Reflexive Team Supervision: questioning 'by whose authority'

Abstract

Consultants working in large complex systems face a daunting task. They must address the problem as presented by the client, but in the process they must access the larger organizational context in relation to which the problem is inevitably symptomatic.

Reflexive team supervision is a method in which a shadow consultancy team enables the consultant to engage with the way this larger context shapes problematic behaviour in its attempt to manage anxiety. The aim of the method is to discover how those problematic behaviours are driven by the way 'truth' is being authorized. The shadow team challenges itself to question its own thinking and to experience its own tendency to manage anxiety through ignoring the painful issues and intractable resistance to movement exhibited by the consultant as she intervenes in the client system. The team offers a composite voice through the way it makes sense of its experience, accentuating the impossibility of the situation and making the dilemmas of the case visible as it exposes the lacunae in its own ways of thinking about what is going on. In this way the shadow team becomes a learning system with the consultant by making transparent its difficulties of shared thinking and collaborative hypothesis building.

The methodology of reflexive team supervision combines key elements of group relations conference dynamics and the practices of systemic shadow consultancy. The paper presents a case example of work with a single consultant within the UK's National Health Service. The supervision design, consulting processes and client outcomes associated with the case are discussed and conclusions drawn about the nature of the anxieties confronted.

Introduction

The process described as reflexive team supervision emerged as a means of supporting an independent consultant's learning about leadership and self-authorization in relation to a complex client system. The influences behind the particular approach taken to reflexivity in this paper owe much to Foucault's understanding of discursive practices (1972), placed within the context of a Lacanian understanding of the subject's relation to the unconscious as being fundamentally mediated by the nature of the social (Fink, 1995). The client system is understood as being a social system, and a good account of the importance of the 'social' as constitutive of the context within which to situate reflexive accounts of 'truth' can be found in Hardy et al (2001). Reflexive team supervision is based upon the notion that all learning depends upon reflexive interpretation of one's experience in relation to the experience of others, in the radical sense of being able to call the formation of that relation to others into question (Beck et al, 1994). The supervision team is required to develop the habit of examining its own part in order to enable the consultant to recognize how she is included in the subject matter she is attempting to understand (Holland, 1977). She experiences how her own subjective responses implicate her in the client dilemmas she intends to influence (Campbell et al, 1994).

Overview of reflexive supervision process

Reflexive supervision is a means to support the consultant's discovery of the ways in which power and knowledge are being authorized within a complex organization in order to diagnose the causes of an intractable problem and propose a direction for more adequate intervention. The reflexive team helps the consultant(s) to move beyond the presenting problem by maintaining a position of 'not knowing', paying particular attention to discordant details, and integrating their own feelings and intuitions with emerging knowledge.

This interactive process unfolds because the supervision team has authorized itself to put into question their own assumptions that drive behaviours and reactions to the matrix (i.e. the context of dynamic interactions) formed by the consultant/client system. The team formulates hypotheses about the consultant/client matrix by processing its own confusion and examining the separate voices within the team to identify different aspects of the client system's dynamics. This particular use of parallel process permits the team to join with the consultant in order to create and hold open a space for different meanings to emerge. Both the team and the consultant are committing themselves to take positions that address the hidden benefits being derived from the current organizational structure that sustains problem behavior. In this way the consultant is enabled to formulate potentially useful interventions that can positively connote dynamics so that new structures and behaviors are free to emerge in the organization. New learning becomes available to the client system through the consultant's challenge to develop a leadership style in which she uses herself differently by self-authorizing new behaviours. The supervision team members in turn are challenged to adapt the way they work reflexively to meet the needs of the consultant/client matrix.

Models that explore 'by whose authority'?

The understanding of "authorization" is fundamental to our approach to reflexivity, and we choose the word "sponsor" as a device to explore the question 'by whose authority'? We suggest that intra-psychic dynamics 'sponsor' dysfunctional behaviours in the individual, family patterns of interaction 'sponsor' symptoms in the child, and configurations of vested interest 'sponsor' recurring problems in the organization.

Thus we build on related processes that facilitate exploration of 'by whose authority':

- Psychoanalysis enables an individual to explore how she *sponsors* her own behaviours through attending to the effects of her relation to her own unconscious dynamics, and hence to being the subject of the unconscious (Lacan 1975).
- A group relations conference enables an individual to explore how she sponsors her own behaviours through attending to the effects of her relation to the unconscious dynamics present within the conference system, (a recent account of the emergence of this form of conference can be found in Fraher, 2004).
- Systemic therapy enables the family to recognize how its system of meaning *sponsors* dysfunctional patterns of behaviour by addressing who benefits from these interactions and what alternative means of gratification can be found. This epistemology emerged from the foundations of family therapy (Hoffman 1981).

Reflexive supervision enables the consultant to explore the relationship of the sponsoring system to the problem behaviour demonstrated by the client system. The sponsoring system is here understood as the tacit system of meaning within which acceptable behaviour is constituted, and in terms of which configurations of vested interests can be said to 'sponsor' the problem behaviour. The parallel processes that emerge in the supervising team allow the effects of the sponsoring system to become accessible to the consultant.
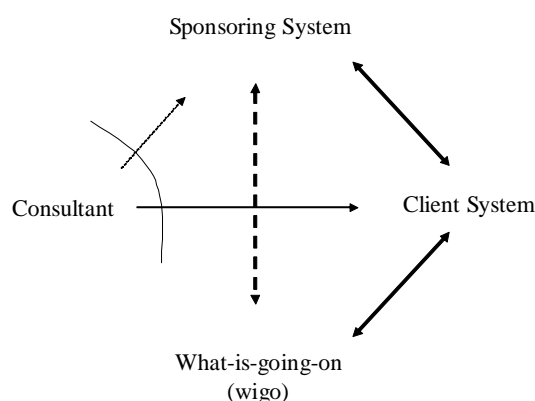

Figure 1: The dynamic relationship between the consultant/client/sponsoring system

The position of the consultant can be thought of as the place from which a *truth* may be articulated in relation to the client system *within* the context of the sponsoring system. In Figure 1, this position of the consultant is shown in relation to a 'circuit'

defined by the relationships between the sponsoring system, the client system and what-is-going-on (wigo). The relation of the consultant to this 'circuit' is derived from a reading of the topology of Freud's Project (1955) by Lacan (1972: pp57-58). In this circuit, the sponsoring system has an implicit relation to 'wigo' manifested in what it chooses to ignore. The organization of the things it chooses to pay attention to are shown by the behaviour of the client system. The consultant's relation to wigo is always mediated by the consultant's relation to the sponsoring and client systems.

The concept of 'sponsoring system' gives us a way of speaking about how power, or the authority to say what is true, produces its effects within a client system. The power of a sponsoring system is understood as the effects of obedience it commands to its particular forms of authorization; this obedience becomes present through the way in which authorization may be taken up by individuals within the system (Foucault 1980). Thus, a reflexive supervision process becomes a means of questioning how power is wielded in a complex organization through questioning the nature of the benefits derived from obedience to the organization's particular ways of understanding what is going on. Specifically, the process questions who gains from accepting this definition of what is taken as being 'true'. In this way we are able to question both how leadership is being and could be authorized in a way that allows it to be distributed.

How is the process organized in this particular case?

The aim of the supervision process is to enable the consultant to make sense of what is going on in relation to herself and her client and sponsoring systems; it serves to punctuate and support the development of her intervention as a whole through the specific use of timing in the way the team delivers interventions to the consultant as the supervision process unfolds. This use of timing is derived from an understanding of timing as 'logical'(Lacan, 1945), and is described below in terms of three stages. The process used a three-person supervision team, with one member of the team taking responsibility for the work of the team as a whole. Three was considered the minimum needed to be able to surface the dynamics of the client system within the parallel process (see Figure 2).
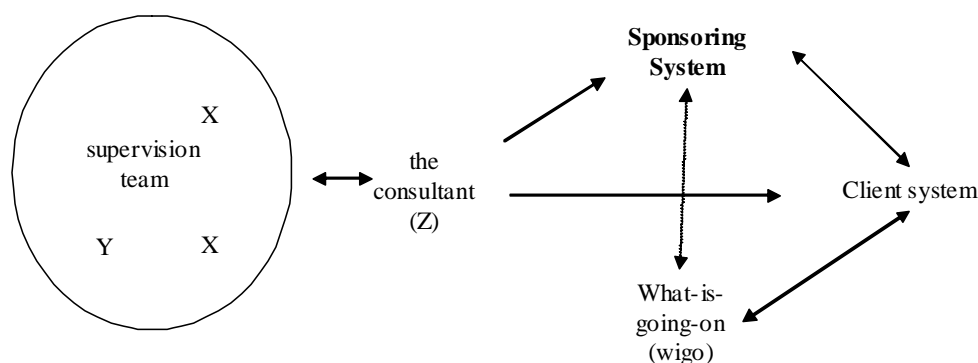

Figure 2: the supervision model

The contract made with the consultant

The initial contracted interactions between this consultant and supervision team are agreed in the following ways:

- The consultant provides a weekly 'split screen' journal reporting on one side what is going on in the client system, including what she is doing, and on the other side, her reflections on her experience, including reactions to the supervision team itself. This is in order to create the conditions for learning (Argyris 1975), but also to sustain the consultant's reflective relationship to her interactions (Schon 1983).
- Responses to this journal are shared via four-way e-mail in which each team member formulates his/her own 'reflection' and replies directly to the consultant in his/her own specific voice. One of the most interesting things we learned was just how effective the use of this medium could be within the context of the process as a whole.
- The supervision team's work is to discover how these different voices reflect different parts of the consultant/client/sponsoring system matrix. Work is done to discover 'what is going on' through face-to-face and e-mail communications between its members. We then provide the consultant with feedback on our own process of making sense in the form of a team intervention.
- Face-to-face meetings between supervisor and consultant are proposed to mark the transition between the three stages of the project. The purpose and method by which we timed our team interventions is elaborated on the following pages.
- It is understood that this is an experiential process and that the format will remain agile enough to meet the situation as it unfolds.

The three stages in the formation of the team intervention

The timing of the team intervention is conceptualised in three stages designed to mark the shifts in how the consultant seeks authorization from the supervision team as her understanding of the client system evolves. These are shifts in how she formulates her intervention, and are based on the notion of three different kinds of time (Lacan, 1978 p288):.
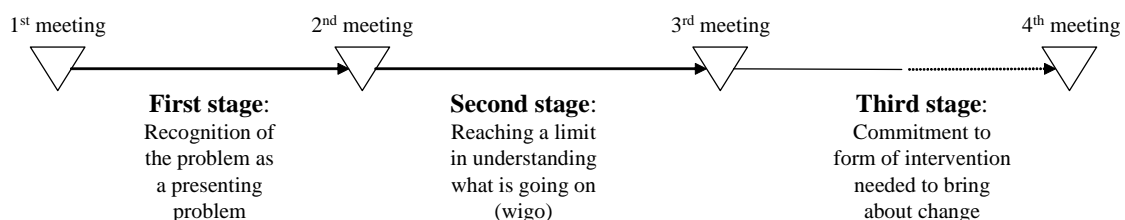
Figure 3: The three stages

- The first stage *ends* when the consultant realises that the presenting problem is a symptom of something more. This is the moment of realising that the 'answer' is not immediately apparent just by looking/asking.
- The second stage e*nds* when the consultant becomes aware that a limit has been reached in being able to understand what is going on; explanation is not sufficient to account for what is driving what is going on. This is the moment of realising that the 'answer' can not be worked out by reasoning alone because the way of thinking is itself a part of the problem.

▪ The third stage s*tarts* when the consultant realises that she must make a commitment to the form of intervention needed to bring about change. This requires that she self-authorizes the taking up of a position from which she can go beyond what she already knows. This is the moment when the subjective position of the consultant herself changes as she realises how she is personally implicated.

In Figure 3 these stages are shown along a time line. The utility of this conceptualisation of beginnings and endings of the stages plays a key role in authorizing the interventions of the supervision team and, ultimately, of the consultant. Each stage ends/begins when the consultant shows signs of reaching an impasse after a period of significant movement. Face to face meetings with the consultant are set up at these pivotal moments. In the particular case presented here, there are three team interventions during the first stage, one during the second, and two during the third. During the course of the third stage, the consultant reaches her 'moment to conclude'(Lacan, 1945). This is the moment where s/he realises that s/he must take action, make a commitment to her position, and deliver her intervention. We think of this 'moment to conclude' as a particular kind of ending that is also a new beginning in the consultant's relationship to herself, to her client, and to the supervision team.

The use of a 'Shadow Consultancy Matrix'

The supervision team drew on its experience with the psychodynamic and systemic approaches described earlier, and built upon the concept of a 'systemic shadow consultancy matrix' as described by Hawkins (1998). This shadow consultancy matrix emerges as a parallel process with the 'consultancy matrix', in each case understood in terms of the dynamic relationships as represented in Figure 1. Systemic shadow consultancy is a method in which:

> "a consultant (or team of consultants) with the help of an experienced shadow-consultant, who is not working with the client, attend to understanding better the client system and themselves as part of the client/consultant system. It focuses on the interconnections between what the consultant(s) need to shift on order to be more successful in themselves, in their relationship with the client system, and in the outcomes achieved. Attention is also paid to what is happening in the parallel process in the Shadow Consultancy system." (Hawkins, 1998)

As Hawkins points out, this method suffers from twin dangers: on the one hand "replicating the unconscious process of the client system", and on the other, "staying aloof and burdening the consultant with the weight of the shadow consultant's wisdom." It was these twin dangers that led us to expand the systemic shadow consultancy model to include the use of a three person reflexive team rather than a single shadow consultant. The agreement the team makes to share the condition of 'not knowing' and the way in which the team makes transparent its own process work against the danger of taking a guru position.

The danger of unconscious replication of the client system processes is coped with by enabling the consultant to recognize and make positive use of this replication through sorting personal feelings from those induced by the client system. The challenge to both the team and the consultant is how to utilise these counter-transferential reactions by putting them back into the system so that they inform and advance the work. The particular advantage of the reflexive team is that it enables a

parallel process to emerge that provides access to the nature of the multi-dimensional sponsoring system. Figure 4 depicts the parallel process between the shadow consultancy matrix, and the consultancy matrix.

Figure 4: the parallel process

In order to work with the parallel process in the shadow consultancy matrix, the team questions its own way of authorizing its own understanding. This questioning is made explicit and apparent to both the consultant and the team members through the inclusion of our multiple voices, which represent how the three team members take up the unconscious dynamics in the sponsoring system according to the valency each one has because of his/her own particular unconscious processes. The relatively heavy use made of the e-mail medium, compared with relatively few face-to-face meetings, gives the timing of these meetings special significance. They are used by the team to mark the stages of the process itself, and are not immediately gratifying for the consultant in the expected sense of providing answers.   An important learning from the process was the effectiveness of the use of e-mails as a medium in which not only to engage each other in dialogue, but also to build a rich and cumulative insight into and appreciation of each other's positions.

An account of a Reflexive Supervision Process

The consultant's commission with the NHS was "to examine the culture and practice of a hospital wing in order to shed light on problems experienced by different groups of the workforce, and on the concerns of senior management to make the wing an attractive and productive environment in which to work". The hospital wing itself provided rehabilitation for elderly patients on a few wards and continuing care on another ward. A key issue that emerged was that a large proportion of patients who were being referred to the wing were not receptive to rehabilitation, or not recoverable, and needed intensive nursing care. The consultant's struggle was to find a focus that enabled her to get a larger systemic view of her client system and sponsoring system that would include senior management in her conceptualisation of the problematic issues. The dilemma was that when patients' needs did not fit the primary task of rehabilitation, the systemic anxiety increased.

The following account of each stage is meant to give the flavour of the process as it actually unfolded. The indented comments in italics relate to the parallel process of the supervision team. In this first stage, she focussed on the 'blame culture' that located the problem in the non-professional behavior exhibited by the nursing staff,

and the parallel process between the shadow and consulting matrices began to develop, although it was not yet visible to the team who were immersed in it.

The 1st stage: In which everyone gets interviewed and the sponsoring system remains hidden.

1st meeting with Consultant. The supervision method is proposed.

Team agrees on structure/method

Contract letters exchanged - consultant rushes into acceptance without really understanding and questioning.

Team doesn't notice acceptance came too easily. Begins to feel discomfort, doesn't know what isn't being understood

Consultant has meetings with client system. Conducts many interviews, but leaves her own responses out of journal descriptions

Team members send clarifying questions directly on receipt of split-screen journal. We send a lot of questions- her lack of focus is visible and the difficulties of her approach become apparent.

Consultant is too quick to assume she sees real problem and can act on it – doesn't notice paradoxes in desire of senior managers who don't feel implicated in problem

Team tries to review concepts of timing, hypotheses, intervention, but she ignores and blocks us from being useful – the parallel process has begun and we are all in the dark and feeling disquieted. We begin to question our own responses

Consultant expresses her anxiety: feels alone, angry, and hopeless. She is over identified with nurses who have great responsibility and get blamed. Sees senior managers as bullies

Team members take up different anxieties in the system: fear for peril of female position, responsibility without authority; frustration at absence of messiness, no patients mentioned; nervousness at lack of focus -who is her client and who is her sponsor?

Consultant observes double bind experienced by nurses: "while managers moan about front line staff not taking responsibility, they require them to report all incidents, creating an impossibility; managers don't see their impact"

Team notes the parallel messages:we say take responsibility, but demands she tell us everything,

Consultant expresses her determination "I may be bloody minded", but I believe something meaningful will emerge from understanding.

Team takes her determination to understand at a deeper level as the signal to deliver a major intervention in order to move the work on to the next stage. This addresses the challenges required to shift to the 'real problem' on a systemic level and includes inviting her to request a face to face meeting.

Essentially, the important team intervention that marked the end of the first stage represented a refusal to provide a direct answer to her dilemma, that is, a refusal to be the 'ones who knew'. The effect of this refusal was to encourage her to own the problem of coming to an understanding of underlying issues.

The following text is excerpted from the formal team intervention and it is paradoxical in nature:

About our sense of your process:
- It is not apparent who your client is. If your client is actually the system that includes the commissioning manager, then we can't tell who or what is the sponsoring system. Specifically, what interests are being served through the symptomatic behaviour of the nursing staff? This is a major gap for us.
- Your process strikes us as being highly symptomatic of behaviour within the larger system. For example, it is as though you face a choice between a 'laying down the law' approach to resolving issues, or the night nurse's position (take the money, and sleep on the job while putting real energy elsewhere).

About our own process:

- The barrage of questioning to which you have been exposed is itself symptomatic of a leadership that is absent from the larger system.
- Leadership is not recognising the dilemmas confronting managers and staff and how these dilemmas are to be managed in a way that coordinates the actions of the individuals in the system.

So what is going on?

- The non-professional behaviour of the nursing staff conceals an impossibility in the nature of the Wing's work. We think this has to do with a patient group that is confronting the impossibilities of recovery within the context of effective professional endeavour.

So what is to be done if we are to proceed?

- We cannot proceed with this process (a) with the client as currently conceived by you, and (b) without some explicit ownership of the timing of your task
- The commissioning manager would have to address the invisible (to us) place of her sponsoring system.

The consultant was being challenged to move beyond elaborating the nurses' behaviour to addressing the nature of the client system in which it was embedded. The consultant's difficulty in doing this was reflected in her lack of focus on the nature and role of the sponsoring system. We later learned that this refusal to identify her sponsoring system was in itself a repetition of the commissioning manager's refusal to inform her boss that the consultation was actually taking place. In a continuing parallel process, the nature of the consultant's contract was being kept secret from the supervising team. We were all feeling the effects of working within a system where information was withheld and leadership could not be trusted to provide adequate support.

The 2nd stage: In which the client system is reframed and the sponsoring system begins to emerge.

2nd meeting with Consultant.

> *Report on 2nd face to face meeting with the consultant and team leader: "unpacked ideas of timing and of client/sponsor distinction. She understood that what was happening in relation to us was very like what was going on in relation to client system."*

Communications from consultant stop for almost one month. She conducts more interviews with staff, collecting complaints, but is unable to find a focus. She is still over identified with nurses who get blamed. Then Consultant begins to share more of her own thoughts: "managers need to have more contact with front line staff, but need help themselves in overcoming fears of being criticised. Team leader's role undermines authority of ward managers"

> *Team is frustrated by lack of material, no formulation of systemic hypotheses, sense of things being withheld from us, and feeling bored. We leave her floundering by not confronting her as she doesn't confront her commissioning manager.*

Consultant reports severe personal distress, recognizes much is induced by client system, spends time to sort personal from system induced reactions.

> *Team leader makes intervention to team on immobilisation of its own process: "alliance between ourselves is not working in same way alliance between herself and us is not working etc. Notes feeling of having 'given up'.*

Almost simultaneously, consultant produces journal which indicates that she is now meeting with commissioning manager, and notes that the "important task is to decide what is the purpose of this wing and to discuss referral process of patients ". She is anxious that "this will be controversial with the doctors", and is suffering insomnia. She goes on holiday.

> *Team agrees to make its process more transparent to consultant by more direct responses and by rotating team member at face to face meetings. Team note sent to consultant about our own work; we call the moment for 3rd meeting. This meeting was signaled by consultant's recognition that her intervention was going to have to look at the functioning of the larger system, including the doctor's responsibility; and that this perspective will cause a disturbance to the current functioning of the system.*

The team changed the structure of it's interactions with the consultant during this second stage as a result of the examination of its own process. The internal team intervention captured a moment in which the team challenged its own functioning as it mirrored the disturbance experienced by the consultant. We recognized that it was necessary to reorganize ourselves in order to create a discontinuity that emphasized this disturbance. We made a team intervention to mark the limit of the consultant's rational understanding and to force a shift to the final stage in this current cycle of her work; this final stage began with the realization that something new had to happen to move forward. The separate voices of the team members were accentuated by simultaneously sending individual commentary on the process as it was being experienced by the consultant and by announcing a rotation of the team member who would participate in face to face meetings. The third face to face meeting confronted the consultant with the need to formulate a systemic hypothesis.

The 3rd stage: In which the team gets to say what it thinks, and the consultant discovers where she stands

The third face to face meeting consolidates the shift in the level at which the consultant is making sense of the client system, and reveals further depths to the nature of the question concerning the sponsoring system.

Team questions hypothesising about different level of system versus hypothesising about why the system at that level is as it is...

The consultant makes a huge effort to understand the dynamics for herself and struggles to formulate a hypothesis; she requests a different kind of help from the team. She needs recognition of her progress and confirmation of the validity of her findings, and we provide her with this, but at the same time challenge the continued absence of a true systemic hypothesis. She is not able to reveal the client system's subjective investment in the current organization of hospital functioning. Consultant asks for more support and individual team members respond simultaneously

Consultant receives final team intervention: We think you have done an excellent job of establishing a critical perspective on wigo, but your concerns about whether or not this is just shifting the problem onto the managers is very appropriate. There is a sense in which what we have is a description of wigo, but not a hypothesis. Thus you say:

- *The management is acting as if the hospital Wing's primary task is to relieve pressure on acute beds nearby.*
- *There is almost no assessment of patients' needs at the boundary of the system.*
- *Discharges become delayed as many patients are waiting for nursing homes or full social care packages, which are expensive and take months to prepare.*
- *The anxiety of senior staff about their own role, and, in particular their anxiety about their ability to meet the needs of patients, has led them to withdraw from the painful aspects of direct care.*

So we have a hypothesis about why the nurses' behaviour is symptomatic of their context, but do we have one about why the context itself is as it is?

This brings us to the question of what constitutes an adequate hypothesis. A hypothesis is about the way a system 'refuses' to address a dilemma it faces, instead suppressing it in a way that provides secondary gains for those in the system. This raises the questions: what is the 'system' we are dealing with, and who is gaining from its current formation? But bearing this in mind, a hypothesis also carries with it an implied proposal for change.

So your concerns about not just shifting the problem onto the managers becomes the difficulty of addressing the valency between the way the existing system is running and everyone's pleasure/pain investment in it continuing in that way.... in its context (defined in relation to the sponsoring system) as well as in the client system itself.

Hence the possible intervention that positively connotes everyone's positions by saying that "nobody should be accepted onto the ward without an agreed plan for how they should leave it." The failure of the system to create the conditions in which this happens creates the very

> *situation that you have described so vividly.*
>
> Consultant uses the insights from team process, and reports back that the commissioning manager is beginning to engage with the larger system boundaries. However, she is very frightened of confronting her boss and uncovering the extent of bullying at more senior levels. The consultant proposes that she meet with this manager to help her determine how to involve higher level senior managers as a part of the intervention.
>
> *Team sends Consultant recognition that the current cycle of work is at an end, and new cycle is starting. She is invited to request her final review meeting.*

The third stage was started by the consultant's realization that she was now challenged to take a different kind of position in relationship to her client/sponsoring system. The dilemma she was facing appeared to be that she was protecting both herself and her client from having to question their own investment in accepting the truths they were acting upon. The team's commitment to make sense of its own responses to the consultant required that we reflect back these responses in the form of an intervention that she could use. This was a key moment for the process as new learning emerged.

The team intervention included the offering of a framework for conceptualizing and clarifying wigo, key to which was the idea of a 'Faustian pact'. This was based on N-S and E-W models of the enterprise (Boxer, 2004), in which the N-S axis was concerned with control, while the E-W axis was concerned with the appropriateness of the response to the demand. (see Figure 5) This distinction between N-S and E-W dominance can be understood as the difference between rule-based and trust-based organization (Atkinson and Moffat, 2005), in which the Faustian pact represented the splitting of these two bases of authorization, so that the latter basis becomes purely informal.
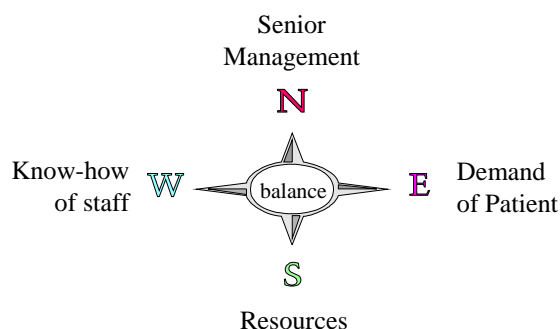

Figure 5: The axes of authorization the enterprise

The hospital was a N-S dominant system, in which senior management set things up 'as if' the hospital's primary task of rehabilitation was possible to fulfil by following its policies and procedures, and then said to staff: "do whatever you want for the patients as long as you satisfy these rules about how you interact with us." Staff were therefore free to develop whatever E-W informal systems worked for them as long as problems did not come to the attention of the public or otherwise cause a disturbance. The nurses were in direct contact with patients who could not be rehabilitated, and when the internal system for providing lower levels of care became overwhelmed, the problem emerged in the form of 'unprofessional behaviour'. The pact was 'Faustian' because there was a fundamental disconnect here between the two axes, which made the system as a whole unmanageable.

An E-W dominant system would have reversed this, asking what needed to be delivered to the patient based on individual needs, and then setting up a N-S context

that could support it, or else agreeing a different understanding of what could be delivered. The Faustian pact was therefore a way of understanding how a N-S dominant enterprise coped with E-W complexity without having to address it explicitly. For example, a doctor could 'buy' clinical autonomy by agreeing to give the N-S system the statistics it wanted. In this way the system postponed facing the challenge of E-W dominance and did not have to change its structures or confront the anxieties behind the way it was organized. By challenging what the consultant understood to be a hypothesis in the third meeting, she was encouraged to confront her own ethical dilemma.

The ethical challenge of the case

The issue that the hospital wing needed to address would represent a significant change in structure that could unite its primary task with the way it actually delivered its service to patients. The consultant faced a choice that required an ethical decision: if she pointed out the impossibility of resolving the nurses' 'unprofessional behaviour' without addressing the issue of patients' needs for appropriate placement, she risked being excluded from an 'authorized' consultant role, that is, she risked displeasure and confrontation with the powers that be. However, if she didn't, she colluded with the way the system ignored this issue, with its attendant physical symptoms, depression and the desire to flee that were rampant among the hospital staff.   In essence, if she failed to self authorize and deliver her intervention in such a way that it was useful and possible for the system to address, she was not responsibly meeting the commitment to her own work. Her ethical challenge paralleled that facing the client/sponsoring system in 'outing' its faustian pact.

The fourth face to face meeting with the consultant reviewed the process of this work cycle and re-framed the direction that future work might take. The issues addressed included the parallel consultant/client anxieties experienced also in the supervision team: fear of losing control, fear of revealing incompetence, fear of having dependency needs exposed. Of course, these were also the anxieties of the patient population on this hospital wing. This meeting took place after the cycle of work contracted with the team had ended. A new work cycle that emphasised possibilities for including senior managers in the continuing process was explored and the consultant was left to decide how she would use her awareness to carry her intervention into the sponsoring system during the hours she had remaining on her own commission with the hospital.

Two months later, the consultant sent her final report to her client with a copy to the team and a note that indicated her efforts to encourage her client to set up a working group which included senior level managers to discuss the issue of re-defining the primary function of the wards and to review the admission of patients from local hospitals. Her note provided evidence that she was using her own feelings to inform her thinking and had repositioned herself with her client such that she recognized the continuing parallel process in her anxieties about being exposed through this report; and she acknowledged her ambivalence and fear of confrontation. However, she was able to give her client needed space and to empathize without over identifying. The note ended with the words "I feel on a huge learning curve…"

Comparison with other reflexive models

This reflexive methodology has brought together the ethos of psychoanalytic supervision, family therapy supervision and group relations conference methods of learning to build a particular form of systemic shadow consultancy matrix that enables the consultant(s) to explore the complexity of the vested interests that exercise power in a complex organization. For example, the shadow consulting team offers a composite voice in the form of a hypothesis about the dilemmas experienced within the consulting matrix. The team does this by confronting its own projections and counter-transferential reactions and uses this work to provide feedback to the consultant. This has the effect of accentuating the impossibilities in the structure of the client system and the larger dilemmas exposed by these impossibilities. The parallel processes within the supervision team support the consultant's learning about the senior management within its context. This builds upon the systemic family therapy ethos of looking at the context of previous generations to determine what 'truths' are being enacted in the form of symptoms.

The team supervision process is also enabling the mirroring of system-wide anxieties within the consultancy matrix associated with the way the sponsoring system manages that anxiety. The team does this through its absorption of a complicated set of feelings, through its integration of those feelings with awareness of team members' valency for attracting those responses, and through its capacity to use this recognition to act within the shadow consultancy matrix. This is the group relations conference ethos, with underpinning in the understanding of psychodynamics and commitment to the supervision team transparency in its formation of large system thinking and hypothesis building. The challenge for the reflexive team is to simultaneously work on the effects of the consulting matrix and on its own dynamics. It is this circular relationship, in which the team confronts its own dynamics as the context for its work in relation to the consulting matrix, which makes the supervision process reflexive.

The particular form this circularity takes in a reflexive team contains elements of other forms of reflexive approach, but brings them together in a way that is importantly different in its relation to the wigo of the client system .

- In the case of systemic family supervision, the focus is entirely 'outwards' towards the consultant and her interactions with the family. All of the family system is made present to the supervising team, but no attention is directed towards the dynamics of the team 'behind the mirror' other than to ensure that personal considerations are kept out of it, unless for training purposes (e.g. McGoldrick, 1982).

- Group relations conference processes are also set up in such a way that all of the interactions within the system are present within the conference boundary; in this case the processes of both staff and conference participants are relevant and material to understanding what is going on, but there is in addition an explicit psychodynamic dimension to the relationship between them. (Armstrong 2005).

- Psychodynamic supervision works with this dimension too, except that the supervisee's client is not present, and of course supervision has an exclusively personal focus, even though different levels of transference interpretation may implicate more and more of the supervisee's context (Roth, 2004).

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The reflexive team makes use of systemic understanding within the same group relations conference ethos, but is like psychodynamic supervision in that it only works with the consultant/analyst and never directly with her client. The dynamics of the actual client system become apparent indirectly through the parallel processes within the supervision team and its interactions with the consultant. This underlines the way the team sponsors its own understanding in the way it makes sense of what is or is not 'parallel', which in turn depends on how it takes up its own ethical dilemmas.

Discussion

Psychoanalytically informed approaches to interventions in organizations use counter-transferential responses to the client system to discover how truth is being authorized. This authorization flows from the way the organization as a social system can defend its workers against the unconscious anxieties inherent in their work (for examples of this approach see Obholzer & Roberts, 1994). Thus the person's relationship to their role within a hierarchy provides a means of limiting that individual's personal anxiety, that is, the individual uses their role within that hierarchy as a defence against anxiety (Menzies Lyth, 1988). Looked at from the point of view of the organization, however, the hierarchy is also providing the organization with the means of preventing that which it anticipates as being 'traumatic', that is, capable of overwhelming the system on which it impinges.

The case example concerns a hospital ward whose primary task is the rehabilitation of elderly patients, to enable them to return to the community. The hospital ward can also be said to be intent upon preventing the untimely death of its patients, so that we can speak not only of the organization's primary task of rehabilitation, but also of its primary risk of failing to prevent death (Hirschhorn, 1997). Primary risk is defined as "the risk of choosing the wrong primary task, that is, a task that ultimately cannot be managed" (ibid, p3). This unmanageable task is an anticipated trauma for the organization which it must seek to prevent. In this case, if the patient population becomes too old and ill to benefit from rehabilitation, the hospital ward may be confronted by its primary risk.

The effects of anxiety on the authorization of what is taken to be 'true'

By considering the organization as an 'organizational object' in its own right, rather than simply as a construction of those working within it (Armstrong 2004, p22) it becomes possible to speak of the organization's defences against being overwhelmed by trauma. The organization becomes *secondarily* the individuals' defences against their own personal anxiety, and *primarily* a defence against the anxiety associated with failing to manage its primary risk. Increasingly, the nature of the organization's social system is becoming such that authority is "continuously negotiated in relation to the current task" (Cooper and Dartington 2004, p146). Authorization becomes more problematic, requiring leadership to be distributed. However:

> "Without a clear and shared idea of the organization and how it is defining itself in relation to its context, what it is seeking to achieve, how it frames its practice, and the values that inform this, its standards of excellence, and the competencies that underlie these, distributed leadership will be prone to fragmentation and/or the dynamics of conflict and evasion…" (Huffington, James and Armstrong 2004, p80)

Distributed leadership has to be able to make sense of the organization's work in such a way that it can manage the primary risks the organization faces as a whole, while at the same time providing the needed containment of individuals' personal anxiety. The issue becomes one of how this 'sense' is to be made, and can be approached through the use of a reflexive supervision/consultation model.

Conclusion

In this reflexive model the task systems that constitute what the organization does are considered to be the client system, but the particular way in which this client system is organized in relation to primary risk is designated by its relationship to its 'sponsoring system'. It is this sponsoring system that has built into it assumptions about what is and is not relevant to the way the organization is allowed to function. The sponsoring system is the particular way the organization seeks to manage primary risk.

The work of the reflexive supervision team involves each member committing to the learning process through a willingness to put their own assumptions in question, to tolerate the anxiety of not knowing, and to bear the uncertainty and risk of their own position within the process. In this way, the team discovers what is or is not being authorized in the client sponsoring system through the way its own shadow sponsoring system emerges. To do this, team members have to utilise their counter-transferential responses to reorganize their thinking and to create systemic hypotheses that can move forward the consultant's learning. Thus, the supervision team has to be dedicated to the consultant's learning and transformation process, and to making their own learning processes transparent to the consultant in a way that enables the consultant to retain their responsibility for delivering to the client system.

The value of a reflexive team approach is as a learning system that generates insights at the formative stage of a project, and at later stages surfaces the learning within the shadow consulting matrix through making sense of crises and/or key turning points in the project's development. This learning is expected to go beyond what the consultant and supervision team already know, involving a creative act that introduces the dilemma of taking a position that can challenge the 'as if truth' that is driving the client system. As such, a strong working alliance is needed between the consultant and the supervising team if they are to face the messiness of uncertainty and the surfacing of impossibilities which will disrupt comfortable associations in the pursuit of change.

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The Authors

Philip Boxer is an independent consultant working as a strategy analyst with organizations in the voluntary, public and private sectors. He is a Council Member of the Tavistock Institute and Associate Member of the Centre for Freudian Analysis and Research, his research interests focusing on the nature of leadership 'at the edge', asymmetric demand and organizational agility.

Carole Eigen, PhD practices as a psychologist specialising in role consultation and group dynamics. She is Vice President of Bridgewater Professional Associates and former clinical director of the doctoral program in Family Therapy at Seton Hall University, NJ. She was a member of the Orientation Committee, International Forum for Social Innovation, Paris, France, and designs leadership learning systems that provide training and supervision for consultants and systemic therapists.