The Use of Self in Social Work Practice

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Introduction

Relationship based and therapeutic social work practice relies on us 'using ourselves' as a resource in direct work with service users. But what do we mean by the 'self' in this context, and how do we 'use' it? In this chapter I explore some psychoanalytically based answers to these questions, and present a number of case studies and clinical vignettes that illustrate different aspects of the use of self.

Effective therapeutic social work is not primarily about using theory to understand other people or ourselves. Rather, it concerns a capacity for attunement to our emotional experience of ourselves in relation to others; attunement to the flow of emotional transactions between ourselves and our service users and colleagues, which are occurring constantly whether we choose to recognize them or not. This is why the use of self is so important. Concepts like transference, countertransference, projection and splitting can seem daunting, but they describe powerful processes that will destabilize our best intentions to practice effectively if we cannot track them and work with them as they are occurring. Equally, understanding how to recognize, track and make sense of the emotional dynamics that are always alive in our work deepens our practice, improves our performance, and our effectiveness and decision making, and helps protect us from the sometimes psychologically damaging impact of the work we do. In other words it is a core professional skill, perhaps *the* most central skill we need to develop, sustain and hone.

The chapter begins with a detailed case study of one to one work and a series of reflective commentaries on this unfolding story. It then offers a further case study of multi-agency practice with a family where a newborn baby is deemed to be at risk, and some further reflective commentary. Finally some brief extracts from a case and how it ended are presented. Along the way a number of key concepts are introduced and readers interested in pursuing the more theoretical aspects of the chapter can follow up the references provided. A very helpful concise introduction to key concepts is Marion Bower's (2005) chapter. But the focus of the present chapter is on the immediacy and power of the 'lived experience' of practice encounters, making sense of these, and the meaning of 'using yourself' as a resource in the work.

A panic attack

A social worker in a voluntary sector mental health organisation began work with a socially isolated single man in his fifties. Mr A. had been referred by his GP who felt concerned about him but unable to clearly 'diagnose' his problem. The GP described the man as 'difficult' and complaining. He attended the practice frequently with

relatively minor medical ‘complaints’ - gastric symptoms, eye infections, and chest pains that did not respond to routine medication and for which tests could find no obvious cause.

The worker agreed a contract of sessions with Mr A. who accepted the offer but seemed noticeably reserved and perhaps rather cynical and suspicious of whether ‘it would do any good’. After three meetings the worker felt he did know more *about* Mr A, but did not feel he had *got to know him* at all. Mr. A. expressed much disappointment with his life. He had hoped to be married and have children, and he felt his career had never taken of. He spoke of an older brother who had made his childhood miserable with teasing and bullying that his parents had never protected him from, and of a few friends, but the worker felt that these relationships were all very ‘thin’. The worker tried to be empathic with Mr A’s account of his life, but these efforts to make emotional contact with him were often met with a critical response. Mr A implied that the worker had misheard him and ‘got it wrong’. At the start of each session following the first meeting, Mr A. would refer to something the worker had said the previous week, and again convey his dislike and disagreement. However, the worker did not completely recognize the remarks Mr A. reported him having made. It was as though they had become ‘twisted’ in some way and it was this distorted version to which Mr A. then reacted critically.

The main feeling the worker had was the sense of Mr A’s isolation and loneliness, but he felt that the sessions had not led to any proper emotional contact with the sad or emotionally isolated aspect of his client. The worker found it hard to like Mr A, and began to rather dread seeing him, feeling apprehensive about receiving yet more subtle criticism and confusing communications.

Then, during the fourth session, which on the face of it developed much as the previous ones had, the worker was gradually overtaken by an anxiety that Mr. A might be suicidal. He could not really account for where this feeling came from, but it gripped him increasingly as the session progressed. Not feeling he had a real alliance with Mr A., and unsure about whether the feelings and thoughts were meaningful, he said nothing. But after the session, the worker became more and more anxious and panicky. What if Mr. A attempted suicide and he had done nothing? Were his case notes written up fully? Should he be alerting the GP, but if so on what grounds? The state he found himself in did not feel like his usual professional self which he believed to be normally quite composed. The worker realized that he could not really ‘think straight’ and that something unusual had taken place, which he did not understand. He sought out his supervisor. He was fortunate to have access to a supervisor who was skilled in relationship based work. What happens if you are not so fortunate is a question I take up later in the chapter.

The supervisor listened carefully and then made some suggestions. It seemed the worker had been ‘invaded’ by these powerful feelings and anxieties during the session

with Mr A. It did not feel convincing that this was actually the worker's 'stuff', but more that he had been 'taken over' by feelings that were definitely not his. Surely there might be reason to suppose that they did have some meaningful connection to his client? He fully acknowledged the worker's sense that he did not feel he had been able to 'make contact' with Mr A at any deeper level, and that in turn Mr A. seemed to feel systematically misunderstood by the worker. So was it possible that these very powerful feelings were another form of communication, and should be taken seriously. Rather than feel too panicked, the worker might think that he now *had* made some contact with Mr A, or rather that Mr A had 'got through' to him with his deeper anxieties – it just hadn't happened in words, or in the way the worker expected or hoped for.

The worker felt more settled, and his supervisor suggested that he needed to test out these hunches directly with Mr A at the next session. He helped the worker to think about ways to do this, at an appropriate moment in the flow of the session. So when he next met Mr A the worker found an opportunity to say 'Now I have been able to get to know you a little, I have the sense that you often feel very lonely and isolated, and very disappointed with the way things have worked out in your life. I wonder whether at times you may feel really despairing, and perhaps have thoughts of suicide?' The impact of this remark on Mr A was definite, although quite subtle. He visibly relaxed slightly, looked hard at the worker, and said simply 'Yes'.

Reflecting on the process

What can we notice and learn from this account of the work with Mr A?

Engaging and creating the frame

First, it takes time to establish a working alliance with any service user, or family. Both parties are anxious and the early meetings will be full of uncertainty, as everyone works through their worries about whether they feel they can 'work with this person'. Salzberger Wittenberg's (1970) beautifully simple and direct account of the way these anxieties are active for both worker and service user is a valuable resource that unpacks the fuller meaning of a statement by the psychoanalyst Wilfred Bion: 'In every consulting room there ought to be two rather frightened people: The patient and the psychoanalyst. If not one wonders why they are bothering to find out what everyone knows' (Bion 1990, 5).

Second, while these early phases of the contact are being negotiated, the worker's most important role is simply to carry on being reliably 'there'. A consistent 'frame' for the work, a regular appointment time and place helps immeasurably, as well as an absolute commitment from the worker to honour these arrangements. Failing, suddenly changing, or being late for appointments will convey that the worker's mind is not really on the client, and likely confirm worries in the service user that they are

not worth the bother, that the worker cannot tolerate whatever difficulties the service user is carrying, and so on.

Recognising and engaging with the transference

Third, the phenomenon we call the 'transference' and its companion, the 'countertransference' takes time to make itself known fully and clearly. In the case of Mr A., as in every case, there are early signs and signals, and we try to take notice of these and make sense of them. The worker very quickly has an experience that Mr A is not easy to get to know and is unable to present his problems in an open and clear way so that the two of them can 'get down to work' on some issues. Perhaps then we gain some insight into why the GP made the referral – nothing the GP offered or provided or recommended seems to work to make things better, and in the early sessions this is the social worker's experience as well. Service users who frustrate and perhaps make experienced staff feel deskilled are often handed over to another service. The hope is often as much that another agency will relieve the first one of the strain, anxiety, frustration and guilt associated with a lack of progress, than a genuine wish that the service user might be better helped. The referral itself may be freighted with such transferential material, and our recognition of this helps us orientate to the case we are taking on.

When a transference communication does leap to the fore, it often does so from 'left field', catching us unaware and throwing us off balance. This is the nature of the 'unconscious'. If the state the of mind causing anxiety for the client were better known and understood by them and hence communicable in words, it would all be much easier for us to understand and get to grips with. But painful or frightening unconscious processes are shaped and constrained by the defences the client has evolved to manage them. The worker needs to be emotionally available to receive both the defensive manifestations (often but not always hostile or rejecting) of the troubling mind states, as well as the communication of anxiety, panic, despair or mental conflict that underlies the defences. In Mr A's case it seems the underlying feelings are of extreme loneliness, a fear or belief that he cannot be 'reached' emotionally or that it will be painful and humiliating if he allows this. So he rejects efforts to reach him, and seems to make the worker feel useless, hopeless and angry. The latter 'defensive' states of mind are what the worker first receives, but later he succeeds in making some tentative contact with other layers of Mr A's mind and feeling states.

Projective identification

In the case described here, the hypothesis is that the worker's 'anxiety attack' is meaningful in a special sense, if only we can discover the meaning. It is the product of a powerful form of communication we call projective identification, in which one person succeeds in exporting a state of mind more or less directly 'into' someone else who then comes to experience this state of mind as their own while simultaneously

being aware that something has ambushed them internally. Casement's (1985) characterization of projective identification as 'communication through impact' is a very helpful and accessible discussion of this process. In the case study the worker experiences a tumult of disturbing thoughts, feelings, and confusion. He has the insight to suspect that something has 'got into him' or under his psychological skin. But what, and how, and can he be sure? We might notice that in the midst of this experience he says he cannot 'think straight', and be reminded of how he had noticed Mr. A. seeming to 'twist' the worker's communications and feed them back to him. The worker's experience is that he is not 'himself'. This captures what being subject to an experience of projective identification is like. It is more powerful, direct and perturbing to the worker than simple projection, in which one person may attribute qualities to another in a more explicit and symbolized form, although such processes occur on a subtle spectrum of intensity (Goretti, 2007).

Containment and using the 'self' to make a difference

Once the worker has explored his experiences with the supervisor, who offers a suggestion about how to use them in the next session, the question becomes one of finding the confidence to do this. Psychoanalytic work has often been critiqued on the grounds that the worker or therapist may seem to take up a position of secretly and arrogantly 'knowing the patient' better than the patient knows themselves, or of laying claim to some 'magical' type of understanding. The reality for any thoughtful practitioner is very different. We are groping in the dark much of the time, doing our best to think about the service user, and find a way to use our experiences to increase emotional contact with the deeper layers of anxiety and distress in our clients. Any interpretation of the service user's difficulties is always provisional and tentative, and most importantly must be *tested* with them in a careful and sensitive manner. If an interpretation seems to 'hit the spot', make the patient feel understood, and increase genuine emotional contact, then we can be more confident we are on a helpful track.

Mr A.'s response does seem to indicate that the formulation developed by worker and supervisor is accurate. However it is useful to review and notice everything that has led up to this point. The worker's emotional receptivity is a key foundation. He is able to receive Mr A's critical and suspicious communications without rejection or retaliation; he tolerates the experience of becoming invaded by anxiety in the fourth session, and then his subsequent panicky state of mind; he uses his supervisor to 'think with' in an open way; and out of this process which unfolds over several weeks, some words take shape that, when sensitively delivered, appear to calm the service user and reach a deeper level of distress and fear within him. This process exemplifies the psychoanalytic idea of 'containment' (Bion 1962). It is both simple and yet subtle and complex. The steps involved in the containment process are first emotional receptivity, then tolerance of the suffering and confusion that ensues, and then an effort to think and make sense of these experiences, and finally 'returning' the experiences to their originator in a new form that they find 'digestible', meaningful

and helpful. We believe that this process replicates or re-enacts something of what goes on between a baby and its mother or primary caretaker in the period before the infant has the ability use words or even symbols to help make sense of its experiences, and when projective identification (see above) is the main means by which emotional distress is communicated to the mother. .

Seeking help

The worker does the sensible thing, and seeks help from his supervisor. His supervisor's response is thoughtful, neutral and attentive in the service of making sense of professional experience. Unfortunately the quality and availability of supervisory or consultative help evoked here is in too short supply in contemporary social work agencies. But it is a vital element in the total picture involved in the 'use of self' in practice. The fact is we cannot do this work alone, although with experience and the right training we become better able to manage complex and difficult practice encounters without seeking help all the time. A worker who can use their psychological experiences effectively will not to be ashamed or afraid of asking for help, of 'not knowing' what is going on, or of feeling incompetent and confused. As we shall see a bit later in this chapter, struggling on with experiences like the above one lodged somewhere inside us, but unprocessed, is ultimately harmful in at least two ways: we miss vital information about how to help service users with their difficulties, and we become psychologically burdened and deskilled ourselves.

Of course, as workers in busy, hard pressed front line services, we do have a lot of other people on our minds, and many anxieties of our own, but these matters are not the service user's problem. Even if we are lucky enough to have access to a sensitive supervisor or manager, it is unlikely that they are available 'on demand'. Living with the uncomfortable feelings and thoughts that practice encounters throw up until we can find access to a reflective supervisor or colleague, is just part of the job. Colleagues can help of course, and most offices are alive with conversations about workers' recent encounters. But just 'discharging' difficult feelings and thoughts does not usually lead to better understanding of the *meaning* of it all. A better grip on what difficult practice encounters mean is the real goal, and echoing the therapeutic helping process itself, this usually needs another thinking mind with which to work.

Thus, a key message of this chapter is that relationship based practice is not something you can practice in isolation. The power of case dynamics requires *organizational* attention, in particular the provision of reflective supervision as a standard part of agency life. As suggested however, this is often not in practice available, so what is to be done? This is really a topic for another chapter, but one line of thought which owes something to Group Relations thinking is to say that as professionals we need to 'take our own authority' in asking our organisations for what we believe we need in order to practice well. Modern social work managers are hard

pressed people, but we can expect them to listen to us in a thoughtful manner – just as our service users have the right to expect this of front line staff.

Two recent research studies that examine in minute qualitative depth the experiences of front line child protection workers, show how they may become in effect 'secondarily traumatised' because of the long term impact upon them of particular cases which they found impossible to process or make sense of (Noyes 2016, O'Sullivan, forthcoming 2017). A classic text that also brings alive the experience of front line social work practice in a statutory setting is Janet Mattinson et al's (1979) *Mate and Stalemate*. This book was based on action research undertaken in a London social services department in the late 1970s, and while some aspects of the service context now seem dated, the processes illustrated are as recognizable as ever.

.So, what is this 'self'?

The above discussion might reassure readers that when we speak about the use of self in social work, we are not referring simply to 'gut feelings' or even 'intuition', although both these notions play a part in the bigger picture of the professional self I am advancing in this chapter. The self I am interested in here is more a process than a 'thing'. It concerns our ability to scan, monitor, reflect upon, make sense of, and put to work our awareness of occupying a *total field of experience* (Ogden, 1999) in what I hope to have conveyed is a sophisticated and above all thoughtful and reflective manner. This 'field' is not just subjective, but inter-subjective, which means that we are attending to the continual impact of ourselves on others, and them upon us. These relationship impacts are active at the conscious, pre-conscious and unconscious levels of our own and others' experience.

Our task as workers is to know ourselves well enough, so that we can disentangle the influence of others upon ourselves, and us upon them, and thus make sense of how their anxieties, conflicts and distress are being communicated. This distinction is partly captured by the idea of distinguishing the 'personal' countertransference (what we might be projecting into our own perception of a situation) from the service user countertransference (our registration of what they might be projecting into us). Personal psychotherapy is the most helpful way a worker can evolve the deeper capacities for 'knowing themselves' that I am speaking of here. But there are other routes to deeper self-awareness, including some that reach parts of the self which individual therapy does not. Undertaking an experiential Group Relations Event in which a large body of people come together, with a staff group of facilitators, for the sole purpose of studying their own behavior and experiences in groups and inter-group processes, are one such route. The experience of undertaking an infant or young child observation, or being a member of a 'work discussion group' are others. These experiences are not psychotherapy but especially in combination, their impact on the development of the worker may be very similar.

However, good social work, and sound decision making cannot rely solely on the use of self as it is conceptualised here. We need our more cognitively oriented rational analytic faculties too in order to make sound assessments, decisions and plans. Knowledge of child development theory and research, and organizational theory are crucial, and appropriate, though not unquestioning respect for agency procedures is vital. There is a helpful discussion of the important balance to be struck between 'intuition' and 'reasoning' in Eileen Munro's work, including her reports into the state of the child protection system (Munro 2010).

At the sharp end

How can we use the self in pressurized, multi-disciplinary, front line service contexts, when the opportunity to create a stable frame may be compromised and urgency, risk and unexpected demands may undermine our best efforts to plan the work carefully? In a performance driven and risk-averse practice culture, can therapeutic social work really still find a foothold? The answer is definitely 'yes', but few writers have really tackled this. Heather Bailey's (2015) paper is an excellent account of how a worker can make huge advances in understanding of a complex case through thoughtful reflection and follow though of an urgent, unplanned and rather crisis-laden phone call. The 'crisis' led Bailey to re-evaluate the kind of provision a traumatized child might need in order to feel contained and be able to develop.

In another paper about the Victoria Climbié report (Cooper 2005) I focused some attention on one passage from the mass of evidence and analysis presented. It concerns the evidence given by a senior social worker, which is first quoted, followed by some commentary of my own:

> "The third strategy meeting recommendation to seek some proof that the child was Kouao's, arose from a feeling she had when Kouao came into the office on 2 November that something was amiss in the interaction and bonding between Kouao and Victoria" (Stationery Office, 2003, p. 179). Later this worker is directly quoted. "Part of me, with the feelings I got from the visit with mum, it must have been still something that was niggling at me and I suggested just to be on the safe side, just to be certain, just to make sure, that she was not returned to Manning's" (Stationery Office, 2003, p. 187).
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> The reason these short passages spring out is that they demonstrate, in the context of the report, a rare a quality of emotional aliveness to the situation facing the worker. Something troubling, and perturbing is registered and is being thought about. This speaks to what it means to have, and make use of a professional relationship in child protection work. Through an emotionally alive relationship with the family, it is possible to access something the nature of *their relationships*. In registering a sense of disturbance, a practitioner registers signs of the potential risks, dangers and disturbances in the family relationships. Such experiences are not sufficient grounds on which to act of course, but they are necessary information which when ignored or reasoned away may be the first step on a path to tragedy. (Cooper 2005, p. 159)

Here we see an illustration of how crucially important it can be for a worker to trust her feelings, even if she can't articulate their meaning very coherently. This case eventually ended in tragedy of course, but without doubt the social worker quoted here made the right decision at the point in time she had the opportunity.

A baby at risk? A worker keeps her head…

A social worker in a busy children's services referral and assessment team was 'collared' rather anxiously and urgently by her manager as she came into work. A referral had been made by the local hospital maternity unit who were concerned about the parental care of a newborn baby boy with Downs syndrome. The main worry seemed to be the baby's father who was described as extremely angry, blaming of the hospital staff for somehow causing his son's condition, and unable to relate to or hold the child. The baby's mother was also causing some concern. She had shown signs of bonding with her newborn, but was also distracted and had failed one opportunity to visit her baby who was still in hospital.

The manager asked the worker to make an urgent visit to the family home to meet the parents and their two year old daughter, and then attend a professionals meeting at the hospital. On the basis of the hospital team's experience of the 'aggressive' father, she advised strongly that the worker be accompanied on the home visit by a male social worker 'to protect her from violence'. Here, once again, we see that powerful feelings and anxieties are embedded within the referral process. The worker writes:

> 'However, I was concerned that an image of this family was being presented to me before I had even had any opportunity to connect with them. I was being invited to be fearful and defensive before I had even met the family, as if a state of mind that may have belonged to the hospital staff was being projected into me.
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> I decided to make contact with the father before the arranged visit because I felt that if effective work was to take place with this family, an atmosphere of fear and anger needed to be avoided as much as possible. When I phoned father and spoke to him, my impression was of a man who certainly was angry but also expressed a lot of vulnerability. In my countertransference I did not feel afraid of this man, but concerned for what the family including the mother and the two year old were going through this major life changing trauma.
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> I think with hindsight this initial phone call and the feelings that I got from it that contrasted with the feelings I was being invited to have by the hospital professionals, was crucial in developing an effective therapeutic relationship with this family. It was as though I was able to then treat them as a family suffering as opposed to a family on the attack, and they were more able to welcome me in to the family as a potentially helpful figure.' (Erdogan, 2016)

At the meeting with the family the father remained angry and blaming of the NHS and the system. It emerged that the mother had never been offered, or maybe had not

taken up the chance of a second routine test to establish whether the foetus was healthy or not (the first test had been negative). Language difficulties may have plays a role in this oversight.

> After introducing myself, father asked if I knew what happened. By this it became clear that what he meant was how the hospital had let him and the family down in not being informed about the disability of the baby before birth. He said, "You killed me, you killed my family, we are dead".
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> At that point I was clearly part of "the system" undifferentiated from the hospital staff who he felt let down by. I reflected and acknowledged his anger and said: 'You seem to be very angry, feel let down by everyone and might wonder if I will let you down too?' The latter part of my comment addressed the man's lack of trust towards me in the transference in a direct way, which may have helped him feel that at least I was not going to avoid painful and difficult feelings. The sense of unknown was very powerful and included my own feelings of facing the unknown with this family, and I used this to say something about how hard and powerful it is to be suddenly faced with such an unknown painful experience as suddenly having a disabled child.'(Erdogan 2016)

When she meets the hospital maternity team the worker is confronted by a fresh challenge.

> The number of hospital staff involved in my various meetings with them was always surprisingly high. The hospital child protection nurse who chaired the meeting outlined their concerns and there was particular emphasis on father's verbal violence to hospital staff and his lack of bonding with baby. From the outset all the hospital staff spoke with one voice. They were also concerned about mother not visiting during day time or staying at night. The idea of the baby being taken into care was put forward as the solution from the very beginning.
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> On reflection, it was as though hospital staff had made up their minds about what should happen, and my role would have been to implement their decision. By contrast, I fed back to the meeting my views about the home visit, agreed that father was clearly very angry but thought that such a big decision might be premature for a family who are still at early stages of coming to terms with very traumatic event. I said "We have to give this baby and her family a chance", and that placing the baby even temporarily in care would harm the bonding relationship rather than help it.
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> That challenge to the overriding opinion of the meeting seemed to permit some other professionals to break away from the fixed idea that placing the baby in care was the best option, and I received some support for my suggested course of action. We ended the professionals meeting deciding that there needed to be further assessment and observation of the parents' interaction with the baby and agreed to meet the next day. (Erdogan 2016)

From this point on, the case begins to take its more hopeful course. The worker meets daily with the family over a period of two or three weeks, father and mother start to bond well with the baby, and everyone's anxieties about risk recede. The worker is able to engage both parents in the necessary grief work associated with their loss – loss of a much hoped for healthy second child.

Reflecting on the process

What more can we learn from this story? Many of the same thoughts we considered in relation to the first case study apply. In effect, through astute and composed understanding of the transference forces active in the case before it has really crossed the boundary of her agency, the worker keeps her head, steadies the thinking of a complex professional system that has somewhat 'lost its head' with anxiety, and establishes a therapeutic contract with a family in great distress who are at risk because a reactive professional system has stopped 'thinking'. When she meets the father of the family, she finds a form of words that speak to his anger, his sense of being let down, and crucially locates *herself* within this transference based interpretation - 'You seem to be very angry, feel let down by everyone and might wonder if I will let you down too?'

Because she succeeds so well in staying calm and thoughtful, it becomes easy to feel critical of the hospital team, and perhaps label them risk-averse, or over-anxious. Once the social worker has got hold of her side of matters, a more balanced view would consider that different parts of the whole professional system around the family are 'carrying' different aspects of the case dynamics. While the hospital team is acutely identified with the vulnerability and needs of the baby, the worker is in touch with the same qualities in the parents. The worker is more hopeful about change and the parents' potential, and the hospital more pessimistic. The case dynamics become split very quickly, and might have remained so had the social worker hot handled theses dynamics as carefully as she did. The task is to try to meet in the middle, not in a spirit of compromise, but because to make a sound assessment and decision the whole system needs to be in touch with as many dimensions of the emotional dynamics as possible.

This reflection points up how, because we are always working as a part of systems and networks, we must be capable of standing outside ourselves and seeing how we may be caught in a systemic split. Sometimes this is called occupying a 'third positon'. This is not easy, because the power of the feelings of identification with one or another side of a split picture can be immense. These often reflect, but are also not reducible to, a dynamic between parents or carers in the family situation. Workers make a contribution to the strong patterns of feeling and conflict that are mobilized. Roger Bacon's (1988) paper 'Countertransference in a case conference' explores such dynamics in some depth, and Woodhouse and Pengelly's (1992) book *Anxiety and the Dynamics of Collaboration* examines how these projective and

splitting processes can play out among different professions in a fixed manner, making collaboration almost impossible. Something of this is visible in the case study – the hospital team hold a conviction about the risk to the baby, but want the social worker to take on the painful and difficult task of 'taking the baby into care', thus relieving them of having to think further about the case. However, the worker succeeds in handing this projection back, and insisting quietly that they must all continue to think together, rather than rush to premature action.

There are real risks in becoming caught in dynamics like these. Feeling ourselves to be 'recruited' or pressurized into joining the 'groupthink' we will be inclined to either comply or rebel, but neither response is helpful, and risks us losing sight of vital elements of the family's situation. The skilled use of self is, in the end, about sustaining a position of independent but connected thoughtfulness.

Conclusion – and endings

The use of self in social work is central to successful practice. Over the course of a sustained piece of work, the complexity and subtlety of the processes involved will take many forms. In more conventional therapeutic work, where there is the opportunity to maintain a stable and consistent treatment frame over a long period of time, transference and counter transference dynamics can be observed and worked with more easily than in circumstances where statutory responsibilities and anxieties are mingled with the therapeutic process. Nevertheless, when a genuine therapeutic attachment forms it is vital not to lose sight of how significant you, the worker, become for the service user, and thus how important the ending of a piece of work will be for them.

A social worker who undertook a lengthy assessment of Anna, a young woman who had applied for a Special Guardianship order with respect to her niece was able to explore the applicant's strengths and difficulties in depth. This was a process the young woman undoubtedly found very valuable. For example the worker wrote:

> When Anna was able to 'think' and 'reflect' on her feelings and actions, she became less guarded, she opened herself to new realities, new possibilities.
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> During session six, Anna told me that she had renewed contact with her brother who she had not spoken to for the past two years, she stated
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> 'I kind of realised that the reason he had not contact me, was maybe because I had been a bit stand offish with him, maybe he thought that I did not care, that I did not want to talk to him. Anyhow he told me he loved me at the end of his Facebook message, do you want to see it?' (Harris 2014)

At the end of the assessment, the worker decides she cannot recommend Anna to be a special guardian, and clearly this affects how the process of ending the work unfolds.

> In our last two sessions, Anna appeared more guarded and less trusting, I associated this with Anna reading in my assessment my identification of her vulnerability and difficulties and her disappointment with my decision. Even though Anna was more guarded, she was able to make good use of our meetings. Mostly we explored Anna's feelings and difficulties in coming to terms with the fact that her niece was in foster care and would be adopted if Anna's appeal were not successful.
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> I had offered to meet with Anna until the end of the court proceedings. She came to two further sessions but did not attend the subsequent ones. Somehow this felt like a natural ending. Anna was now focusing on her appeal; understandably she may have felt that communication with me may have further diminished her chances of success. (Harris 2014)

At the end of any meaningful therapeutic process, the patient or service user will often start to miss, or be late for appointments. Unconsciously perhaps the message is 'If you can leave me, then I can do the same to you'. The worker needs to stay close to her countertransference and understand that her own feelings of disappointment or frustration at missed sessions are most likely another instance of 'communication by impact' or projection. A 'good' ending, is not necessarily a smooth or comfortable one. But as therapeutically aware social workers we are not in the business of seeking out gratitude or emotional reward of any kind, although of course it is pleasing if this is conveyed. Our task is to use ourselves reflectively, maturely, and professionally.

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