

Ethical dilemmas and challenges of a supervision group in a statutory service

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As systemic thinkers and practitioners, we all recognise the importance of context in shaping ideas, theories, meanings and local professional-practices. This article shows how contextual factors have impacted on my experience as a supervisor in a statutory service, including the voices of two members who joined the team to develop their systemic skills.

This article is written in a dialogical style; i.e. an initial monologue that I have written in my role as a supervisor in training, complemented by my supervisees' comments. This dialogue reflects and gives a flavor of the numerous and stimulating team-discussions on dilemmas emerging in our work.

The key players in the team: their voices

Chiara – supervisor: I am white Italian, in my forties, heterosexual, married, no children. I moved to England sixteen years ago and qualified as a family therapist in 2008 and as a systemic supervisor in 2012. I worked in a statutory agency for ten years. I am also a lecturer at the Tavistock, teaching in an agency-based systemic training in London, and have been a tutor of the certificate in systemic practice at the Institute of Family Therapy for 4 years.

Rajini – family therapy trainee: I am a female psychiatrist in my thirties, of Sri Lankan origin, with a Malaysian background, having grown up in Switzerland. I am in my second year of systemic training, and am not currently working as a psychiatrist. I have another placement in a GP surgery.

Felicia – team member: I am a female art therapist, white British, in my sixties, divorced, with three adult children and three grandchildren. I am employed as a supervisor in a third-sector agency, which offers outreach support to children and

their families. I have a basic introductory knowledge of systemic thinking and practice and am interested in developing systemic skills in my agency.

“Warming the context” of supervision

I worked with children and families in social care for ten years, initially with looked after children and then within a statutory child-protection agency whose main purpose was to carry out parenting assessments and short specialist-interventions during care proceedings or under a child-protection plan. I started supervising a family therapy team as part of a pilot project. The team underwent many changes and only Felicia and Rajini completed the 16-month project, which came to a premature end due to organisational restructuring.

Referrals were received from social workers with case responsibility within their own teams. All children and families seen within the Family Therapy Service were at high risk of physical, emotional or sexual harm, with complex and multiple presenting-issues ranging from serious domestic abuse and violence, parental conflict and separations, contact issues, multiple partners, sexual abuse, neglect, mental health issues, attachment issues, and sibling violence. This client group is mainly from the most socially and economically disadvantaged backgrounds, often unemployed, and with poor education.

Rajini: Working in this context raised many questions. Many families attended the initial sessions. I wonder: what was it like for the family to have a discussion about attending therapy? Why did they agree to come? What were their expectations? Did they feel coerced to attend because the recommendation was from a statutory service? Did they feel they had a choice?

How did these factors influence how the families positioned us? How did the system impede on their values and beliefs about families? What role did the referrer – the absent member – have in the family system? How did this affect the engagement process? It became increasingly obvious that power inequalities played a significant role in the therapy and needed to be addressed.

Felicia: Where I normally work, power issues are different because the parents usually give consent without reluctance. They are often worried about their child and so will self-refer via the school. Alternatively, the school has concerns and refers the child after consulting the parents, who therefore feel a degree of control and have power within the context. In the case of the family therapy work, many families refused or were unable to engage, either not turning up for appointments; by the parents denying there was a problem or becoming so emotionally overwhelmed in the sessions in front of the children that they did not attend again.

Who is setting the agenda for change? What change? Whose change?

As a supervisor with my main clinical experience in this statutory agency, I was aware of the possible tensions of working therapeutically with a statutory mandate and receiving referrals from social workers, endorsed by a child-protection plan. I was reasonably confident about my experience in this agency and my positive relationships with many social workers. However, I certainly underestimated the progressive changes of thresholds for therapeutic interventions and the additional challenges of being a supervisor, often caught up in the conflicting demands of, and the space between, social control or statutory powers and therapy as empowerment of clients. This was

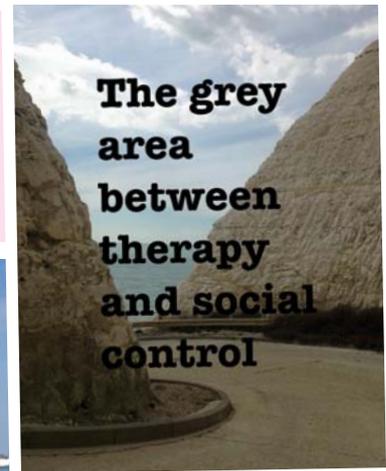
reflected in questions and dilemmas in relation to 'change'.

Tension with referrers, who were setting the agenda for change, was apparent in our team discussions when, for example, in pre-sessions, we had to acknowledge a tendency for the referrer only to highlight the concerns and to dismiss areas of strength; and to engage in blaming processes and further victimisation by a focus on identifying 'the victims' of abuse, i.e. the children, and 'the abusers', i.e. their parents, who were expected to change.

Rajini: *Faced with such complex and multiple needs, and due to my inexperience, it was easy to fall into my own agenda for change, based on my own standards of living, my own beliefs and values about family life, resulting from my privileged background and my prejudices. Focusing on privilege, dominant discourses and prejudice was useful in this context. I became aware I could contribute to blaming and shaming clients. This was not my intention nor how I saw my role as a therapist. I always believed we, as professionals, have a duty of care, and a responsibility towards our clients' wellbeing, and our remit as therapists is to give them an opportunity to find alternative ways of thinking, being, and living. However, at times, the sessions felt coerced, as if families were forced to come and 'talk about their problems', which they denied having. I therefore wondered: is coerced therapy helpful to families?*

The court-ordered rehabilitation programmes in the US, for clients dependant on drugs, suggest therapy can be an alternative to incarceration or loss of benefits, giving motivation to attend. Research showed that **"coercion applied therapeutically can result in improved psychosocial status, and reduced cost from criminal health and employment consequences in most of the population with alcohol and drug disorder"** (Miller & Flaherty, 2000). In our team discussions, we often wondered: can therapy, 'strongly recommended by social services', become an alternative to heavier social repercussions (e.g. removal of children from their parents' care) and a motivator and/or facilitator for change?

Felicia: *In my experience, the fear of having their child removed can motivate families to co-operate and can work successfully for the parents and, in turn, for their children. However, when this co-*



operation is driven by fear, resentment, lack of empathy and professionals not working well as a team around the family, it can lead to a rapid process of disconnection between both sides, preventing an opportunity for change.

I often wondered about the definition and professional meaning attached to 'therapy', e.g. 'a means to achieve change', and perhaps assuming 'therapy is always good for you', like taking a pill when you have headache. In the team, we often asked ourselves: "What is therapy for, when clients are clearly saying, 'We don't have a problem' or 'We don't want to change' or 'We can't change'?"

As a supervisor, I tried to be self-reflexive (Burnham, 1993) and enable everybody in the team to recognise and challenge our own prejudices and preferred ideas about change: e.g. how we measure or expect change to happen in clients' lives. Towards the end, through noticing and reflecting on the process of change in families, we came to a more systemic view of change as discontinuous and erratic rather than continuous and linear. In fact, the idea of progress is often an implicit expectation, which does not necessarily fit with patterns of ongoing family crisis and partial or temporary solutions that families may

find. Accepting or acknowledging our prejudices about linear change as the resolution of the issues in question allowed us to evaluate and reframe some of the outcomes as 'achievements' and positive outcomes, even if different from expected outcomes. This seemed to convey a more hopeful attitude towards the possibility of change; promoting the belief about things being different in the future.

A case example

During a first session with a couple, there was general dismay and some disconcerting responses by the leading therapist (and myself!) because they had been referred for significant domestic violence, which had occurred two years before. The couple were guarded in sharing any information and, during the session, never acknowledged the extreme severity of the violence. The leading therapist, keen to practice some solution-focused ideas, found herself in a paradoxical situation having to find 'exceptions' to their repeated statement, "It's all different now. No problem". The referrer clearly had a different view and there was still a child-protection plan in place, suggesting there was still significant or unquantifiable risk, particularly as the mother was now heavily pregnant with her third child.

My live intervention as a supervisor was to clarify to the couple that it was their responsibility to speak to the social worker about their decision whether or not to come back for further couple-sessions, or to seek alternative psychological help for the father privately (which he stated he had started). This implied there was an expectation of change but **they** were invited to think about how to make the process of change both happen and be evident to professionals. This was also designed to promote collaborative practice and engagement in the process of change, should they wish to come back.

Post-session discussions in the team highlighted the dilemma of having conversations with clients whose only reason for attending was to 'comply' with the child-protection plan (a box-ticking exercise!) and/or to 'please' the social worker. We found ourselves wanting to trust the couple's own assessment of risk, that there was none in their relationship

or in relation to their children, and wanting to promote their agency in making a choice about family therapy. At the same time, we needed to take into account the social worker's concerns and assessment of potential risk, as well as acknowledging and reflecting on our own 'gut feelings' that this was 'all too good to be true'. The couple never came back and I informed the social worker of our team discussion, indicating a clear delineation of professional roles in leaving the social worker the role of assessing the risk, whilst maintaining a more therapeutic role for us by leaving the door open to the couple to come back, should they wish.

Felicia: *Maybe it would have helped both the couple and our team if we had linked more closely with the social worker and his team by enabling both teams to discuss and better understand the power dynamics and differing roles we each had. Perhaps the above example illustrates a family disconnecting at the first available opportunity from a difficult and intrusive process in their lives, which they were keen to end. This shows how, sometimes, we were caught up in a role of mediators in the power struggle between social services and child-protection services and the families we were working with.*

Systemic tensions and dilemmas in negotiating boundaries between therapy and social control

Negotiating the therapeutic space with statutory clients is a skill I have developed over the years striving for a 'smooth travelling between domains'; i.e. moving between child protection, therapy and prevention of further harm (Gross, 1991) or, as Nielsen (2002) describes it, working in the "grey area" between therapy and social control.

Naively, I perhaps thought that, by trying to keep the context of therapy separate from the context of child protection and social control, I could create and protect this 'therapeutic bubble' to the benefit of families and my supervisees' learning. This separation of professional roles could be a way of managing the tension between the contexts so some independence is preserved (Crowther *et al.*, 1990), as in the previous example. This was in theory! In practice, after the initial engagement with some families, I found myself acting

and intervening during therapy sessions not only as a 'supervisor or consultant' in relation to the more technical aspects of therapy – e.g. suggesting something, changing the course or the tone of the session – but also as 'supervisor and agent of social control' when punctuating, highlighting the reasons for the referral, clarifying confidentiality and its limitations. Furthermore, social workers were keen to know about family therapy sessions to inform their decision making and with an expectation to be regularly updated on 'progress' and receive reports, or requesting my opinion in child-protection conferences, which I always shared with my clients.

Felicia: *I think our relationship with social services was unclear and it felt like we were stuck between them and the family. This possibly reduced our therapeutic potential as it was hard to be perceived as neutral and therapeutic by most families because they might not have agreed they needed help. Families were identified as being willing to change, but many of them might just have been 'playing the game' to comply with social services demands for change.*

Flexible positioning as a survival strategy

As time progressed, I realised I could not actually claim a separation of roles between therapy and social control and it was more helpful for me to think about flexible positioning; i.e. the position I was consciously choosing at each moment to maximise therapeutic potential for the family.

Positioning theory (Davies & Harré, 1990; Harré & Langenhove, 1998) seemed the most helpful theoretical tool to manage this tension and the triangulation we were experiencing between the social-control system and the therapeutic system. It was equally helpful to name this dilemma of being part of both systems and trying to take a 'both/and' stance, hence acknowledging mutual influence between the two, a typically systemic approach.

Rajini: *Positioning was to become an important and useful concept. Not only did I find myself, at times, learning and tolerating the 'to-ing and fro-ing' between a first-order position of the professional with a duty of care, and a more collaborative second-order position, but I was also learning how to 'de-position' myself from*

my own more personal position with my prejudices. I learnt the impact of these on my work and how valuable it was for me to deconstruct ideas and uncover prejudices with my team members. This was my survival strategy at this point in my learning and growth as a therapist. Positioning also offered me a chance to contemplate power differentials in the therapeutic work with clients. The 'power gap', on many levels (education, opportunity, finances), was much larger than with other clients I worked with. I wondered how this influenced the families' sense of safety and engagement in the process. How was I to create a safe therapeutic culture in this context?

It was also useful to redefine boundaries between the statutory role of the social worker and the therapeutic system as part of a wider system where change was to be promoted and negotiated. For this reason, I later introduced a consultation model, taking the lead in running the first session in the presence of the social worker, to openly explore and discuss with the family the wider issues and concerns and, where possible, to establish a therapeutic contract and collaborative ways of working together. Similarly, I have tried to involve the social worker in reviews and ending sessions as witnesses to the process of change that had taken place.

The balance between clinical needs and supervisees' learning needs

During this sixteen-month period, balancing the needs of supervisees wanting to develop therapeutic skills, with the needs of families in crisis, who find it difficult to engage in therapy, has been challenging. It required an ongoing process of negotiation between mutual expectations, local and specific organisational-practices, thresholds, agency requirements and individual learning-needs.

I was often preoccupied with the impact of the constraints and challenges of working in my agency, which could undermine supervisees' confidence as practitioners and learners. Also challenging, was the balance between challenge and support in order to meet supervisees learning styles and needs (Kolb, 1984) and finding ways for them to practice in a context of 'safe uncertainty' (Mason, 1993) when there is a lot of

uncertainty in the wider professional-systems. It was equally challenging to encourage supervisees to take relational risks in their development as practitioners (Mason, 2005a, 2005b) in a context that is inherently confronting in relation to presenting problems, regular attendance and difficulty in achieving therapeutic engagement and positive outcomes. Furthermore, I was concerned that supervisees could experience this as a personal failure, working in a statutory agency for the first time, learning systemic skills in a way that was unexpected; e.g. more through discussions about missed appointments than actual therapy sessions!

Rajini: *Although Chiara might have felt like this, I found working in this context an incredibly enriching experience, in spite of the missed appointments and the slow progress in our work with clients. She was able to create a safe context in the learning process, enabling me to be self-reflexive, to discuss key concepts of systemic theory and their application in practice.*

Gender issues: a patriarchal model of supervision?

During this journey as a supervisor, gender issues seemed to become particularly relevant in a whole female team. I started noticing the level of 'closeness' and intimacy that soon developed and wondered about how being all female from various cultural and professional backgrounds impacted on defining and negotiating supervisory relationships, and what difference it would have made had we been a more balanced gender mix.

As time progressed, I noticed how self-critical statements were immediately responded to with positive affirming statements by other team members, valuing respect and caring attitudes as a team. I realised this made the balance between support and challenge particularly difficult to maintain as a supervisor with my natural tendency towards a 'cosy reassuring' stance, constraining my ability to be more confronting with supervisees.

Specific gendered meanings and the co-construction of the supervision group as non-judgmental and supportive, led to questions such as: "Was there any room for my authority if this was associated with maleness and dominance as opposed to

femaleness as nurturing, supporting and caring?"

During a group review, where more-personal experiences were shared, male gender narratives were hinted as associated with 'painful' experiences of subjugation, lack of communication and domestic violence. This had clearly a strong resonance with the clinical work, an example of isomorphic processes (Liddle & Saba, 1983). It is interesting that supervisees described my role as a supervisor as 'motherly' and 'gentle authority' where the interplay between gender and hierarchy seemed apparent. I wonder whether a male presence in the team would have used the same language. The feedback suggested that my style was appreciated as a vehicle for learning and personal and professional growth. However, this was not without dilemmas, which were more strictly related to the clinical work. As a supervisor, I had to be mindful of the group tendency to polarise gender stories and I was often mindful to keep 'a male presence' alive in our case discussions, particularly when trying to engage fathers who were often presented as 'the abusers' and reluctant to attend therapy.

During discussions about lack of engagement with a father in couple work, one supervisee made the suggestion that the therapeutic system could somehow replicate a patriarchal model of family. I reflected that, as a supervisor live intervening at times in therapy sessions, I could be seen as 'using a male authority' to assert my position within the family therapy team (when acting as a consultant) and with the male client (when acting as a social control or gate keeper). It made me wonder whether this could actually convey male dominance with the unintended effects of disempowering the male client, who was actually being separated from his own family. The local authority, in fact, was not allowing unsupervised contact with his children at the time, due to his issues with "anger management" and previous incidents of domestic violence towards his partner, who was now rejecting him as she had started another relationship with a new partner. He could also see me as a female with the power to overturn this decision, but possibly siding with his partner by stating our moral position against violence.



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As a supervisor in this case and others, I tried to bring more balanced gendered meanings beyond subjective experiences and personal and/or professional beliefs and prejudices. This could potentially engender alternative stories of men and fathers as being caring as well as abusive, avoiding professionals unwittingly prescribing a “way of being a father” which may reflect patriarchal views in the wider society or professional views that might disempower men as fathers with authority. This highlighted the need to address gender issues within the personal, the professional, the relational and the societal contexts, both in the therapeutic and supervisory systems.

Felicia: *I have a clear memory of one session when we invited a male family therapist as an observer. I was the lead therapist and was finding it hard to engage the couple that denied that there was serious domestic violence (see case example above). Post-session, the male observer questioned why I had not challenged the male parent’s denial of the abusive situation. I remember thinking maybe he had hoodwinked me into letting him get away with something – a repeat of the abuse his partner was deemed to have experienced. Was I colluding with her quietness and lack of challenge? I thought this was possibly because I was a female and wondered: “Had I been male would I have been more challenging?” This example highlights the benefit of having a mixed therapeutic team. It also made me reflect on how power is easily swung and how we, as therapists, have to pay close attention to how it impacts in our practice.*



Rajini

Conclusion

Throughout this experience, ethical dilemmas and the specific challenges of working therapeutically in a statutory agency, were at the heart of our supervision-group experience.

As a supervisor, the balance between providing a therapeutic service to clients in order to empower them to make changes which are mandatory, and the learning needs of supervisees, whose main aim is to practice systemic skills, has been a challenging but enriching learning experience.

The main challenges and dilemmas were to provide a ‘safe enough context’ for learning and, create the possibility of change for this client group, when child protection is the highest context-marker and engagement in the therapeutic process is fraught with difficulties and complexities within the interrelated systems i.e. therapeutic system, supervisory system, social-control system, legal systems. A systemic perspective is certainly helpful here, and a flexible positioning between therapy and social control is a precious survival-strategy to maximise therapeutic potential.

A special thank you to my supervisees who made this project possible and raised some of the key dilemmas I have struggled with for many years. This contributed to further clarifying my ethical stance towards therapy as a choice and my critical learning as a therapist and supervisor.

For further dialogue on this article please see www.familytherapyservicesra



Felicia

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