Reflexive Team Supervision: questioning ‘by whose authority’

by

Philip Boxer and Carole Eigen, PhD

Abstract

Consultants working in large complex systems, for example the NHS, face a daunting task. They must address the problem as presented, but in the process of so doing, they must also address the 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 these issues by utilising the way s/he functions in relation to the consultant-client system. The shadow team challenges itself to question its own thinking and to experience its own tendency to avoid anxiety through ignoring the painful issues and intractable resistance to movement exhibited by the consultant as s/he intervenes in the client system. It offers a composite voice through its circular questioning, paradoxical intervention and systemic hypotheses. As a result, the impossibility of the situation is accentuated and the dilemmas of the case are made visible as it exposes the lacunae in its own ways of thinking and knowing that which is to be taken as being true. The shadow team, in making its difficulties of large system thinking and hypothesis building transparent in this way, thereby makes its learning available for use by the consultant.

The methodology of reflexive team supervision combines key elements of working conference dynamics and the practices of systemic shadow consultancy to explore the ways in which problems experienced in the client system are being authorized. The paper will present a case example of work within the NHS, discuss the supervision design, consulting processes and client outcomes associated with the case, and draw conclusions about its impact.

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Introduction

The process described as reflexive team supervision emerged as a means of supporting an independent consultant's learning about leadership and self-authorisation in relation to a complex client system. It is based upon the notion that all learning depends upon the reflexive interpretation of one's experience together with the experience of others. The supervision team is required to develop the habit of examining its own part in order to enable the consultant to recognize how s/he is included in the subject matter s/he is attempting to understand (Holland, 1977). She experiences how her own subjective responses implicate her in the client dilemmas s/he intends to influence (Campbell et al, 1994).

Consider the challenge one faces as an outside consultant who has been granted a contract to solve a problem within a complex client organization. It is safe to assume that there will be widespread recognition within the client organization that the identified problem exists, and that many people have already tried to solve it, even though it keeps recurring. The consultant must find a position somewhere between confronting the behemoth system that has been operating in this way for so long, and being absorbed into the organization's accepted ways of doing things that are influencing the maintenance of these intractable problems. These 'ways of doing things' impact on the behaviours of the employees themselves and must be identified and linked to the 'powers that be' that ultimately authorise the repetition of these dynamics.

Overview of the reflexive supervision process

Reflexive supervision is a means to discover 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 process helps the consultant(s) to move beyond the presenting problem by maintaining a position of 'not knowing' that allows new discoveries to be made. The consultant(s) are enabled to put their own assumptions into question, pay particular attention to discordant details, and integrate their own feelings and intuitions with emerging knowledge.

This interactive process unfolds because the supervision team has authorized itself to put into question the assumptions that drive its behaviours and reactions to the matrix 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 a position that addresses the hidden benefits being derived from the current organizational structure that sustains problem behavior. In this way the consultant is enabled to formulate a potentially useful intervention that can positively connote dynamics so that new behaviors are free to emerge in the organization. Concurrently, new learning is available to the client system, the consultant and the supervision team members.

Models that explore ‘by whose authority’?

The understanding of “authorization” is fundamental to this reflexive approach. In order to specify our meaning, we choose the word “sponsor” as a device to explore the question of ‘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 s/he *sponsors* her own behaviours through attending to the effects of her relation to her own unconscious dynamics
- A working conference enables an individual to explore how s/he sponsors her own behaviours through attending to the effects of her relation to the unconscious dynamics present within the conference system
- 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
- Reflexive supervision enables the consultant to explore how the *sponsoring system*, that is, the configurations of vested interests, *sponsors* the problem behaviour demonstrated in the client system. The parallel processes that emerge in the supervising team allow the effects of the sponsoring system to become accessible to the consultant.

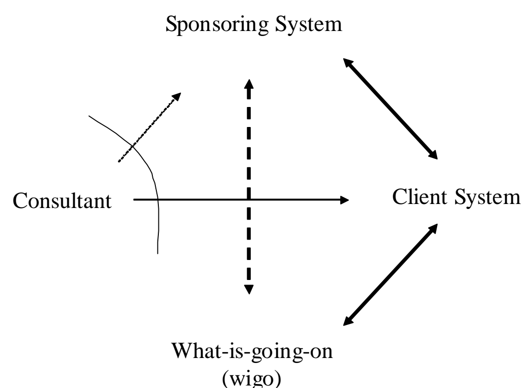

Figure 1: The dynamic relationship between the consultant/client/sponsoring system

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 (see Figure 1). Psychoanalytically informed settings use counter-transferential responses to the client system to discover how truth is being authorized. This use of 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 this

authorization may be taken up by individuals within the system. Thus, the 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'.

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 trough the specific use of timing in the way the team delivers interventions to the consultant as the supervision process unfolds. This process uses a three-person supervision team, with one member of the team taking responsibility for the work of the team as a whole. Three is considered the minimum needed to be able to surface the dynamics of the client system within the parallel process (see Figure 2).

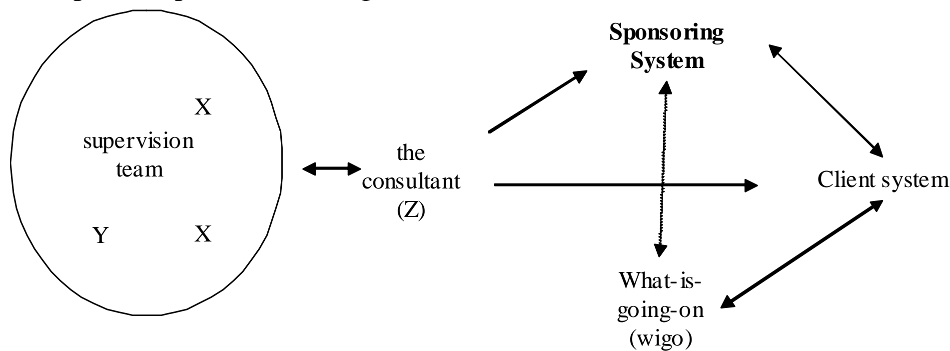

Figure 2: the supervision model

The 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.
- 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.
- 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 stages of the project. The initial meeting is to evaluate the consultant's readiness to participate in the process and agree to the initial

contract; the second meeting indicates her readiness to begin formulating hypotheses about the 'real problem', after she has established the 'presenting problem; the third meeting signals readiness to formulate her intervention in the light of her understanding of the 'real problem'; and the last meeting occurs when she is ready to evaluate the process as a whole.

- It is understood that this is an experiential process and the format will remain agile enough to meet the situation as it unfolds.

The three stages in the formation of the intervention

The timing of the 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. She moves through three stages in formulating her intervention: Is the problem immediately obvious? Can she work out what the problem is? What does it require of her?

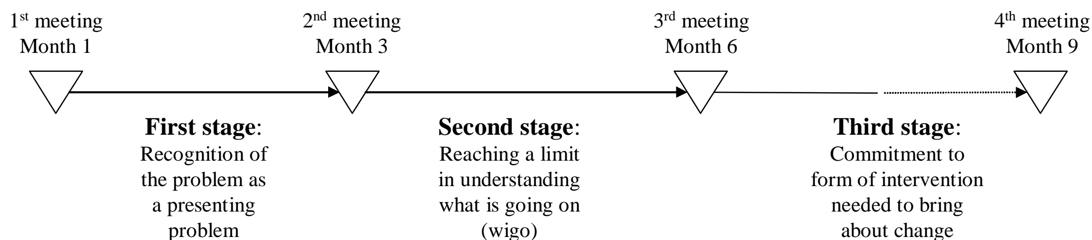

Figure 3: The three stages

- The first stage *ends* when the consultant realises that the presenting problem is just that; it is a symptom of something more.
- 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.
- 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.

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'. 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.

What is the reflexive supervision method?

The supervision team drew on its experience with the modalities described earlier, and built upon the concept of a 'systemic shadow consultancy matrix' as described by Hawkins (1998). Systemic shadow consultancy is a process 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: to be successful in themselves; in their relationship with the client system; and in order to be more successful. Attention is also paid to what is happening in the parallel process in the Shadow Consultancy system."

As Hawkins points out, this process 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 its 'not knowing' and the way it models 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.

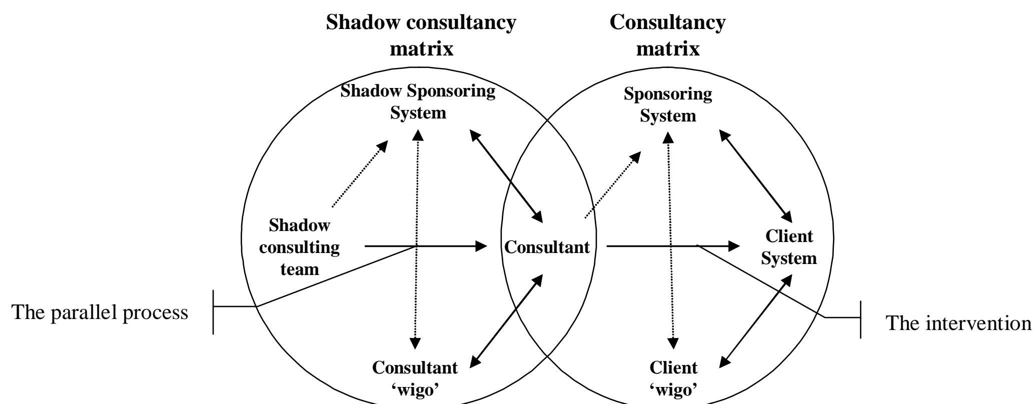

Figure 4: the parallel process

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 multiple voices, as well as through the relatively heavy use made of the e-mail medium, compared with relatively few face-to-face meetings. This gives the timing of

face to face meetings special significance, as 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.

To summarise, the work of the 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 can discover 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 reorganise 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.

So what actually happened?

The consultant's commission with the NHS is "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 is that a large proportion of patients who are referred to the wing are not receptive to rehabilitation, or not recoverable, and need intensive nursing care. The consultant's struggle is to find a focus that enables her to get a larger systemic view of her client and sponsoring system that would include senior management in her conceptualisation of the problematic issues. In the first stage, she focuses on the 'blame culture' that locates the problem in the non-professional behavior exhibited by the nursing staff.

The following account of each stage is meant to give the flavour of the process as it actually unfolds. The indented comments in italics relate to the parallel process of the supervision team. In this first stage the parallel process between the shadow and consulting matrices begins to develop, although it is not yet visible to the team who are 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: it says take responsibility, but demands she tell it 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 marks the end of the first stage represents a refusal to provide a direct answer to her dilemma, that is, a refusal to be the 'ones who know'. The effect of this refusal is 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 is being challenged to move beyond elaborating the nurses' behaviour to addressing the nature of the client system in which it is 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 are all feeling the effects of working within a system where information is withheld and leadership cannot 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 internal intervention on immobilisation of our 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 changes 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 challenges its own functioning as it mirrors the disturbance experienced by the consultant. We recognize that it is necessary to reorganize ourselves in order to create a discontinuity that emphasizes this disturbance; we make 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 begins with the realization that something new must happen to move forward. The separate voices of the team members are accentuated by simultaneously sending individual commentary on the process as it is being experienced by the consultant and by announcing a rotation of the team member who will participate in face to face meetings. The third face to face meeting confronts 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 described in detail below.*

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 is started by the consultant's realization that she is now challenged to take a different kind of position in relationship to her client/sponsoring system. The dilemma she is facing appears to be that she is protecting both herself and her client from having to question their own investment in accepting the truths they are acting upon. The team's commitment to make sense of its own responses to the consultant requires that we reflect back these responses in a form that she can use. By challenging what the consultant understood to be a hypothesis in the third meeting, she is encouraged to confront her own ethical dilemma. Here is the team intervention, repeated verbatim:

> 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 etc 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. If we include the context in this, then it also raises the question of what is the 'system' we are dealing with, and therefore of who is gaining from its current formation. But bearing this in mind, a hypothesis also carries with it an implied proposal for change which has a number of characteristics. To summarise:

A hypothesis describes:		In this case:
A	The way in which a dilemma is suppressed; and	A: Faustian pact separates E-W realities from N-S pogroms[1]
B	The way this suppression provides secondary gains to those involved	B: Everyone gets to complain that it is not possible to do anything
C	… which is also a proposal for change	C: By 'calling' the pact, management and staff can ally around a common 'cause' that "nobody should be accepted onto the ward without an agreed plan for how they should leave it."

As a result, a hypothesis also provides direction for change which:		Thus if the Faustian pact is 'called', then a number of consequences for change can follow:
1	Is grounded in the specifics of wigo in the system	1. To meet needs means agreeing what it is possible to do
2	Can connect with where there is energy in the system	2. Everyone wants to contribute to outcomes that are wanted, and without such a policy in place, a Faustian pact becomes inevitable
3	Builds on the existing capabilities and competencies of the system	3. This is what the system is there for
4	Addresses the demands being placed on the system	4. It is impossible for the larger care system to refuse such a policy, since that is what it is there for
5	Makes it possible to hold 1-4 in relation to each other in a way that is balanced.	5. This becomes what senior staff are there for – to create the conditions in which the work on the ward can be aligned to outcomes

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."

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[1] Just to 'unpack' this: North = senior management; South = the resources under the control of North; East = the demands of the patients; West = the know-how of staff in how they respond to East. In a N-S dominant system, senior management set things up, and then say to staff: "do whatever you want for the patients as long as you satisfy these rules about how you interact with us." Staff are therefore free to develop whatever informal systems work for them. The pact is Faustian because there is a fundamental disconnect here in both directions, which makes the system as a whole unmanageable.

An E-W dominant system reverses this, asking what is needed to deliver to the patient E-W, and then sets up a N-S context that can support it – or agreeing a different understanding of what can be delivered. (see Boxer (2003) for a fuller exposition of the implications of the Faustian Pact.)

> The failure of the system to create the conditions in which this happens creates the very situation that you have described so vividly.
>
> Q. What is the evidence for the collusion/existence of a Faustian pact currently?
>
> A. The fact that the intervention is itself a secret – a part of the informal system running E-W in a way that is disconnected/uncoupled from the N-S.
>
> Q. What should you be doing?
>
> A. Unless you address both axes, you are part of the problem, by addressing the E-W issues without addressing their 'cause' in the relation to N-S.
>
> Q. How can we help you take up this position?
>
> A. We can't – you have to 'help yourself'.
>
> Q. How do we avoid a de facto Faustian pact with you?
>
> A. We include you in our thinking, and let you choose what to do with it.

The issue the hospital wing needs to address represents a significant change in structure that would unite its purpose with the way it actually delivers its service to patients. The consultant faces a choice that requires an ethical decision: if she points out the impossibility of solving the real problem without addressing the issue of patients' needs for appropriate placement, she risks being excluded from an 'authorized' consultant role, that is, she risks displeasure and confrontation with the powers that be. However, if she doesn't, she colludes with the way the system ignores this issue, with its attendant physical symptoms, depression and the desire to flee that is rampant among the hospital staff. In essence, if she fails to self authorize and deliver her intervention in such a way that it is useful and possible for the system to address, she is not responsibly meeting the commitment to her own work.

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 include 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 are also the anxieties of the patient population on this hospital wing. This meeting takes place after the cycle of work contracted with the team has ended. Possibilities for including senior managers in the continuing process were explored and the consultant is left to decide how she will use her awareness to carry her intervention into the sponsoring system during the hours she has 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 includes 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 provides evidence that she is using her own feelings to inform her thinking and has repositioned herself with her client such that she recognizes the continuing parallel process in her anxieties about being exposed through this report; she acknowledges her ambivalence and fear of confrontation. However, she is able to give her client needed space and empathize without over identifying. The note ends with the words "I feel on a huge learning curve…"

What makes this process reflexive? : Comparison of the models that explore 'by whose authority'

Further exploration of the theoretical frameworks from which this process derives its authenticity, challenges us to question the reflexive nature of our process. This methodology combines the ethos of psychoanalytic supervision, family therapy supervision and working 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 upper management and/or sponsoring systems within the client system. This builds upon the systemic family therapy ethos of looking upward to senior generations to determine what 'truths' are being enacted in the form of symptoms.

The team supervision process is also enabling identification of system-wide anxieties within the consultancy matrix. 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 working 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 on its own dynamics. It is this circular relationship, between working on the team's dynamics as the context for its work in relation to the consulting matrix, which makes the supervision process reflexive.

Clarifying the circular relationship that underlies reflexive models

The particular circularity of the reflexive team approach is visible through noticing the similarities and differences in the supervisory/staff system (S) and consultant system (C) focus for each training model (see Figure 5). In the case of systemic family supervision, the focus is entirely 'outwards' towards the consultant and her interactions with the family. 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, but all of the family system is made present to the supervising team. Working 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. The fundamental difference in the reflexive team supervision model is that the consultant-client matrix is never made present directly to the supervising team.

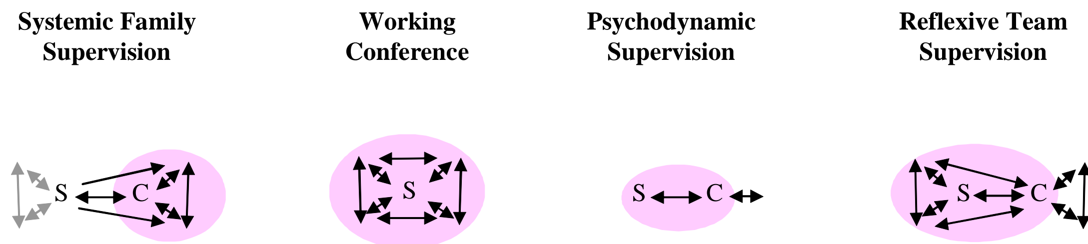

Figure 5: the different focus for each model

This helps us understand why this method of team supervision is particularly 'reflexive'. Unlike the working conference, the interactions within the client consultancy matrix are wholly beyond the boundaries of the process. Therefore, no backcloth of assumptions about what is going on can be presumed to remain constant across successive processes, and the assumptions must be constructed *de novo* on each occasion.

Psychodynamic supervision characteristics are the same as for a working conference, except that the supervisee's client is not present, and of course supervision has an exclusively personal focus. Reflexive team supervision makes use of systemic understanding and adopts this same working conference ethos, however, it is like psychodynamic supervision in that there is no direct contact with the client and sponsoring systems. The dynamics of the actual client become apparent indirectly through the parallel processes within the supervision team and its interactions with the consultant. Thus, the way the supervising team sponsors its own understanding of its work becomes critical to the way it is able to make sense of what is or is not 'parallel'.

In conclusion

The value of the reflexive team approach is in the insights it generates at the formative stage of a project. At later stages in the unfolding of a project, its value lies in its ability to surface the learning within the consulting matrix, and to provide a means of making sense of crises and/or key turning points in the project's development.

The learning that emerges from reflexive supervision always expects to go beyond what the consultant and supervision team already knows, always involves a creative act, and always 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.

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The Authors

Carole Eigen, PhD., Vice President, Bridgewater Professional Associates, clinical specialists in group dynamics and executive coaching; Member, Orientation Committee, International Forum for Social Innovation, Faculty, Leading Consultation, Paris, France.

Carole practices as a clinical psychologist and organizational consultant specialising in institutional transformation and role consultation; she designs leadership learning systems that provide training and supervision for consultants and systemic therapists.

Philip Boxer, BSc, MBA, CMC. Council Member of the Tavistock Institute and Associate Member of the Centre for Freudian Analysis and Research, his research interests focus on the nature of asymmetric demand and of consulting processes.

Philip is an independent consultant working as a strategy analyst with organizations in the voluntary, public and private sectors.