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Editorial

John Whitwell

When I heard that a whole issue of this journal would be devoted to the work of the Cotswold Community, following the closure last summer, I was really pleased that there would be an opportunity to pull together some key papers in one publication. There hasn't been a book written about the key concepts and principles developed at the Cotswold Community in the years 1967–1999.

The nearest we have to this is Patrick Tomlinson's book (2004), *Therapeutic Approaches in Work with Traumatised Children and Young People*. This was based on the work of the Therapeutic Resource Group, which met weekly with the Community's consultant psychotherapist (initially Barbara Dockar-Drysdale and then Paul Van Heeswyk). Notes were taken at these weekly meetings and circulated within the Community. The subject matter was mainly whatever was preoccupying the group members. It might have been a child care management issue (for example, bedtime), or an organisational matter (for example, the relationship between the school and the group living households). The book is an invaluable resource when thinking about the elements which together make up what we refer to as 'therapeutic child care'.

The papers we have selected, some of which have been previously published in this journal, aim to show the development of the thinking at the Cotswold Community from the very early years, when there was a desperate struggle to establish a therapeutic culture out of a top-down, punitive regime that was the Cotswold School, which had been an 'approved school' from 1942 to 1967. This transformation was graphically described in David Wills' *Spare the Child* (1973), which is still a good read and goes some way to explain why it is so difficult to transform institutions.

On reading Richard Balbernie's 'The Impossible Task?', the blood, sweat and tears involved in the change process comes through very strongly. On re-reading it I found myself wondering if the preoccupation with subculture as a destructive force was overstated. However, I know that the resistance to change that Balbernie faced was very powerful indeed. He didn't have the benefit of a complete clearout of staff and boys from the approved school days. One gets a sense of the fierce determination necessary in the leader for change in these circumstances to occur. In this paper Balbernie sets out his personal philosophy which informed the vision to change the Cotswold Community. Some things he changed overnight, for example, the removal of a punishment system to control the boys. Other things changed more slowly, for example, establishing a

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genuinely therapeutic culture. This change was more like the development of an 'archipelago' child, initially with small islands of functioning, which gradually join up to form a land mass, a therapeutic culture.

Barbara Dockar-Drysdale's paper, 'Staff Consultation in an Evolving Care System', was written in 1973, two years later than Balbernie's. This is significant because it shows more confidence in a therapeutic culture having been established within the context of a management structure which was generally supportive of therapeutic care (in contrast to the top-down, hierarchical management structure of the previous regime). Mrs D, as she was known, describes the importance of Winnicott's concept of emotional unintegration and the achievement of integration. She continuously stresses the importance of communication and whenever a boy 'acted out' she looked for the breakdown in communication which preceded it. This put pressure on the staff teams to be ready to receive communication, in whatever form it took, however symbolic. She also described the tools that were used in the therapeutic work, for example, need assessments, context profiles and 24-hour management programmes. I find myself harking back to the value in doing a need assessment every six months on a child. It is an excellent way of showing 'distance travelled' when looking at 'softer' outcomes.

Isabel Menzies Lyth was the other consultant crucial to the development of the Cotswold Community in those early years. She helped to transform the management structure of the Cotswold Community. This included looking at the senior management team, the structure of the group living households, the education area, the farm etc, and how they all inter-related. It was important to define who was responsible for what and enable the staff, at the 'coalface' with young people, to be empowered. The work of the Tavistock Institute was a continuous thread throughout the history of the Cotswold Community. In those early days it was looking at basic things like the need to decentralise the main kitchen into the group living households, the role of domestic workers, the roles of male and female staff (in what had previously been an all male environment). I think what was most unusual about the Cotswold Community was the interplay between the therapeutic care of the boys and the way the Community was organised. This was embodied in the work of Barbara Dockar-Drysdale and Isabel Menzies Lyth.

Eric Miller took over Isobel's consultancy when she handed over in 1979. He then provided 'management consultancy' for the following 20 years. Unfortunately there isn't one paper written by him which summarises his work at the Cotswold Community so we have included two short 'working notes' (previously unpublished), 'Thoughts on Staff Dynamics and Group Work' and 'The X Factor', which give a good feel for the way he worked, and what he helped to develop.

Eric Miller's influence very clearly comes through in my paper, 'Boundaries and Parameters'. His concept of semi-permeable boundaries as shock absorbers from the child outwards towards the external world and from the external world towards the child was an important part of how the Cotswold Community was organised. My work since leaving the Cotswold Community with ISP (Integrated

Services Programme), an independent provider of therapeutic care with foster families, has brought home the lack of 'shock absorbers' in families within a local community. The acting out of a child can be straight into the external environment with a consequent backlash for the child and family. Equally it is so much more problematic trying to protect children from external impingements in a family setting with minimal shock absorbing capacity.

Providing continuity of care for emotionally unintegrated children was an important pre-condition for their recovery. We tried to achieve this day-to-day by staff working very long hours. However, this probably led to some staff 'burning out' quicker than others which, of course, undermined the continuity we were striving for. Also some staff clearly found the level of emotional disturbance in a group living household very difficult to live with, leading to some premature departures. We enlisted the help of Olya Khaleelee to examine more carefully our staff selection process and to have a better understanding of the personality types best suited to this therapeutic work. Olya's consultancy helped us to get better at staff selection but also to improve the level and kind of support that staff needed. The paper that we have included, 'Intrapsychic Factors in Staff Selection at the Cotswold Community', describes the research which led to the above improvements.

We have included a paper about the farm at the Cotswold Community because previously it had been described as an important 'cordon sanitaire' rather than for the value of the farming activity itself in the development of young people. For most of my time at the Cotswold Community I was aware of the threat of gravel extraction to the farm and wrote about it in, *Gravel Barons versus a Therapeutic Community* (1992). Dave Cooper's paper describes in more detail how the farm's educational importance grew under his influence. This was education in the widest possible sense. Just before the Cotswold Community closed, Dave showed me round the farm workshop and I saw all the different learning experiences which he provided, from making felt from the sheep's wool and then using it to make hats and bags to stripping down machinery and learning how engines work. It is interesting to see how agricultural and horticultural environments are currently being rediscovered as valuable learning environments, especially for children who do not do well in conventional classrooms.

I remember a time when the threat of gravel extraction was most intense. I had a meeting with a senior manager in Wiltshire Social Services (the managing body). One of the options was for the Cotswold Community to relocate, to which I was firmly opposed. He said, 'If your community has such a clear set of therapeutic principles surely this can be put into practice on other sites.' At the time I didn't want to hear this because he didn't understand the importance of generations of young people and staff investing in the physical development of the site. We had a strong sense of 'ownership' in the Cotswold Community on that land and in those buildings. However, when I look back now, in one important sense he was right, because the therapeutic principles remain now that the site has closed.

I have tried to use these principles of therapeutic child care at ISP since leaving the Cotswold Community in 1999. I have found that it is more difficult to put them into practice in an organisation that is more loose-knit than a therapeutic community. One of the strengths of the Cotswold Community was the cohesiveness of the staff team, which was partly due to all of us being in it together twenty-four hours a day, seven days a week.

The obituary which I wrote for *Young Minds Magazine* attempts to summarise what was created in a very special set of circumstances that allowed the Cotswold Community to take shape in the late 1960s and 1970s. I don't think it could be created now, which makes it even more important to extract whatever we can from this experience to inform current and future practice. I hope this collection of papers is helpful and even a bit inspirational in this respect. Further relevant papers can be found on my website www.johnwhitwell.co.uk

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The Impossible Task?

Richard Balbernie

Perhaps I might just preface this paper with a quote from David Wills (1971), a man who described himself as quick-tempered and sarcastic and claimed as his only virtue 'an invincible faith':

> If you have a boundless and invincible faith in what you are doing, and that faith is based on the unchanging and eternal verities, you will survive. But if your confidence in what you do is based on some pragmatic assessment of its value, measured against the yardstick of some human scientific concept, then I advise you to keep bees or become a business tycoon.

As I experience it, we are in a period of potentially overwhelming helplessness, anxiety, and uncertainty in the social services and probably particularly in residential work. It is a time of big, powerish disputation, argument, assertiveness and polemic, and this I believe simply to be a smokescreen which plasters over an increasing sense of real and important uncertainty and doubt and the loss of attention to immediate, small, down-to-earth detail and reality.

I believe this particularly affects the residential worker into whom, almost traditionally now, the social services put the weaker half of the split between arrogance/domination and dominated/confused/castrated powerlessness. So far the residential worker has, for some reason, all too 'happily' accepted this Cinderella, masochistic and martyred role. It is perhaps so much easier to suffer under an aggressor than to take things on and sort them out a bit; or to bring out and then accept the aggression from another when you interrupt their delinquency.

This is, I think, why subcultures – especially, perhaps, staff subcultures – thrive in residential work.

If one is concerned with a *culture*, one is concerned with the performance of a definite and specific *task*. This inevitably faces one without one's sense of inadequacy, of weakness and one's fear. It also means that one must know what the task is and whether or not one is performing it.

*Sub*cultures, on the other hand, are anti-reality and anti-*task*: one has an external aggressor and an enemy ('them'); one can remain within a persecuted 'we' in which one is collusively identified with anti-task in a delinquent way, and is never faced with or confronted by reality. The subculture thus provides the very primitive form of security found in the delinquent gang, which subsists over and against authority.

The dynamic of the subculture is somehow itself very primitive: the avoidance of the facing of the pain, anxiety and helplessness in ourselves and

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Richard Balbernie was a former principal of the Cotswold Community. He died in 1986.

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others, which so easily leads each and every one of us in this work to lose *belief* in the structures which we create and maintain, and in the order which it is our task to bring to the disordered, disorganised and unordered lives of others.

Subcultures can only be brought out and dismantled by insistence on a focus on *task* and its performance, and by being faced, interrupted, and challenged by this. But face the collusion of the subculture and bring it to the surface and all hell breaks loose, in terms of aggression and denial. It is just this that we have been concerned with for the past four years at the Cotswold, in our task of converting a traditional, orthodox penal (and punitive) approved school into a therapeutic community.[1]

It may be useful at this point to comment on the main problem of such a 'conversion task'. The severely emotionally damaged adolescent 'offender', above all others, continuously and dramatically evokes the subculture – creating splitting processes in others – both in staff and in society. His own acting out, his own violence, his own destructive aggression – his entire self-made survival kit of defences, evolved to protect a very weak or completely unformed ego from annihilation in a rejecting and scapegoating environment – generates a massive group dynamic. Teachers may find themselves becoming the competent, confronting, authoritative aggressors. Child care workers, who have to live with the child (and into whom the child is consequently more likely to put the undifferentiated, psychotic, disordered and damaged side of himself), may find themselves taking on the other side of the split – the helpless, permissive, woolly side, with an evasion of taking on the negative from the child.[2]

Society's ambivalence towards delinquency and delinquents continually drives those involved with delinquents into extreme love/hate attitudes: either they deny their hatred and recognise only their love, or they deny their love and recognise only their hate. It is therefore perhaps small wonder that those who have to cope with delinquents sometimes find their own uncertainties – about their own authority and ego-functions – drive them into inflexible attitudes. Especially in the past these were at least consistent attitudes: too consistently authoritarian on the one hand, over-determinedly permissive on the other. Hence, in the past, the absolute split between the authoritarian repressiveness and punitiveness of the approved school and, more recently, a whole woolly, permissive, and sentimental so-called 'treatment attitude to the young offender, which so easily ignores the severe delinquency and delinquent acting-out which are a symptom of severe emotional deprivation.

With these remarks, which I am making at a time in the history of social work which I believe to be a climax of the gravest doubt, uncertainty and confusion, and also of hope, I want as simply as I am able to retrace the steps of my own experience and work in this field over the last 25 years, to state some personal beliefs and principles derived from the experience.

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[1] The transformation of The Cotswold School, in Wiltshire, into The Cotswold Community began in 1967 under the direction of Richard Balbernie, and is the subject of David Wills' book *Spare the Child*, Penguin, Harmondsworth (Middlesex), 1971 (Ed.).

[2] Or vice versa. The situation is easily reversed.

It was from child guidance experience that I developed the belief in a really substantial and authoritative assessment of need within the *total* situation. Not just a rag-bag, but an assessment, the basic elements of which are always and everywhere essential: involving, for example, a really substantial social history which *includes* the early developmental stages, and particularly information on such things as the child's development of dependence/independence and so on; a really sound intellectual assessment and assessment of abilities, skills, attainments, and educational development; a substantial assessment of personality structure and emotional development. But more than this there must be a very clear diagnosis of the level of integration and ego-functioning which has been achieved, and a clear differentiation made between the child who is unintegrated and the integrated neurotic, the assessment of whom must primarily be centred on the gathering of information from a group of people all of whom have been *involved with* or have *lived with* the child. Only these people have the necessary knowledge. But because the knowledge of each will be lop-sided, according to what the child has put into them, that knowledge must be pooled, pulled together and meaning made of it.

Without this assessment (and of course assessment must also be a *continuous* process) our work does not even begin. I would go back to absolute first principles – back to Mary Richmond's (1965) four stages, in fact: substantial investigation and assessment of need involves the bringing together of sufficiently adequate information; careful diagnosis; cooperation; and finally, and after sufficient reflection and assimilation of this, action.

It was from my child guidance days that I also gained the experience of continuously working together in a small team drawn from different disciplines, and the disciplined *regular meeting* of the staff group to bring experience together. It was here that I came to appreciate the need really to know one's colleagues as real people. A belief in the treatment of the individual: because most of the problems with which we deal are not responsive to mere external environmental change; the individual is stuck inside himself and severely damaged. A belief in the treatment of the *whole* situation insofar as this is practicable and realistic and not merely a woolly ideal.

I also learned that there were certain families (or alternatives to families) in which a child could not survive, and where if internal obstacles and impediments to his evolving and integrating were to be removed, special additional security in the environment would be required. It seemed also too often true that residential placements were made which were a mere collusive and temporary dispersal and distribution of a family or social problem. It was absolutely clear that if a child could be treated within his own home then that was where he should be.

I learned that there were certain *very* intractable treatment problems, particularly centring on the most panicky and disruptive children, who could not be treated in a group, and who as adolescents became exceptionally violent, anti-social and delinquent. With the slightest disruption of environmental containment, security, or communication, acting out would be dramatic. All their

excitability was always put into the other children with whom they came into contact.

These 'intractable treatment problems' were not 'environmental' problems; that is, merely reactive to here and now environmental circumstances. They were those children who had been the most grossly emotionally deprived and bashed up, particularly in the very earliest stages of infantile separation and development. It was equally clear that we placed most of these children in residential settings, that their placements broke down very rapidly, and that they were then simply off-loaded from one residential setting to another, eventually landing in an approved school.

I remember a simple and telling explanation which was given to me in the earlier stages of my own experience by Dr Robert Moody[3] of what constitutes a 'problem'. Dr Moody described how, if a factory worker was continuously getting headaches, an investigation might show that he was working near noisy machinery. The worker would constitute a particular treatment 'problem' only if, when removed from the noisy machinery or when the machinery was quietened, he continued to get headaches.

In the cases with which I was particularly concerned, and which were particularly intractable, mere change of environment effected no inner change; these children were 'stuck', emotionally, at very early stages of development.

It was also at this stage of learning and experience that I began to discriminate between problems which it seemed useful to differentiate as *primarily* 1) emotional, 2) intellectual, 3) environmental, and 4) multiple. It was clear that we in child guidance referred for residential placement primarily children who were either unintegrated or neurotic: whose problems, that is, stemmed from severe *emotional* damage in the earliest years.

It became equally clear that, as one unit off-loaded its residual 'intractable' populations into another, a rag-bag population was created made up of children with emotional, intellectual, environmental and multiple problems all mixed up together; for whom there was no clear primary task in terms of their treatment; and who descended in an unselected avalanche onto the approved schools, at which stage they were all 'safely' locked behind the iron curtain: undifferentiated and undiagnosed.

I saw that if all these distinctly different problems are jumbled together in a single unit then of course it cannot define its primary task: nor does it have to work out what in the child's make-up is damaged, what the treatment is, or to discover whether or not this treatment is being undertaken. Such rag-baggery, in other words, provides a wonderful opportunity for a collusive re-distribution and evasion of clear responsibility: the more muddle and obscurity one has, the happier one is (though only in one sense: this happiness is short-lived; since, to

[3] Dr Robert Ley Moody trained in child psychiatry at Guy's Hospital before the war; was Consultant Psychiatrist with the EMS from 1940 to 1945, Clinical Director of the Child Guidance Training Centre from 1946, Psychiatrist to St George's Hospital and the Victoria Hospital for Children from 1948, and at the time of his death in 1970 was Physician-in-charge, Department of Child Psychiatry at Saint George's Hospital, London (Ed.).

survive, a unit has in the end to perform a necessary task); everyone colludes in this highly motivated confusion and in this collusive distribution of responsibility. No clear boundaries or control systems need exist, no clear-cut structures. There persists a nice, readily available off-loading system in which residential staff can feel at home: moaning, and at the same time justifying their moans.

As far as the children are concerned such systems, rather like those for old people, have no clear intake control structures. This in the past has, in one sense, suited the approved schools very well, and they have in fact developed a sort of pride and dignity in undertaking just this totally impossible task. The only way it has been possible for them to manage it has been by simply containing and holding enormous quantities – in large and unselected groups – of acting-out, violence and destructiveness. They have developed superb and effective techniques for undertaking this, not all of which have been negative.

After child guidance experience I moved into residential work with maladjusted children. Again, certain quite basic principles seemed to me to emerge more clearly.

1. The importance of defining the primary task, and the significance of task confusion and its effect on staff.
2. The need for *continuous* accurate assessment, and total coordination.
3. The need for a clear baseline: the need not only to know what was damaged in the population, but for whom each unit and each structure and each part of each unit and part of each structure was suitable or unsuitable and what the criteria of satisfactory performance were.

In fact, that to survive one had to know: (a) what is damaged; (b) what the treatment is; and (c) for whom the unit is suitable or unsuitable. And one had to know the criteria of satisfactory task performance.

At this time, especially, the *off-loading* element in residential work became clear to me, as did the importance of the power to off-load: the power within the unit itself to say yes or no to what it could or could not undertake, and the dangers when this boundary control function was castrated or morally dominated or subjugated from outside.

From that realisation emerged a rather painful truth which is so often evaded, especially at the moment when there are so many fantasies of providing equally for all people. The realisation was a Napoleonic one: that is, the concept was originally devised by one of Napoleon's surgeons, who called it 'the triard system'.

This surgeon recognised that where there was massive injury and wounding but limited surgical resources it was necessary to quickly patch up as best one could and send back to the front those who could totter back there; to use one's surgical resources realistically where they would be most likely to be effective, for the very few who might recover; and for the remainder of the wounded to be discarded to a scrap-heap to fend as best they could (though perhaps without withdrawal of concern and with prayer).

The 'triard system' is painful and readily evaded, especially in social work, simply because of the fact that if there are units which are selective (which is necessary if we are going to talk in terms of treatment) then some units will continue to be required to cope with the residual rag-bag populations of unselected quantities of damage which – going further down the line – is something which prisons and (in the past) lunatic asylums have had to do. Also given is the fact that in these rag-bag receptacles the majority of inmates will *not* be placed according to their need, but will be there simply because of the lack of suitable resources. This reality must be accepted and faced.[4]

What became clear in my residential work, in short, was that *selection* must be a boundary function of a residential unit; though external *assessment* must take place outside, in a separate system. It is where these two functions meet that the most pressure, stress and conflict exists, and this has really got to be worked at until the boundary control function of the leadership of residential units is fully understood and respected: understood and respected in terms of the protection of the performance of the of the specific primary task of the particular unit, the needs of the children (or adults) already there, and the survival of the staff.

Thus it became clear that in fact the majority of children referred residentially were not just violent, continuously acting-out, given to unspeakable panic anxiety, needing continuous containment and provision geared to the gaps and spaces in the earliest stages of life, needing opportunity to work through depression, extreme excitement, oral greed and so on; but that, as soon as the defences and masks of self-made self-sufficiency (which the child had erected in order to survive) could be slightly put aside, the child behind the scenes was immensely weak, immensely fearful, immensely uncertain, and the main problem was always and everywhere to work through an absolute crocodile of emotional dependency. And by work through I really do mean work though in a highly professional way.

The basic problem can be stated fairly simply: the child has a weak or non-existent super-ego; a weak or non-existent ego; a high unconscious (id) charge, which so easily, without additional security, swamps and dominates the whole personality. For the child's defences to be dropped at all, the environment has to provide especial additional security; having worked through a massive and often group negative transference of hate, mistrust, negative feelings and aggression.[5]

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[4] Incidentally, we might spend some time differentiating between the true lunatic asylum which was really intended as an asylum and what came to be called the 'bin' in the same way as approved schools were originally designed to protect young people from prison and to help them but more recently have been labelled as 'dustbins'.

[5] Perhaps a story might illustrate what I mean. In the earlier stages of change at the Cotswold we had the invaluable help of a young 18-year-old blind community service volunteer. She described an experience in which she was sitting beside a grossly institutionally damaged boy (and I mean doubly institutionally, for the majority of boys we work with have not only been in institutions for most of their lives and been kicked out of one after another, but are additionally institutionalised within the traditional approved school as well, not only by the regime of the institution, but by the split

On top of this, many of the adolescents with whom we work have additional symptoms which make them continuously a special danger to others and to themselves; for example, repetitive fire-raising, sexual interference, sophisticated forms of violence (often displaced into sometimes subtle forms of verbal sadism), and delinquency (that is, the taking from other people as if what was being taken was one's own by right).

It became clear that, in many cases where such symptoms existed, those special and additional elements and difficulties had to be seriously considered; and there was no gain if one became woolly or sentimental about them. All that happened in that case was that one took on what one could not manage and then rejected the child (or someone else, as when staff left or lost morale).

Enumerated as simply as I can, the various elements of the problems of 'delinquents' which I first encountered residentially are:

1. The persistent and often senseless-seeming destructive acting-out and taking what did not belong to oneself as if by right, which is their major continuous and repetitive symptom.
2. Their proneness to infections of extreme excitability, always followed by destructive and often violent acting-out.
3. Their negative and rejecting and totally mistrustful attitude to authority and control. (They need to test a human containing environment to destruction for reliability and confidence and it has to survive. A staff and structure are required with sufficient authority and faith in themselves and their structure to bring in a helpful and secure order over against the terror of chaos. Incidentally, there is more 'permissiveness' in traditional approved schools than in almost any other institution: behaviour is simply not confronted nor interrupted; it is left and only repressed by ritual talion.)
4. They seem almost wholly to have rejected any need for help and are, on the surface, self-sufficient, pseudo-independent, brutalised, extremely nasty and often extremely cruel and bestial. Having been hurt by dependency and environmental failure, they are not going to make themselves vulnerable again or place themselves at risk by moving into relationship or trust.
5. On top of any other difficulties the majority are severely institutionalised already (some of them being institutionalised within their own homes).
6. In the majority of cases the family situation or the character disorders in the parents are such that modification is a very remote possibility and could certainly not take place whilst the child is in the home.
7. They all present *massive* remedial teaching problems, and furious denial and resistance to learning and the acceptance of their weaknesses and need for help.

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subcultural system of sadists and victims which any punitive environment engenders). She was sitting bedside this boy in the evening and said she wished she could roll cigarettes like he could. He was immediately abusive, angry, defensive and offensive about it; 'Yah, you silly blind bitch' etc., etc. Then there was a silence and then he said, 'Well, you can.' She then asked him how he could know that and he said, 'Well – I practised for two hours last night with my eyes closed.'

During these last four years at the Cotswold I have been concerned in attempting – and by that I really do mean *attempting* – to effect some change within a traditional and orthodox approved school structure. The object has certainly not been to attempt to produce dramatic results or smokescreen formulae, but rather to stay with the task and try to understand the substantial problems involved and to learn from this experience (and survive).

During these four years I have become increasingly conscious of increasing anxiety and seeming helplessness among residential workers; as the magnitude of their task increases, so do the doubts and uncertainties of residential workers and residential work generally. And residential workers have developed a general malaise which they describe as 'being buggered about by social workers' whom they believe to be in incredibly powerful positions, while they see themselves as vulnerable, likely to be engulfed and swamped and unable to survive. (There is, of course, a reverse set of fantasies too.)

They feel paranoid and unprotected because they have not really hammered out and worked on and clarified their own tasks, and are unable to state with absolute belief and conviction what their structures stand for, what their philosophy is, what their task is.

Equally it is true that residential workers have practically no help whatsoever in terms of good, sound consultancy. On the whole, residential therapists can neither be trained nor helped by non-residential workers, since those who have not experienced residential do not know what residential work is – at least not in a way in which they can really help. Furthermore, much of our training of residential workers is irrelevant, contributing more to an intellectual 'knowing about', which leaves the person out, than to role learning, which must primarily be learning from experience with the skilled supervision of another residential worker, who has insight and authority. Nor does much of current training help the residential worker to formulate and develop his own authentic personal philosophy – that in which he really believes and for which he stands on his two tiny residential flat feet.

Residential group living needs to be formulated much more clearly as specific treatment – I like the title 'environmental therapist' to refer to someone who is skilled in planning and creating a healing structure and environment.

If residential workers are to achieve a professional dignity, then, what are beginning loosely to be described as 'communities' will have to be directed by a number of people who share in and contribute to a common and clear aim and task; who are positively identified with that aim and task; and who have a real belief in it. They will have to pull themselves out of the bog by their own shoestrings.

And since our primary task is to help emotionally damaged and difficult children and adolescents not towards mere conformity or mere 'adjustment' but towards that kind of freedom, real responsibility and adaptability which is absolutely essential to modern day living, to help them to take a more rational authority for their own behaviour (what to accept, what to reject, when to conform, and when to deviate) the kinds of authority structure which such large institutions as are at present being created and the kinds of authority structures

which they engender are all too likely to create those very patterns which are likely to destroy any form of creative or therapeutic work. This, too, at a stage when the absolute need from the social service institutions is for what the Americans call 'running interference', to defend the residential unit from outside pressure and attack so that there may be experiment and opportunity within a secure framework of authority for these children and adolescents to learn from choice and from their experience of making mistakes. This form of 'permissiveness' is strictly governed by the needs and welfare of others (the child must not be permitted to make such mistakes that responsibility becomes split and one-sided and the child is rejected; the structure must always be secure and firm enough for him, never *woolly* – permissive).

Thus, this is a critical period of potential danger, which also means that it is a period of existing challenge.

From a residential worker's point of view the dangers seem especially great at a time of social worker-centring of powers of unilateral decision-making; and at a time when the predominant fantasy of therapy involves the mere dismissal of the treatment needs of the individual, and concentration on the treatment of 'total situations' and families.

In this fantasy the individual is simply seen as reflecting symptoms which are 'put into' him as the unwanted parts of the sickness and weakness of a total situation to which he is simply a scapegoat. Alter that situation, so the fantasy goes, and he changes. In the majority of cases with which I have worked residentially over about 22 years this has certainly not been the case, and without specific treatment such environmental change would have effected little change in the individual. Nor is it realistic to talk of such 'social' treatment as if it were a reality, because neither the training, skills nor resources for it are available, except quite exceptionally.

Thus, the residential worker increasingly, rightly or wrongly, in fantasy or reality (it is certainly an inner reality) feels helpless and vulnerable in a new and growing power structure within which he feels himself to be the least protected member and in which he or she feels, rightly or wrongly, that whilst everyone else seems to be free to flit from one position or job to another, he or she is left literally carrying the baby. There is a real danger of a lop-sided social work philosophy that is far too 'other'-centred, and too little 'inner'-focused or centred.

Here again I feel a need to state some, to me, basic and first principles of treatment. I feel these must apply within the whole 'planning' superstructure.

1. Always central is the decision making of the individual client as a free and choosing person and one who needs help to choose – not to become over-dependent; a person who has, in fact, to be 'let down' and betrayed into himself. This is 'stern love', not a child care sentimentality. It is best illustrated perhaps by the Jewish (*not* anti-Semitic) story of the father who was playing with his little boy jumping down one stair after another. Finally, he jumped and the father stepped aside. The little boy crashed, shocked,

bruised and shattered. His father said, 'Never trust your father – especially if he is a Jew'.

All treatment centres on the freedom of the individual to choose and learn from his mistakes, insofar as he does not harm others – which is the opposite of bureaucratic, autocratic, or hierarchical 'advice' and decision making.

2. That (following Mary Richmond's straightforward principles) casework always and everywhere centres on respect for the delicate, often very vulnerable, and always demanding relationship with an individual. Central is the treatment of the individual within the security of secure therapeutic and individual group relationships.

   Again, the concept of the treatment of a 'total situation' may be a reality or may simply become a mere catch phrase, mere power words, a smoke-screen for in fact doing nothing, and for camouflaging the weakness and inadequacies of the reality situation: the total situation can so seldom be controlled!
3. Not treating people as if they were temporarily submissive zombies and without respect, dignity, and clear boundaries. An *utter* respect at all levels for the person, for territories and sentient boundaries – and knowing and respecting who is inside and outside what, so that people draw the same lines in the same places; boundary skirmishing is continuous and destructive.

If that is the case, then how can we work towards the situation in which each person in whatever 'section' or compartment of the whole begins to know and respect and understand his colleagues, to test their reliability or otherwise and to experience them as essential colleagues and friends and workers?

Experience has taught me the absolute need for all workers concerned with any situation to meet continuously in very *small* (sentient) groups. This is absolutely and essentially the key. No staff can help clients unless they first learn to help each other, unless they first wash their own hands, and unless they begin to recognise and accept a special form of 'stern love' in relation to belief in a task and in maintaining a firm structure which they man and operate, designed to perform that task. Unless there is to be loss of integration (an out-centring or 'them'-centring, a complete loss of the individual stand-point and the individual's belief in himself and his work) it will be necessary for each of us, especially at present, to keep our real small inner circles ordered, and to develop the critical attitude to it and to the outer circles; certainly we must not play to the gallery.[6]

I want to end on the simplest of all notes, from my experience. Our task in both residential and field work is one of daily increasing uncertainty, confusion, complexity, doubt and anxiety. Unless we can meet regularly with our colleagues in small, intimate, face-to-face working groups, and unless we experience security

[6] The great new social service juggernauts, where the individual increasingly counts for so little, in this our sophisticated 'social work' era – and in a service which is essentially set up to help just this respect for the individual in society – could so easily run over all this.

in both sharing and holding the painful realities and limitations of our work, we shall not survive.

If residential workers are to survive they must hammer out the boundaries and control systems and the nature of their own tasks; failing this, they will increasingly be used simply as convenient off-loading systems in their establishments.[7]

So, to practical examples of what is painful and evaded, and must be accepted and faced:

The residential *treatment* of a young offender will be expensive. Staff/child ratios will need to be about 1 to 1. Groups and Cottage Group Living Units for treatment must essentially not be more than 8-10 in size. Unintegrated adolescents – that is, those who have achieved no capacity for reflection or control and are continuously swamped by id impulses – cannot be treated with integrated adolescents, and these (that is, the integrated neurotics who can benefit from shared responsibilities, self-government and so on) need to be clearly differentiated in terms of treatment need and environment.

Perhaps more painful still is the fact that without *selection* along clear-cut principles no treatment unit can survive and also perform its primary task – staff will become id-soaked, or stressed beyond tolerance. And it must furthermore be absolutely recognised that selection must primarily be a function of the boundary control of the unit itself and cannot be externalised (though it may be shared, and help given). Change within a residential unit is so unpredictable that such selection can only proceed on a continuous basis as the internal dynamic evolves and develops. A treatment unit cannot really have a waiting list.

Whereas in a 'residual population' institution (such as prisons) one must accept about a 70% breakdown rate afterwards (the client slides on through borstal and prison, becoming further institutionalised and pseudo-independent and more delinquent either in a conformist, expedient or a belligerent way) with *treatment* the adolescent reaches substantial over-dependency and gradually relatively more normal inter-dependence, and is thus more in need of continuing ordinary care and support in a *living* context. A high and increasing proportion have no such base and there are no suitable places for them. So-called 'after-care' is irrelevant (except to maintain information and contact, and at present even that has almost completely broken down). This, of course, is bound to have a disheartening effect also and we have to do something about it.

But centrally and critically, unless there is a determined, non-permissive, and really authoritative and firm insistence on working groups really meeting regularly, there will never develop that inter-personal and inter-dependent confidence and security which is needed in order to look at the painful and real actualities.

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[7] So much of the 'violence' from staff (which in the past was ritualised in the form of beating) is engendered by a sense of 'helplessness'; violent reaction to a fear of annihilation. When they are anxious, residential workers may become aggressive, assertive, difficult and stroppy, or as delinquent as any other delinquents.

There is no security without such open communication, reality confrontation, and relationship. The magnitude of the difficulties are such that aloneness evokes a basic terror of engulfment and loss of being (powerlessness) and so this, the very simplest of all human needs in this work, must be met. Only so can directness and confrontation with the reality of the effects of one's own behaviour on one's colleagues become possible and tolerable; it is essential also so that the freedom and necessity to say what one really feels and actually experiences really can develop. This takes a long time and the process is hell on wheels, so there is much motivation to evade it. But we must insist, for only so can the real sources of fears, suspicions, and anxieties be located and faced, rather than projected outwards or upwards into a convenient 'them' in a paranoid way.

Conclusion

Freud (1951), in his introduction to August Aichorn's famous book *Wayward Youth* says of the application of psychoanalytic insight to the residential treatment of the young offender: 'In my youth, I accepted it as a by-word that the three impossible professions are teaching, healing, and government …'

We do not believe, I think, that we belong to an 'impossible' or 'hopeless' profession; not, that is, unless we are deluded or omnipotent. If we seek reality, if we are modest, small, bunchy and truthful in relation to the magnitude of the problems, we can fall back, again and again, on a very simple faith.

Such a faith was expressed recently to me by a struggling new Area Director: a very experienced family caseworker. She was writing about a boy we all felt we had utterly failed to help:

I still cling fervently to the idea that the seeds of genuine concern for a child never totally fall on stony ground and that the odd one takes a very long time to germinate. Unfortunately (she went on), during this present period of re-orientation as far as the new services are concerned, we find ourselves in such a confused state and so full of anxiety that this is bound to have serious repercussions on the people whom we call our 'clients'.

It is my belief from my experience that meetings and decisions must be made in the open, not in little pairings and threesomes. Staff must learn to work *openly* together in small groups, which means openness rather than split-off 'power pockets' in systems and agencies. With this there may gradually be real hope and opportunity within the new social services. Gradually there may develop less collusive non-communicating, which is highly motivated by the denial of reality and anxiety. Then, as with approved schools (so also with sub-normality units and old people's homes), less would be covered up and there would be less need to pretend that the impossible was being done. A more objective and honest picture of reality would emerge, and at least there would be some security in facing, for example, the fact of residual and rag-bag residentially-placed populations, and in differentiating them from treatment units. A valid if painful picture of a residual population 'hierarchy' of units, in a true sense of differentiation of function, might begin to emerge.

Only so will staff find confidence in each other, and confidence and belief in what they are doing (the task); only so will the structures and cultures they are developing grow creatively. Failing this, any enterprise will become dead, static and anti-life.

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Appreciations of
Richard Balbernie's Life and Work

This photograph of Richard and Joy Balbernie was taken in 1984 outside the Old Farmhouse at the Cotswold Community

Obituary* for Richard W Balbernie

When in 1942 Richard Balbernie joined the 4th Battalion – where inevitably he became known as 'Balbo' – his youthful and slightly saturnine good looks gave no clue that he was barely out of his middle teens. He had, in fact, joined up at the age of 16, overstating by several years in order to get past the recruiting authorities. Thus, he cannot have been more than 17 or 18 when he ran the Battalion's M.T. with great energy and efficiency, though seldom without expressions of the deepest pessimism regarding the qualities and capabilities of the M.T. in his charge. Needless to say these were invariably falsified in the event. He then took over B Company, shortly before the Battalion moved into Burma, and immediately proved himself to be a commander of great dash and gallantry. Indeed, whilst most of us in those days felt reasonably satisfied with

* This Obituary appeared in 6th Queen Elizabeth's Own Gurkha Rifles Regimental Association Spring 1987.

our performance if we were able to do what was required of us without visible signs of panic or alarm, Richard appeared untroubled by such human frailties. As far as we could see, he was totally without fear, and it was no surprise when he became the first officer in the Battalion to be decorated – almost the first of any rank, in fact.

He left the Army in 1945, took a degree in Psychology at Cambridge, and for the next 35 years or so followed the calling in which he was to make a distinguished name for himself both in this country and internationally: the training and rehabilitation of delinquent or maladjusted boys and men. In post-war years he was a regular supporter of Regimental occasions, both in London and at the Watersplash, and will be greatly missed by all of us who used to meet him there. Our thoughts are very much with Joy and her family in their sad and untimely loss.

The eulogy, delivered by Bill Allchin, at Richard Balbernie's funeral

Friends

This is a sad and heavy occasion as we come together to bring to mind the recent death of Richard Balbernie. His presence was a very salient one, and the comfort and stimulation of it has, perhaps, only become fully clear to us now that it has gone. Yet, because of the kind of person he was and the creative and healing nature of the work to which he so fully committed himself, our meeting together is also something of a celebration, and an affirmation of our own free commitment to the same objective as his.

I feel myself honoured to have been asked to say these few words this morning, for I know that there may be others who knew Richard as well as I did, or better, and there are certainly others whose eminence, originality and competence in the field of child and adolescent care far exceeds my own. There are things about Richard's life that I have only learned in recent weeks, on reading what others have written about him. For example, the style, panache and bravery of his army life, suggested by the few details that have emerged, reminded me of that story in Plato's symposium where Alcibiades the general, is describing Socrates, in the role of a foot soldier, during their defeated army's retreat from Delium. He noted that Socrates was going along, just as if he was walking down one of the streets of Athens, with his usual 'lofty strut and sideways glance', the sort of person you'd never have a go at, because you'd know you'd get more than you bargained for – he was the sort of man who faced up to danger and difficulty rather than running away from it.

Richard was in some ways a very private person, a modest man whose courage, integrity and compassion were great. He did not flinch from hard

work, disagreement or disturbance. There was nothing of complacency about him or of wanting a 'quiet life'.

But my task this morning is to make some reference to Richard's work in the field of child care, particularly its residential aspects.

Firstly, what struck me was that he worked to a body of theoretical knowledge, a coherent body of ideas which made both conceptual and clinical sense. He drew on the work of some of the most important and original minds of our time, such as Winnicott, Bion, Dockar-Drysdale and Bettelheim to name but four who come immediately to mind. Eventually this sound body of theory reached a tangible expression in the Cotswold Community. Thanks to the heroic and persistent efforts of Richard and his staff, not forgetting at this point the work of Bill Douglas and many, many others over the years.

The story of how the healing work changed the conventional Approved School into such a community is told by W David Willis in his book 'Spare the Child'. Many of us were aware of the kind of boy from the old Approved School, clean and tidy on parade, full of yes sir's and no sir's, outwardly conforming, inwardly with his own priorities such as date of release, extra privileges and supply of tobacco. Not many of us were fully aware of the strengths of the delinquent and perverse sub-culture which permeated the place. The rule of the bullies meant that most of the teaching and learning went on after hours and after dark, and it was a brave boy indeed who would risk defying that rule. Two recent cases of sadistic bullying in the Remand Centre behind the Main Prison in Winchester are typical; in the most recent case, a 16-year-old remanded for medical reports nearly lost his life (through internal bleeding, and he was transferred to the hospital on the other side of the road to have his damaged spleen removed).

In my work over the last 30 years I have seen many special units, small hospitals, children's homes, hostels as well as approved schools, YC centres, DCs and prisons of all kinds. The Cotswold Community, as Richard and his staff built it up, and through the psychological ruins of the old order, became a shining light. For, not only was Richard himself a man of unusual depth and quality of soul, but the staff working with him were, and are, an exceptional group of people. Many have relevant training and experience in the work, others have university degrees, others again will be going through personal analysis or therapy. They work for long hours, and are in the closest proximity to the centres of psychological disaster, in each resident, centres from which emanate fear, distrust, hatred and despair. Richard saw to it that his staff not only had support systems within the Community, but consultants from outside who came in on a regular basis – Pip Dockar-Dyrsdale. Thus, there is a continuous learning situation as well as much needed support in facing the day-to-day tension and crisis. This means that it is possible to check theory in the light of experience, and guide action in the light of theory. This was neatly put in a saying attributed to the late Joseph Stalin:

> Theory without practice is sterile: Practice without theory is blind.

This unique work at the Cotswold Community naturally attracted attention, some of it critical. It was thus an important occasion when in February 1982 the DHSS Social Work Services Officers, M. Enright, D. Lambert and T. Strettle, made a thorough assessment of the work of the Community and produced a report on it. Fully detailed, carefully written and checked over with those involved in the work, the report documented the facts ascertained and the real 'on-the-ground' and 'in-the-heart' achievement. An effective, humane, insightful and compassionate treatment programme which results in many residents leaving the Community substantially integrated, recovered or significantly improved, and showing, on such a crude measure as reconviction rate, a figure of 10% rather than the usual 60–80%.

So it has fairly proved to be a light shining in the dark work which is now continuing and developing under the good care of John Whitwell and those working with him, and this at a time when the possibilities of full residential care, prolonged if need be, seem to be steadily diminishing.

We certainly haven't seen the last of the therapeutic power of the Cotswold Community, but it is unlikely that we shall see another example of it, and I am reminded in this connection of the magnificent pioneering work of Maxwell Jones, whose first therapeutic community (TC) in Britain, again a great light and challenge to the darkness, has never been fully replicated.

The truly TC healing, making whole, or holy, those who work within it constitutes in our time, one of widespread and active social pathology (disease), a true island of sanity.

Perhaps it should not surprise us that out of places designed to help the ill, or disturbed, the abnormal or delinquent, should begin to originate the healing impulses and insights that our society as a whole so desperately needs.

So we meet together today to share and acknowledge our sadness (at the death of Richard Balbernie) but also to salute and celebrate his life and work. Together today we can give thanks for him, realising that the world we know is a better place because he lived and worked in it, and that because of his achievement and generosity of spirit, our hopes, too, are revived and strengthened. So that we, in our turn, may be able to leave, as Richard has done, something of lasting benefit to some of the children and young people who will build the future.

Amid the darkness the light shone but the darkness did not master it (John 1, v.5).

This is a photograph of Richard with the Larkrise staff team at the Cotswold Community in the mid-1970s.

Dedication and charisma

Eric J. Miller offers an appreciation of Richard William Balbernie, who died recently[†]

Richard Balbernie died on 17 June, three days before his 63rd birthday. Ill-health had forced him to retire last August, after 18 years as principal of the Cotswold Community.

When he was appointed in 1967, out of a field of 120 applicants, the then Cotswold School was a conventional Approved School operated by the Rainer Foundation.

[†] Eric Miller was on the staff of the Tavistock Institute of Human Relations; Richard Balbernie died in 1986 and this article appeared in Community Care, 3 July 1986.

It was on the brink of collapse: morale was abysmal, delinquency was rife not only among the boys but among the staff, and some 85% of boys leaving the school were re-convicted within two years.

The task that the Foundation assigned to Balbernie was to transform the school into a TC.

This was a time when the Home Office Children's Department was reviewing the future of the approved schools, which under the 1969 Children's and Young Persons Act were to be converted into community homes, oriented to care and treatment rather than punishment, and accordingly the Rainer Foundation's plans for the Cotswold were strongly endorsed by the Home Office as a pilot experiment in making such a transformation.

Balbernie took on the task with uncompromising dedication and single-mindedness. In fighting for his principles he was no respecter of rank or power; and in the process he made some enemies, but won the grudging or ungrudging respect of many. His capacity to involve himself heroically with the young was beyond compare. Yet he was not just a charismatic figure, of whom there have been a number in this field: his approach has been based on an explicit theoretical framework, which he developed in the light of experience.

Hence the model of treatment was one that could be tested and replicated elsewhere. He, and the staff he trained, applied it with love and understanding, without sloppy permissiveness, and with firmness without repression – a demanding balance to strike.

A planned transfer of the Community from the Rainer Foundation to Wiltshire County Council was completed in 1973.

By that time the approach had demonstrated its effectiveness for severely disturbed young offenders with unintegrated personalities. But the conditions for maintaining it – for example, devolution of budgetary management to small households, long working hours for staff – were often inconsistent with local authority policies and regulations.

Successive directors of social services, subjected to repeated pressure from Balbernie to meet those conditions, were at times exasperated. They nevertheless became his allies: his integrity and his utter commitment to the task of the Community were irresistible.

Although Richard Balbernie was characteristically modest about his achievements, a follow-up study four years ago showed recidivism reduced from 85% to around 5%. But for the Cotswold Community literally hundreds of young men would be in and out of prison.

Scores of men and women who worked in the Community over the years, and a large number of students, have also carried the benefits of training and experience to a wide range of other settings in residential care and beyond.

However, Balbernie's contributions to residential care of children extend back long before his stint at Cotswold.

His lifelong concern with juvenile delinquency dated from his experience when, forced to leave school when his father, a regular army officer, was killed early in World War II, he began work in the office of a magistrate's clerk at the age of 15.

His vocation was interrupted by a distinguished war career, which used and developed his flair for leadership.

At sixteen, overstating his age by two or three years, he enlisted in the regular army. Before he was 20 he was a major and company commander with the Ghurkhas in Assam and Burma, and was awarded the Military Cross. He was also mentioned in despatches.

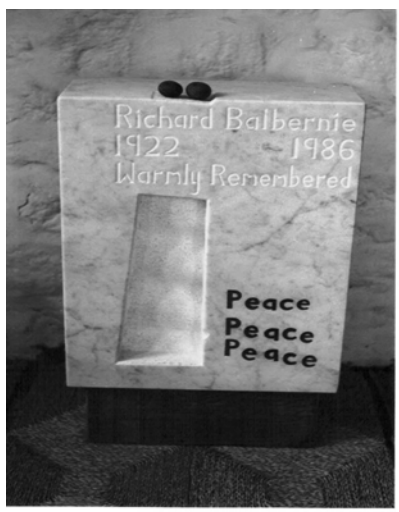
The wounds he suffered in rescuing a wounded fellow-officer led to his retirement in 1945.

Graduating then from Cambridge in psychology, with a Certificate of Education, he trained as an educational psychologist, and it was while working in this capacity for the City of Oxford that he raised the money to set up Swalecliffe Park School for delinquent and maladjusted boys. He was its principal for five years.

From 1957, he spent ten years first at Oxford, in the Department of Social and Administrative Studies, then at Bristol, in the Department of Education, combining part-time work in a TC for mentally ill adults with research, consultancy, teaching social work students and writing – and also earning an Oxford B Ltt to add to his Cambridge degree.

His book, *Residential Work with Children* (first published in 1966, reissued in 1973, and also translated into Japanese) became a classic in the field.

It is to be hoped that a book on the Cotswold Community, which was to have been a retirement project, can be completed. But that will not make up for the loss of the person.



This commemorative stone was carved by Simon Balbernie and for several years had a home in the Chapel of the Cotswold Community.

Staff Consultation in an Evolving Care System

B.E. Dockar-Drysdale

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

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

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

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

Long ago, I remember, there was a student at the Mulberry Bush who could not manage a play group of three disturbed children. She left us after a few weeks, and when we next had news of her, she was working for an organisation aimed at achieving world peace. I also remember, to give another instance, the

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

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young wife of a new member of staff at the Cotswold telling me 'But this way of working is not *possible.*'

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

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

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

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

> Initially we saw my tasks to be (firstly) the provision of ego support in order to facilitate ego functioning in integrated children; (secondly) the containment of unintegrated children with provision of primary experience with which to build the self and achieve integration. These two tasks were to be carried out through work with both staff and boys. It was assumed that unintegrated children would form a small minority group in the place: this group would need, as soon as possible, to be insulated in order to receive appropriate treatment. The mixture of integrated and unintegrated boys was recognised as undesirable.
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> In the event, I was assigned to a house, St David's, consisting of very deprived and disturbed boys; this group was not yet separated in any way from the rest of the Community, but was self-selective in terms of gross disturbance as a common factor. I talked with the boys and with the staff individually, until the staff themselves asked for group meetings with me. These staff groups became the nucleus of my work in the Community. My sessions with boys could – with their permission – be used to help staff to gain insight and to understand the need for teamwork in order to provide experience. These individual sessions were – and remain – of necessity brief – 20 to 30 minutes. I have found that, where residential workers are themselves carrying out a therapeutic programme, sessions with individual boys have what I call a 'key' function, helping to open and deepen channels of communication between boys and workers.
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> St David's became presently the unit for unintegrated boys known as 'The Cottage'. Once this kind of insulation had been established, my task became more

> precise. By discussing weekly 'happenings' chosen by the Cottage team, I was able to help them to provide primary experience, through individual adaptation to need, based on early dependence and involving localised regression within a relationship in a firmly structured containing environment. In this way, the team came to realise how disciplined any real therapeutic work must be, and the danger of collusion and the need for confrontation of a non-punitive kind. The team did good work, although naturally making many mistakes which with adequate support they could face. The development of an ego culture in the Cottage minimised authoritarian attitudes at one extreme, and subcultures at the other. The establishment of open communication between staff and boys reduced acting out; and the insulation and containment of this group of unintegrated boys enabled ego growth and strengthening in other groups within the Community.
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> For various reasons it was decided after a time that I should work in a similar consultant-tutor role in the remaining three house teams. My weekly discussion groups evolved into seminars, with learning based on the group experiences during the current week. Each group seminar lasts for 45 minutes, with periods of from 20 to 30 minutes available as before for key sessions with boys, usually at their own request and tutorials with team members – often the heads of houses. I have a close liaison with the head of group living, who plans my day's work each week, and with whom I discuss my work in detail each Wednesday evening on the telephone, after my return home. I have also meetings with Mike Jinks, the head of education. I meet Richard Balbernie frequently, and discuss problems and recommendations with him, both at the Cotswold and by telephone.
>
> The development of a system of need assessment has enabled us to chart all houses on a basis of integrated or unintegrated: and if unintegrated, to chart the specific syndrome of deprivation (see my paper for the Home Office course at Bournemouth, 1970). From this 'inside diagnosis' we are now in a position to plan treatment on a foundation of need, and to select with some certainty those boys to whom we can offer help. The work on need assessment is also enabling the staff to conceptualise and communicate what they are doing; and recently teams have begun to carry out these assessments themselves, checking results with me, so that we can plan treatment programmes in an exact way.

In order to understand the nature of the task facing a consultant, in this particular set of circumstances, it seems important to clarify the nature of a classification such as I have just mentioned; that is, into integrated and unintegrated. I shall now quote from my own work (Dockar-Drysdale, 1968).

> Winnicott (1958) and others have postulated a primary state of unity of the mother and her baby. In thinking about emotional deprivation I find it necessary to take as a starting point this state of unity at the very beginning of a baby's life. Freud (1926) wrote: 'For just as the mother originally satisfied all the needs of the foetus through her own body, so now, after its birth she continues to do so, though partly through other means. There is much more continuity between intra-uterine life and earliest infancy than the impressive caesura of the act of birth allows us to believe.' In the course of normal development the separating out of mother and a baby is a long and gradual process; at the completion of this the baby exists for the first time as a separate individual, absolutely dependent on the mother, but no longer emotionally part of her. If integration of the personality is to take place usually by the end of the first year of life the evolution of this process must not be

> interrupted. Interruption of this essential process, which mothers and babies work through together in their own time and in their own way, is in my view the trauma which lies at the root of the various types of cases of emotional deprivation referred to us.
>
> The point at which traumatic interruption has taken place determines the nature of the survival mechanisms used by the child: the primitive nature of these mechanisms does not prevent them from being used in a highly complex manner. Winnicott [1963] has said: 'All the rest of mental illness (other than psychoneurosis) belongs to the build-up of the personality in earliest childhood and in infancy, along with the environmental provision that fails or succeeds in its function of facilitating the maturational processes of the individual. In other words, mental illness that is not psychoneurosis has importance for the social worker because it concerns not so much the individual's organized defences as the individual's failure to attain ego-strength or the personality integration that enables defences to form.' The emotionally deprived child is pre-neurotic, unable to experience guilt or anxiety, and functioning at various primitive stages of development. For a neurotic child there may have been inadequate continuity between the intra-uterine and postnatal phases, but nevertheless he has enough protective and protected environment to make it possible for him to build a separate personality structure, capable of integrating good and bad experiences and his responses to them, rather than being helplessly buffeted by them. He is thus able, having reached integration because of 'good enough infant care' (Winnicott, 1958) to embark on the long voyage of secondary experience.

When we first classified all the boys in the Cotswold on the basis of integration as individuals, we found that 75% of our population turned out to be unintegrated: this was a rough-and-ready emergency classification, using the presence of panic and disruption as the factors determining whether or not a boy was to be considered integrated. A unit for the integrated 25% was set up, which accepted boys who achieved integration as the result of treatment within the Community; and those very few who on referral seemed to be integrated. Obviously my work with the staff of the unit for integrated boys (Boulderstone) was very different from discussions with teams in other units.

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

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

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

> On the basis that anti-task, acting-out, and subcultures of all kinds tend to spring from a breakdown in real communication, it would seem of the utmost importance to keep all lines of communication open – between members of the team, between grown-ups and children, and between the consultant and all others in the place. The making of a need assessment involves the whole staff group of a residential unit, working with the consultant, and pooling resources in order to evaluate need. Often insights are reached in the making of these assessments which are not only of value to the child under consideration, but also to the treatment team themselves, throwing light on problems of delusional counter-transference – splitting mechanisms, for example – but in a way which is tolerable because it is indirect and shared. Such an approach seems to me to give child care workers a proper professional position in the scheme of things – the consultant being entirely dependent on the material brought forward by the unit team (see my paper on 'Need Assessment'; Dockar-Drysdale, 1973).
>
> The questions asked in the need assessment are those which I have asked myself in attempting to analyse a context profile, which is a method of reporting by the team on experience with one child during a week (I have written about this technique elsewhere; Dockar-Drysdale, 1968).
>
> I have tried to approach the problem of meeting the child's needs – whatever these may be – by classification (rather than by considering his symptoms). I have so far used this form of need assessment in both the Cotswold and the Bush. I think that it would always be necessary for a senior worker to lead such a group discussion; asking and explaining the questions, and recording the answers. There can be no 'yes' or 'no' answers: all replies must be based on actual experiences with the child.
>
> We have found that this kind of need assessment helps us in planning for the child's management and care. A need assessment in no way replaces other assessments (case history, intellectual ability, and so on). I find it a valuable addition to other information.
>
> The questions can only be answered for the first time by a group of people who are living with the child, and have been doing so for at least three weeks or a month: they must understand that this is a first need assessment – that there will be others necessary in order to meet the child's evolving needs. I think that only a group of resident workers can draw on the kind of experience essential to this type of assessment [Dockar-Drysdale, 1973].

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

to considering boys in this rather exact and disciplined way, and to applying the concepts to *themselves* as well as to the boys.

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

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

> The questions may seem odd at first, but they do seem to obtain the kind of information necessary. Workers quickly become accustomed to this approach, which is still at a 'workshop' stage. A need assessment usually needs an hour of group work to complete.
>
> **Classification** Is this boy integrated as a person, or is he unintegrated? To judge this, one should ask oneself.
>
> (a) Does he panic? By panic, I mean a state of unthinkable anxiety – almost a physical condition. (Many so-called 'temper tantrums' are panics.)
> (b) Does he disrupt? By this, I mean does he disrupt a group activity or a happening between two other people.
>
> It would appear, from evidence so far, that the presence of panic and disruption fairly frequently in a child's life justifies us in considering him, for the present, as being unintegrated.
>
> If he seems to be unintegrated, go on to the next question.
>
> 1. What is the *syndrome of deprivation?* This can be judged by answers to the following questions. What is the state of feelings in this boy with regard to:
>   (a) personal guilt. This refers to concern; to what one could call healthy guilt – not a fear of being punished or found out, but an acceptance of personal responsibility for harm done to others, of a kind which can lead to making reparation.
>   (b) dependence on people or a person.
>   (c) merger. This is the way in which some children become merged with one other or with a group (a typically delinquent phenomenon).
>   (d) empathy. I like to think of this as being a capacity to imagine what it must feel like to be in someone else's shoes, while remaining in one's own.
>   (e) stress. How does this child deal with feelings of stress?
>   (f) communication. Does he *really* communicate, or does he just chatter in a stereotyped way?
>   (g) identification. Does he, for example, seem to model himself on a grown-up he admires, or on another child? Be careful not to confuse this with merger.
>   (h) depression. Is he sometimes very depressed, or is he indifferent, or always apparently cheerful? Is he at times deeply sad? There is a kind of state of low-level of consciousness – just 'ticking over' – sometimes seen in deprived children, which I call 'hibernation' and which should not be confused with depression.
>   (i) aggression. Verbal and physical.

2. What is his *capacity for play?*
   (a) narcissistic. Does he play a lot alone with pleasure?
   (b) transitional. Does he, for example, make use of a transitional object?
   (c) pre-oedipal. Does he usually like to play with one other, usually a grown-up?
   (d) oedipal. Does he play with more than one grown-up at a time?
   (e) post-oedipal. Does he play with other children, is he able to keep to rules, and so on? (See 'Play' in 'Therapy in Child Care'.)
3. What is his *capacity for learning* – in every sort of learning situation? Does he learn from experience?
4. What is his *capacity for self preservation?* i.e. is he accident prone? Does he take care of himself and his belongings? Does he seem to value himself?

[Dockar-Drysdale, 1973]

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

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

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

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

This was a very obvious example of unconscious collusion, there are many more subtle and hidden ways in which this sort of mechanism can operate – *but only as long as the worker remains unconscious of it.* The surfacing of such material puts an end to the unconscious technique which cannot now be employed *without guilt.*

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

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

During this period I added 24-hour programmes to our established need assessments. The whole group went over 24 hours with me in respect of the needs of an individual boy – for example, how he needed to be woken in the morning. A programme like this ensured that a unit team would all know a boy's needs at that time, so that newcomers could quickly gain information. Changes in the programme could be recorded. This 24-hour programme has proved to be especially valuable for new boys on arrival (prior to actual need assessment).

At this point I reported (Dockar-Drysdale, unpublished) as follows, on 'therapeutic structure'.

> Let us assume the presence of a management structure which divides sixty boys into groups of from nine to fourteen persons, in four units. Each unit has a head, a senior housemother and two or three others, any one of whom may be called on to substitute for the head. One of these units caters for integrated boys, three for unintegrated. Usually the integrated boys have achieved integration within the place.
>
> The needs of each boy must be formally assessed by the team group within the first month, and thereafter at intervals of about three months. Ways of meeting these needs must be found within management structure (in terms of working hours of staff, life style of unit, etc.). At present we do not have adequate referral assessments. Integrated boys will not require need assessment so much as good reporting. Within this management structure, a therapeutic structure must exist. Selection of staff depends on personality, training and experience. In the one unit for integrated boys, staff will need to be ego-supportive: in the other three units they will need to be ego-providing (i.e. you cannot support what is not there). (For comments on all this, see Winnicott, 'The Family and Individual Development' – 'Group Influences and the Maladjusted Child'.)
>
> This classification is the initial structure required for therapy to take place in order to carry out the two primary tasks in the place provision for integrated and provision for unintegrated boys. Such classification can fit comfortably within the management structure.
>
> Within the therapeutic main structure are the substructures. Therapy can take place within many fields; food, bedtime and getting up, school, communication, play, bathing, clothes, and others. In each and every case, however, the therapeutic structure must contain the therapy, which must also fit into the management structure: i.e. if, for example, 'Lights out' is at ten o'clock, this is not the moment to start therapeutic communication with boys. Equally, no therapeutic structure could exist within a management structure which sends most staff off at weekends. The use of 'weekends' is an obvious example of the need for a management structure within which a therapeutic structure *can* fit. Night care is another example.
>
> In the unit for integrated boys we can think in terms of a group. Here the whole group could meet daily with the team to discuss the problems in the unit, and reach decisions. We can assume an ego nucleus or ego functioning (they will also need other forms of communication).
>
> In no other units *is there a group* (the *false group* structure in one unit led to breakdown in communication, and subculture). These unintegrated units need what Winnicott called 'cover'. We find, however, that small talking groups (four boys to one adult) with separate lifelines to the adult *do* lead to communication.
>
> The small talking groups can be contained within the management structure, and form part of the therapeutic structure. Within the talking groups, matters to do with inner reality can surface safely.
>
> These groups have no part to play in management, i.e. decisions are not reached – the aim is not to make decisions but to facilitate open communications. There can be house groups of staff and boys for all sorts of communication, but this is not therapy but good management. The large meeting in Boulderstone also fits within the management structure, but has an objective social purpose and can reach decisions.

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

All therapeutic communication needs to take place between the same people, at the same time, in the same place and for the same duration. This time and place structure must fit into management. Of course there is unplanned, casual communication in context, at any time. Within the Polytechnic area there is plenty of planned communication, both individual and in small groups.

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

Twenty-four-hour therapeutic management programmes are needed for all unintegrated boys, to ensure reliable continuity of provision in a unit. Here again, 24-hour programmes must fit into the main management structure of the whole place and of the unit – otherwise programmes will breakdown. Equally, any change of management must respect programmes.

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

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

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

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

Note All therapy requires a close and deep relationship between boy and worker. Adaptation 'dosage' would do harm. There can be no de-personalised care, whatever the boy may feel about the worker. The worker must remain concerned about the boy, even when hated by him. Vague dishing out of 'Tea and Sympathy' is not therapeutic work. All provision must have symbolic meaning if the boy is to

> experience symbolic realisation. Any therapeutic structure assumes that this is already understood. There are many therapeutic techniques not available in the circumstances: we must make good use of what we can do. For example, verbal interpretation often cannot be used with our very ill clients – it will then be what we do rather than what we say that can be of use to them: but what we do must be planned, realistic and reliable.

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

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

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

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

make use of this comment and the next squiggle took him back to the creatures of his inner reality.

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

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

There have been further developments. There is now in each unit a manager, a management continuity resource person, a therapeutic resource person, one or two educational skills resource people, and one or two team members. The therapeutic resource person is responsible for 24-hour programmes, context profiles (a detailed type of reporting on a boy for a week by the whole team), need assessments, talking groups and communication plans, adaptations to individual needs, and therapeutic play.

Richard Balbernie and I meet the therapeutic resource people (there are four – one to each unit) weekly to discuss their work. There is also a training group which I run each week for newcomers to the place; and a group run by Richard Balbernie and myself for staff wives (this last has proved to be essential). I feel we have achieved a therapeutic structure which has evolved in a gradual and realistic way. There are in all this great hazards and problems which sometimes seem insuperable.

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

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

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

If I accept an introjecting person as an incorporating one I run the risk of supporting a worker who *says* all the right things whilst continuing to go his own way, doing what he has always done. This kind of person stays up half the night talking with a boy, without resentment and without guilt, because it never occurs to him that he is getting pleasure from this himself. The introduction of structure into his work – the realisation that a complete experience lasting 20 minutes (with a beginning, a middle and an end) can be therapeutic in a way in which hours of talk may never be – interrupts a well-established drift towards collusive pairing, producing fierce resistance. In these circumstances the worker accepts the theory (by word-swallowing) but continues the long drifting talks even though he may now feel that this is delinquent (because this has been demonstrated to him). He continues, but he feels *guilt*. I think this is important to understand: insight will arouse personal guilt in areas where there has been none before. Obviously the worker will be very anxious and resentful, so that I sometimes meet a lot of anger at this point. Equally, the worker may take flight – Richard Balbernie calls this the 'going tomorrow syndrome'. I find that I must be very careful not to surface too much at any time – never more than can be tolerated and incorporated in a gradual way.

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

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

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

Syndromes of deprivation are graded in terms of ego strength: for example, a frozen boy scores 1, whilst a caretaker syndrome scores 4. Since we are now in a position from which we can assess the syndromes within any unit, we can also score – roughly – the ego strength. On occasions when the ego-strength

drops below the minimum level required, the team ego-nucleus has to be drawn on if the unit is to survive. This leads to impoverishment of grown-ups and eventually to breakdown. The team can now say, for example, 'We cannot admit a frozen boy when we next have a vacancy – our score would be too low'. We are even learning what combination of such syndromes produces a working group (e.g. there cannot be more than one new frozen boy in a group).

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

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

To summarise

Need assessments provide a basis for planning treatment for the individual boy as well as classifying the particular syndrome of deprivation. *Treatment programmes* cover the 24 hours in the daily life of each boy, so that everyone in the unit knows the agreed approach in everyday situations to each boy. *Talking groups* are small groups, meeting with the same adult in the same place, and facilitate communication and lessen the risk of acting out. *Communication rating* makes it possible to judge the current level of communication of the individual and of the group. *Ego scoring* adds up the ego nucleus in any unit in order to make sure that at least the minimal required ego strength is possible. *Therapeutic resource workers* introduce and maintain a therapeutic structure within the management structure of each unit. *Educational need assessments* assess the underlying educational needs in deprived children (for example, problems of perception).

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

My aim has been to allow people to experience, to reach realisation and to conceptualise; rather than to be bogged down in panic, which is only lit by

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

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

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

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

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The Experience of External Consultancy in a Therapeutic Community for Children

John Whitwell

ABSTRACT: This paper is about the work of Isabel Menzies Lyth as an external consultant to the Cotswold Community in its transition from being an approved school to a therapeutic community (TC). The role of an organisational consultant is to work at the dynamics of the whole organisation and how the various parts relate to each other and to the whole. I attempt to illustrate the way this works by choosing five themes, among many, which emerged during the period of Isabel's consultancy. Although these themes relate to work done in the 1970s, they are still relevant for the Cotswold Community and I believe they will be relevant to other TCs and the residential sector in general.

The Cotswold Community is a therapeutic community (TC) based on a small group way of working (Whitwell, 1989). The setting suits this approach, located on a farm, with numerous buildings, creating a 'village' type of community. This is in contrast to those residential centres that revolve around one large or main building. The client group, emotionally 'unintegrated' boys who have been abused (emotionally, physically and often sexually), find being in groups immensely difficult and need to be in small groups with a lot of individual attention. In addition most of the staff live on site, which contributes to the sense of a therapeutic village, with sufficient emotional health to contain the collective emotional disturbance. The boys attend a physically separate school which is within the Community.

Boys are referred by Social Services, Education Departments and Health Trusts from all parts of Britain. We prefer to make a start in the therapeutic work before the onset of adolescence, so the age of intake is 9-13. Our therapeutic approach requires a long-term placement, which is on average four years, but could vary from two to six years. Our work is informed by psychodynamic principles and we especially draw on the work of Winnicott (1976 and 1984) and Dockar-Drysdale (1990 and 1993).

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The boys live in four separate households, set in their own grounds, with up to ten boys in each group. You could say that the Cotswold Community consists of four mini-TCs and a therapeutic school. Each household has a staff team of six residential social workers, two domestic workers and a volunteer. In addition, two teachers work with each group in the school and they also contribute some time into the household outside of the school day. Therefore, the 'treatment team' working with each group of boys consists of residential social workers, domestic workers, teachers and a volunteer. The Cotswold Community as a whole requires a management team, office staff, and maintenance and farm staff to make it work.

Three of the four households are 'primary', working with boys at the first stage of their treatment, helping them to achieve emotional integration and to begin to develop a sense of self. The fourth, 'secondary', household admits boys from the three 'primary' households when they have outgrown the need for the more regressed culture and need to be in a more age-appropriate environment, which encourages them to take on more personal responsibility and responsibility for the group and the way the household functions.

Historical introduction

A community was first created, out of the original farm, in the mid-1930s when it became a Bruderhof (a place where brothers live) community, consisting of people who fled from Nazi Germany. They converted the original farm buildings into dwellings and places to meet and built the buildings we now use for our school and two of the four households. In 1942 the Cotswold Bruderhof came to an end when the German members had to leave the UK to avoid internment and the farm and buildings became the Cotswold Approved School. There were scores of approved schools throughout the country housing young offenders on approved school orders made by Magistrate Courts. They were in effect junior borstals with the emphasis on training (or punishment, depending on your perspective). Approved schools were supposed to be rehabilitative. Increasingly, research demonstrated their ineffectiveness in this respect (Millham, Bullock & Cherrett, 1975). In the early 1960s there were numerous scandals in several approved schools which hit the headlines. The time was ripe for a change. The government of the day was drawing up the 1969 Children and Young Persons Act, which abolished the approved school system. However, as far as I am aware, out of the many approved schools, only two successfully transformed themselves into TCs: Peper Harow (Rose, 1990) and the Cotswold Community (Wills, 1971). Richard Balbernie was appointed in 1967, by the Rainer Foundation (the managing body), to lead this transformation.

In my view, the appointing of two consultants in 1968 was a vitally important decision, which confirmed the success of the wish to transform. The first was the appointment of Barbara Dockar-Drysdale as Consultant Psychotherapist to work with the staff teams, providing clinical supervision and helping to develop a fully therapeutic culture. She continued in this role for 18 years.

The second important consultancy was from the Tavistock Institute and in particular Ken Rice for the first two years of the transformation until his sudden death in 1969. Since then the Community has had continuous and ongoing consultancy from the Tavistock Institute. After Ken Rice's death this was taken on by Isabel Menzies Lyth for the next ten years. Following her retirement in 1980 Dr Eric Miller took the role of consultant and has continued to the present time.

Organisational themes

A theme which runs through the consultancy provided by the Tavistock Institute is the Community's relationship with its parent organisation because Cotswold is unique among TCs for children (not so for adults), in that it has always been part of a large organisation: the Rainer Foundation until the end of 1972; Wiltshire County Council from then until 1 April 1997; and since then NCH Action for Children.

In Ken Rice's (1968) words '… what can be said with some certainty is that if the Cotswold Community is to be experimental (and innovative) then it requires special protection – in particular protection from interference. The more it is buried in the administrative structure the more likely it is to have its freedom restricted by the need to satisfy too many authorities'.

Each time the Cotswold Community has transferred from one parent organisation to another, it has been a very painful process with deep-rooted fears and anxieties coming to the surface in the form of mutual recriminations and mistrust. For example, when we transferred from the Rainer Foundation to Wiltshire County Council in 1973, the predominant fear was that we would be swallowed by a large bureaucracy which would insist on enforcing the rule book and diminish the flexibility which a TC needs to thrive. In 1997 when we transferred to NCH Action for Children we had fears about our corporate identity being engulfed and lost by their corporate identity. This took the form of arguing about logos and whose logo went where on the official writing paper or advertisement. TCs in particular strive for a strong 'we' feeling to bind the community together. This can lead to the negative feelings being projected outwards onto the harsh, uncaring, unresponsive parent organisation, who are equally wondering what on earth possessed them to take on the responsibility of this problem child and accordingly oscillate between feeling punitive or permissive towards the community. Consultancy is vitally important to help make sense of this dynamic and to avoid its worst excesses.

I think this theme has probably been one of the dominant issues during Eric Miller's period of consultancy, when for at least 15 years we have been trying to move back into the voluntary sector, in order to achieve a more secure basis for the future. Having now achieved this, with Eric's help, and solved one major life-threatening problem, we are faced with many smaller problems which the transfer has thrown up.

The working notes

Between them Ken Rice and Isabel Menzies Lyth produced approximately 20 working notes (papers), based on this consultancy work at the Community. This is unpublished material. Going through the papers which Isabel wrote, I have selected five themes which seem to me to have an ongoing relevance. Perhaps more importantly they give a feel of how Isabel worked with the presenting problems from the Community at the time and helped us to think about them in a different way.

The frequency of Isabel's consultancy was usually every two or three months. However, during more difficult periods it may have been monthly. She would either spend a complete day or sometimes two or three days together, for each consultancy. There would have been some discussion, during the preceding days, within the staff groups, concerning the most urgent issues with which we would like her help. A programme would be worked out in advance to make sure the relevant people were available. For example, if there was to be a discussion on the role of household manager it would have been important for all four household managers to be involved in the work.

The programme was not supposed to act as a straight-jacket and, especially on the 2-3 day consultancies, Isabel would follow her nose if she felt the presenting problem was hiding a more important unconscious problem. The verbal feedback session at the end of the consultancy would be important when some emerging ideas would be debated. This was followed several days later with a written working note which would be available to the whole staff team to read and debate and take action where appropriate. These working notes would sometimes hold no surprises, being more of a synthesis of our collective insight. At other times they would be a bit of a bombshell to the consciousness of the Community.

The working notes were circulated very widely throughout the staff group. There would be a period of discussing, arguing over her observations. Some areas of work featured in working notes over several months as observations and responses were batted backwards and forwards, e.g. the work around the decentralisation of central services into the four households. Over these bigger issues the integrative process was more protracted.

Theme 1: Male/female staff

Isabel started her consultancy to the Cotswold Community in 1970 and one of the themes which she picked up on, in her first working note (Menzies Lyth, 1970, 1988), was the importance of the quality of the relationships between male and female staff.

> Also important for the establishment of masculine models by male staff is their relationship with female staff, since an important aspect of mature masculinity is to be able to develop a secure, concerned, respectful and confident relationship with women. In the running of a house, as of a family, male staff and also boys might do

> what are conventionally feminine tasks and female staff what are conventionally masculine. In a family these matters tend to be worked out implicitly and operated according to the idiosyncrasies of the personalities concerned. In a working unit they need to be clarified and operated more explicitly although still within the limits of the personalities deployed.

The approved school was a completely male environment, with virtually no female staff, so it was no wonder that in Ken Rice's working note the emphasis was on male identification, male role models, and the constructive use of male aggression. Clearly, as the therapeutic approach of the Community was evolving, the importance of women in the staff team was developing and has continued to do so. However, we still have further to go because, although the Community is 50% staffed by women, it is seemingly difficult for women to succeed in more senior management positions, especially the role of household manager.

Theme 2: Managing scarcity

Those of you who have been to the Cotswold Community will probably have noticed that it is a bit 'scruffy', although well looked after. We have clearly never had masses of money to throw at problems, although on many occasions have been seduced into thinking this is the answer. Some TCs for children and adolescents have made a virtue out of a very lavish lifestyle. Isabel did not collude with the pressure to recommend more and more money as the answer to problems. Quite the contrary. For example, staff and boys continuously lobbied for more and more money for food. Isabel's approach was to encourage the household to accept budgetary responsibility for the food money. Almost overnight the money went further. Staff and boys were in a position to decide where to get the best buys. There was far less wastage when everyone was involved in preparing meals and deciding on the menu. Facing up to scarcity, having the conflicts, but also having the responsibility and the authority to overcome the problem, was a very creative exercise.

> It was clear throughout all the discussions, as always, that the resources available to meet demands and needs are quite inadequate. Nor can one hope that they ever will be fully adequate.
>
> What in some way is more important, then, than that they should be adequate, is how the inadequacy is managed. There is a very crucial but very painful management task for the whole Community and for its sub-systems. Only too often the whole Community can become persecuted or distracted by the idea that 'they' should give us more and become involved in attempts to get more from any available source. From the point of view of ego-functioning in the real world, however, it is important for both staff and boys to recognise that life is like that – resources are always limited. The central therapeutic task is how to learn to live with this problem. Staff could help by a realistic approach, i.e. we cannot have everything, how do we make do as best we can with what we do have? This includes not only the development of physical resources, but also of less tangible things like staff time.

Facing up to the scarcity of resources, but not being defeated by it, led to a sort of self-help culture where we felt able, for example, to convert buildings ourselves, with the boys' involvement, into dwelling places. This was a fundamentally different approach to bringing in expensive outside contractors. Although we have had to adjust this to take account of the younger boys now, the spirit of self-help is still to be found in our culture. It also still feels a relevant model to present to boys, which will be of use in their future lives, a model of shaping one's environment and owning it rather than being swamped and defeated by it.

Theme 3: Decentralisation

The approved schools, like many large institutions, had centrally provided services, e.g. kitchen, dining room, laundry and sewing facilities. This was seen as the most efficient and cost-effective way of providing them, which in fact it wasn't because of the huge amounts of wastage. During Isabel's period of consultancy the Community decentralised the kitchen, dining room, laundry and sewing into the four group living households. Although many of the arguments would today be more readily accepted, at the time in the mid-70s it seemed revolutionary. The staff working in these central areas had profound fears about closer contact with the boys, having been hidden away in their own little bolt-holes. The bureaucracy, of which we were a part, had major worries that standards would fall and spending would go through the roof. What Isobel was able to demonstrate was that giving people clear budgetary responsibility is more likely to lead to a greater sense of economy, a more careful use of resources and greater value for money. This was very clearly seen in the decentralisation of the provision of meals. Isabel identified three major benefits of decentralisation:

1. It would directly enhance the therapeutic work with the boys by bringing them into closer contact with the nurturing side of basic care, but also the anger that goes with facing up to scarcity. The more conflicts to do with scarcity can be brought into the group living households, where they can be worked out in small group situations, the better, since this lessens the likelihood of paranoid projection systems developing between different parts of the Community, which would be anti-therapeutic as a model for boys.
2. There is the growth in stature of the staff who take on the delegated tasks. This cannot but make them more effective in work with boys, especially as regards providing positive ego-models for identification.
3. Maximising the opportunity for boys, with staff, to have an experience of living as similar as possible to that of normal boys living with their families, e.g. to go shopping, to experience the conflicts involved in choice, to learn to deploy the limited amounts of money available.

Theme 4: Rivalry between staff groups

Residential schools or children's homes with education on the premises are usually bedevilled by intense rivalry between teachers and care staff. This may relate to different conditions of service. Historically teachers have tended to look down on care workers. Teachers have had a stronger professional identity, linked to a clear training programme. Most care workers are professionally untrained. The Cotswold Community was keen to establish a sense of belonging to a treatment team, whatever the professional identity. Richard Balbernie was so determined to elevate the role of group living workers in relation to teachers, he was in danger of relegating teachers to the 'second eleven'. During her consultancy Isabel continuously worked at the dynamic between group living and education.

> The question posed was whether the Polytechnic (the Community's school) is a service to group living, or not, and the focus of concern appeared to be whether the Polytechnic was 'justified' in returning a boy to group living if he appeared too disturbed or disturbing to be effectively managed in the Polytechnic for his own and other people's good.
>
> Discussion of such issues aroused a number of questions in my mind. I felt that the problem might have been wrongly formulated, i.e. not is the Polytechnic a service to group living, but rather, how the Polytechnic and group living can best work together in the service of boys. This was when I became concerned about possibly anti-therapeutic group and individual projective systems operating between and within the Polytechnic and group living. For example, a Polytechnic group could be viewed as an 'inter-group exercise group' exported into the Polytechnic from group living and vice versa. It would seem important, therefore, to keep in touch with these processes and control rather than be controlled by them. An example quoted led me to suspect that a particular boy in a Polytechnic group who was very difficult for the teachers to manage and disruptive to the work of the group could, in fact, be a receptacle and actor-out of group forces coming from the other boys in the group, the whole thing very much reflecting something that was going on between group living units as reflected through the boys in the Polytechnic group. The other boys took no responsibility for this disturbed boy's behaviour and one could only have the suspicion in this case that he and the group were acting out the idea that the Cottage boys are the most, or even impossibly, disturbed. This seemed to be linked to a tendency to see boys perhaps too much as individuals and not enough as themselves being precipitates of group forces and acting under the influence of very powerful projections into them.

This rivalry and boundary skirmishing can still flare up over who is left holding the messy baby, but we did establish a clear sense that both group living and education are part of the same treatment task. I think the problem we face now is the growing pressure for our education area to be more school-like, to follow the national curriculum, and for education to become separated from the therapeutic task. This could split the staff groups.

Theme 5: Dealing with dirt and mess

By now it should be clear that within the Cotswold Community system any part or subsystem was open to scrutiny, including its relationship to the whole system. In June 1973 a presenting problem was the discontent and stress within the group of women employed as 'cleaners' within the group living units.

> The cleaners themselves state that they do not get 'job satisfaction' in working in the houses and do not get the results they would like.
>
> They deal on a physical level with the dirt and mess caused by boys. How far are they somehow reflecting similar feelings in professional group living staff about doing an inadequate job or less adequate job than they would wish with the 'dirtiness' and 'messiness', i.e. the illness and lack of integration in the boys themselves? It may be significant here that my visit happened very soon after two major outbreaks of violence, a fire in one of the households and Danny's attack on Margaret. How far are the cleaners being used to discharge in a relatively harmless and displaced way the counter aggressive feelings raised in staff by boys' aggression and the fear of violence? The cleaners are reported as using rather violent language or it was used about them, e.g. 'shock troops descending in pairs on units brandishing their mops'. An aggressive attack on dirt and mess is acceptable, whereas it is not acceptable to attack the boys who cause the dirt and mess.
>
> How much does the cleaners' problem reflect a continuation of the situation I hypothesised in my last report, that a dependency subculture might be developed as a means of keeping at bay the feared violence and the counter aggression of the staff? As a member of another similar institution said to me the other day, 'the children here expect the place to run like a hotel.' Trevor Blewett has made similar remarks about the boys in his unit. I also had the impression that the standard set by the cleaning women and not reached, might very well be unrealistically high, with the professional group living staff and the cleaning staff in some collusion about this so as to give gratification to boys and exert a civilising influence. I am reminded here of some of the comments made about boys recently treating professional staff like servants and slaves and the difficulty in breaking that subculture.
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> I think it might be worth having a look at these suggestions at least and if there is any validity in them to attempt to revise the situation in terms of these mutual projective systems as well as taking what steps are possible to relieve realistic work pressures on cleaners.

Conclusion

These themes that I have selected have their place in the Community's history, but they are all relevant today, and I imagine resonate with problems in other organisations. They are about the forces and pressures that never go away, i.e.

- splitting
- projection
- avoidance of pain/responsibility

- passing the buck
- anti-task forces
- inter-group rivalry
- boundary skirmishing
- scapegoating

As I see it, the role of a consultant is to help us to see some of these dynamics, in which we are so caught up, whether at the level of individual work with a child, group of children, staff team, inter-group dynamics and organisational dynamic. Residential institutions are especially prone to redefining bad practice as good practice, hence many of the abuse scandals that have come to light in the last few years. Consultants can play an important part in helping to prevent this because they are less likely to get drawn into a collusive system. Their job, in my view, is to be a continuous irritant in the sense that the equilibrium is disturbed by fresh insight and feedback, which the staff group, by themselves, may not see because they are too defended or 'can't see the wood for the trees'.

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The Cotswold Community
Thoughts on Staff Dynamics and Group Work
A Working Note

Eric Miller

Some months ago – I think during the turmoil in the Cottage – I commented that not enough work was being done on the dynamics of household staff groups. Individual staff members were evidently being put into isolated and untenable positions, scapegoated and extruded, without sufficient recognition that they might be victims of group processes – within that staff group, within the household, and possibly within the Community as a whole. It is notorious in Cotswold that staff rarely have good leavings: they tend to depart under a cloud of negative projections. And perhaps this happens to many of the boys too.

During my most recent visit (June 6, 1986), two staff independently raised questions about the possible need for 'group work'. I also consulted to the working group that has been set up to look at the working patterns of people in the Community. The stimulus for setting up this group was what one staff member (not part of it) described as 'the non-sustaining fantasy of the 80-hour week.' Long hours seemed to be a factor in staff turnover: could they be reduced?

Explorations with the working group suggested that, although complaints about long working hours and broken periods of time off have some reality (for example, not enough time for sleep), a reduction in working hours, consolidation of time off, or changes in household staff establishments would probably deal only with symptoms and would not alleviate the underlying feeling of oppression. Quality of work is significant. Different activities carry different subjective meanings, values, satisfactions and frustrations. A particular source of oppression is that so-called 'time-off' is not a respite because it is constantly invaded by unresolved problems and feelings that the individual carries home. So a shorter working week might not effectively increase the time off that staff could really feel was theirs; and correspondingly improved quality of work might increase the experienced period of time off even without any reduction in the formal working week. One possible objective therefore might be to reduce the spillover of unresolved issues from work to leisure.

In society, generally, notions of work and leisure have become more polarised over the last 25 years as negative and positive (except that more recently we have learned to be grateful for work in the sense of employment, in

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Eric Miller wrote this article whilst at the Tavistock Institute, June 1986.

contrast to unemployment). The residential therapeutic community, on the other hand, belongs to an earlier set of values which emphasised living together as in itself rewarding to staff and therapeutic to boys. Instead of work, we had vocation. Currently, these two sets of values co-exist uncomfortably in the Cotswold Community. 'Vocation', with its meanings of commitment and dedication, always has the propensity to generate guilt. If boys are not getting better, is it because I am not committed enough, not dedicated enough? (In the background is generalised guilt at being a more privileged member of the society that has produced the disturbance and delinquency that the boys present.) Guilt may be compounded for younger members of staff who have been feared on the work/leisure model and may be asked to display more sense of vocation than they actually feel.

Guilt has been a significant feature of the Cotswold culture. There is an underlying pressure, when things go wrong with boys, for staff to take blame on themselves for deficiencies in management, in insight or in care. (And at times this has been powerfully projected outwards on to the non-understanding, non-caring local authority.) The positive side of this culture is that it encourages and drives people to give of their best and to gain the satisfaction of doing so. On the other hand it also makes the experience of failure – which is endemic in an institution of this kind – more difficult to bear. And that reinforces negative perceptions of work.

Thus what may be operating here is a circular reinforcing process. Guilt about less than total commitment is reinforced by the culture of self-blame, which makes work feel more stressful and less satisfying, thus increasing guilt about less than total commitment …

This analysis may throw light on what sorts of group work may be appropriate and useful. We have to distinguish on the basis of tasks. If the task is to help individuals to understand group behaviour and their own complicity in it – i.e. an educational task – then it is appropriate to go to a Leicester Conference or some similar event outside the Community. The same applies if the task is attainment of greater personal insight or reduction of inhibitions: therapy groups, encounter groups, assertiveness training etc. are available. It has become fashionable in many residential and non-residential establishments working with mentally ill or disturbed people to run 'staff sensitivity groups' – typically a regular weekly session, with an external consultant. My observations suggest that the usefulness of such groups depends on how the task of the group is related to the task of the organisation. An inwardly focused group ('closed system') may enable 'open communication' to occur among the participants (staff members can say what they feel about each other) but it is dubious how far this actually helps them to engage with each other more effectively when they return to their work roles and relationships.

My proposition is that the appropriate focus in such a setting is the relatedness of the client group to the staff group and more specifically the ways in which projections from the client group are affecting staff group dynamics. Thus, the primary task in each session is to restore the effectiveness of the group, and derivatively of the members of it, to resume the task of the unit.

Cotswold Community staff, consistently with the culture I have described, have tended to focus on the reciprocal process, i.e. interpreting disturbances among the boys as products of disturbances within the staff group and the institution as a whole, and seeking to protect the boys from them. I have always been impressed by the capacity and integrity of staff in working at this, and in no way do I regard it as inappropriate. My proposition, however, is that study of projection onto the staff from the client system has been relatively neglected and should be given equal or greater importance.

Psychoanalysis offers a relevant model. The analyst is working with the transference from the patient onto him/her. In order to do this, he/she has to be aware of the counter-transference: it is necessary to distinguish between what is being projected by the patient from what belongs to, and is evoked in, the analyst's inner world. Analysts are no more immune to unconscious processes than the rest of us; but their own analysis and training makes them more alert to these processes inside themselves and helps them to distinguish between what belongs to them and what belongs to the patient.

I would expect much the same to apply to the Community. Just as a patient can evoke strong feelings in the analyst, so the client system of boys, with their dependency, despair and internal conflicts, will generate both strong feelings in individual staff and powerful dynamics in a staff group – feelings of omnipotence or incompetence, splitting and so on. Through processes of projective identification, the client group will mobilise staff to enact dramas that express the internal world of the boys. Correspondingly, then, a staff group, in order to be therapeutically effective, needs constantly to review what is its own dynamic and what is being projected onto it. And this includes the projections of boys onto individual staff members which then get played out within the group.

To sum up

By working only or mainly on the counter transference, which seems to have been the prevailing pattern, staff are not only constantly reminding themselves of their own inadequacies, and thereby reinforcing their feelings of oppression, but are neglecting to analyse, interpret and use therapeutically the projections that are being put on them.

Introduction

Unlike Isabel Menzies Lyth, Eric Miller did not write a 'Working Note' after each of his consultancy days at the Cotswold Community. I guess this reflected his style, which was paying more attention to the process than producing 'answers'. However, now and again (and it was very much worth waiting for) Eric wrote something, arising from his consultancy, as a catalyst for further work within the Community. This working note was written early on in my tenure as Principal (1985–1999). The concept of the 'X' factor was something we came back to time and again, especially when we sensed that staff morale had taken a dip.

John Whitwell

The Cotswold Community

A Working Note

Eric J. Miller

At the request of the Principal, I am writing about two topics that came up in my discussions at Cotswold on 19 April. The first is a conceptual framework that has some practical implications; the second is a possible alternative model for the exit household at Cotswold (currently Larkrise).

A conceptual framework

I think it was the psychologist Heider (1958) who first noted that in any dyadic relationship (A-B) there is always a 'third' (X).* Heider was discussing the interpersonal pair; but the model applies also to dyadic groups; for example, staff and boys in a household, or staff and boys in the Community as a whole.

One might translate X as 'task', using that term in a broad sense. Exceptionally, as in the psychotherapeutic dyad, X is internal to the dyad; in that case we might define it as 'trying to understand the inner world of the analysand.' Usually it is external and often it is explicit: for example, the shopkeeper, the customer and the community; or the teacher, the pupil and the lesson. The mother–child relationship comprises a succession of X_1, X_2, ... X_n, relating to food, toileting and a multitude of other activities, some very brief,

* I am not here presenting Heider's theory but using it as a jumping-off point for my own speculations.

Eric Miller, Tavistock Institute, April 1986.

others more prolonged. Beyond the explicit X_{-x} there may lie another X_{im} that is implicit, unstated and perhaps even unconscious and unrecognised: for example, girl (A) and boy (B) meeting to dance (X_{-x}) may have a shared fantasy (X_{im}) about a future state of that relationship, be it bed or marriage.

A relationship is in equilibrium when A and B have a shared picture of X (Figure 1). Probably it is never perfectly shared – not least because of the complexities of X_{-x} and X_{im} – and much of the 'work' between A and B is concerned with trying to reach and maintain an equilibrium in which $X_A = X_B$ (Figure 2).

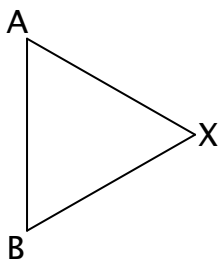

Figure 1

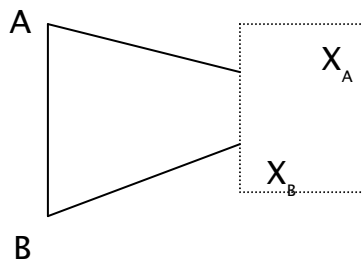

Figure 2

From these diagrams we can also infer what kinds of things may go wrong in a dyadic relationship. In Figure 3, both A and B have notions of a shared X, but these are irreconcilably different. In Figure 4, A has a notion of a shared X, but B is withdrawn: $B=X_B$. Figure 5 shows yet another dynamic, in which not only has the idea of a shared external X vanished, but each has projected it onto the other. The outcome for the dyad in this third case then takes one of two forms: either fusion – the two becoming one – or an all-absorbing conflict. In both forms the external environment has disappeared: the pair are totally wrapped up in each other, whether in love or in hate.

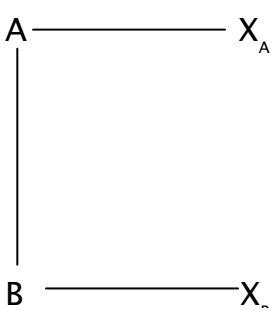

Figure 3

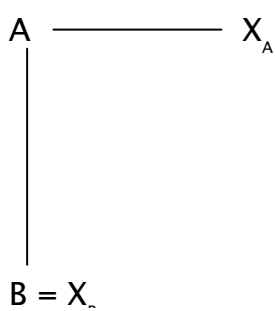

Figure 4

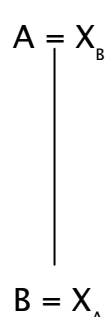

Figure 5

My proposition is that this conceptual framework offers a way of analysing the dynamics of the Community at three levels: individual staff member and boy; staff and boys within a household; and staff and boys within the institution as a whole. Such an analysis can point to possible corrective action. The dyadic relationship at each of these levels needs its X. And I am inclined to believe that this X also needs to have some felt consistency with the X of the dyad at the next higher level.

To illustrate

I have heard recently of several instances of a staff member and boy being locked in a mutually absorbing relationship of love or almost murderous hate. In such cases, not only does this dyad lack a shared X, but they have cut themselves off from their respective groups at the level of the household. This could imply that the household itself does not have a sufficiently compelling X – an activity, a project, a sense of shared purpose, a basic assumption – to sustain the collective dyadic relationship between staff and boys. Such a household X should make it possible to unlock the all-absorbing dyad of the two individuals and enable this to establish its own new external X. Similarly, at the level of the institution as a whole, a significant X_{im} between 1982 and 1985 was a fantasy of a revitalised independent Cotswold Community within the voluntary sector. That underpinned the more daunting X_{-x} of providing treatment for disturbed and delinquent boys. It may be that loss of that $X_{im,}$ with its notion of almost magical cure, accounts for some of the tiredness and depression in staff which seems to me to have become more noticeable in the last six months. Making the Cotswold video may provide an interim X_{-x} for the Community in the coming months; but the need for an X_{im} – a sustaining myth? – deserves further thought.

An alternative model for the exit household

Turbulence and loss of morale in Larkrise are currently a cause of concern. To try to restore stability, some boys are being temporarily sent home or back to Northstead. Senior staff are now wondering whether the three-step process, with the separate exit household, is viable, in that it disrupts established relationships at a time when boys facing the anxieties of leaving are vulnerable.

Many explanations for the immediate problems are being put forward:

- There is a tendency for one household to be the trouble-spot on behalf of the Community. Most recently it has been the Cottage; now it is Larkrise.
- Staff turnover: several fairly new staff, and experienced staff leaving.
- Overall the age of staff is lower than in Northstead, so boys approaching adulthood experience the paradox of acquiring younger parent figures.
- Larkrise staff's lack of control over the intake boundary: they feel they are having to accept some boys who are unsuitable.

Probably all these factors contribute, and others besides.

The A-B-X framework offers one way of looking at the problem. In relation to each boy in the exit household there is a need for an X that represents the idea of his future: an X within which the individual staff member can also work with him on issues of leaving and separation. Beyond that, the staff and boys in the household require a collective X. This almost certainly needs to be a tangible project which gives them an experience of potency in relation to their environment. It will thereby be representing and reinforcing the individual boy's belief in his own ability to be effective in the world outside. Creation of the Larkrise small-holding some 5–6 years ago was one such project. By now, however, it has become something to be maintained – a chore – and offers boys little experience of creativity.

If a new X can be invited, it will reinforce a positive Larkrise identity and in that way help to restore the boundary around the household. It will also communicate a positive message of success to younger boys in the Community. Larkrise is then more likely to be perceived as a positive stepping-stone to the future, rather than an ordeal that has to be gone through.

One possible resolution of the 2-step versus 3-step argument would then be to make admission to Larkrise selective rather than automatic. At present movement between households is based on a 'social work' placement procedure. The alternative would be to invite boys to apply for vacancies in Larkrise and to set up a system of negotiation and selection. This should stimulate boys to think more clearly in advance about what they want from the Larkrise experience and, when selected, to join with greater commitment. Also of course it would be advance preparation for applying for jobs when they begin to take the next step.

There are obvious counter-arguments against this model: that it would be elitist; that it would simply be transferring the Larkrise problems to Northstead. These have to be considered seriously. One would certainly not want to see admission criteria set at a level that cut out most applicants; but, unless there were a serious hurdle, Larkrise would lose its distinctive and desirable culture and boys would be less motivated to apply. My tentative view is that the proposed model would bring about a positive shift in the culture of Northstead – a shift perhaps in the Northstead 'X' – in that reaching the standards for admission to Larkrise would help to focus the work of both staff and boys.

I hope this proposal will stimulate further discussion.

Reference

Heider, F. (1958). *The Psychology of Interpersonal Relations*. New York: Wiley.

Management Issues in Milieu Therapy: Boundaries and Parameters

John Whitwell

ABSTRACT: This paper is about the management and boundary issues Involved in working with an individual emotionally unintegrated child, a group of such children and the residential therapeutic community (TC) as a whole. For children with few and underdeveloped inner controls, the structure in which they are emotionally and physically held is a crucial part of their treatment. The concept of the 'organisation as therapist' is an important part of the therapeutic milieu of a residential centre. My argument is that a TC needs to provide the model of an 'integrated treatment system' if it is to support and enhance the individual and group work with children.

Introduction

I will be drawing on my 25 years' experience at the Cotswold Community (Whitwell, 1989) to demonstrate the need for clear organisational boundaries as a key part of the treatment programme for the most seriously disturbed children. The Community's primary task is to help children who are emotionally 'unintegrated' (Dockar-Drysdale, 1993; Winnicott, 1976), achieve 'integration' and develop a sense of self. I hope to show that the more unintegrated the child the greater is the need for clear boundaries around the child.

The unintegrated child has problems being in a group and a group of unintegrated children needs to be managed in special ways. I will be linking this together to show the way the Cotswold Community has developed to meet this particular task, which includes the distinctive features of the Community's environment.

Overall I will be moving from the management issues around a disturbed child (the micro level), through to management issues at the level of the organisation as whole (the macro level).

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Emotional unintegration

D.W. Winnicott explained that the first 12 to 18 months of a child's life are crucial for his future emotional development. It is during this period that a baby moves from being completely dependent on the mother, almost of her, towards becoming a separate person, the birth of the psychological 'self', an emotionally integrated person.

Erikson (1965) describes this process as achieving basic trust. This will happen quite naturally, providing the care of the infant is 'good enough'. It doesn't have to be perfect, but it should not include experiences which the baby would find traumatic, e.g. sudden, prolonged separation from the mother or withdrawal of concern. For a baby the fear would be of annihilation and psychological damage would occur. The degree of emotional damage will vary considerably, but in extreme cases will prevent basic trust being achieved. This is psychologically akin to a building without foundations. Without therapy this person will remain psychologically damaged throughout life, every aspect of his life being affected until his emotional foundations are repaired. People suffering from this early emotional deprivation are 'unintegrated', having failed to achieve emotional integration. They are psychologically fragmented with no coherent sense of self. This deep-rooted damage will not right itself. Bruno Bettelheim gave one of his early books the title *Love is Not Enough* (1950) to convey the fact that love by itself will not cure these severely damaged children. They need to be in an environment which is planned to be therapeutic, twenty-four hours a day, seven days a week.

> Adam's birth mother visits for one-and-a-half hours each term. She comes so that she may help him talk about his anger and confusions towards her, which he has trapped inside himself. The last visit took place a few weeks ago and was a moving experience for all concerned. After some initial banter, Adam asked his mum, 'Mum, why did I have to leave you when I was young?' His mum took some time to compose herself and gather her thoughts. She seemed to be on the verge of speaking several times but paused. She then said, 'I was very stupid Adam. I drank and because I drank I wasn't able to look after you properly. Other people tried to help and get me to stop but I couldn't. If I had my life to live over I would do it differently, but I don't and I have to live with my mistakes.' Both Adam and his mum were on the verge of tears. Their eyes showed exactly how they were feeling. After a few moments Adam invited his mum to play with his remote controlled car. They played with the car, which went skidding round the hall for about five minutes. Adam and his mum are survivors of the same trauma. They are both victims of their past. Adam usually collects most of the sympathy, understandably, considering there is very little he could have done to change the situation of his birth. Adam's mum also deserves some understanding, for her own life was shaped by an unstable childhood.

Diagnostically, the two main behaviours that would lead one to consider a child to be unintegrated are: firstly, he becomes extremely anxious and panics when under stress and this leads to either a violent rage or despair; and secondly, he

is driven to disrupt group experiences, especially if the group appears to be functioning well, in such a way that he brings about confusion and chaos. Such children often find individual psychotherapy difficult to cope with and are more likely to be helped by a living experience in a therapeutic milieu.

The least integrated (or most unintegrated) children have been described by Barbara Dockar-Drysdale as emotionally 'frozen'. This is one of the most primitive forms of survival mechanism caused by the fracturing of the primary bonding process with the mother at a very early age.

A typical 'frozen' child in a therapeutic milieu presents a curiously contradictory picture. He has charm, he is apparently extremely friendly and seems to make good contacts very quickly. He is neither shy nor anxious in an interview and in his everyday existence he is usually healthy, clean, tidy and orderly. He is frequently generous and kind to younger children, especially one particular child, whom he protects from all attacks. In contrast he may become suddenly savagely hostile, especially towards a grown-up with whom he has been friendly. He will fly into sudden panic rages for no apparent reason, in which he smashes and destroys anything in his vicinity. He is a disturbing element in class – a storm centre – and frequently has acute learning difficulties. Sometimes he seems to build a high wall between himself and other people, which is impossible to scale or break through. He steals, lies and destroys relentlessly and without remorse. He is either cruel or over-indulgent to animals, which appear afraid of him. It is repeatedly reported that he is improving and hopes are raised; it is claimed that he is making a relationship at last, but each time disaster follows until finally he becomes intolerable. The longer the period of supposed improvement, the more drastic is the breakdown; experience teaches us to think in terms of lull and storm, rather than maturation and regression or recovery and deterioration.

The 'frozen' child is, of necessity, delinquent; he may easily become a 'delinquent hero' who gives permission to the other members of the group to break in, steal or destroy. His own lack of remorse, the fact that he can do these things without emotional discomfort, has a disastrous effect in a group.

We know that he cannot risk being left short of satisfaction for a moment because when the level of his pleasure drops, pain will flow in. Having withdrawn from frustration he must use any means in his power to maintain the pleasure level and this tends to be delinquent. If this form of excitement is blocked because, say, a door is locked or a pocket is empty, he will panic and in the effort to keep himself from self-destruction he will attempt to destroy his environment, which is felt to be an extension of himself.

The 'frozen' child ignores the inevitable consequences because he has achieved what Fritz Redl (Redl & Wineman, 1951) termed 'reality blindness'. He does not merely deny that he has done some delinquent or aggressive act; he does not know that he has done it. In addition he has no concept of time. There can be no past to regret and no future to consider. He lives in the present.

It is very difficult to treat 'frozen' children. From a state where nothing is felt and no-one is important, you begin to see some internal conflict and dependence

on grown-ups, with evidence of depression and anxiety, which to us are real signs that emotional recovery is occurring.

Permissiveness is completely inappropriate when working with a 'frozen' child. The behaviour pattern is carefully observed by the therapist until patterns emerge. Next, interruption is introduced; this involves breaking into a behaviour pattern at a critical point in order to make the child aware of what he has done, is doing and plans to do. A next stage is reached when the first signs of a pattern can be recognised. Each child has a sort of signature tune, which becomes familiar. Interruption now takes place at so early a stage that we can speak of anticipation.

When interruption or anticipation is used correctly, acute disturbance is felt by the child and he needs a great deal of support and reassurance. He will do anything to try and close the gap that has been made in his defences. His response to early interruption is panic and rage. If, however, the gap can be kept open by steady interruption and anticipation used in the context of his everyday life, then the next stage may be reached. Here we meet the first phase of depression which affects every aspect of the child's life; during it he re-experiences the loss of the unity (mother and baby) and faces the fact that this cannot be restored.

It is at this stage that a bond begins to be achieved with the therapist, the child becoming baby-like, dependent and trusting, vulnerable and helpless; a far cry from the arrogant, delinquent defence. It is from this point that he can slowly become loving and loved as a complete person. An example of reality confrontation follows:

> At the end of the session we spent time with Stephen, whom we knew had stolen a large quantity of Lego. In many ways it was an arduous process, with one step forward and one back. After three-quarters of an hour he acknowledged that he may have taken one piece by mistake. After one-and-a-half hours he acknowledged that maybe it was a few more and we could go to his room, and after three hours a pile of Lego was able to be returned. This piece of work was only possible through three of us working together. It enabled different aspects, feelings, and thoughts to be voiced and held by different people at different times, i.e. someone holding the empathy, someone the depression, someone the anger etc., and created something which was eventually sufficiently containing and challenging to enable Stephen to be able to put something right in a context where there was no blame or devastating consequences. It was a moving experience, and something significant had taken place for Stephen and our relationship with him.

I have already said that unintegrated children do not need permissiveness. Their lack of personal boundaries requires an emphasis on clear external boundaries. However, control, sanctions, and punishment are not words that sit easily in a therapeutic environment. At the Cotswold Community we do not have a system of punishment and reward to control children because having children 'under control' is not our primary task. As therapists we are more interested in the meaning of their behaviour than simply controlling it. If a child is behaving in an anti-social way we want to know why and ultimately we want the child to

understand why because a gain in insight by the child will lead to a change in behaviour. If one understands why one is driven to steal, it is no longer possible to steal with impunity. We are not interested in children behaving well while they are residing in the Community and then falling apart when they leave.

An emotionally unintegrated child has very few inner controls. His behaviour is impulsive. Emotionally he is a baby or toddler and we wouldn't expect babies and toddlers to be able to control themselves. We know that they need almost constant support and supervision from their parents. This is our task at the Cotswold Community when children first come to us. We call it therapeutic management. It is bringing together the emotionally disturbed child's need for therapy and management. It is not possible for one to succeed without the other. Punishment is irrelevant to this task. These aren't children who can respond rationally to the 'carrot and stick' approach. These children steal in such a way that they ask to be caught. The task of the residential therapist is to make a judgement about what the child can manage. This takes a good deal of skill and knowledge of the child. Over a period of time we want the child to become emotionally stronger so that he can take over some of this responsibility for himself, i.e. to move from a position of having few inner controls and needing to be managed to having self-control and needing minimal management.

> Babies who have not had enough primary experience from their mothers experience helpless rage. I believe that panic violence – which sweeps the person involved off his feet – is just this helpless rage and the acting out of this omnipotent violence. A person in a state of violence is therefore both omnipotent and helpless, but the omnipotence is a denial of the helplessness. It follows that if, through verbal and non-verbal communication, we can reach the helpless baby, we can establish a wavelength which may reach the original source of the violence (Dockar-Drysdale, 1990).

The following is an example of a boy who was in a panicky and distressed state and who, for a while, needed to be physically managed by his focal therapist, Susan.

> I walked into his bedroom to do his bedtime visit and Trevor was frantically putting on several layers of clothing, including five pairs of socks. I told him that I would not just let him run off in such a state. He went to the window. I explained it was cold, dark and wet outside and that I would take hold of his hand if he started to climb out the window. Knowing this boy very well, I predicted openly what may follow. I said that if he went to scratch me I would take hold of him so that he couldn't scratch. I went further to explain that if he then went to kick I would then have to take hold of him fully. I re-stated that I really did not want him to run off.
>
> The holding felt inevitable, but at each stage I was able to clearly state what would happen next and explain that I would be with him until it was over.
>
> There came a point during the holding when he became so desperate to go outside for some fresh air. I felt I had to respect this. Before I let go I explained that as before I did not want him running off and would stay with him. He went through the French doors and walked a short distance with me closely behind. He then looked up in astonishment, saying 'my feet are wet'. I explained that socks are not

waterproof, so it did not matter how many layers you had on. He said his feet were cold, so I asked if he wanted me to pick him up, he nodded. I held him across my hip, as you would a toddler.

It is worth noting that when I let go he called me by his natural mother's name and did not want me even holding his hand. At this next stage we carried on in the same direction, as if we were mother and infant. I turned round and he anxiously said that he did not want to go back inside. I replied, 'You don't feel ready', but explained we would have to go back in as it was getting late, but not yet.

Trevor looked up at the moon and started asking questions about the universe, God, spirits and witches. We discussed all these things with me carrying him back and forth, the length of the house. We were getting very wet but neither of us noticed. He then spoke about being held. He said he felt safe when he was held, but not when I held him, as I was his carer. He explained that he did not feel safe because he scratched and bit me. I said he did not want to hurt me. He stroked my scratches on my hand as he said this. I went over why I had held him and how it had come about.

We chatted some more about this and that and I suggested it was time to go back in, he agreed and got changed for bed. I tucked him in with a hot water bottle. He held my hand affectionately and we said goodnight.

This vignette conveys both the omnipotence and helplessness referred to earlier.

Communication and play

Time and again we come back to the importance of communication. Emotionally disturbed children need to be helped to communicate how they are feeling. Failure to do this will inevitably lead to the acting out of these feelings in anti-social and violent behaviour. It is important that these children are offered non-verbal models of communication because their ability to put feelings into words is inhibited and some of the unconscious feelings belong to a pre-verbal era in their lives.

Rebecca Adams spent some time at the Cotswold Community researching material for her book *The Playful Self* (1977). She wrote the following piece on the healing power of play.

The profound benefits of play can be seen most clearly in the lives of those whose capacity to play has been suppressed or distorted as a result of trauma or deprivation. In such cases, play itself can be an extremely effective method of healing, for 'Play, like dreams, serves the function of self-revelation, and of communication at a deep level' (Winnicott, 1942). This is the central premise behind play therapy. Using play as both the vehicle and the cure for psychological distress, play therapists aim to break the destructive circularity of that distress. At the Cotswold Community, a therapeutic centre for severely disturbed boys, play is highly valued. One of the central tenets is that play is a vital ingredient in well-being. Playing is an essential part of the emotional 'work' that the boys must do, and this is reflected in the daily time-table, which gives as much to play as to school-work.

However, many of the boys are unable to play or rather their play is as disturbed as they are. Mock-fighting often escalates into real fighting; competitive

games can quickly become unbearably stressful; even relatively gentle fantasy play with toys can feel quite threatening to these children whose own lives have provided so little of the safety and stability that are the necessary pre-conditions for play. They invariably come from broken homes, many will have been in several children's homes and foster families, and the majority will have a history of delinquency. The Cotswold Community is often a last ditch attempt to stop them sliding into juvenile crime.

In the centre's highly supportive environment the boys are given the opportunity to discover a way of playing that is not destructive either to themselves or others. This process of self-discovery through play is extremely powerful. The boys are able to regress to the age at which they 'lost themselves' and, as it were, start again. A thirteen year old may retreat to the age of three or four year old in which he clings to his teddy bear and uses it to communicate to the world. There is nothing unusual in asking a toddler 'what teddy would like for tea', but addressing a thirteen year old in this way is a poignant reminder of the necessity of childhood play, as necessary to our future well-being as learning to walk or talk.

'Peter' came to the Community when he was ten. He seldom spoke and seemed locked away inside his head from where he viewed the world with unconcealed mistrust and fear. The only clue he gave to his inner state were the pictures that he was constantly drawing. There were several striking features about these pictures: they were always of a town encircled by high, thick walls, drawn in heavy grey or black crayon; inside the town there were a few buildings dotted about but there were no streets or paths to connect them. On the outside of the wall a few wiggley roads led to the perimeter of the town but no further, for there were never any gates in Peter's drawings either into or out of the town.

For a long time, Peter's pictures, or 'maps' as he called them, remained unchanged. But very gradually they began to acquire new features. More streets and pathways appeared inside the town, connecting up the different buildings; more roads appeared outside the town too, so that there were now several approach routes; a small gateway appeared on the south side of the town, although no roads as yet led directly to or from it.

The therapist working with Peter let him discuss the design and detail of his maps without making an attempt to 'connect' them to his psychological state. The turning point came one evening when the therapist came across a bundle of papers tied up in a plastic bag and dumped in the outside dustbin. The bundle turned out to be Peter's latest maps, hurriedly rejected for what they might reveal. And indeed they were revealing. He had drawn a town that resembled the maps of medieval London, bustling and beaming with life and laced with a thick network of roads. And, most startling of all, at the four compass points, there were now four gateways permitting access to and from the town. Peter himself recognised this as a turning point, hence his frightened reaction to this brave new role he'd discovered. Nevertheless, it signalled the start of his recovery from his psychic wounds and his gradual return to the world (Adams, 1977).

Symbolic communication is extremely important in therapeutic work with emotionally unintegrated children. It is often associated with a child being in a regressed state, i.e. being younger than his actual years. The following is an example of symbolic communication between a boy and his focal therapist, Steve.

I first met Joe in 1989, he was a small slight boy approximately ten years of age, full of fun, very lively and could be experienced by people as a much younger child. He used to spend a good deal of time walking around holding my hand or being carried on my back.

From somewhere he developed an interest in dolphins and whales and in particular the killer whale. At Christmas I gave Joe a cuddly killer whale; he quickly began to take the whale everywhere with him and it took on a position of great importance for him. This 'teddy' was called 'Whale' and at times of greatest stress for Joe I was able to talk to Whale who would tell me how Joe was feeling (Joe would use a special voice for Whale when he was talking to me). Whale started to fall ill as my time off approached and on my return would be at 'death's door' and it would take a good deal of care and time to enable Whale to recover. This pattern would repeat itself every time I had time off.

In discussion with Mrs Drysdale, our consultant at that time, we devised a way of enabling Whale and hence Joe to bridge the space of my time away.

When I was away Whale stopped eating, so I suggested to Joe that I left a 'sugar shrimp' (a candy in the shape of a shrimp), so that Whale would not go hungry when I was away. This seemed to make the space more bearable and Whale thrived.

One day Joe told me that Whale's name was Winnie; not only had he named Whale but had also sexed it. Whale or rather Winnie was a female. The routine with the shrimp continued and Winnie used to swim happily in the sea while I was away.

One night when I was putting Joe to bed he told me that Winnie was not feeling very well. This confused me as my time off was not due. I asked Joe what was wrong with Winnie and he told me that he could not tell me but that Winnie would whisper it to me. Winnie whispered that she was pregnant. Joe told me that Winnie would need a lot of looking after and that she would let us know when the baby was due.

In discussion with Mrs Drysdale we decided that the lead of Joe and Winnie would need to be followed and that if the outcome was that the pregnancy ran its full term then I would need to produce a baby whale. The pregnancy lasted a number of weeks and as fortune would have it, I found a baby killer whale one day while out shopping. I had to have the baby whale close at hand at all times in readiness for the birth. Winnie had similar stresses and pains to those that most pregnant woman have, morning sickness being particularly evident.

The day of the birth arrived. Joe sent me for hot water and towels as Winnie went into labour. As I returned Joe told me that Winnie needed covering with a towel, which I did, and that her brow needed mopping. When the baby cries started that was my cue to bring the baby whale from beneath the towel. Mother and baby were fine and went for a swim in the sea.

Father was never on the scene and was always away swimming in a far off sea. Joe told me that Winnie was only going to have one baby, which was of great significance as Joe was a twin.

Through this birth we were able to do a great deal of work around the issues of mothers, fathers and Joe's twinship as well as the difficulties involved in looking after a baby.

Groups and structure

Most of the discussion so far has taken place at the level of the individual child, but one of the most difficult phenomena to work with in group living with the very disturbed children is group mergers. Emotionally unintegrated children with

very undeveloped personal boundaries are especially prone to merger. These children have not had the experience of being emotionally merged with their mother as babies and then gradually separating out (emotionally) during the first 12-18 months. For a variety of reasons that early merged state was interrupted, which makes them especially prone to seek merger, in the here and now, at every opportunity. With the boys we work with it is used as a defence against experiencing painful feelings. The mergers we see are often very wild, driven by the search for delinquent excitement. A merged group contains no individuals one can relate to. It is a blob, a mini-mob, capable of doing extreme things which the individuals by themselves probably wouldn't do. A merged group is a frightening phenomenon, capable of physically attacking someone or doing considerable damage. The only way that, at the Cotswold Community, we know of preventing a merged group from spiralling out of control, is to have enough adults to take individual children away from the group until they can calm down and find their own sense of separateness. The alternative strategy is to stand back and allow the merger to burn itself out. This is a risky strategy because mergers have considerable energy, can last a long time and be very destructive towards people and property around them. It is interesting that the government's guidance on permissible forms of control in children's homes (DoH, 1993) avoids the issue of groups becoming out of control. Their advice is based on an assumption that problems of control occur only in one-to-one situations. This is astounding considering that residential workers are more often going to behave inappropriately, when a group is out of control, because they are frightened.

> In practice, the collectively low level of ego functioning in the group meant that I and other staff members spent many days (and nights) attempting to bring boys down from the roof, where they had retreated from 'unthinkable anxiety' (Winnicott, 1976) in a state of raucous delinquent merger. So I suppose my first hard-won lesson was that you cannot 'do therapy' until you have management, boundaries and containment (Mikardo, 1996).

A disturbed, chaotic child needs to be in an ordered integrated environment to hold all the various bits of him together. In the Cotswold Community it is possible for a child to be looked after, to play, and to go to school all in one environment. If there is a problem in one part of his life everyone knows straight away, e.g. if he has a difficult afternoon in our school, the adults who work with him in the evening will know about this and they can continue to work with him on the problem. This is not usually the case in our society where it is possible for a child to have a problem at school for weeks before the parents get to hear about it and vice versa. Disturbed children do not find this containing enough and they exploit it, creating 'splits' between the different groups of adults in their lives. A boy at the Cotswold Community cannot get away with working those splits for long and this is difficult for him, confronting him with his problem.

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

In some respects the therapy is the 'order' of the community and the ego-functioning and behaviour of the staff. The milieu, the whole management structure must reinforce and support this; if contradicted it will re-enact and echo earliest environmental failure and breakdowns.

Unintegrated children need: a basic sense of wellbeing, which they have never had; an order that they can identify with and internalise; the symbolic equivalent reliably provided, of missed earliest experience. This external order or holding environment is for the unintegrated very like the earliest mother and baby experience.

The organisation as therapist

In order to explain the importance of organisational issues at the Cotswold Community I need to say a little about its history and what had to change for it to become a therapeutic community (TC).

The Cotswold Community was formerly an approved school from 1942 to 1967. Only two approved schools managed to transform themselves into a TC, Peper Harow (Rose, 1990) and the Cotswold Community (Wills, 1971). Richard Balbernie was appointed in 1967 to lead this transformation.

Richard Balbernie realised from the beginning that a TC couldn't be created by simply adding a dose of psychotherapy to the existing approved school* organisation and structure. The whole of the Cotswold Community had to be restructured and reorganised to support the therapy and be a part of the therapy. It had to be much less hierarchical, top-down and centralised. Power had to be shifted towards the staff working directly with the boys.

Richard Balbernie turned to the Tavistock Institute in 1968 for consultant advice to help with this process and we have had ongoing consultancy from the Institute. For the first two years this was from Ken Rice, then Isabel Menzies Lyth for ten years or so and since then Dr Eric Miller. Ken Rice explained the importance of the organisational model in the following way:

* Approved schools were in effect junior borstals for young offenders. The Approved School Order was issued by Magistrates Courts and it lasted for up to two years. The approved school system was abolished by the 1969 Children and Young Persons Act.

> The organisation of the Cotswold Community should provide a model that is structured in such a way that the 'ego-function' of the whole institution and of all its parts are mature and sophisticated. The organisation model for this institution must provide well-defined boundaries and adequate control over transactions across them.
>
> To put this another way: the members of the Community must be clear about and committed to the task of the whole and the different tasks of its different parts, they must be clear about their structure and accept the different responsibilities and authorities of the different roles they take. They must be aware of change in situation and role and change in response called for.
>
> In this way the Community can provide models of an institution and of institutional behaviour, and the staff of appropriate adults, authorities with which the boys can identify themselves. Moreover, the models should be transferable to the external world, i.e. they must be of use to the boys when they leave.
>
> … Even for the very disturbed, psychiatric or psychological therapy, as direct treatment, cannot take up more than a comparatively small proportion of waking life. The milieu in which it takes place should therefore reinforce and support specific treatment. Certainly if it does not support it, then any results of therapy will almost certainly be jeopardised. Without specific treatment, the institution and staff behaviour provide the only therapy available (Rice, 1968).

It took several years before a genuine therapeutic culture was established at the Community. Some things, like the abolition of formal punishments, changed rapidly whereas other things evolved more slowly, e.g. incorporating psychodynamic thinking into daily life.

Eric Miller (1989) has identified four distinct features of the therapeutic process of the Cotswold Community.

1. There are separate systems for daily living and for education. Even though education is tailored to the individual's treatment needs, he experiences change of role, which is reinforced by physical movement between one building and another for the different activities.
2. Daily living is provided in four separate houses, each in its own territory. There are ten boys per household with a complement of staff. The number is small enough to provide security and family-type intimacy, but large enough to offer a range of potential relationships, and also to give an 'open system' experience of boys (and staff) joining and leaving, while maintaining a group identity. Each boy has his own room, with his own possessions, which affirms his identity as an individual. The household, like a family home, is self-contained for catering, cooking, cleaning, laundry etc., and operates within a budget, which is part of the Community's financial culture and which helps the boys develop a sense of economy. In the primary households, to which the unintegrated boys are initially admitted, the therapeutic approach is to reproduce the positive experience of parenting that they have commonly lacked in infancy. There is opportunity for individual regression – soft toys, special foods, bedtime stories. Through such experiences, positive inter-jections of caring and loving parental figures lay the foundations of an ego function. Each boy has a 'special relationship' with one adult. When the boy moves to the secondary household, after two or three years, his ego boundary

is still fragile, and the therapeutic task is then to reinforce it and to begin to prepare him for a more autonomous life outside the Community.

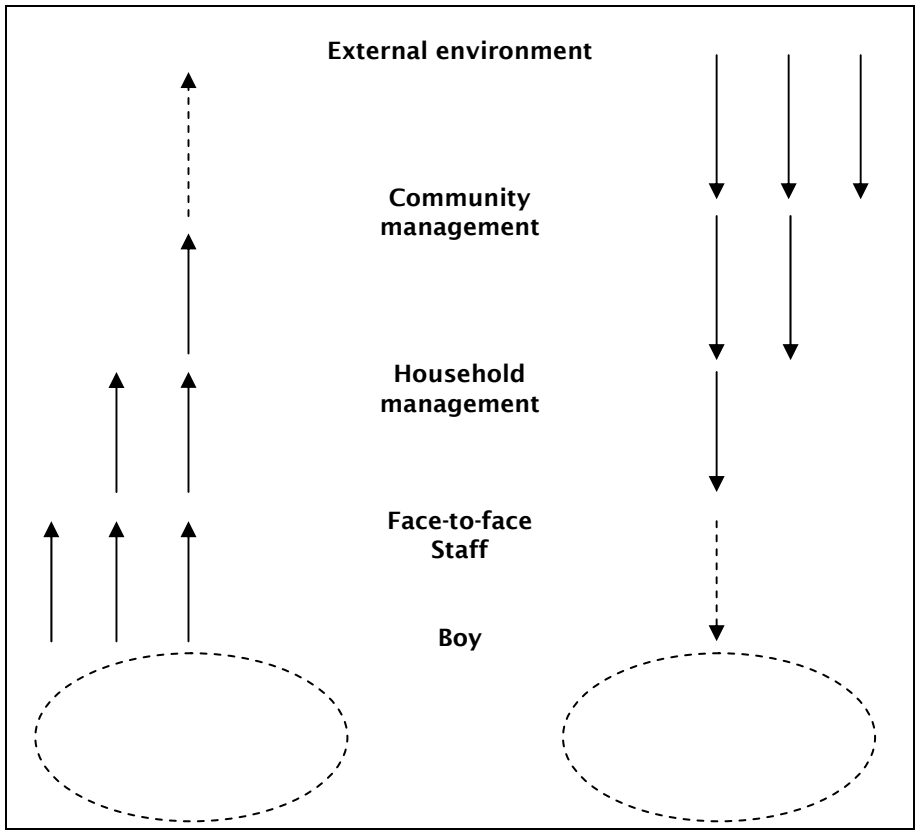
3. The Cotswold Community includes a farm which serves several important functions. It is an example of productive work – another type of adult role-model. Boys benefit from helping with farm activities, including looking after animals. Awareness of the cycle of seasons, and of animals' lifecycles, is symbolically very valuable for their own development. Through the existence of the farm the territory of the Community is greatly enlarged, providing a safe space, an alternative to a fence or wall.
4. Staff and their families live on the campus. For the boys it is reassuring that staff are not far away, and also beneficial to observe, and sometimes be in contact with, off-duty staff in their family roles. The Cotswold Community is a therapeutic village which is the setting for a therapeutic organisation.

The concept of boundary is central to the work of the Community. The therapeutic task consists of two (on the surface) contradictory tasks; to contain and to provide separation. As the unintegrated boy's ego-boundary is inadequate or unstable, the organisation has to provide an outer boundary on his behalf. At the same time the boundary has to allow enough space for the boy to experience being separate and to begin to acquire a personal identity.

The concept of 'negotiated space' describes the space within which varying degrees of containment and separation can occur. The more unintegrated the boy the more containing the space needs to be and as he grows emotionally the space needs to allow for more separation. Testing the limits is necessary for development so limits have to be clear enough to be tested and resilient enough to survive the test. The dynamic of treatment is the management of the continual tension between containment and separation. Each boy's experience of using this space within the Community will equip him with the skills to use a corresponding negotiating space between himself and others in his external environment: his family, his friends, his social workers, etc. This is tried out during regular periods away from the Community.

The organisational boundaries may be viewed as a series of membranes. The first membrane is around the individual boy – his ego boundary, which is wafer thin or incomplete. Face-to face staff provide a second membrane, which defines the boy's negotiating space. When this is tested the manager of the household provides another membrane, and beyond that the fourth membrane is the management of the organisation as a whole. These layers of membranes act as 'shock absorbers' for disturbances exploding outwards from the boy or group, and therefore need to be flexibly firm.

Figure 1: Boundaries as shock absorbers



Occasionally the outer boundary is breached when, for example, a boy absconds and the police have to find him. Figure1 also shows how the membranes work to absorb the shock of external environment impingements.

An external environment impingement can come from a boy's family, especially when the parents themselves are emotionally deprived, and over the years their needs have been unmet. It is not surprising, therefore, that they will have complex feelings about their son having such special treatment.

> David frequently phones his parents when he is in a distressed state and claims he is on the receiving end of maltreatment from other boys and/or the staff team. His mother, Mrs F, in particular reacts very strongly to this and she phones to complain and accuse. There is no way that reason can prevail. She 'knows' that her son has been wronged and abused. On one occasion, when David was aware that his mother was on the phone to a staff member, he let out the most awful screams knowing that his mother would assume his intense distress and indeed he got the reaction from her that he was looking for. Previously David and his parents,

> between them, have destroyed several placements. We have identified a senior staff member, outside the household, to take the 'good object' role as a means of facilitating communication. So far this has enabled his placement at the Cotswold Community to keep going despite enormous disruption. Occasionally there are periods when the parents are working cooperatively with us. This coincides with periods when David has been at home for a holiday and has been a management problem. For a while they feel more sympathy towards our staff, but it doesn't last. When Mr and Mrs F are at war with their neighbours, and the negative/paranoid feelings are going elsewhere, we can temporarily bask in their positive feelings. At times when the hatred from Mr and Mrs F is at its most intense, to relieve the stress, we have fantasised about bribing the neighbours to start another dispute to take the pressure off us!

Another example:

> Mr B has a reputation within his local Social Services Department for sabotaging his son's placements and threatening violence to staff. When Billy was admitted his father was prohibited, by the court, from any contact with Billy. A senior staff member took the role of befriending Mr B and gradually won his trust and confidence. This helped considerably, although he would occasionally phone at midnight, the worse the wear for drink, threatening to come and beat us up. At least the membranes were working in the sense that Billy was not being urged by his father, as in previous placements, to be as disruptive as possible in order to sabotage the placement. Over a period of about nine months we have moved towards Billy having direct contact with his father and going to stay with him. Just recently Mr B, his wife (not Billy's mother), his brother and sister came to stay in a house we have specially prepared for families. By 'looking after' the parents we have established a trusting relationship which should enable Billy to feel safe, in the sense that he will be less able to create splits between the adults in his life.

Another sort of external impingement is when the local authority, who have purchased our service, decide to end the placement on financial grounds. For young people trying to overcome their own basic inner insecurity, this can feel traumatic. Fortunately there are not many occasions where we have failed to get a reprieve or a reversal of the decision but the process itself can be so destructive. The exception is when a boy has sufficient ego strength to be in touch with reality to know about the financial problems of local authorities. He knows he will have to mount a campaign, to issue a formal complaint against the local authority and with luck he can experience it as empowering, especially when he succeeds. It can also help him value his placement at the Cotswold Community and the purpose of the therapy.

The membrane analogy denies the fact that these are human beings struggling to cope in immensely demanding roles constantly having to make difficult judgements about when to contain and when to promote separation. The vicissitudes of the unintegrated boy can threaten the sense of self of the staff, who may find themselves swinging between the poles of authoritarianism and permissiveness, of either loving or hating, without being able to hold on to a realistic ambivalence. The hatred may be repressed. As the boys have

experienced emotional deprivation, and physical and sexual abuse, this can inhibit staff from acknowledging their own anger towards the boys. Sometimes staff wish a violent boy to leave because they feel unable to cope with his increasingly murderous attacks on them. Maybe, on the other hand, the staff feel unable to contain their murderous impulses towards the boy.

The therapeutic process is a long, slow process with many setbacks. It is important to keep the dynamic of the institution at all levels under constant review. What are boys projecting onto staff and vice versa? How far is the violence displayed by one individual a product of the group? Inter-household dynamics need to be kept under scrutiny. A culture of continuous self-examination is necessary and is supported by external consultants.

Conclusion

It is our experience that there is a clear link between the needs of an emotionally unintegrated child for a 'holding environment' within which therapy can take place and the organisation structure of a residential treatment centre. If the organisational structure of the residential treatment centre does not mirror the need for clarity of boundaries, needed by an unintegrated child, then the therapeutic process itself will be in jeopardy.

The Cotswold Community has been through a transition from one parent organisation to another in which there was a loss of clarity of boundaries between the Community and the new managing organisation; almost inevitable, I imagine, in such a transfer. However, it did not end with administrative inconvenience. The membranes (shock absorbers) in the above model were affected and consequently we witnessed a higher level of acting out in the boy group.

I think we have also seen a loss of clarity in boundaries through some of the procedures following the 1989 Children Act. These procedures are designed to prevent malpractice and abuse in residential centres, an aim which we all support. However, the consequence has been a breaching of the external boundary of residential centres, e.g. through unannounced visits and inspections. The paradox is that, in order to achieve one kind of safety in relation to child protection matters, we have seen a loss of another kind of safety which is achieved through a residential until being able to manage transactions across its boundary.

In the past TCs had the reputation for being little kingdoms accountable to no-one. However, we are now in danger of creating a situation where it is very difficult to manage the boundary of the organisation and this creates a less containing environment for very disturbed children.

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Intrapsychic Factors in Staff Selection at the Cotswold Community

Olya Khaleelee and Patrick Tomlinson

ABSTRACT: The authors examine how a psychodynamic assessment method has been used in a residential therapeutic community for staff selection and development. The assessment method, which includes the Defence Mechanisms Test and an in-depth interview, is used to develop a personality profile clarifying defence mechanisms for each staff applicant. Using a sample of 40 staff, the authors carried out a detailed analysis of the correlations between the staff assessment results and length of stay at the Community. The analysis shows how hypotheses can be formulated which give accurate predictions about the likely length of stay for individual staff and also some of the difficulties they may experience in various professional roles. The paper explains some of the complexities involved in staff selection for such demanding work and shows how an understanding of the intrapsychic factors involved can greatly aid the process, leading to improvements in staff selection, development and turnover.

In this paper the authors demonstrate how a careful examination of the fit between the personalities of staff and the demands on staff in their roles at the Cotswold Community, a therapeutic community (TC) for disturbed boys, enables predictions to be made about length of stay of staff. The study discussed below developed from a pilot study initiated by the management of the Cotswold Community following a period of concern about high staff turnover during the late 1980s. The pilot study aimed to understand better what attracted staff to the Community, why they left and whether they brought particular personality characteristics to their work. One of the present writers was brought in with a colleague, to carry out this project. The results are documented by Khaleelee (1994) and indicated that accurate predictions of length of stay of staff could be made on the basis of an assessment process, using the Defence Mechanism Test together with an in-depth interview. The assessment generated some useful additional information about the fit between the candidate and the role,

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which aided the process of staff selection. It also often provided the staff being assessed with valuable information about themselves, indicating personality strengths and limitations, potential in relation to different roles, patterns in personal development and so forth.

Olya Khaleelee has continued to work with the Community over the intervening years and she and Patrick Tomlinson, Head of Training and Development at the Community, have assessed over 40 staff during this period. The assessments have taken place either as part of selection, for developmental purposes during employment, or on leaving the Community. This process has also led to changes and improvements in many aspects of the Community's selection procedure. During each of the last three years, an average of 20%-30% of staff have left. This is an improvement on the average of 40%-45% who left in the previous three years. Consequently, the average length of stay is now longer than the preferred three-year period.

The Cotswold Community

The Cotswold Community is a residential TC which provides care, treatment and education for emotionally deprived boys. There are forty boys at the Community living in four household groups of ten. Six group living workers, two teachers and two domestic assistants work with each group. This work takes place within the larger context of the Community with its support structures, services and working farm.

The treatment approach is largely based upon Dockar-Drysdale's (1990, 1993) application of Winnicott's theory. The management and organisation of the Community are based upon a systems approach developed in conjunction with consultants from the Tavistock Institute (Miller, 1992).

The boys placed at the Community have all suffered extreme levels of deprivation and abuse, often beginning from birth. Prior to their arrival this deprivation has not been successfully treated and the task of the Community is to rectify this by filling the gaps, enabling the boys' development to recover. For this to happen each boy has to return to the 'point of failure' and have needs met that are normally associated with early infancy. This involves 'regression' reached in a trusting relationship or environment. As the boys have so often experienced being severely let down, they will not easily allow themselves to be dependent on anyone and experience the vulnerability that goes with that. To trust someone enough for this to happen they need to test the staff's and Community's capacity to survive their most destructive impulses. The fear of being let down is so great that a boy's only way of being sure it will not happen is to try and make it happen. This process of testing often involves very rejecting, aggressive, spoiling and denigrating behaviour. Once this period has been worked through and survived, the dependency involved in the treatment often mirrors the 'normal' dynamics of infancy which in itself is testing as well as potentially rewarding work. At the Community this work takes place in a group setting, which is also a demanding environment, although if

the dynamics within the group can be successfully worked with there is great therapeutic potential.

This description of the treatment context gives some indication of the demands made upon the staff who are working directly with the boys. Surviving and maintaining effective work requires a high level of staff support and individual qualities in each staff member. From a treatment point of view, skilled work as well as consistency and continuity are required. High staff turnover can have a very negative effect on the treatment of individual and groups of boys. If there are too many people coming and going, a boy's sense of being in an unreliable environment that cannot survive him is soon confirmed. A boy's treatment in a primary household generally takes between 2½ and 3½ years. Thereafter he either moves to a 'secondary' household for a further stage of treatment or he leaves the Community. The Community requires a commitment of at least three years' work from staff in order to see boys through each stage of their treatment.

Low levels of staff turnover are therefore important in order for the Community to achieve its treatment aims. A further factor is the cost of high turnover through the investment in the recruitment process, training and the substantial experience needed before a new staff member becomes an asset to the Community. So while issues such as staff support and the organisation of work are seen to have a considerable influence on staff turnover, staff recruitment and selection are also of central importance.

The selection process – theory and practice

The selection of staff to work with emotionally disturbed and deprived children is a difficult and complex task. The work specifically requires staff to use their most inner resources, both consciously and unconsciously. This is similar to how Winnicott (1956) describes a mother being unconsciously identified with the needs of her infant, through her own internalised experience of maternal provision. Winnicott argues that this unconscious identification helps the mother to respond appropriately to her infant's needs. He also describes how difficulties in the mother's own experience of infancy, of which she is unconscious, may cause a conflict for her when represented with similar situations by her infants. This conflict may then complicate her response. Scenarios similar to these are created time and time again in the residential treatment of emotionally disturbed children. For example, a deprived child may have a real need to be 'messy' in a way that an infant can be 'messy' and to have this mess cared for or 'contained'. If the child's carer's own childhood experiences were of overly controlling parents, perhaps not allowing her/him to be messy, then the carer may have a difficulty in responding to the child's need in this area. S/he may feel envious of the child if s/he allows him to be messy, or feelings of anger towards her/his own parents may be aroused by the situation. The degree to which the carer is able to respond to the child's needs will largely depend upon the capacity to recognise feelings that are connected to past experiences and to distinguish them from the present situation.

Bettelheim (1974) vividly described how living through difficulties like this with disturbed children gradually has an impact on the staff's own defences. He claimed that the pressures can lead to a temporary breakdown of the staff's defences before they develop new defences through insight and realisation which are more adaptable to the new situation in which they find themselves. He calls this process 're-integration'.

From the point of view of staff selection, how does the selector assess an applicant's underlying defences and the impact on those defences when working with emotionally disturbed children over a long period of time? Attempting to make such an assessment is a very difficult task in itself. The underlying issues which will be the most important in the long term are often not easy to detect in meeting someone for a short period and in a relatively less demanding situation, such as an interview. For example, the personality trait of 'laughing in the face of adversity', being cheerful and enthusiastic in difficult circumstances – can be used defensively to deny more anxious and difficult feelings. This defence may seem quite convincing in an interview or informal meeting, but tested intensely over a period of time may break down, possibly revealing a much more vulnerable person. Such a 'breakdown' of defences may be healthy and useful in terms of the work. However, its usefulness will depend on the extent to which the individual is able to carry on functioning effectively – the individual's level of inner resilience – which in turn will be helped or hindered by the level of staff support offered by the organisation.

Another aspect of personality which is difficult to assess is how a person manages feelings of aggression. For example, how would a selector know if someone maintained the appearance of being friendly and cooperative by turning more aggressive feelings inwards, rather than risk expressing them towards others? This defence may develop in early childhood as a response to a sense that one's parents are easily overwhelmed by aggressive feelings. A child may then turn these feelings inwards to protect the parents and to maintain the appearance of a happy or non-aggressive child which is more tolerable for the parents. In some cases parents may unconsciously indicate a preference for a sick or withdrawn child rather than one with aggressive feelings. So if turning these feeling inwards helps the child to be cared for by his/her parents the defence is further reinforced. Staff selection for work with disturbed children is particularly vulnerable to the seductive nature of this defence. The very nature of the work involves working with the full force of primitive aggression. Inevitably, feelings of aggression are aroused in the staff which can be quite difficult to acknowledge and work with. The response of introaggression may lead to depression, withdrawal and psychosomatic illness. A potential new staff member who has a tendency to please others with a denial of more difficult aggressive feelings may feel like a breath of fresh air. The staff may have unrealistic hopes about the difference such a new person may make.

Given these complexities, many variables need to be taken into account when selecting staff for the difficult work at the Community. We describe below the current selection process which has been developed at the Community, a

summary of the research following up the original pilot study and finally some case examples.

The selection process

The selection process includes a letter from the applicant describing her/himself together with a completed application form; a one-day informal visit; a three-day visit; opportunities to be involved in the workplace; meetings and interviews with senior staff; informal discussions with staff in general; and written exercises related to the visits. The next stage is for the applicant to have a formal psychological assessment which includes an in-depth interview about personal development and uses, amongst other instruments, the Defence Mechanism Test (DMT). A confidential assessment report is taken into consideration by the Principal along with other data as part of the selection process. A copy of the report and feedback is made available to the applicant. Beyond this, confidentiality is maintained.

The Defence Mechanism Test (DMT)

The DMT was developed by Kragh (1955) at the University of Lund as a predictor of resilience in the face of stress. Many follow-up studies have taken place (Olff, Godaert & Ursin, 1991) with workers in different industries who have to manage stress during the course of their work. While Kragh initially applied the DMT successfully to the selection of fighter pilots, it was subsequently used for selecting others in dangerous occupations such as trainee and qualified air traffic controllers (Svensson and Trygg, 1991), divers (Kragh, 1962), commercial and fighter pilots (Neuman, 1971; Torjussen and Vaernes, 1991). It has been used on the assessment of subjective fear in training for parachute jumping (Vaernes, 1982) and in research on the assessment of serious drinking and driving offenders (Saitner, 1991). More recently it has been successfully used in senior management selection and development (Khaleelee and Woolf, 1996).

The DMT is based on an examination of the perceptual process using a tachistoscope. The applicant is shown a series of 18-20 exposures of a stimulus picture with a peripheral threat at gradually increasing levels of illumination. From the verbal and visual material produced by the applicant, a profile is developed which indicates how the defence mechanisms, mobilised by the ego to cope with the anxiety generated in stressful situations, have impinged on the individual's emotional development. The DMT identifies at what stages in an individual's development the defences emerge. The defence mechanisms include those Freud (1926) described: isolation, denial, repression, reaction formation, projection, introjection, regression and introaggression or turning against the self. The defence mechanisms act as the unconscious shock absorbers of the mind, preventing excessive stimulation either from the inner world or from the external world and thereby protecting the individual from anxiety.

Our research was carried out on a number of people assessed at the Cotswold Community between 1989 and 1996. Assessments have been carried out for three different purposes:

1. staff recruitment and selection;
2. staff development;
3. staff exit assessments.

For the sake of economy we may refer to applicants and staff in these categories as 'candidates'. Every member of staff who has been assessed during this period is included if they satisfy one of two criteria:

1. if they have left within the first two years of employment;
2. if they have remained in employment for three years or more.

Those leaving within two years are classified as 'leavers', and those staying for three years or more as 'stayers'. Those assessed consist of 22 stayers and 14 leavers. Data concerning the six staff who remained at the Community for between two and three years are not included in the analysis because our interest is in shorter and longer periods of stay. Similarly the three staff who are presently working at the Community in their third year are not included. However, the data from their assessments are included for interest, in Appendix 2.

Analysis of DMT profiles

Each candidate was assessed and tested to ascertain which defence mechanisms were used to protect the self from stress. These were analysed as integrative (sometimes called autoplastic) and assertive, (sometimes called alloplastic). These terms – autoplastic and alloplastic – distinguish between two kinds of adaptation at an early stage of development, one directed towards the subject, the other directed towards the outside world, both of which allow the ego to maintain its equilibrium (Laplanche & Pontalis, 1973). For example, with introaggression, the direction of the defence is against the subject and equilibrium is maintained by the subject absorbing the feeling and taking it inside. This is an autoplastic response. With reaction formation the subject converts a threatening reality in the environment into its opposite, the experience is a form of denial actively asserted in relation to the environment. This is an alloplastic response. In each instance the subject controls the threat in a different way.

These categories are in turn made up of various types of defence mechanisms such as repression, isolation, reaction formation and so on. Some defences, mobilised in different ways, can be common to both types of adaptation. Each defence is scored according to when it appears on the candidate's profile and for how long the defence remains in place. This provides hypotheses about the age at which a defence was mobilised which can be discussed in relation to the individual's life history. It is then possible to score a candidate's defence with an overall score, with an assertive and integrative

score and with scores of specific defences within the assertive and integrative bands. Our theories about the likelihood that individuals will be able to manage working at the Community suggest connections between these scores and length of service. In order to examine these connections more fully, the type and level of defence mechanism scores of stayers and leavers were compared in some detail.

Tests of the connections for statistical significance were conducted by using a standard approach – Fisher's Exact Probability Test (Siegel, 1956). The following are the results for both stayers and leavers. We shall indicate where these results are significant.

Total scores

These scores – a quantification of all defence mechanisms used – combining both the candidate's integrative and assertive scores, range from 50 to over 650 and can be separated into four bands, giving the number of stayers and leavers in each band. From this the percentage chance a candidate has of being a stayer in each band can be ascertained.

Total scores	Stayers	Leavers	% Stayers
50-249	8	3	73
250-449	3	3	50
450-649	9	3	75
650 and over	2	5	28

This pattern of scores is not significant. However, when one separates the integrative from the assertive, the following patterns emerge.

Integrative scores

These scores range from 10-630 and can be separated into three bands.

Integrative scores	Stayers	Leavers	% Stayers
0-180	16	3	84
181-360	3	5	37
360+	3	6	33

A clear pattern emerges here. Those candidates with scores of 180 or less have the most chance of being stayers, and those with scores over 180 the least chance ($p<.01$).

Assertive scores

These scores range from 20-420 and can be separated into three bands.

Assertive score	Stayers	Leavers	% Stayers
0-140	4	5	44
140-280	12	5	71
281-420	6	4	60

There is no significant difference in the pattern of these scores.

Further analysis of DMT data

Having analysed the total scores it is possible to analyse the specific defences within the integrative and assertive bands. Each of the two defensive types is made up of different individual defences. For instance there are the following integrative defences: regression, introaggression, certain aspects of introjection, isolation and repression. Assertive defences include denial, reaction formation, certain aspects of introjection, isolation and repression.

A framework is outlined below in which a candidate's defences are correlated with staying or leaving. Some integrative defences have positive and some negative relationships with staying, while there are no assertive defences that have a negative relationship. For example introaggression has a positive correlation with leaving, and regression a positive correlation with staying.

If each candidate's integrative defences are scored, scoring positively for defences connected with staying, negatively for those connected with leaving, and neutrally for those which have no influence either way, then each candidate will either have a positive, negative or neutral score. We now have four types of data: total defence scores, integrative and assertive defence scores and +/-/n scores.

If we consider each candidate's integrative score alongside his/her +/-/n score the following pattern emerges.

Integrative/+/-/n score	Stayers	Leavers	% Stayers
0-180 and (+/n)	14	3	82
0-180 and (-)	2	0	100
Over 180 and (+/n)	6	2	75
Over 180 and (-)	0	9	0

These results are very significant. Where a candidate has a score less than 180 there is a positive correlation with staying regardless of whether these candidates have a (+/n) or (-) score. Where a candidate scores over 180 there is a significant relationship between staying or leaving and a (+/N) or (-) score, $p<.01$.

The drawing of boundaries around the data inevitably involves a degree of bias. However, the key question is whether the positioning of the boundaries makes theoretical sense. As we describe below, given the nature of the work, the stresses involved and the defences that are most likely to be effective in these situations, we think they do make sense.

Summary of the research results

The analysis provides a clear hypothesis about the probability of a candidate staying or leaving. The most significant correlation is firstly that the integrative score has the most bearing on staying and leaving. If the integrative score is less than 180 there is a positive correlation with staying. If the score is over 180 the candidate's individual integrative defences need assessing in detail. If (-) defences predominate then leaving is most probable and if (+/n) predominate, staying is most probable.

Integrative defences are connected to the need for group support rather than the capacity to work things out on one's own. In a particularly demanding and stressful environment where individuals are thrown back more on their personal boundaries, those candidates with high integrative scores may be less resilient as they are more likely to perceive the work group as unsupportive and inconsistent. On the other hand candidates with low integrative scores may be more able to work things out on their own during times when the work group is under pressure.

When candidates' integrative scores are high, the nature of their defences indicated by the +/-/n score is the critical factor in determining whether they are more likely to be stayers or leavers. For example, the defence of intro-aggression is likely to compound difficulties for candidates with high integrative scores. Not only may such candidates have little capacity to work things out on their own, they are also more likely to blame themselves for difficulties being experienced.

In contrast, candidates with the defence of regression may be less self-critical and more tolerant of temporarily feeling overwhelmed. Also, staff who work with emotionally vulnerable children may be more receptive and supportive towards colleagues who respond to stress in this way.

The outcome of the research suggest that individuals who are either heavily defended or who are undefended in certain ways, are likely to experience a high level of anxiety in the work. Those who are heavily defended have to use more psychic energy to defend themselves against anxiety, leaving less available for coping with external reality. Those who are undefended are open to intense external and internal pressure and may suffer high levels of anxiety. The greater the pressure, the greater the likelihood that the susceptible individual may gradually feel exhausted, overwhelmed or 'burnt out', depending on their defensive structure.

Case studies

At first Annabel* became very popular with virtually all the staff and boys. Before long different teams were almost in competition to recruit her. She seemed to be thriving in this situation. As part of the selection process Annabel went through an assessment. Her DMT assessment showed high levels of reaction formation or 'laughing in the face of adversity' and introaggression. Her life history interview seemed to confirm this, with very little sign of acknowledged difficulty in her life or aggression in her family relationships. However, there were a number of quite serious accidents around significant life changes and quite a lot of illness-related fatigue. The accidents seemed to coincide with points of separation such as starting school and leaving home. It is possible that a person who unconsciously turns aggression inwards may actually hurt herself through an accident or illness. Also, considerable psychic energy is used up if difficult feelings have to be held inwards and a cheerful exterior maintained.

In Annabel's case, she began to struggle to maintain her liveliness and enthusiasm after the first 2-3 months' work at the Community. This gradually led to periods of complete exhaustion and minor but persistent illnesses. During this period Annabel was able to acknowledge more of her difficult feelings connected with the work and became more in touch with her limits. After six months Annabel decided to use the experience she had gained to help her apply for a different job. She clearly felt that the work at the Community was too demanding, though she had found the experience valuable. In her case there was no disruption to the boys' treatment as she was only employed on a temporary basis and not assigned as a carer for individual boys. If she had been employed on a longer term basis, the outcome would have been far more disruptive.

On those occasions when a staff member who had not previously been assessed leaves prematurely, we have carried out exit assessments and often found personality profiles similar to Annabel's. Derek was one such example. Derek seemed to be progressing quite well in his work for the first year or so, appearing very even tempered, understanding and sensitive to the boys' needs. However, at times in the face of quite provocative, aggressive behaviour, he seemed almost too 'even tempered'. Gradually Derek began to struggle much more in his work, becoming increasingly anxious and distressed by this difficulty. He became quite run down, developing a number of minor physical ailments. It became more worrying when he began to experience dizziness, feeling faint and on two occasions actually fainting. A medical examination was inconclusive. Derek made use of the support and supervision available but,

* Annabel applied to work at the Community when she had just finished university at the age of 23. The initial impression was of a friendly, quietly confident and easy-going person. After the initial interviews and visits it was decided to employ her as a volunteer for six months. This was mainly to test out the possibility of longer term employment.

after further deterioration, was signed off long-term sick and left. He was assessed at this stage and his DMT profile indicated introaggression as one of his main defences.

On many occasions the assessment process has been helpful in revealing issues that have contributed to a positive change for a staff member. Andrew, who was 24 and a university graduate, had been working at the Community for about a year, when he began to experience acute levels of anxiety and a sense of feeling overwhelmed. He began to suffer from prolonged bouts of 'flu'. The impact of this was to generate a sense of unreliability which created difficulties for the staff, the boys and for Andrew. He began to receive negative feelings from staff and boys, such as 'he's not trying hard enough', or 'he can't be bothered'. This made matters worse for him. It was agreed with Andrew that he should be assessed to help try and clarify the underlying difficulty.

His assessment suggested that he was an extremely intelligent and sensitive, but very undefended person. His lack of defences combined with his sensitivity would leave him particularly vulnerable in such a demanding situation, so it was not surprising in view of his test results that he felt overwhelmed. Added to this was Andrew's distress at feeling he was letting everyone down and failing. His previous sense of achievement and positive feelings about himself were getting lost. It was particularly the intense work with individual boys and their emotional dependency on him which he had found overwhelming. It was agreed to employ him differently in a way which would enable him to move around different groups as a relief worker. He found this less intensely demanding and soon recovered to an effective level of functioning. Staff and boys felt very positive about his contribution in this new role. Andrew was relieved to discover there was an explanation for his previous difficulties and to have some of his capacities and attributes re-affirmed. After about a year he moved on to pursue an academic career.

Terry was assessed during his application to work at the Community. His DMT profile indicated a generally resilient though sensitive person who seemed suitable for the work at the Community. His underlying motivation attracting him to this work appeared to be linked to an unconscious wish to fill some gaps in his early development. The Community chose to employ him and he soon became an effective team member, working well with boys individually and in groups. In particular, he soon became a very competent deputy manager. However, towards the end of his third year he began to think about leaving. At this point, his manager suggested he have another interview following up his initial assessment, to help clarify the issues for him in thinking about his future.

This interview, along with his DMT profile, indicated that Terry experienced an underlying difficulty in relation to authority and leadership. During his childhood he had always felt himself to be in the shadow of an authority figure. This pattern then repeated itself within his work life. Terry had held a number of deputy positions and always moved on when the position of manager or leader became a possibility for him. The interview helped Terry become more conscious of this pattern and less unconsciously bound by it. This realisation alongside the progress he had made in his work and development, helped Terry

reach a decision to stay and apply for a Team Manager's position rather than leave. He succeeded in his application and became an effective manager.

These examples illustrate the value of assessing the emotional resilience and other underlying factors related to personality and emotional development, as these are likely to surface once the staff member begins to feel the impact of the work.

Experience shows that candidates like Andrew or those who are undefended in certain ways are unlikely to have the emotional resilience necessary to withstand such demanding work. Similarly, candidates with high integrative scores are likely to need a level of support from others that outweighs their capacity to work things out on their own and the support may not be available when it is needed. At the same time, there may be room for improvement at the margin. There may be some candidates who might either stay or leave, depending on the situation. Effective staff support may enable more of them to stay and work effectively rather than leave.

There may also be some candidates who have profiles associated with staying who fail to do so. Some of this may be circumstantial. However, it needs to be recognised that there may also be other issues and variables involved.

For example, the one leaver out of seventeen candidates who had a favourable combination of defences and was predicted to be a stayer was someone who could be considered to be different within the context of the Cotswold Community. Abigail was employed by the Community when she was in her 40s. She was the oldest member of 25 'group living' staff who had an average age of 30. She was also a foreigner with a non-European culture. It is important that factors such as these are also taken into consideration alongside the candidate's DMT profile. The stresses and anxieties involved in the work for Abigail will have had a different impact and different implications than for a younger English candidate with a similar profile. To some extent this is true for any candidate who exhibits a markedly distinguishing difference. The life history interview which forms part of the assessment helps to focus on each candidate's individual personality and development and their capacity to adapt to the distinctive culture and norms of the Cotswold Community. However, our data and theoretical understanding are not sufficiently developed to use these boundaries rigidly when selecting staff. In any case, as we say above, other material has to be taken into account in making selection decisions.

Finally, the actual process of participating in an assessment is likely to lead to some changes in outcome. The feedback from the assessment may make a significant difference to the way the candidate and the Community respond to issues that arise in the candidate's development once employed. In the case of Andrew, who, in feeling overwhelmed and exhausted, began to be seen as unreliable, his assessment led to a greater understanding both for him and the Community about the difficulties being experienced. This led to a positive change in the role he was allocated so that he regained his competence in the work, leading to a positive shift in the perception of Andrew by the boys and staff with whom he worked.

Concluding remarks

These examples highlight some of the most important issues involved in staff selection. They clearly indicate how rigorous the process of selection needs to be in order to succeed in selecting staff with the appropriate skills and personal qualities. The thoroughness of the assessment process at the Cotswold Community together with other innovations related to induction procedures, developmental opportunities, and a greater awareness of unconscious processes at the organisational level, have resulted in a considerable drop in staff turnover and an enhanced capacity to engage in the primary task of Community. The DMT is a vital part of these improvements and this paper has demonstrated how the defensive constellations it reveals are associated with length of stay. The overall statistical results for the small number of staff included in this and previous studies are impressive. However, they also show there is more to be learnt about the way in which the detailed defences it reveals are associated with the ability to tolerate work with disturbed children and how the organisation can support staff with less favourable defensive structures to enable them to work more resiliently with these children.

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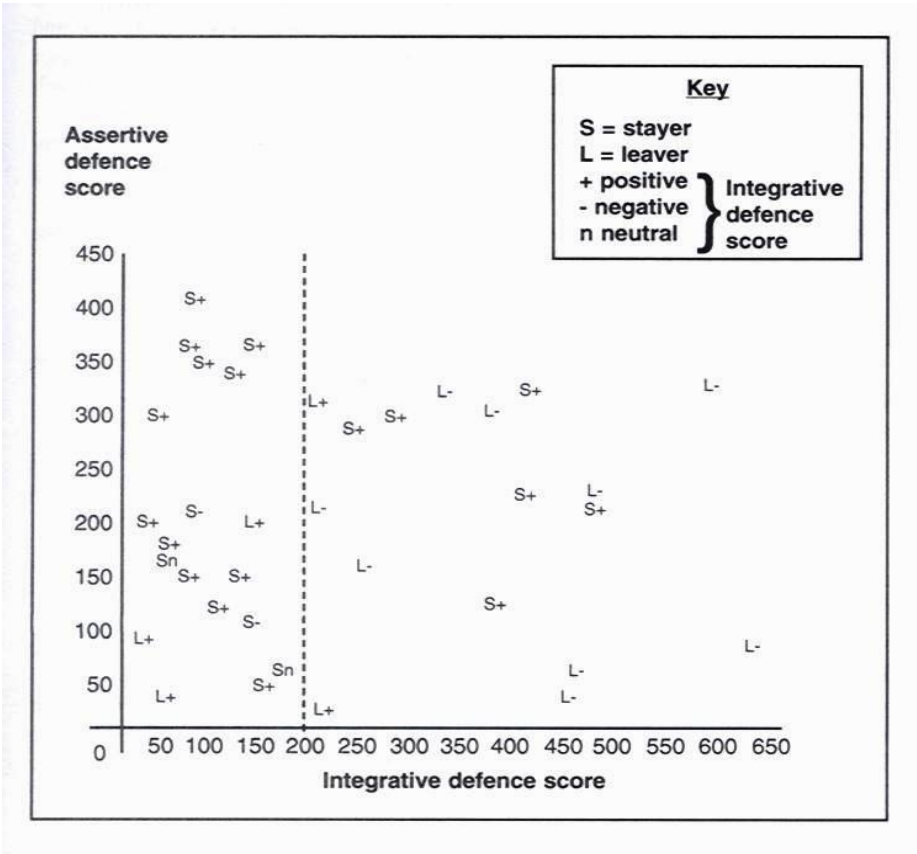
Appendix 1: Total assertive and integrative defence scores



Appendix 2

These are the scores for the six candidates who stayed for 2-3 years.

Candidate	Assertive score	Integrative score	+ - n
1	190	310	+
2	40	150	+
3	40	110	n
4	210	40	+
5	270	260	+
6	220	170	-

Candidates 1 and 5 have an integrative score associated with leaving but a (+,-,n) score associated with staying. Candidates 2 and 3 have integrative and (+,-,n)

scores associated with staying, but assertive scores lower than any stayer we have assessed so far. Candidate 6 has an integrative score associated with staying but a (+,-,n) score which includes a high level of introaggression.

Candidate 4's score correlates most strongly with staying. He left the Community after 2½ years' work at a point when his work with individual boys had reached a natural conclusion.

These are the scores for the three candidates who are presently working at the Community and are in their 3rd year.

Candidate	Assertive score	Integrative score	+ - n
1	190	130	+
2	380	240	+
3	460	470	+

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The Cotswold Community Farm

Dave Cooper

Chance is a fine thing and often travels in unexpected ways. I first arrived at the Cotswold Community in 1985 to work as the farm assistant. Three hundred and ten acres of arable crops and grassland surrounded the tight cluster of buildings that is the 'village' that is the Cotswold Community. Now for over 30 years the Cotswold Community has been a therapeutic residence, working, using psychodynamic principles, with boys carrying severe emotional disturbance. It has a school, housing for staff, separate 'households' for groups of up to eight boys each, a trade maintenance unit and converted Cotswold farm buildings in use for administration, offices and meeting rooms. There is a gym, heated outdoor swimming pool, pottery workshop, forge, large playing field and lots and lots of trees. Most importantly, or tragically, whichever way you want to look at it, there can be up to 32 boys resident during the school terms, boys coming from all over the country. And there is the farm. A ring of peace, containment and security, a 'cordon sanitaire' between the storms that beset the boys resident here and the general public; a place to run to. The farm is managed along commercial lines to make a profit. It is a 'real' situation and the staff 'real' people. When I arrived, some of the older, more integrated boys might have been using it for a bit of work experience and there were usually groups of boys that would help stacking the straw and hay bales into the barns during the summer. But for most, the farm and its staff was a case of 'them over there'. And, apart from making *that* profit, little more was expected of it. The farm had become severely run down and inefficient during the Community's post-war role as an approved school. A major task had been to concentrate on improving on this, and all that hard work was just coming to fruition. There was little, if any, thought of the farm being a therapeutic resource.

Soon after I arrived, I started a routine of regularly visiting, one evening a week, one of the primary households which are the homes for unintegrated boys. It wasn't a required element of my job but something I did out of interest on a voluntary basis.

Doing that, and building up trust and relationships with the boys, led to several of them asking to visit the farm to help out. So we tried it. Young, physically immature unintegrated and disturbed children working alongside commercially minded agricultural professionals. God, it was and is hard work. Frustrating, mentally taxing, and requiring the patience of Job. The farm team

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(the farm manager plus one assistant) has a job to do and the boys work alongside us. The boys have to be given time to achieve but five minutes is a heck of a long time when you are waiting until a boy achieves the task of hammering home a nail! But something apart was happening. On returning to their households boys were talking about it to the staff. Comments were coming back from the school about boys playing at farms in the sand trays – playing? Play usually meant broken windows, thieving, illicit smoking and drinking, breaking into places, cussing and swearing, winding other boys up! Soon, also drawings and colourings began to be given to us and the farm office became a gallery of artistic efforts. Perceptive residential social workers soon realised what was happening and that certain boys were going to be able to use the experience of being with us as a piece of the jigsaw of the road to their recovery. Before long those boys were having regular visits to the farm on a weekly basis. No doubt one of the initial attractions to many of the boys of having a regular farm visit was not having to attend school. We soon transcended that particular aspect by getting the boys to quickly realise that they were going to have to do some work and that there was an obligation to turn up, rain or shine, warm or cold. As a waiting list developed of boys eager to have a farm time, the actual possession of one became quite important to many boys who were relishing what they were getting out of it.

A system was developed. We would only have one boy at a time. We had to be aware of the safety factor and we also had a farm to run. A boy would have a maximum of half a day a week. Unintegrated boys have a low concentration threshold and are low in confidence, so initially they would be with us for just 1½ hours. As they grew in confidence and their concentration improved, then we would increase their time, usually in two increments until they were with us for the whole of a morning or afternoon. To put an expectation on the boys of having to be able to cope immediately, with a complete half-day, would knock them for six, and jeopardise much of the hard work that has already been done by the residential social workers. A boy will always have a couple of informal visits first. I want to be able to make a judgement on whether a boy will be safe enough before agreeing to a formal farm time, and also it gives a boy a chance to see what he is letting himself in for. The boys are provided with overalls but we developed a system whereby we would give the boys a month, both for them to decide whether they wanted to keep coming, and for us to decide if they were coping with the situation. After that time they would be provided with a pair of overalls, not as a reward but as a recognition that they were coping. And what happened? After one week a child would ask 'When can I get my overalls?' After two weeks a child would ask 'Am I ready for my overalls yet?' In time this obviously became a goal that the child would aim for, as was the increase in the length of time they would be with us. This was an unexpected bonus; another way to instil a sense of achievement.

As time went on we began to see more and more how the boys benefited from being involved in a farm environment. It is so easy to give them a sense of achievement, a feel-good factor – a nail hammered in straight, a fencing staple put in, a straw bale carried across the yard without having to stop for a rest,

managing to climb up a ladder, merely the farm staff saying thank you for the help, being able finally to shout at a cow and seeing it move to where you want it to go, survive a hard frosty morning. Simple things that we take for granted but, for the boys, door-opening factors. Slowly, imperceptibly, through the practice of the individual farm times, the farm too became more an integral part of the Community and its culture. Within the 'formal' framework of boys' individual farm times there were still the occasions when groups of boys – and staff – were able to get involved. In particular loading up bales of hay and straw onto trailers and stacking them into the barn were popular and even 'fun' times, sometimes bordering on the 'organised' chaotic as whole households would turn out. But the importance of those times would be demonstrated a year on when some boys would remember and remark upon the good time that they had had the year previously. So gratifying and so easy to have been part of providing an experience for these highly disturbed children that not only was good enough to provide a memory, but also strong enough that they felt 'safe' to be able to verbalise that good memory.

Later, purely a farming decision, we started a sheep enterprise, rising eventually to a flock of 250 ewes for fat lamb production. We had always had cattle, but generally we were restricted as to how we could directly involve boys with them, due to safety factors and also simply that most of the boys were frightened of them. However, from a therapeutic tool viewpoint, having sheep proved ideal. If the boys had any fear they quickly got over it. The sheep were very much a 'hands-on' form of help: they were small, there was something to hold onto (wool) and there were many different kinds of experiences involved in the general husbandry. With sheep too, there have been occasions when we have been able to give a boy a certain task to do which we have deliberately left him to do unsupervised. The response of the boy to that trust in him and our confidence in his ability to do the job – the light in his face, the straightness of the back, the walk two inches taller – shows again how the farm can be used. The cows and the sheep, particularly in winter when they are housed indoors, began to fulfil another function when sometimes a boy could suddenly turn up at the farm buildings alone. As generally unsupervised and unaccompanied visits to the farm by the children are not allowed, we knew that the child in that moment was probably experiencing one of the more frightening aspects of his disturbance and was using the calming influence of the animals to get himself through it.

We began to notice, too, other benefits the farm environment was able to provide. Educationally the boys were picking up so much as we talked and as we worked; the passage of the season, plant growth, animal growth. Let's put in some science, or animal health and diseases. Oh yes, and sex! Reproduction and artificial insemination, just where these boys are so streetwise and screwed up. Teachers started coming down with boys: maths (what weight of milk powder do you use, how many litres per day, what is the cost, how big is a hectare, areas of fields; if sheep need 1½ square metres of space each, how many sheep can we put in this pen?); rural science (weights of new-born lambs and a six-week growth curve) and more. Learning without pain for boys, where

education previously was only pain; and seeing how the learning is applied in adult life, i.e. the whole point of learning.

Practical skills also came into the equation. Traditionally, farmers need to be able to turn a hand at most trades – albeit at various levels of proficiency and no doubt at times we would have sent a qualified tradesman into apoplexy! However, despite that, there are times when water-pipes need to be fixed or laid (plumbing), walls built or repaired after they had been run into with a tractor (bricklaying), as well as needing carpentry, welding, and mechanics. We do draw the line though at electrics. With all of these skills we are able to involve the boy in doing even some small part, to put him onto the first step. I guess that in a way it goes towards providing a parental experience when the child would be involved with a father in DIY jobs around the house.

Don't let me try to fool you that it is all a bed of roses. The frustrations and exasperations can be immense. Boys have their 'off' days, when other preoccupations and difficulties within themselves make us want to throw in the towel and send them back to the household, or when we can breathe a deep sigh of relief that their time is finished for the day so that we can take them back to the household and return to get on with the job properly. Often their manual dexterity is poor initially and we are torn between giving the boy the chance to finish his task and having to get on with the work. Our own feelings have to be contained within ourselves as the boys soak up our projections so easily and translate them into their own inadequacies. The ego strength of the boys is so low that it is very difficult for them to fight through feelings of tiredness or heaviness. So many times it is a case of 'I've got to have a rest', or 'it's too heavy for me'. And yet, I firmly believe that managing the farm on commercial lines and providing a real experience of a working role model is an important factor in the use of the farm as a therapeutic tool. The boys respond to that difference. To re-create the farm as a teaching farm, or to move along the lines of providing multi-experiences, such as having fewer or more types of animals, or more types of crops, without a thought for the economical factors involved, would lessen the impact and, I feel, its usefulness. The sense of reality is further strengthened when we have to suspend farm times during peak periods of the farming year when we have to get on with tractor work and combining etc. We also selectively suspend, temporarily, some individuals during lambing time. Intimate involvement at lambing brings boys into contact with the more messy aspects – dead lambs, prolapses, deformities, afterbirth etc. For some we feel it would be too disturbing and difficult to cope with. For others, it is good to confront it. And imagine the other parts of the children's lives that are confronted, even if unconsciously, in relation to sheep and lambing – orphan lambs, fostered lambs – e.g. a triplet lamb taken away from the ewe and fostered onto a ewe with only one lamb, ewes that won't allow a lamb to suckle, ewes that will batter a lamb, lambs that have to be bottle fed. How much do the children identify with what can be going on and perhaps use it to sublimate their own sadness. And if they can't cope then at least it is exposed for the staff to help them. We are able, too, to give the boys the opportunity to use and challenge their functioning bits. Many times we have

been surprised to see how some of the most difficult children have been able to respond and function quite normally (as we would recognise it) and have allowed the expression of their innate intelligence to show initiative and common sense.

Thus the scope and usefulness of the farm environment has broadened and increased as we learn. The realisation that the children with us are experiencing a facet of life and are gaining the kind of experiences at such close quarters, that probably most other children do not have a chance to do, is immensely satisfying for us and immeasurably sustaining to the children involved. For inner-city children to be able to look over a hedge and to know intimately what is going on in the field must improve their quality of life. Boys' achievements and increase in confidence on the farm are visibly tangible both to the staff and more importantly to the boys themselves, and relationships are long-lasting. Long faces are smiling, under-achievers are learning, pessimists are persevering, and fat, ungainly children are soon performing physical feats that they never realised they were capable of. Indeed, one boy who began with us unable even to climb onto the back of a small farm trailer, has gone on to represent his country at adult level in his chosen sport but that is another story.

Footnote

I came to the Cotswold Community in 1985 as the assistant to the Farm Manager, having worked in agriculture for the greater proportion of my working years. A few years after, I was offered, and accepted, the position of Farm Manager. It was out of interest of getting to know more of the problems that the children referred to the Cotswold Community carry with them and a desire to do a little bit more to help out than just to work on the farm, that I began to visit one of the households once a week in the evenings when the seasonal farm work allowed it. I also asked to be allowed to attend the weekly internal training groups that took place. This training took the form of discussion groups facilitated by one of the experienced senior staff. Papers and articles had to be read beforehand. It was generally informal but totally centred on the therapeutic work that was done and the psychodynamic processes involved, including not just current practices and thinking but also some of the historical processes and thinking that led up to it. The papers included works by Winnicott, Wills, Bettelheim, Klein, Menzies-Lyth, Dockar-Drysdale and many others. The training groups consisted of a cross-section of members of staff so was invaluable also in getting to know the staff personally and the types of problems they faced in their work. The training generally lasted three years.

When I became the Farm Manager, and directly involved in the recruitment process for the farm, I too recognised, as no doubt did the senior management already, the importance of the farm personnel to be receptive and perceptive to the problems and needs of the children who might be with us. The interview process of subsequent farm assistants put just as much emphasis on this quality in the applicant as on farming ability and experience. I made it a requirement to attend the training. I also encouraged whoever was employed to

voluntarily spend some regular time in the households as I had done, if only for a year or so. As is well known, exposure to the children's disturbance opens us up to our own and if we allow ourselves to think about it then we learn to be truly empathic. But we also have to find a balance in the way we use the knowledge we learn. Part of our role on the farm is as a bridge between the core work being undertaken in the school and households and the reality of the outside world. It is important for the children who work with us to be able to relax so that a particular kind of relationship can be formed. Therefore it is best that we on the farm are not seen to 'know too much' and to sometimes 'react normally'. Difficult to do when it is so easy to empathise.

The Cotswold Community's internal management recognised the work of the farm staff, the effect on some of the agricultural practices, and the value of the therapeutic input we provided, by arranging for the Education Department to 'buy' our services at a cost of a third of the farm salaries. A paper exercise certainly within the Cotswold Community finances as a whole, but an acknowledgement of the farm's usefulness.

Dave Cooper

A Lost Community

After more than 70 years, the Cotswold Community, one of the first therapeutic communities for troubled boys, has closed. **John Whitwell**, a former principal, laments its loss.

The Cotswold Community has closed, ending more than 70 years of looking after, 'training' and 'treating', troubled and troublesome boys on a 350 acre farm near Ashton Keynes. I lived and worked there with my family from 1972 until 1999, and for the last 14 years I was the principal, succeeding Richard Balbernie, principal from 1967 to 1985.

Balbernie was the founder of the Community as a therapeutic programme, leading the transformation, perhaps more accurately described as a revolution, from its former incarnation as an approved school. The change was vividly described in *Spare the Child* by David Wills, published in 1971. This brought fame to the Community as the book was widely available. It is still a good read. It convinced me that this was where I wanted to work to deepen my knowledge of therapeutic residential work.

Spare the Child is an account of how the staff of an orthodox approved school are trying, with vision and tenacity, to convert it into a therapeutic community (TC). Their concern was to rid the school of its hierarchical and repressive culture, and to establish instead a community which could provide the care and understanding of which the boys had been deprived. What was encountered was violent hostility to such changes from some of the staff, and, even more alarmingly, the existence among the boys of an established and vicious subculture which mirrored all too accurately the official system of rewards and punishments.

Change in this hostile climate was hard won, requiring considerable bravery and tenacity and a clear vision. Having experienced the resistance to change, I am unsurprised by the many failures to change institutions that I have witnessed in my lifetime. I think it took approximately five years to establish a therapeutic culture.

Balbernie brought in eminent consultants to help drive the process. Key was Barbara Dockar-Drysdale as consultant psychotherapist. She founded The Mulberry Bush School in 1948 and then trained as a psychotherapist which brought her into contact with Donald Winnicott whose work on how small children achieve emotional integration was the key concept underpinning the Community's work. The boys referred were diagnosed as emotionally unintegrated. In today's parlance they would be described as having attachment disorders, attention deficit hyperactivity disorders, oppositional defiant disorders.

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In other words they were chaotic, disruptive, prone to panic rages, had low self-esteem and very little concern for others.

The Community's therapeutic work was to help emotionally unintegrated boys achieve emotional integration, a stage in development which would be normally achieved before the age of three. The fact that this reparative work was taking place with boys in the age range 9-16, whose age appropriate needs also had to be addressed, meant that this was complex therapeutic work. Dockar-Drysdale's consultancy was to the staff teams of the group-living households and the education area. The therapeutic model was that the residential workers would be trained and supported to provide therapeutic child care. This was a very different model from residential child care where the child might see a therapist once a week. Emotionally unintegrated children need therapeutic management 24 hours a day. Staff had to be trained to take full advantage of the moments in a day when a child might drop their defences and be receptive to being cared for. It was this daily process over many months that basic trust was achieved, the cornerstone for ongoing therapeutic work.

Another decision that Balbernie made, crucial to changing the culture of management, power and authority, was to bring in the expertise of the Tavistock Institute. Initially this was Ken Rice, followed by Isabel Menzies-Lyth and subsequently Dr Eric Miller. Their task was to oversee a change in the management structure that would support the therapeutic task. The previous regime had been top-down and hierarchical: the staff who were directly involved with the boys were the least effective people in the organisation. The pyramid had to be stood on its head, delegating authority to the staff looking after the boys to make decisions in their best interest. This meant the residential workers had the authority and confidence to draw the boys into the decision making process, a key attribute of a TC. These practices are taken for granted now but at the time it was unheard of for staff to have authority and budgetary responsibility. The idea was to enable the staff to role model effective adult behaviour to the boys which, in the absence of family life, was vital for the sake of their future wellbeing.

It is now accepted that the aim of therapeutic work with emotionally damaged children should be to break the cycle of deprivation, enabling them to develop a feeling of self-worth and the ability to sustain meaningful relationships in adult life. The boy who was read bedtime stories grows into the father who reads bedtime stories to his children.

Sad though it is that the Cotswold Community has closed, the work will live on through the many generations of people who experienced working and living in a TC with an explicit and coherent philosophy in the 1970s, 1980s and 1990s.

Reference

Wills, D. (1971). *Spare the Child*. Penguin.

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Guidelines for Contributors

Therapeutic communities were born out of the radical and creative forces that established alternative forms of mental health care, from the 1950s to the present day. Therapeutic environments, influenced by the ideas developed by this movement, exist in psychiatric settings, social work or penal institutions, in community schemes, in projects for the homeless, in the drug and alcohol fields, and in educational and industrial settings. The *therapeutic communities* journal (hereafter known as the Journal) aims to build upon this creative legacy by stimulating a continual critical re-thinking of the possibilities for developing therapeutic and relational potential, within whatever communities readers work and live. It aims to provide a forum in which those engaged in developing, managing and sustaining therapeutic cultures can communicate their experiences, the effects of political and social policy on their own settings, their ideas, developments and findings; and can disseminate good practice and explore what happens when things go wrong.

The Journal publishes academic papers, case studies, empirical research and opinion. The Journal is interested in publishing papers that critically and creatively engage with ideas drawn from a range of discourses: the therapeutic community movement and other related professional practice, psychoanalysis, art, literature, poetry, music, architecture, culture, education, philosophy, religion and environmental studies. It will be of value to those who work in health services, social services, voluntary and charitable organisations, and for all professionals involved with staff teams, service users and experts by experience in therapeutic communities, therapeutic environments and supportive organisations.

General Guidelines

Original contributions that fall within the scope of the Journal are welcomed, including articles on current issues, practice, theory and research (academic papers), case studies of particular communities or organisational environments, and personal contributions arising from the experience of the author. The Editorial Board uses different criteria to assess contributions in these categories, and the following guidelines are provided. It will assist us in assessing papers if authors indicate which guidelines they have followed.

Final articles for publication should be typed in double spacing and submitted in Word format as an email attachment to Ginette Taylor, the Journal Manager (ginette.taylor @nottshc.nhs.uk). All articles are submitted for peer review by anonymised assessors drawn from the Editorial Board, the International Editorial Advisory Group, and a panel of assessors. Authors will receive acknowledgement of their submissions.

Note: For authors submitting an article where English is a second language, it is recommended that the article be proofread by a fluent interpreter prior to sending, in order that intended meanings can be checked in the translated article.

Ethical Issues

The Editorial Board aims to ensure that all articles published in the *therapeutic communities* Journal report on work that is morally acceptable. To this end, the Journal will appraise the ethical aspects of any submitted work that involves human participants and will ensure that authors obtain informed consent from any participants included in their research.

Academic Papers

These can include reports of original research, papers developing original links between theory and practice, review articles and critiques of current practice. The normal conventions of academic papers should be observed, with a brief abstract (up to 150 words), followed by a review of the relevant literature, statement of the problem, method, findings, discussion and conclusion. References should follow the APA 6th style. Academic papers should normally not exceed 5,000 words excluding references (articles over 8,000 words in length will not be considered for inclusion and will be returned to the author unread).

Case Studies from Practitioners

These describe examples of practice, innovation, action research or evaluation in the practitioner's own unit. They should include: a brief description of the setting, of the piece of work undertaken and the reasons for doing it; a clear account of the process and findings with relevant data in easy to read tables or graphics; a brief conclusion with discussion of the findings and their implications for practice within the unit and perhaps more widely. A small number of relevant references may be included, following the APA 6th style, but no literature review is needed. Case studies should normally not exceed 2,500 words.

Commentary/Response

The Journal would welcome short papers (up to 2,000 words), which address topical issues. These issues may arise from recent themes or views addressed within the papers in the Journal, from within therapeutic communities, they may emanate from strategic developments within The Consortium for Therapeutic Communities (for example the issues of accreditation of communities and training), or be generated by national and international policy initiatives that have an effect on therapeutic practice, or the way in which it is thought about or conducted. We are seeking relevant commentaries, which are reflective and thoughtful, yet critical and perhaps at times controversial; and views and opinions which will stimulate debate, provoke thoughtfulness and hopefully new ideas, with which to approach contemporary issues.

Letters

The Journal would welcome short letters (up to 200 words) from readers picking up on issues raised within the Commentary/Response section that develop and debate issues further.

Personal Contributions

Readers are invited to send in personal accounts of some aspect of their work that may be of interest to others. The intention of such contributions is to share experience and problems, raise questions and encourage discussion. These may describe an event or situation involving the writer, occurring at the individual, group or organisational level. Contributions from experienced practitioners as well as novices are welcomed. The account should begin with a brief description of the setting, participants and background, followed by details of the particular event or situation and, if appropriate, the responses of the writer and others involved. No literature review, theoretical exposition or references are needed. Confidentiality should be maintained by disguising the identities of individuals or organisations, and authors may request that contributions are published without attribution. Personal contributions should normally be limited to 1,500 words. With the author's permission comments may be sought from practitioners with relevant experience to appear alongside personal contributions.

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