fact, among many, came to light.

A student took three boys in her car to the nearest town: one boy sat in front, two behind. On the back seat of the car was the student's bag with money in it. The boys asked her to move this bag, as they found it too much of a strain to have it on the seat beside them. The student laughed and said that she was not worried leaving the bag where it was; later, the boys stole money from the bag and went on to further delinquency. The student did not initially tell me about the bag: when she eventually did, she reported it all without guilt. It came to her as a great and quite genuine shock to find that she had triggered off a delinquent explosion in a collusive way.

This was a very obvious example of unconscious collusion, there are many more subtle and hidden ways in which this sort of mechanism can operate – *but only as*

9 Dockar-Drysdale, B. E. '*Consultation in Child Care*' London, Longman, to be published this year.

long as the worker remains unconscious of it. The surfacing of such material puts an end to the unconscious technique which cannot now be employed *without guilt.*

Presently staff teams began to understand just how important communication could be: this realization made it possible for me to introduce the idea of 'talking groups'. Morning meetings of total groups (staff and boys) had not proved successful, prior to classification. It now seemed that while integrated boys could communicate in this sort of setting, unintegrated boys were unable to tolerate the high degree of stress, becoming disruptive, withdrawn or panicky. The integrated boys in Boulderstone could stand this experience, while those in the other units could come together with staff or *information* to be imparted to them (plans, etc.) without too much strain. For the purpose of *inter-communication*, I suggested the introduction of very small groups (four boys to one adult). In this setting all boys became able to exchange communication, and these small groups have continued to function with a reasonable degree of success. Of course talking groups did not replace deeply personal communication between a boy and a grown up, sometimes spontaneous, and more often planned for a definite short span of time in each day, usually at bedtime.

At this point, therefore, the staff groups with which I was working formulated need assessments with me for all boys, carried out the recommendations of the assessments, and ran small talking groups. They discussed all these activities with me, both individually and in groups , and gradually deepened this understanding of delinquency equating with deprivation. In parallel, Richard Balbernie and Isobel Menzies were also making workers more conscious and responsible. The people in the place were therefore going through a very difficult period of growing awareness, both individually and in groups.

During this period I added twenty-four hour programmes to our established need assessments. The whole group went over twenty-four hours with me in respect of the needs of an individual boy – for example, how he needed to be woken in the morning. A programme like this ensured that a unit team would all know a boy's needs at that time, so that newcomers could quickly gain information. Changes in the programme could be recorded. This twenty-four hour programme has proved to be especially valuable for new boys on arrival (prior to actual need assessment).

At this point I reported as follows, on 'therapeutic structure'.[10]

> 'Let us assume the presence of a management structure which divides sixty boys into groups of from nine to fourteen persons, in four units. Each unit has a head, a senior housemother and two or three others, any one of whom may be called on to substitute for the head. One of these units caters for integrated boys, three for unintegrated. Usually the integrated boys have achieved integration within the place.
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> The needs of each boy must be formally assessed by the team group within the first month, and thereafter at intervals of about three months. Ways of meeting these needs must be found within management structure (in terms of working hours of staff, life style of unit, etc.). At present we do not have adequate referral

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assessments. Integrated boys will not require need assessment so much as good reporting. Within this management structure, a therapeutic structure must exist. Selection of staff depends on personality, training and experience. In the one unit for integrated boys, staff will need to be ego-supportive: in the other three units they will need to be ego-providing (i.e. you cannot support what is not there). (For comments on all this, see Winnicott, 'The Family and Individual Development' – 'Group Influences and the Maladjusted Child'.)

This classification is the initial structure required for therapy to take place in order to carry out the two primary tasks in the place provision for integrated and provision for unintegrated boys. Such classification can fit comfortably within the management structure.

Within the therapeutic main structure are the sub-structures. Therapy can take place within many fields; food, bedtime and getting up, school, communication, play, bathing, clothes, and others. In each and every case, however, the therapeutic structure must contain the therapy, which must also fit into the management structure: i.e. if, for example, 'Lights out' is at ten o'clock, this is not the moment to start therapeutic communication with boys. Equally, no therapeutic structure could exist within a management structure which sends most staff off at weekends. The use of 'weekends' is an obvious example of the need for a management structure within which a therapeutic structure *can* fit. Night care is another example.

In the unit for integrated boys we can think in terms of a group. Here the whole group could meet daily with the team to discuss the problems in the unit, and reach decisions. We can assume an ego nucleus or ego functioning (they will also need other forms of communication).

In no other units *is there a group (*the *false group* structure in one unit led to breakdown in communication, and subculture). These unintegrated units need what Winnicott called 'cover'. We find, however, that small talking groups (four boys to one adult) with separate lifelines to the adult *do* lead to communication.

The small talking groups can be contained within the management structure, and form part of the therapeutic structure, within the talking groups, matters to do with inner reality can surface safely.

These groups have no part to play in management, i.e. decisions are not reached – the aim is not to make decisions but to facilitate open communications. There can be house groups of staff and boys for all sorts of communication, but this is not therapy but good management. The large meeting in Boulderstone also fits within the management structure, but has an objective social purpose and can reach decisions.

In all units there is opportunity for one-to-one communication, often at bedtime. This must be structured to fit within management.

All therapeutic communication needs to take place between the same people, at the same time, in the same place and for the same duration. This time and place

structure must fit into management. Of course there is unplanned, casual communication in context, at any time. Within the Polytechnic area there is plenty of planned communication, both individual and in small groups.

Every boy should have opportunities for individual and group communication daily. This is the only answer to unintegrated subculture and acting out. Every bit of acting out can be traced to a breakdown in communication. Unintegrated boys need a structure to contain 1. regular small talking groups, 2. individual communication with an adult, and 3. immediate communication in context.

Twenty four hour therapeutic management programmes are needed for all unintegrated boys, to ensure reliable continuity of provision in a unit. Here again, twenty-four hour programmes must fit into the main management structure of the whole place and of the unit – otherwise programmes will breakdown. Equally, any change of management must respect programmes.

Localization of provision is essential, and indeed without localization therapeutic work of this kind is impossible. Ten minutes, properly used, are more valuable than two hours of permissive "floating". Primary provision must be individual – one cannot provide localized regression or adaptation for a *group*, but only for individuals in a group with adequate cover for all.

Play Many unintegrated boys cannot play in a way appropriate to their age. They will, however, play in a sand heap, with small toys on a play tray, in dens or tents, and with soft toys in bed. A play tray should have a small box of toys for the particular boy. A soft toy should be made for him, if needed, and should be cared for and mended. Therapeutic play should also take place in a regular, structured way – not anywhere at any time, with anyone.

Food This is of course an invaluable field for primary provision, but it must never be de-personalized. Eggs at breakfast can be cooked to individual requirements without causing difficulties of management. Midday meals in a canteen are not therapeutic, but are appropriate for integrated boys as a social experience. If midday meals must be centralized, then at least efforts are made to give complete experiences (e.g. a whole small jelly). Food adaptations must sometimes be specially arranged with management (e.g. a sack of apples for Keith).

The Poly has a particular problem in that boys are not classified as integrated or unintegrated in terms of group arrangement. Essentially, the Poly must be concerned with ego functioning elements. Where these are not – or are barely – present, it is a question whether a boy should be in any group learning situation. It would seem that for the more unintegrated boys, "lifelines" must be arranged (for example individual remedial settings). One could imagine two parts of the Poly, if this were practical. Obviously the integrated people in Boulderstone should function well in group situations of learning and living.

Note All therapy requires a close and deep relationship between boy and worker. Adaptation "dosage" would do harm. There can be no de-personalized care, whatever the boy may feel about the worker. The worker must remain concerned about the boy, even when hated by him. Vague dishing out of "Tea and

> Sympathy" is not therapeutic work. All provision must have symbolic meaning if the boy is to experience symbolic realization. Any therapeutic structure assumes that this is already understood. There are many therapeutic techniques not available in the circumstances: we must make good use of what we can do. For example, verbal interpretation often cannot be used with our very ill clients – it will then be what we do rather than what we say that can be of use to them: but what we do must be planned, realistic and relaiable.'[11]

One of the factors which tends to make workers feel helpless is their conviction that it would be inappropriate for them to make interpretations to the boys in their care. This conclusion often immobilizes them and prevents further efforts towards other goals. Whilst I would agree that deep interpretation should not be used by unanalysed people, however talented, symbolic communication remains at their disposal and is often of considerable use in their therapeutic work.

To give a simple example: a boy draws a small house surrounded by a high wall. The therapist may well comment: 'The person who owns that house must feel safe inside those high walls – but can he see the countryside beyond them?' Such a comment may lead to a dialogue which will have a lot to do with the crippling nature of the boy's defences, but which can remain in the context of the picture. There are now many workers at the Cotswold who can use this sort of technique extremely well. They also acquire the art of therapeutic *listening* – listening to a boy's communication with the whole of themselves, to the exclusion of all else, which is not so easy.

One of the most difficult tasks which I have undertaken in working as a consultant to a 'caring establishment' is what I think of as coping with 'the Crunch'. The crunch means for me the collision of objective with inner reality, and can perhaps best be explained by example. Jimn a boy at the Cotswold, became interested in chess, so that presently he wished to carve a chess set. He made a king, a queen and a pawn, which he brought to show me. His instructor told me that he now refused to complete the set. However, Jim *had* – from his point of view – completed another kind of set: a father, a mother and a child – the family life he had never known. It is difficult for workers to accept this other kind of reality, especially when there is such a clash of interests and investment.

Recently a boy who had great problems of communication started to play Squiggles with me. He turned all my squiggles into strange creatures which lived underwater. (One of these creatures was large, round, soft and pink: it had *lost its mouth* at the bottom of the river. This was his mother's breast, and the lost mouth was his own, which had lost her breast. Now he attributed the mouth *to her breast).* I spoke a little about this material to a colleague saying that it would be terrible if somebody was to teach him about real underwater life at this point. A few days later Peter turned a squiggle into something amorphous. He said with marked hesitation 'Something like jelly with black dots ….' I asked if he meant frog spawn, and he said at once 'Oh yes …' and went on to try to speak about tadpoles, in a muddled and hesitant voice, which as he usually employs – quite different from the easy flow of his underwater voice. I asked 'Has someone been explaining to you about tadpoles and all that?"

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He said that his teacher had taken him to the pond and had shown him frog spawn and so forth. I observed that I thought *his* creatures lived in much deeper water: he was able to make use of this comment and the next squiggle took him back to the creatures of his inner reality.

There was another child, long ago, who used to ask me 'What does one and one make?' The answer was 'One' (the child as part of his mother). This incorrect arithmetic was very important to him just at that time.

I think 'the Crunch' between objective and inner reality explains some of the problems faced by teachers and therapists working together. At the Cotswold we are trying to see the importance of both realities, so that one is not sacrificing one for the other at certain moments of conflict. In dealing with unintegrated children, internal reality must be established before objective reality can be recognized.

There have been further developments. There is now in each unit a manager, a management continuity resource person, a therapeutic resource person, one or two educational skills resource people, and one or two team members. The therapeutic resource person is responsible for twenty-four hour programmes, context profiles (a detailed type of reporting on a boy for a week by the whole team), need assessments, talking groups and communication plans, adaptations to individual needs, and therapeutic play.

Richard Balbernie and I meet the therapeutic resource people (there are four – one to each unit) weekly to discuss their work. There is also a training group which I run each week for newcomers to the place; and a group run by Richard Balbernie and myself for staff wives (this last has proved to be essential).

I feel we have achieved a therapeutic structure which has evolved in a gradual and realistic way. There are in all this great hazards and problems which sometimes seem insuperable.

I have spoken of some of the difficulties – of the presence of the shadowy Dinosaur surviving from the institutional past; the presence from time to time of anti-task, often represented by some new member of a group; selective communication so that some things are not allowed to surface in discussion with me – I could not work without communication from Richard Balbernie; delusional equilibrium – the thin ice which is so smooth and deceptive with chaos beneath.

There are other problems, difficult to recognise, let alone solve. For example: it can be very hard to diagnose a delinquent pairing of an adult with a boy which can seem to be a conscious therapeutic involvement. It is very difficult to assess just how much insight workers can tolerate without becoming immobilized by anxiety. It is not at the moment that insight is gained, but later, when the worker discovers changes in himself that a danger point can be reached – when for example long established crisis avoidance techniques can no longer be unconsciously employed. There is an almost opposite risk, however, when a worker accepts and 'learns' a theoretical concept without 'digestion' – he introjects but does not incorporate the idea within himself in terms of his own experience. A worker who does this word swallowing trick will produce the concept just as it went into him, present it to others – his colleagues and

the boys who are his clients – in such a way that will be rightly and bitterly resisted because they will not feel it is 'real'.

I have also found myself making a blunder which I call 'opening the oven door while the cake is rising'. By this I mean that it is disastrous to conceptualise some part of a process through which the workers may be living at that time. Experience must be realized and symbolized before it can be conceptualized. Premature conceptualization by a consultant can interrupt and possibly stop a process which is dynamic and necessary for the worker's evolvement.

If I accept an introjecting person as an incorporating one I run the risk of supporting a worker who *says* all the right things whilst continuing to go his own way, doing what he has always done. This kind of person stays up half the night talking with a boy, without resentment and without guilt, because it never occurs to him that he is getting pleasure from this himself. The introduction of structure into his work – the realization that a complete experience lasting twenty minutes (with a beginning, a middle and an end) can be therapeutic in a way in which hours of talk may never be – interrupts a well established drift towards collusive pairing, producing fierce resistance. In these circumstances the worker accepts the theory (by word-swallowing) but continues the long drifting talks even though he may now feel that this is delinquent (because this has been demonstrated to him). He continues, but he feels *guilt*. I think this is important to understand: insight will arouse personal guilt in areas where there has been none before. Obviously the worker will be very anxious and resentful, so that I sometimes meet a lot of anger at this point. Equally, the worker may take flight – Richard Balbernie calls this the 'going tomorrow syndrome'. I find that I must be very careful not to surface too much at any time – never more than can be tolerated and incorporated in a gradual way.

Of course there are the more familiar phenomena: envy of me as the consultant, sometimes dealt with by identification with me as a psychotherapist; devaluation of the consultant in which I am played along in a patronising way with everyone being 'nice to me'. There are also accusations against the institution, some of which really are unconsciously directed against me.

I am not doing group therapy, so I leave transference alone and do not make interpretations. Occasionally a worker really needs professional help whilst going through some special difficult experience – he may be very distressed and confused. In this event, I may refer him to his own request to a colleague, usually in London, for a period of psychotherapy. This works well and prevents people using colleagues as therapists. I do myself meet workers alone, usually at their request, to sort out less acute difficulties.

Recently we have added to the therapeutic structuring. It seemed absolutely necessary to assess the amount of ego strength present in any unit, in order to judge what sort of boys could be safety admitted. With the help of others in the Community, we now have a kind of chart which evaluates ego strength in each boy and in the whole group within a unit. Should this strength fall below a specific level, we can know that the unit is at risk.

Syndromes of deprivation are graded in terms of ego strength: for example, a frozen boy scores 1, whilst a caretaker syndrome scores 4. Since we are now in a position from which we can assess the syndromes within any unit, we can also score – roughly – the ego strength. On occasions when the ego-strength drops below the minimum level required the team ego-nucleus has to be drawn on if the unit is to survive. This leads to impoverishment of grown ups and eventually to breakdown. The team can now say, for example, 'We cannot admit a frozen boy when we next have a vacancy – our score would be too low'. We are even learning what combination of such syndromes produces a working group (e.g. there cannot be more than one new frozen boy in a group).

Richard Balbernie, the therapeutic resource people and myself have also evolved a way of scoring communication rating. A communication level of 'A' indicates that the boy is able to talk about himself with real feeling – personally – and about his problems. A level of 'B' would usually be about current affairs in the unit or in the Community. 'C' level would be superficial chatter. A week of communication at 'C' level by a boy, as rated by most people, would suggest a risk of breakdown into acting-out, and would indicate the need for special steps to be taken to reach more real communication.

At present Mike Jinks and I are experimenting with educational need assessments.

To Summarise –

Need assessments provide a basis for planning treatment for the individual boy as well as classifying the particular syndrome of deprivation. *Treatment programmes* cover the twenty-four hours in the daily life of each boy, so that everyone in the unit knows the agreed approach in everyday situations to each boy. *Talking groups* are small groups, meeting with the same adult in the same place, and facilitate communication and lessen the risk of acting out. *Communication rating* makes it possible to judge the current level of communication of the individual and of the group. *Ego scoring* adds up the ego nucleus in any unit in order to make sure that at least the minimal required ego strength is possible. *Therapeutic resource workers* introduce and maintain a therapeutic structure within the management structure of each unit. *Educational need assessments* assess the underlying educational needs in deprived children (for example, problems of perception).

All these techniques help to make staff more aware of what they are doing, more responsible and less likely to project their own inevitable failures on the boys. People now may say, 'we are feeling awful' instead of 'the boys are being terrible'. An example of acceptance of responsibility by workers is the fact that they have gradually grown accustomed to the idea that they must keep notes on any regular sessions with individual boys. These notes are to be available to the consultant and to the group for discussion from time to time. When I first made this requirement it was apparently accepted, but actually by-passed by various means – often on the grounds that there was not enough time available to make notes; and in another case the worker reported what the boys said but none of his own comments!

My aim has been to allow people to experience, to reach realization and to conceptualize; rather than to bog down in panic which is only lit by gleams of

intuition – a state which can force workers to depersonalize and disassociate, as in the Dinosaur subculture.

There are bound to be elements of 'crisis culture' in a community such as the Cotswold, so that 'In the circumstances' can often be used with some validity as an escape from responsibility. However, it seems that the more precise and definite the therapeutic structure, the *less* likely is it to collapse in an emergency: people get into conscious difficulties rather than a collusive muddle, so that they remain responsible for problems, rather than investing collusive muddle in boys.

I have described difficulties but I would not be presenting reality if I did not stress the fact that the workers in the Cotswold Community reach a very high standard of therapeutic work. It used to be supposed by many people that such work could only be carried out by trained psychotherapists already analysed – nothing could be further from the case. Despite the pain of gaining insight, the acute anxiety aroused by accepting responsibility, in the deepest sense, for other people's acting out, the people in the place continue to tolerate a learning process which demands so much of them; and continue to work in a way which calls for respect and admiration. The changes and evolvement in the boys which take place as a result of their efforts can be seen clearer in later need assessments: this gives the workers a satisfaction greater by far than anything they have experienced in the past, because it is not polluted by collusion and subculture.

These people are beginning to prove that the task is not impossible: it remains to be seen whether society can tolerate the realization that change *is* possible in anti-social adolescents – and in themselves.