



What Makes the Work So Difficult: an Intervention in Mental Health

The impact of the work

It is an often repeated joke to say that this school/hospital/social work unit would work beautifully if it wasn't for the pupils/patients/clients. In other words, the thing that gets in the way of the organisation working well is people, both workers and clients. There is also a common observation that the particular character of any organisation will be a reflection of the client group; staff working with adolescents often appear to be quite adolescent themselves (I speak as one who specialised in work with very difficult adolescents for more than 20 years).

My purpose today is to describe my way of understanding these phenomena and then to describe an intervention, based in a psychoanalytic way of thinking, that has proved to be very successful in helping "front line services" improve their practice and, to use a concept much quoted in the United Kingdom, to restore their compassion. To start with I should like to refer to some theory from the model that has informed my work; often described as the Tavistock, group relations approach to understanding organisations.

The moment you get a group together and confront them with a task, anxiety arises (as Bion pointed out, (1961)). It is equally true to say that patients or clients only enter a 'therapeutic' system with anxiety. When the anxiety of the client group meets the anxiety in the staff group, there is room either for a very interesting exchange or an investment in setting up systems to avoid this sort of encounter. Unfortunately the latter option appears to be the option of choice. Hence the term coined by Elliott Jaques when he first described this phenomenon (1951), 'Social systems as a defence against anxiety' (this phenomenon is best described in her seminal paper by Jaques' colleague, Isabel Menzies Lyth (1960)).

The processes that can obstruct healthy functioning in an organisation, not surprisingly, are versions of those that obstruct healthy function in the individual. I shall summarise these in terms of group dynamics and then the extra element, the impact of the client on the staff group.

I hope you won't mind if I was just skim through my theoretical understanding of group dynamics from a particular point of view. To begin with the individual, who has a conscious but also an unconscious mind I want to add a particular aspect to the unconscious part of the personality, something that Bion called "valency" but which we might just as accurately describe as vulnerability. [In my PowerPoint I show this as a hook and I think that expression describes very well the function of this vulnerability in the context of groups, teams and organisations.] Carl Jung pointed out that the wounds of the healer provide an opportunity for close connection the patient. Of course, in order for that to happen, we have to be aware of this tendency in ourselves, which only comes from a good enough analysis. If you don't understand your own vulnerabilities, then you are simply more exposed to further wounding in what will appear to be a very familiar way.

Putting this individual into a group creates an image a bit like ducks on a pond; the conscious part is what appears above the surface of the pond but we cannot see what goes on below. I agree with Bion's assessment that groups of individuals behave as if they are organised



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by a group unconscious. Neither he nor I thinks that there is an actual “group unconscious” but the unconscious interaction of each individual’s unconscious creates the illusion of such an entity. I think this serves as a way to understand group processes very well, so I will use the concept as a shorthand.

One might imagine the group unconscious to be a sort of mirror of the individuals above the surface. The question is, how do individuals get drawn into representing the unconscious group preoccupation? The answer is that we get drawn into playing **roles** on behalf of the unconscious dynamic. The means by which this happens is through our hooks or our vulnerabilities. It is because there is a direct reflection of our own personality in the role that we tend to get caught up in when we are part of the group that people make the understandable mistake that the behaviour of the individual is a reflection of his or her personality and, in this way, they miss the information about the group dynamic.

I don’t have time in this presentation to go into more detail about this, at least not in terms of general ideas about defensive processes in groups. What I want to do instead is to think about a particular kind of institutional dynamic; the one caused by the anxiety of the client group that I referred to at the beginning.

There is a term that I find rather irritating but which has become popular at least in the United Kingdom and that is “parallel process”. In a few moments I shall describe what I think accounts for this process but, for the moment, all I want to do is to suggest that, where a patient or client can manage to off load his internal conflict into the staff group it will look like an individual member of staff being selected to represent one part of the conflict and another member of staff the other; this is an example of mirroring. This phenomenon is well-known in therapeutic communities, indeed it is the recognition of this that forms the most therapeutic part of the process. In an example of a sado/masochistic internal conflict, you could say that the group unconscious seeks to deal with this conflict by selecting somebody to represent the aggressive side and somebody to represent the victim or passive side. Staff whose vulnerability is towards expressing anger obviously get that role and those who are more passive get elected into the other.

Now I want to describe my understanding of how this happens. Given that I would describe myself as a Kleinian psychoanalyst it will be no surprise that I am saying that the mechanism that we are looking at is projective identification. (If I have access to PowerPoint I shall just show a quick animation to demonstrate my understanding of this process.) In the absence of PowerPoint let me just say that, whereas Melanie Klein thought that this was an entirely internal process in which the baby defends himself against unbearable feelings by projecting them into an imaginary object where they are identified with that object, beyond pointed out that actually this process had a real impact on the object itself. The central part of my thesis is that this process goes on all the time in mental health work and patients project unbearable parts of themselves into staff where they are identified as living parts of those people.

We may be sure from our own experience of how difficult it is to manage such processes that it must be extremely difficult for those who have no idea at all about what is happening to them. Added to that is this extra element that I have referred to as valency; since the same member of staff, over and over again, will be selected to represent a particular kind



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of mood or attitude, it is easy to see how both his colleagues and even himself will believe that it is a personal issue. It is because it always feels so personal that the impact of the work, as I like to put it, has such a deleterious effect on workers' morale, compassion and good practice.

By way of an illustration of this phenomenon I want to tell you about my own personal experience. After completing my psychology degree I found myself working at an institution that had been created by an extraordinarily visionary group of special advisors to the government. This was in the early 1970s and I can reassure you that no government since then has allowed themselves creative let alone visionary advice. These advisers to the Home Office were addressing a challenge created by a 13-year-old girl who had murdered some babies. There was nowhere to put her and they realised that she represented a population of very disturbed and dangerous adolescents who might, nevertheless, be treatable within a secure provision. They proposed to set up something that they called a Youth Treatment Centre which would provide psychoanalytically informed treatment within a number of therapeutic units catering for about 12 young people each. They bought and adapted a site that was being built as an approved school and then handed it over to a collection of professionals to try to work out how to do the job.

The first attempt was run by a psychiatrist and collapsed in disarray. The second attempt was managed by an experienced residential care manager. I often find myself quoting this man's approach when I'm teaching about leadership and management skills. For example he had no pretensions to understanding psychoanalytic treatment models but he didn't feel that he needed to do that if he employed people who had those skills; his job was to make the environment suitable for this sort of work. The professionals employed to do the front line work were all experienced and senior people drawn from residential social work, nursing and teaching. Bizarrely, at the age of 24, he employed me as one of those group workers. Even more extraordinary was his decision to appoint me as one of the therapeutic unit leaders when I was just 26. Apart from the young people, I was the youngest person on site. Many of my staff were in their 40s and 50s. The young people in our care were aged between 13 and 20 and had committed very serious crimes including murder and rape. Following my appointment as manager of a treatment unit, I went through the worst two years of my professional life. I would always feel frightened as I travelled to work; often this fear expressed itself physically and I would find myself shaking as I walked to the unit. If the director pointed out (as was frequently the case) that there was a lot of rubbish thrown out of the windows of my unit, I would feel mortified as if I had done it myself. When kids ran away or created a violent disturbance, I would feel that it was my fault that this had happened. When members of staff fell out and there were serious arguments I could not rest until I have found a way to resolve it.

We had good advisory staff; a clinical psychologist and a psychiatrist but I didn't tell them how I felt because I thought this was personal and to do with my own incompetence and lack of ability. By extraordinary good fortune I elected to train at the Tavistock Clinic in Organisational Consultancy because it seemed to me to be the only training that would help me to manage a therapeutic unit because it was based in a psychoanalytic model. During the first couple of weeks, in our small group, we were encouraged to describe our experience in our own workplace. I still remember how I felt following my description of my day-to-day work experience and my new fellow students all said to me words to the effect



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of, “but Phil don’t you realise that the feelings you are describing have been projected into you by the staff group as a direct consequence of feelings projected into them by the kids?

Now the extraordinary thing about this is that I had read Melanie Klein as well as Freud and I thought I knew about unconscious speaking to unconscious and, particularly, about projective identification. But I didn’t. The bit that is left out in the theory is what it *feels like* to be on the receiving end; particularly that it feels absolutely and completely personal. You have a three-dimensional all sounds and whistles *feeling*; there is nothing “as if” about it; it is real, it is now, it is overwhelming and you have to do something about it. What I did about it was to keep it hidden and take it home and nurse it. These people made me realise that it wasn’t mine. It wasn’t just that I felt relief at this discovery, with their help I was able to turn the emotional experience into information about the staff group dynamic and about the way that that was being mobilised by projections from the kids. I won’t bore you with it now but as a result of this epiphany-like experience, I began to recognise patterns in staff behaviour towards each other that led to the discovery, which was shockingly new at the time, that most of our kids had been sexually abused. But that is a different story.

This section of my presentation is called the impact of the work so I shall bring it to a close by summarising my thesis. Whilst I was doing my psychology degree, I used to work in children’s homes during the vacations and had the following advice, time after time from the people running those residential establishments; they would tell me that, if I took my work home with me, I shouldn’t be doing the work. These were also the people who would say about somebody newly admitted, “oh we know what kind of young person this is”. Well my position is completely different; if we are *not* available unconsciously to receive the unconscious communication from our patients and clients, we should not be doing the work. Of course this means that we will be affected unconsciously, which means that we will have feelings that can often be overwhelming. Those of us with a psychoanalytic training are lucky because we understand that feelings that we experience in the course of our work are very likely induced *by* the work and by the patients that were working with. Those who have had no such training will inevitably assume that these feelings belong to them and require some kind of personal explanation. (It is also nonsense to say that you already know what a patient is like; no two patients are the same.) The sad thing about those people who do not know that these feelings have a meaning beyond the personal is not only that they end up struggling to manage things as if they belong to them; they also never access the really important information that has been conveyed in this unconscious way. I shall now turn to describing an intervention that I created 21 years ago at the adult Department of the Tavistock Clinic in London.

The absence of a shared model for human development or group dynamics

Over the many years between qualifying as an Organisational Consultant until I came to work at the Tavistock Clinic, I had a very frequent experience. Someone from a team would contact me to ask for consultation but I would discover that they were unable to use the consultation because they did not have a shared language or model of human functioning for understanding their work. My training suggested that I should simply continue to interpret the group interaction and let them work through the experience but it was obvious that this was not experienced as helpful, in fact it merely served to reinforce an underlying



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sense of hopelessness. I found myself thinking more and more about my own experience at the Youth Treatment Centre and the effect that coming to the Tavistock to train as an Organisational Consultant had on me. Before going there I would have said that I *did* have a model of the human mind but the Tavistock experience made me realise that I needed a different kind of understanding, one based on a psychoanalytically informed explanation *linked to my lived experience*.

The SCI

These experiences led me to create the intervention: a combination of teaching and consultation. We teach a model for the understanding of the emotional and psychological development of the human mind, how that connects with group dynamics and organisational processes. It is unapologetic didactic teaching of a model that the team member will understand at the end of the process although they are free either to accept or reject it. The trick lies in the fact that this teaching session is followed, after a break, by a mini group relations session. The task of this meeting is simply to link what the members are learning to their work and to their current experience in this group. The tutor/consultant (as we call ourselves) points out to the group what is going on that they are not aware of. Thus they have a direct experience of how the model may be applied to them as a team.

It is difficult to know exactly where to begin a description of this intervention. The reason for this is that it is a living application of a particular model of individual group and organisational dynamics. I assembled this under a rubric provided by my deputy; she called it the Healthy Organisation Model. I do not claim that this is my invention, rather it is my understanding of how organisations work arising from a combination of the Tavistock model and my experiences as a Senior Manager and a Consultant. An important element of this is that those functions that are essential to the healthy human individual have to be created *artificially* in an organisation or team and protected through a consciously maintained structure. For example the equivalence of the process that we would call 'thinking' for an individual is *communication* within a group. The spaces for this sort of communication are usually those given up in the face of any anxiety and yet without them no organisation can function properly; so they must be protected in a very conscious structured way.

What follows is a summary of the philosophy lying behind this 'intervention'.

Governing Principles

- Clear Syllabus and learning method
- Clear Primary Task;
- Clear Working Principles;
- Clear Teaching Principles.

Primary Task:

- To help professionals in helping services to function more effectively by giving them a model for understanding what makes the work so difficult and providing an experience of being part of an organisation that has none of the internal structures that serve to protect against anxiety.



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Working Principles

- Finance and Team Development - we are self-financing:
- We charge enough money to ensure that we can train new tutor/consultants
- Our fees also provide a supervision space for the tutor/consultants
- Philosophy
- Protocol
- Partnership
- Evaluation
- Follow up

Philosophy:

- Professionals are primarily motivated to work with integrity and professionally
- Behaviour that appears to be unprofessional has been generated by unconscious processes originating in the work.
- Becoming 'caught up' in such unconscious processes is inevitable; bad practice is remaining caught up
- Since these processes are unconscious, the organisation has a duty of care to provide spaces designed to identify these phenomena and turn them into meaningful information.
- Attendance at such thinking spaces must be mandatory, not voluntary.
- We apply these same principles to ourselves.

Protocol

- There is a particular process that we follow once an approach has been made to us.
- Experience has shown that we must behave with authority.
- It is important to ensure that the purchasing organisation understands that the intervention often leads to internal development in the team.
- The final result will be a clear, written contract; which provides our authority.

Partnership

- Respect for the participant's experience – we are there to enable the team and individuals to discover resources within themselves; this includes the capacity to turn apparent dysfunction into Information.
- This approach is aimed to address the danger of the development of a culture of dependence: our purpose is to interpret such phenomena as part of the 'group relations' approach.
- Our belief is that the dependence is on a process, not on the tutor/consultant. (e.g. the pressure to change the structure)

Evaluation

- We believe that it is important to measure the effectiveness of our intervention;
- We use two approaches; Qualitative Feedback and a before and after measure of attitude change.



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- Very simple record of attitudes towards clients, colleagues, managers, other professionals and the wider society; delivered before and after the intervention
 - These reveal institutional defences
- We give feedback from these evaluations to the managers at the end of the work.
- We are committed to continually improving the measures of effectiveness.

Follow up

- When we have run an intervention for an organisation, we shall return after our evaluations have been rated to give feedback about our experience and receive feedback about theirs.
- We shall offer to arrange continual facilitation of a 'thinking space' should the team ask for this.

Teaching Principles

- We believe that there really is a model which helps to turn what appears to be difficulty into information, so we present that model unapologetically and clearly, whilst conveying that the students are free to take it or leave it.
- We believe that the student's learning is the responsibility of the tutor/consultant, who is free to alter the focus of the session according to what's going on in the room...
- Therefore we provide handouts that summarise the content; so students don't have to take notes.
- We speak plain English: I believe that, although jargon is a useful short-hand amongst professionals, if it is used in teaching sessions, it is probably because you don't understand what you're talking about (or what your task is).
- We encourage questions and challenges during the lectures.
- We believe that the process will reveal the unconscious pre-occupations of the group. Part of what we are doing is to help the team to discover organisational factors getting in the way of the work.
- We go to some trouble to make the intervention fit the needs of the purchasers:
 - Therefore the syllabus includes 'bolt-on units' to meet those particular needs.
 - Although it is usually a 10-week intervention, we can alter this if necessary (we have run the intervention in the form of a series of one-day workshops)
 - We apply our model from the first contact, so we begin by trying to understand why this organization has come to us.

The Model We Teach

- Basic principles of unconscious functioning:
 - Paranoid/Schizoid and Depressive position
 - Projective Identification and Transference
 - The development and vicissitudes of thinking
- Application of these processes to groups...
 - Particularly drawing on Bion's concepts
- ...and Organisations;
 - Particularly drawing on the Group Relations approach...
 - At which point we offer a model of a Healthy Organisation.



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What it does for participants

- It gives them a working model for understanding their work,
- AND it gives them a direct experience of that model being applied;
- Which leads to an understanding of the unconscious processes that have characterised the lived experience of work in that team.

Evidence

Since its inception in 1994, the attitude questionnaire has been given to participants before and after the intervention. The hypothesis is that the impact of the work, in the form of unconscious projection of emotion into the individual members of the team, if it is not recognised for what it is, will distort the perception of the staff of clients, colleagues, management, other professionals and society. If our intervention is successful, individuals will be freed from these effects and this will be shown in a change in attitude towards those others in the direction of reality. The before and after questionnaires are given to blind raters who are asked simply to decide whether attitudes have changed and, if so, how they would describe that. Well over 80% of those surveys have shown the majority of staff changing their attitudes in a direction described by raters as more realistic. In addition, and unexpectedly, the blind raters also picked up very interesting material about the unconscious defences of the organisation.

Although this finding is gratifying, the attitude survey is not sophisticated and it may help to provide a short vignette of a typical experience.

These interventions are not easy and are rarely straightforward. I shall give you a small example of the kind of experience that would often happen. The example that I have in mind occurred with the team working for a homeless organisation in London. As is often the case with such organisations there was a religious and vocational ethos; the organisation had been founded by a religious group and staff felt that their work with the homeless was a vocation. In the first meeting, the team had already filled in their evaluation forms and, after the customary silence, some of them referred to what they had written. One of the team described her work as a privilege and that she had great respect for the clients who were the victims of an uncaring society. She said that she enjoyed her work. One or two others agreed with her and it became clear over the rest of the meeting that there was a powerful group of women who seemed to hold this evangelical position. The tutor consultant noticed two things, one was that a model was being presented for understanding the human condition that was clearly an alternative to the one that he had been teaching earlier. He also noted that there were several people who didn't say anything.

In the next experiential meeting, a week later, there was a delay in the start of the meeting because two of the women from the evangelical group had chosen the end of the break time to go to the toilet. The group seemed reluctant to start talking about anything until they arrived and nobody said anything to them about being late. Eventually one of the silent group said that he wanted to challenge a few of the assumptions that were clearly part of what he had been taught in the morning. He said that *everybody knew* that psychoanalysis was a white middle-class philosophy that didn't allow for any differences in culture and had been replaced by cognitive behavioural therapy that worked directly with helping people to



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adjust their beliefs about themselves so that they could acquire a more positive outlook. He said that they were simply being offered an alternative belief system. This felt like a very surprising and unpleasant attack that appeared to come out of the blue.

The tutor consultant had been teaching about the move from the paranoid schizoid to depressive position in the development of the baby. He was conscious that he had described the former state of mind as essentially fundamentalist. He said that there were two ways to respond to what had just happened, one was to simply engage with the challenge that had been made to psychoanalytic ideas but he thought that this would be a mistake since those sorts of discussions could take place during the teaching sessions and he felt something might be missed if he simply fell back into a particular role as a teacher and defended his model. Instead he wondered if sudden, perhaps even shocking challenges might be a part of *their* everyday experience. And he referred to the statement the previous week about how wonderful it was to do this work.

There was a response to this comment from the evangelical group who seemed to be reinforcing the claim that this was a religious service to people who were victims. The tutor consultant summarised what they were saying and then asked whether it was true that everybody in the room felt that these were innocent victims of an uncaring society. After another pause, one of the "silent" group spoke tentatively about how difficult she found the work. She described how she had a special responsibility for one of the clients and had been enthusiastically guiding him through the system towards moving into a flat of his own and out of this hostel. She said the thing that she had found so difficult was the way that he had trashed his flat by drunk as soon as he was no longer in the hostel and urinating on the floor of his new 'home'. She had felt not only shocked but also abused by this behaviour but had felt that it was a sign that she was not a good enough worker, because she could see from the older members of staff that they simply took this sort of thing in their stride and started all over again.

Over the next few weeks the group was able to address this theme in a way that was both moving and clarifying. It became possible to talk about a belief that appeared to be required for the work but which denied the reality of that work. The inability to challenge the powerful women for being late (and they continued to be late for exactly the same reason for each group for several weeks) was finally broken through by the same man who had challenged the tutor/consultant in the second meeting. This time his challenge wasn't aggressive but much more enquiring; he observed that the group started late week and that this was because a few members decided to wait until the end of the break before going to the toilet and he wondered if this was an expression of the group's reluctance to engage in an enquiry about the nature of the work that they were involved in. I don't need to tell you that the tutor/consultant was thinking what a very psychoanalytically informed approach this was. The result of this intervention (though of course the individuals concerned denied any such motivation) was that the group became able to address their problem as an organisation which was essentially that their clients, far from being innocent victims of an uncaring society, were motivated constantly to attack homes and families. It became clear that the staff were equally constantly reeling from one attack after another on their generosity and professionalism. The atmosphere in the experiential meeting became engaged and alive;



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indeed it became difficult to end the meetings because there seemed to be so much that people wanted to talk about.

By the end of the intervention the staff group decided that they wanted to continue to do the work with this client group only now what they needed was a space to be able to share how difficult it was and they had a model that help them to see that in expressing the feelings created in them by the client group, they had a better understanding of their clients' internal conflicts and problems. When he reported his work to the Short Course Intervention Team, there was a worry at the beginning that, if their defence against facing the reality of the work was removed, they might decide, en masse, to leave the work. But the truth is that the opposite occurred, in the last meeting the woman who had been the 1st to talk about how hurt she was by her client shared that she had been thinking of leaving the job but had decided to stay because of these groups.

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