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The Work Discussion seminar- a learning environment.

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This chapter will consider the potential for and process of learning in a Work Discussion seminar. The relationship between the seminar leader and the members of the group is at the heart of the learning experience. The material brought to the seminar is often profoundly painful and upsetting to both presenter and listeners. The crucial role of the seminar leader is in finding a way for the group to become aware of the nature of the distress being communicated by the worker, and by client to worker, to be able to hold onto it for long enough to get beyond immediate defensive responses and ultimately to understand more about how the worker's relationship to the client may be able to modulate the emotional situation helpfully.

This kind of learning becomes possible as the seminar leader directs people's attention away from learning additional facts and towards reflection on practice. Seminar members may well find that no one else in the seminar shares their profession. This could lead to a view of their being the undisputed expert in their field or, by contrast, allow them to become part of a group where they are free to reflect on their work in a different way. The Seminar Leader's task is to help the group to move in this direction.

A process of learning which boldly asserts that there will be no explicit teaching of techniques intrigues but puzzles people at first, but becomes fascinating as the method gathers steam. On the whole, the written description of work brought to the seminar is sufficient for the task of the group, though interesting additional details are sometimes remembered during the discussion. The process can at first be quite disturbing, since new questions start to arise within areas of work in which the worker had felt quite competent. At times the group can feel that it is being invited to participate in a process of 'unlearning' rather than learning. There is initially a delicate balance between a focus on the material presented and the contributions by others present, including the Seminar Leader. The task of the group as a whole is to be supportive of a process which will involve a fresh reconsideration of what may have been hitherto held rather unquestioningly. The Seminar Leader has to combine encouraging the study of the personality interactions described, and the exploration of the influence of unconscious processes, with an awareness of defensive obstructive processes which will be aroused in the group.

Insights gained about unconscious dynamics go beyond the particular presentation and its subject matter and allow members to have a memorable learning experience which can be applied to many other situations. It is moving to witness a moment when insight is gained by the group as a whole. But this is not the only possibility—sometimes one or two members will stand out in terms of

their capacity for insight. At other times a member will be left behind and struggle emotionally, leading to a feeling of anxiety in the group as a whole. And, of course, there can be a move against new learning in the whole group which the Seminar Leader has to deal with.

I will illustrate some of these themes by describing two Work Discussion presentations in some detail.

Example One: Dealing with renal failure.

A member of the group, a paediatric nurse, presented an account of Juliette, a teenager who had to deal with the terrible consequences of a late diagnosis of meningitis. Not only did she suffer from chronic renal failure, but due to the way the blood supply was withdrawn by the body system, she had to have both legs amputated at the knee, lost finger tops on one hand, and all the fingers on the other hand except her thumb. She had had skin grafts taken from her abdomen and had also had surgery to help her pass stools and urine. Despite this, she was able to go to school and was working hard to catch up with her GCSE's.

I need hardly describe what a profound effect this account had on the Work Discussion Group. There was a sense of incredulity that any teenager could have had life turned upside down so tragically. As a group (and I include myself) we struggled to be informed about renal failure, learning about the different

techniques that are employed to provide kidney function. This search for information provided an opportunity for the group to become 'ordinary learners' at a very stressful time, when it was very difficult to put oneself in the place of the tragic young girl presented. But this process of educating ourselves was not powerful enough to contain all our feelings. For example, mention was made of one consequence of dialysis, namely that very little liquid is allowed to the patient. In fact, patients have to become accustomed to feeling 'parched' all the time, and they often have severe headaches as the body protests against such a strict regime. Though there was, of course, a world of difference between this account, delivered in a seminar, and the impact of being on a renal ward, nevertheless there was a powerful communication of what it would feel like to have one's water supply restricted in this way. The response was somatic rather than reflective. Small water bottles brought into the Seminar for refreshment (the equivalent of a day's supply for a renal patient) were sought for in bags and felt for reassurance, and there were several journeys to the toilet. Out of the blue, a primitive way of dealing with a painful situation thus took centre stage, the somatic response being the price to be paid for the group's struggle to respond in an attentive and emotionally present way to this painful scenario. As Seminar Leader, I remember feeling enormous concern for them, and wondered whether they were being asked to cope with too much. Events proved that I was being over anxious on their behalf since, after a brief drinks interlude, there was a determined return to task.

The following is an account of an evening on evening/night duty with Juliette. The presenter established, when coming on duty, that Juliette had asked if the nurse could watch videos with her during the evening before another serious operation. A number of duties with other patients had to be carried out before she could go to Juliette.

Juliette got up and we went to the cupboard. I asked her what type of movies she liked. She shrugged in answer. So I randomly picked video titles and suggested them to her for her selection. After a few suggestions Juliette asked me what I wanted to watch. I told her that as long as it was not scary I would watch it with her. We finally picked about five videos and returned to her room. Juliette chose the Rugrats to watch and I put that in. She took her prosthetic legs off and scratched her right leg where there was a dressing. I asked her if she was OK and she said she was fine. We watched about 20 minutes and then Juliette decided it was boring so I changed it to a video of the Chipmunks.

Juliette asked if she could have some fruit squash instead of plain water. She was having gut surgery which required that she was not to have food for 24 hours and have clear fluids till 10.30 on the morning of surgery. So, I double checked with the nurse in charge and got her a cup of orange squash. In the time it took me to do that she had decided that this movie was also boring. So we changed the video to Andre. We watched a few minutes of it and the door buzzed.....

I returned to Juliette who had put her supra-pubic catheter on free drainage as her normal routine. She was scratching her arms and abdomen. I asked if she was OK and she said she was a little itchy. I suggested that it was time to take her medication but she preferred to take them a little later. So we watched the movie. Then she began a conversation.

Juliette: *Is it going to hurt, what they'll do tomorrow?*

Nurse: *I don't know much about the surgery but since it's on your abdomen, I think it will hurt some. But I'm sure you'll get some pain relief*

C: *What is morphine?*

N: *It is a pain relief medicine which we can give in your mouth or via a cannular and you can push a button when you're in pain and receive a dose. It's called a PCA which you control.*

C: *What about going after?*

N: *Do you mean when you pass stool?*

C: *Yes*

N: *Well, it's going to be a while before you do that but I don't know.*

C: *But what do you think?*

N: *Well I think it shouldn't hurt because I don't think they are going to touch anything in that area. I think it's only going to be your stomach they touch*

C: *When can I eat?*

N: *I think possibly the day after your surgery.*

C: *What! I would have been starved for two days. That's not happening. I'll eat. I don't care what anyone says.*

At this moment I thought I should back-track and reassure her since I was guessing.

N: *Well they are going to handle your bowel which is part of your gut and this will affect when you can eat.*

C: *But this is about pooing not eating.*

N: *Well it's all linked from your mouth right to your anus.*

C: *You know that it is a mile long. A mile long, all in there.*

She pointed to her stomach.

N: *You are right about that. How come the person who 'consented' you did not speak to you about the procedure?*

C: *The doctor who came was rude and nasty.*

N: *That's not fair on you. Listen, I'll say at handover that the surgeon needs to speak to you before the procedure so that you can ask your questions. And one of us can be with you if it helps.*

C: *OK.*

Juliette asked me to get her lucky pyjamas. I did, and then asked her to take her medication as her scratching had become more frantic. She sat up and put about eight tablets into her mouth at once, took a drink and swallowed them all.

Discussion:

The account is a moving blend of questions that are harrowing in their simplicity and a routine intended to reassure and allow difficult procedures to take place. Many details about hospital life emerged in discussion. Some procedures had to be carried out by the surgeons and this would involve sending a patient away from the Ward. What place would there be for adolescent anxieties such as where a scar would be left due to the passing of blood through the dialysis machine? Would it be below the neckline or above the elbow, so that it could be hidden? What to make of the possibly divergent opinions between medical staff, the teenagers and their parents? Would it be dangerous to acknowledge that this could be an important issue to discuss, given the life and death quality of the work on the Ward? For example a site on the arm below the elbow was often chosen for the link to the dialysis machine when operating, so that if it became infected, it would still be possible to insert another above the elbow. The price of failure would be savage.

It seemed possible that these simple yet heartbreaking questions were being evaded since the consequences of trying to give an answer would uncover other questions for Juliette such as 'How on earth did I lose limbs, continence, the possibility of a sexual life because of a delay in correctly diagnosing a headache?' Enormous efforts were being made to keep Juliette alive and motivated to live. There seemed to be a very fragile line between supporting her efforts to emerge from a state of withdrawal from life and allowing her to voice

something of her pain and rage at what had happened, with all its dreadful consequences.

It was clear to me that there was enormous tension in the seminar room at times. The group was distressed at being part of a drama of life and death played out behind a scene characterised by a succession of trivia. How could the facts of bilateral amputation, the loss of fingers, the insertion of catheters, and anxiety about the imminent operation be reconciled with the picture of the dedicated schoolgirl hoping to achieve good marks at GCSE, or with the apparently insignificant request for orange squash rather than plain water? It seemed gradually to become clear that whilst the members of the group were following the banality of the conversation, they felt filled close to bursting point with the intensity of the tragedy. There was a sense of being asked to bear something apparently missing from the day-to-day exchanges on the ward. Why was there such a disparity between the acutely painful circumstances of the patient and the muted reactions of hospital staff who were dealing in such a matter of fact way with this tragic situation? A similar imbalance seemed to be observable within the seminar itself, particularly in the interchange between the presenter and the rest of the group. Dialogue was difficult for a while, and it seemed that the presenter felt she had to defend the good reputation of the hospital and hold onto a rigid definition of her job.

My dilemma was that whilst I was aware of the impatience, even desperation, of the seminar group for something interpretative to be said to Juliette, I felt great sympathy for the plight of her nurse who was clearly troubled by not feeling able to expand her role. In fact I was strongly put in mind of a similar situation I had encountered when carrying out some consultancy work with nurses from a hospital ward on which there were a number of very sick children, many of whom did not recover. I was grateful for the way in which this situation came to my mind when I felt quite caught between opposing views, and could see no clear way of taking the discussion forward. I will describe what I found myself recalling.

My consultation had been arranged by the Medical Consultant who felt that the nurses would be helped by having a regular space to talk and think about the harrowing situations they had to deal with. I was very impressed by the quality of the work being carried out, but, from the beginning it was apparent that there was a feeling of ambivalence in the group. The group could not manage either to attend regularly or describe their work when asked to do so. The presentations were usually verbal and it was stated by a number of presenters they had not felt able to sit down and write down what had happened. They felt that what happened on the ward was dire enough, but to write something down would be to invite unwanted feelings to return whereas all they wanted to do was to forget it.

This was illustrated powerfully by one nurse describing a disturbing time spent with a girl of just four years, suffering from the effects of an aggressive cancer. As she sat with her, she found herself hoping that the girl would die. The medical staff seemed to have a different viewpoint. Indeed the girl's deteriorating condition was pushing them to further action as they obtained the parents' permission to administer a newly developed drug in the hope that it would lead to a halt in the inexorable progress of the cancer. The intervention was not successful, and the little girl died at 3 o' clock in the morning. The nurse presenting was clearly very upset at the feelings at that time. She went on to say that it was Christmas morning, and she was on duty three hours later. Indeed sometime previously she had volunteered to be Father Christmas and found herself forcing 'Ho, Ho, Ho's' out of her mouth whilst the rest of her was 'in the same place as the little girl' (her words). In other words feeling that life had ended. Later that day, to her surprise and subsequent embarrassment, she became extremely irritated with the parent of another child who had complained to her that one of the hospital's TV sets had very poor reception, and this was

ruining their favourite programme. She was so angry with them about what she regarded as selfishness that she could barely wait till the end of her shift, when she was able to do 'kick-boxing' to get it out of her system. When she had finished her account, most of the group nodded their assent. They clearly expected me to dispute the premise that events which are very upsetting need to be got rid of rather than be processed. I felt challenged to defend the decision to convene a meeting about their work, and I felt that unless the defence of it came from within the group itself, this would be the end. At that moment, in the mind of the group, I seemed to be experienced as an 'annoying' parent who came with nagging requests while they were trying to deal with great tragedy. The group managed to say that these meetings could not possibly mean as much to me as to them. To me, they said, it was a job, however sympathetically it was carried out. They, on the other hand, had to cope with death on a daily basis. They had no space for reflection; they just had to get on with their job, ready for the next death. It was powerfully said. To my relief, one of the nurses offered a different view. She said that she was very grateful for the nurse's account. She had not known what a particularly difficult Christmas Day she had had. Her words had moved her very much and had helped her to recall the child, with whom she also had spent time. It made her sad, but she felt it was better to remember rather than just forget the pain. She felt privileged to be with the children. They were special people, and being with them helped her as a person.

Her words, deeply felt, moved the whole group. Afterwards, I found myself wondering about the different responses to the presentation, one to defend against emotional suffering and the other embracing it as a necessary price for keeping in touch with what mattered, without which one risked being cut off from one's own feelings.

This digression will, I hope, have served to illustrate the situation I encountered in the seminar whilst considering the material from the Renal Unit. The presenter's position was a complex one. One concern was how to manage the routine of death on the ward, and at the same time how to help patients go on with their lives no matter how catastrophic their illness and injuries. As a consequence, a patient's merest indication of a wish to have a future tended to be seized upon. A particular anxiety was that there should be no visible sign of an operation having taken place. Hence the pressure on nurses to be able to promise that once they had left hospital, patients would be able to wear a 'bikini' without

visible scars. Parents sometimes arranged for skin graft operations to take place in addition to the extensive operations that had already taken place, often over many years. It was as if the unrealistic hope of a body without blemish, the restoration of a 'perfect daughter' was a way of holding on to the hope that not everything had been hopelessly damaged. Perhaps the 'bikini' test was deliberately extreme in order to combat the impact of an illness, which took away the dignity of being able to carry out basic bodily functions, and which required particularly intrusive medical interventions. The presenter felt under immense pressure to go along with the culture of the ward even though she had severe misgivings about it.

But what of the response of the seminar group to this scenario? There was a powerful realisation within the group that they were in fact in touch with a quite appropriate sense of sadness and despair, feelings which could not be voiced easily by Juliette or the nurses on the ward. It was at this point that terms I had mentioned in discussion such as 'evacuation' 'projection' and 'splitting' took on a very different meaning. The group had experienced something emotionally profound. They were able to apply psychoanalytic concepts to their understanding in an experiential way. It was quite clear that learning in this way was quite different from merely learning about something, as if it were merely a descriptive process.

The group's realisation of the major forces set loose by such tragedies made it possible for horizons to be broadened and other issues to be considered. It was possible, for example, to consider some larger institutional issues. Did counselling on the ward have to be considered only as a formal referral option or would it be possible to think about the emotional needs of patients in a less formal way and in an everyday context?. This question led to thoughtful discussion about what sort of comment might be made to a child on the Ward, and to a greater understanding of the importance of ongoing relationships within the ward setting. Ultimately, the presenter herself felt sufficiently supported by the Seminar setting to raise the following broad questions about practice:

Why does looking after a sick child make it difficult to look beyond the physical needs?

Why is it difficult to organise a team, communicate effectively and listen?

How does one help a child to understand their own mortality?

Are the boundaries of a nurse's role the real obstacle to allowing some thinking/talking beyond the physical problems requiring care?

Is it lack of time or fear of what might be said or revealed that makes it difficult to start talking about the emotional and psychological issues?

These questions were related to some further reflective points explored in the seminar:

- * *the effect of working in a high stress, high demand environment*
- * *dealing with life and death everyday*
- * *the difficulty of providing real emotional support, to allow space for patients and parents*
- * *a setting very focussed on the pathophysiology issues with comparatively little time invested into the psychological or emotional side of the patients' care.*

- * *lack of resources outside the hospital for the continued provision of support once the patient is discharged.*

It will be evident how wide-ranging the issues the seminar members could gradually struggle with in response to this particular presentation.

Case 2 Reflecting on loss

The previous case presentation concerned a situation within which the worker had to expand her usual practise to introduce flexibility to a narrowly defined job description. My experience is that this is a characteristic outcome over time for many members of Work Discussion groups. However I now want to refer to a different kind of problem, one in which the worker also had a well defined role within a well established therapeutic community. The main issue did not centre on the definition of work, but on whether and how contact could be made with an emotionally vulnerable boy.

Ryan was referred to the Community at the age of six and a half years old. It was clear from case notes that by the time he reached the community, he had had seventeen residential placement changes in his first two years, and forty altogether. He had been subjected to much abuse, and had witnessed extreme domestic violence. He was prone to explosive bouts of rage, and this had probably played an active part in the breakdown of a number of his placements. An extremely challenging aspect of Ryan's behaviour was his soiling, which

seemed to be constant. He would soil his pants and avoid the use of toilets, finding 'special' places for depositing his faeces. He was always on the edge of the group, avoiding company where possible, and the smell of his incontinence ensured the effectiveness of his avoidance strategy.

Alongside this behaviour the ordered regularity of life in the community began to make its presence felt. This was nothing dramatic, but for the first time in Ryan's life there was a regime of clear and consistent boundaries, intended to convey a sense of proportion, predictability and reliability. Workers were encouraged to value the significance of paying attention to the fine details of every child's living experience. Even so, it was not until Ryan had been at the community for a year that he seems to have begun to entertain the tentative hope that his stay (already the longest period he had spent in any one place) might go on for some time. He began to make tentative moves in the direction of his male key worker, who was a member of a Work Discussion seminar. Intuitively he had chosen the person who had been on the staff group for the longest time. Over the next year, the beginnings of a relationship began to take shape. Painfully, as the expectation of regularity began to take root, so too did a greater awareness of any absence. The community tried to be sensitive to this by introducing the concept of a worker couple, whereby Mary, another worker in the home would cover the absences of Ryan's key worker. In the seminar, we discussed how this arrangement mirrored the case of a parental couple. The following is an account of his reaction to this

initiative, at a time when there was also an attempt being made to think with him about his past placements through 'life story work':

Ryan burst out of the room where we were working and had been talking about how Mary would look after him when I was not there, and retreated in a noisy commotion to his bedroom. When I followed him, he jumped up from his bed in an angry rage. Still clutching Whitey (a pet sheep) in his hand, he then proceeded to kick his toy box across the room. The contents exploded onto the floor producing chaos in his room. With a shrill voice he began to swear at me repeatedly calling me a 'Bitch' and saying that he hated me. Ryan picked up a heavy toy car and threw it at me but narrowly missed, and it hit the wall. I decided at this point to stop Ryan, with the aim of at least physically containing some of these powerful feelings...I held him, sitting on the floor just outside his room away from the chaos. His emotional state quickly changed from anger to noisy excitability, shrieking over any words of reassurance I was trying to offer. At this point Mary came up to support me, having heard the commotion. Ryan almost immediately launched a verbal attack on Mary, swearing, and saying that he hated her. His aggression increased again and he was now kicking out in the direction of Mary. I commented at this point that it seemed that recently he had been taking a lot of his angry feelings out on Mary.

A short while later I returned to the subject, once Ryan appeared a bit calmer. I told him that Mary and I had noticed that when I'm away from the community there is often an increase in Ryan finding things difficult, and that, almost without fail he seems to take out his difficult feelings on Mary. I then added that it was my experience that often when I am around, Ryan pretends that everything is fine and that I see very little difficult behaviour. Ryan at this point became annoyed and denied this. I asked him how he felt about me having the next two days off. Ryan looked cross but didn't answer. He attempted instead to change the subject and interestingly began to talk about his wobbly tooth. Ryan said 'I'm going to pull out my tooth and when I do, blood is going to go everywhere!' At this point I reassured him that it was very natural for teeth to come out (thinking to myself that this was a wonderful image of a necessary separation) and that even though it was a bit worrying and maybe painful, things normally turned out OK.

Comment

On listening to this account I was impressed by two very different targets of Ryan's rage. The first was the launching of objects into an unboundaried space, with no way of knowing or being able to control the effects of what is launched.

The heavy toy car carried murderous intent with it. The second episode certainly describes furious rage, but here, the worker's own body marks the boundary, as does his thinking presence. A boy who for a long time could only skulk at the periphery of things was able to launch an attack and come to realise that it could be contained, that he would not inevitably destroy his carer, as had happened so many times before when his placement had broken down as a consequence of his violent behaviour. I was put very much in mind of Bion's comment that if, as Melanie Klein states, an excessive amount of projective identification is harmful, then we can assume that a certain amount is necessary. In this case the experience of having to cope with the absence of his key worker could only be described as the equivalent of an empty cavity, of nothing being there, for Ryan, and he is preoccupied with broadcasting the damage that he feels has been done to him. Nevertheless, after some years in the community a fuller picture is emerging than that presented by his avoidant and incontinent behaviour, which had as its main aim the disguise of his anxious hopes of containment.

The seminar group were very moved by the courage shown by this boy as he began to emerge from his state of angry withdrawal. They felt deeply involved in supporting the work of the key worker who was able to continue to think creatively whilst under enormous pressure. At times, being the recipient of Ryan's pained reaction to loss was almost too much to bear. There was one occasion, for example, when after a number of years in the community Ryan was on the point of leaving a successful weekend camp at which he had been staying

with other looked-after children. At the moment of departure he broke down and cried for forty minutes. Eventually *'he wiped his eyes and said that he didn't ever want to say goodbye to any more people. He then began to describe a pain in his stomach, which felt empty and sore'*: To the worker, as well as being painful to bear, this moment felt like a great development: Ryan was able to put into words his feelings about loss and separation, and also, movingly, about his sense of attachment.

Conclusion: A matter of chemistry.

I would like to conclude this chapter by commenting on what has emerged about the setting of the Work Discussion Seminar, and particularly about the relationship between the seminar group and the Seminar Leader. The setting is, of course, very important since it provides a foundation upon which learning can take place. The fundamentals of the setting become reliably familiar: regular meetings over a two year period; equal opportunity among the group for presentation of work on a predictable basis; the opportunity to look closely at interactions; the emergence of insight into the situation discussed. These are, of course, also fundamental elements of the clinical psychoanalytic setting. But in the case of Work Discussion other quite different elements are present as well. The Seminar Leader needs to be active in creating a non judgmental atmosphere, in promoting curiosity, sustaining the group at times of despair, and treating group members with respect. At first sight these two aims, the analytic

and the developmental, seem at loggerheads with each other, the one essentially passive, and the other active. In fact they are complementary. Sometime ago, when writing about supervision (1997) I described the main challenge of supervision as that of providing useful insights into the relationship between therapist and patient, which, by its very nature, is private and exclusive. The most important role of the supervisor, in my view, is to facilitate communication between therapist and patient, and to augment the resources available for dealing with crises within the treatment rather than attempt to take over command, and conduct the therapy at one remove. In many ways, the role of the seminar leader is similar. One is there to allow a process to take place, not to take it over. The promoting of curiosity therefore is a complex aim and might be viewed as a two edged sword. The seminar leader can help to promote learning in the group, but if too insistent, can also stifle the group's own wish to learn. One needs to hold on to the expectation that if the group remain focussed, a clearer understanding will emerge. Memorably, Bion (quoted in Harris, 1987) describes the meeting between analyst and analysand as giving rise to disturbance which he called an 'emotional storm'. He says that throughout the process 'storm-tossed but not shaken', the analyst must go on thinking clearly. This more disciplined reaction builds up strength and courage and a capacity to stand fast. Bion assumes that very often the analyst will not realise consciously what is happening but says that 'if we stay, do not run away...go on observing the patient, after a time a pattern will emerge'.

I think there are parallels here with many situations brought to Work Discussion Seminars. They may have been deeply distressing or frustrating to the worker and the feelings aroused may be accompanied by an inability to think about what is going on. This was certainly true of the hospital episode described earlier. The group immersed itself emotionally in the world of the patient and the nurse, and was encouraged to do so by me, rather than to take up a more intellectual enquiry into the hospital situation, and thus make suggestions about practice without fully appreciating the enormous difficulty of being open to the emotional impact of hospital life. The thoughts which eventually emerged seemed to me to be rooted in an understanding of complexity and, as such, could be transforming of hospital practice, if developed and sustained.

In many ways I felt, as a Seminar Leader, that the situation of Ryan was even more difficult to deal with. The facts described were so painful. The group had to think about a young boy who should not have had forty placement changes before he was six years old. Anger and frustration at a social care system which could allow such a sequence of events to take place are easily available as ways of not becoming emotionally involved in the current reality. For, inevitably, the painful issues of separation and loss remind members of their own experience. Money-Kyrle (1956), talking about the analytic situation, describes the patient as standing for those areas within the analyst's own unconscious which are still endangered by aggression and still in need of care and reparation:

A partial motive in being concerned for the patient's well being is that the patient is the representative of a former immature or ill part of himself including his damaged objects, which he can now understand and therefore treat by interpretation of the external world.

Money Kyrle is, of course, speaking of an analytic situation, which the Work Discussion seminar is not. Nevertheless, I believe that the inevitable frustration with the limitations of one's own work situation, does enable students, with the help of a supportive group and Seminar Leader, to embark on a process of learning which is personally fulfilling. It is of course a process that takes time and I would like to make a final point about the function of time and space, both in relation to the examples discussed in this chapter and in the functioning of the Work Discussion group. It was noticeable that it was only after a year that Ryan began to entertain the possibility that his stay at the unit might go on for some time. It was at this point that he was able to set up contact with a key worker and embark tentatively on a relationship however stormy it was. Such a process requires time (Canham, 1999) and a process within which the earlier abuses of those early years could be challenged by the provision of a thoroughly dependable space, over time, characterised by its sequence of beginnings, moments of contact and endings. Although this process is most clearly defined by the situation of Ryan the need for time and space was also present in the situation of Juliette, though in her case there was no time to prepare for a cruel transformation of her life situation. It was the brutal nature of the transformation,

giving little space for thought, that was felt so acutely by the Work Discussion group. The provision of time and space within the seminar setting and the dependability of it formed a very important element in the emergence of thinking linked to emotional experience.

What can be possible in such a setting was well articulated by a student nearing the end of Work Discussion Seminars:

I find it easy to substantiate the value of my experience of Work Discussion on a number of practical levels. Yet of most significance to me is the contribution Work Discussion has made to my own personal development and learning. The value I have gained from the insight and support I have received throughout the Seminars has been far reaching-- certainly way beyond my expectations. Indeed, on a daily basis I am reminded of the contribution Work Discussion has made to my whole life learning which I am very grateful for.

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