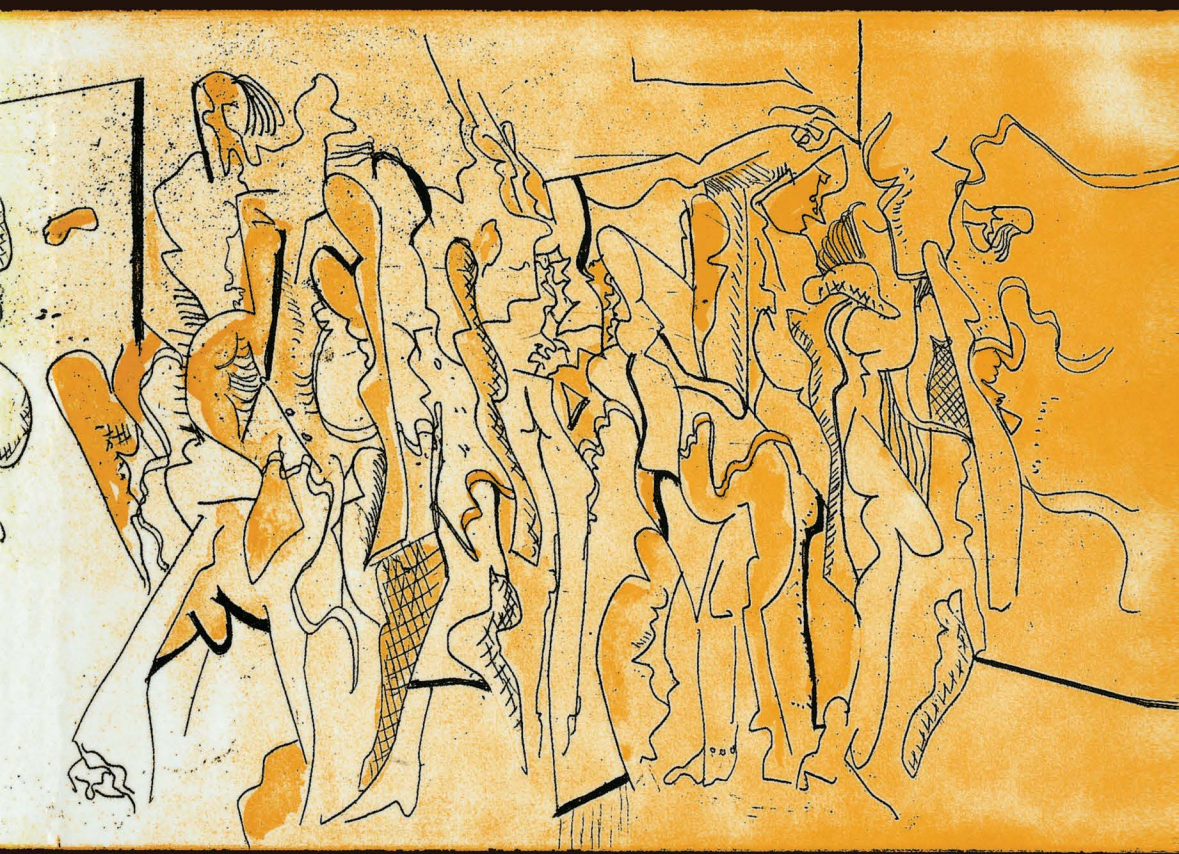
Observing Organisations

Anxiety, defence and culture in health care



Edited by R. D. Hinshelwood
and Wilhelm Skogstad

Observing Organisations

In order to prevent or solve problems within organisations, one needs not only to address the conscious elements but also to understand the unconscious aspects.

Observing Organisations presents a unique approach derived from direct participant observation of small units within institutions, all in the health and social services sector. A range of contributors bring together the results of their own observational projects – in settings as diverse as a mental hospital canteen, an acute psychiatric admission ward and a palliative care unit – to show how they were able to come to a psychoanalytically informed understanding of the cultures that arise within health care organisations. Such an understanding may be used to overcome difficulties that arise within the organisations.

Observing Organisations will help all health care workers, teachers and managers better understand the functioning and difficulties of their organisations and therefore help in the management and practice of their work.

R.D. Hinshelwood is Professor in the Centre for Psychoanalytic Studies at the University of Essex, and was previously Clinical Director of the Cassel Hospital, London. **Wilhelm Skogstad** is a Consultant Psychotherapist at the Cassel Hospital and a psychoanalytic psychotherapist in private practice.

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With a Foreword by
Anton Obholzer

Routledge
Taylor & Francis Group
LONDON AND NEW YORK

First published 2000 by Routledge
27 Church Road, Hove, East Sussex BN3 2FA

Simultaneously published in the USA and Canada
by Routledge
711 Third Avenue, New York NY 10017

Routledge is an imprint of the Taylor & Francis Group, an Informa business

Typeset in Times by Mayhew Typesetting, Rhayader, Powys

British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

Library of Congress Cataloging in Publication Data

Observing organisations : anxiety, defence and culture in health care / edited by Robert D. Hinshelwood and Wilhelm Skogstad.
p. cm.
Includes bibliographical references and index.
ISBN 0–415–19629–9 – ISBN 0–415–19630–2 (pbk.)
1. Health facilities—Administration—Psychological aspects. 2. Health services administration—Psychological aspects. 3. Health care teams—Psychological aspects. I. Hinshelwood, Robert D. (Robert Dayles), 1938– . II. Skogstad, Wilhelm, 1952– .

RA971 .O27 2000
362.1′068–dc21 00–022355

ISBN 978-0-415-19630-7
DOI: 10.4324/9780203135150

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Foreword

I am pleased to have been asked to write an introduction to this book for I have long valued and respected the work described therein. This is an extremely painful book – it tells it exactly as it is in institutions. There is therefore, perhaps, a slight risk of evoking defences against psychic pain in the reader. I urge you to persist in reading it, for it gives an excellent picture of institutional psychic reality. Observation after observation spells out the despair, the misery and the pain of the patients and the reaction of staff who go about their daily tasks in this field 'irradiated' with distress. The present fashion in health management is much given to the creation of standards that are to be adhered to in the provision of services be they mental health or coronary care and for these standards to be monitored, audited, yea policed, to ensure compliance. I have little doubt that this will lead to some increased clarity of goals and some improved performance but I am old enough to remember the problems in cultures with centrist control and command structures and what a nonsense they made of genuine participation by the workers in the centrally set goals.

What in my view is crucially missing in this management approach is the underlying cause of why we have such management and morale problems in the NHS and such a gulf between front-line workers be they doctors, nurses and others in daily contact with patients and others who don't, managers, finance and the multitude of workers bombarding us with demands, circulars, newsletters etc.

What all workers, whether front-line or rearguard, are missing is what is so vividly described in this book. Chapter by chapter reveals the despair, the pain, the mental dulling mechanisms, the defences against pain that all are subject to. The front-line workers are too caught up in attempting to maintain their self and emotional survival to be able to reflect on what they are caught up in, the rearguard workers 'know' what is going on with a 'clarity of blindness' that comes from never going near the coalface of the workplace and further distancing themselves from the pain by engaging in the all too familiar game of 'them and us'. The beauty of the book is that it is rich in detail giving page on page of observation of what happens in

various National Health Service settings. The majority understandably are of mental health or better said mental ill-health settings but there are enough descriptions of other everyday health services to give the book a wide application. It is only by taking into account the 'ecological baseline' of the NHS as described in these chapters that progress can be made in creating the much vaunted new NHS – modern, dependable, equitable.

The book does not set out to address issues of what might be done about the personal and institutional dilemmas so graphically described. It sets its task as presenting the reader with the 'facts', and leaves one to find one's own way of responding. The response could then range from the recognition of these phenomena in oneself and in one's institutions, to moving in the direction of management, or action research, or consultancy interventions such as have been pursued and recorded in the work of the Tavistock Institute, the Tavistock Clinic and other organisations.

The observation approach described in this book thus brings the possibility of *observation* leading to *intervention* one step nearer – supporting forms of practice and intervention characteristic of, for instance, the Cassel Hospital and the Tavistock Clinic.

In passing, it is interesting to note that there are several current 'models' of observation. The one described in this book is one in which observers study organisations that are like or similar to their own. The Tavistock Institutional model, by contrast, is one where students are encouraged to negotiate entry and observation to any institution that interests them, with a proviso that they should avoid observing the kind of institution that they, as part of their career-training or present work, are familiar with. The emphasis is therefore on developing a semi-detached, 'visiting anthropologist' in-yet-on-the-boundary state of mind. The Tavistock course has two aims – to enable workers to achieve a 'safer' personal perspective on the institutions they work in and on the other hand to have a detachment such as might be helpful in forming the foundations for institutional consultancy. The debate is as in this book – is it an advantage or a disadvantage to 'know' about the organization one observes or consults to – another variant of the ongoing clinical debate of whether one should or should not go into clinical assessment services 'free of preconception' or not and how this is to be achieved. There is certainly room for several models, and this book goes a long way to furthering the debate.

This is a much needed and welcome book that does 'tell the truth' about life and death in the health services in a most impressive and clear style – its application is international, its readership should be all concerned from politicians to managers to those in intimate clinical contact.

Anton Obholzer
January 2000

Preface

Generally, a preface tries to give the reader some sense of how the book began and evolved. The collaboration between the two of us originated in an asymmetry. One (RDH) started this work some 15 years ago, whilst the other (WS) has been involved for less than half that time, first as an observer and then as a colleague. It seemed interesting to explore the differences and similarities in our commitments to the collaboration between us.

RDH: I can go back to the days when I was first interested in psychiatry. At that time, there was a vigorous reaction against institutional psychiatry. In the 1960s, those institutions often appeared to be the cause of mental illness – not a means of containing it. I was struck by those large institutions and the insensitivity I found in the attitudes to mental patients in psychiatry.

WS: The experience of insensitivity may have been important for both of us. At the start of my medical career in Germany I worked on various speciality wards within internal medicine. My experience on some of these wards was that patients were often treated as a collection of organs rather than as suffering human beings. I found myself interested in the way patients experienced their illnesses as well as the emotional difficulties that may have contributed to their physical illness, but I felt very alone in this. This led me to go into a psychosomatic department and to start a psychotherapeutic training.

RDH: I, too, on entering psychiatry, found that there was a tendency to treat patients at arms length – an emotional arm's length. I remained puzzled and concerned about this when as a consultant psychotherapist I had a role in teaching psychiatric trainees. I became aware of a typical progress psychiatrists made during their training. Under the pressure of the work, the psychiatric culture and the career structure, their human responses to suffering patients often seemed to be progressively numbed. I had known many of the trainees as medical students and often felt that it was the most sensitive and humane of them who chose to become psychiatrists, but at the endpoint of their long journey of training they seemed to have become

hardened. By then, many had learned to keep a cynical distance from their patients, or had a deep bitterness against the system in which they worked; and, unfortunately, often passed this on to their own trainees.

WS: The process you describe seems to have something to do with the pressure of the culture and the institutional dynamics. In the environment of medical wards I worked in when I started, I was intrigued by the difference in the way patients were treated on different wards, much more humanely and empathically on some and more distantly and mechanically on others. I had a dim sense that this couldn't just be to do with the particular people working on those wards, especially as I found myself being different to patients on one ward than on another. When I came to England, I got to know some of the psychoanalytic thinking about institutional dynamics. I also attended one of the Leicester Conferences, which gave me a vivid experience of the power of those dynamics one gets pulled into, and this suddenly made sense of some of my experiences in medical, psychiatric and psychotherapeutic institutions.

RDH: Well, the Leicester Conference experience was obviously formative for both of us. There, one somehow tries to make sense of what is happening under the surface, whilst being subjected to all those hidden pressures one is trying to identify. When I was at the Leicester Conference, I was impressed that one is somehow in the same position as a psychoanalyst – being put under various pressures from the patient, such as the transference, whilst trying to identify them.

WS: It is very difficult to do that, though, when one is part of an institution. When we met, at the Cassel Hospital, I valued your attempts to make sense of the dynamics within the hospital that I often felt overwhelmed by. Your observation method, however, introduces a greater distance from which to look at the dynamics of such institutions by simply observing them.

RDH: That's right. When I was thinking about the training experience of psychiatrists, my thoughts turned to my own psychoanalytic training. There I had been particularly inspired by the observation of a mother and baby from birth that I was required to do. That exercise carried no responsibility for the care of mother and infant, and yet one did experience other anxieties, just from being an inactive observer. Such an observation seemed to be an important training exercise in experiencing the pressures of the family milieu and developing an emotional sensitivity to it. I was therefore wondering whether similar observations could help trainee psychiatrists develop their sensitivity to their patients and wards – rather than to become hardened against them.

WS: Well perhaps there are many reasons for doing these observations. When I became interested in carrying out an observation myself, I was

particularly interested that this might help me look at and think about the dynamics of the institution I was working in, and potentially also to learn to consult to troubled wards. I was also interested to go back to where I had started from and have a different look at the atmosphere of medical wards. Your interest, I think, was more of an oppositional one, psychotherapy versus psychiatry.

RDH: You may have something of a point there, since I think I do see quite a strong opposition at an emotional as well as at an academic level, an opposition that is sustained by psychiatrists and psychotherapists. I think both sides hold quite divergent value systems. But, you know, what I discovered in fact was something quite different. My initial belief was that there might be something oppositional and subversive of general psychiatric training in my project, but this failed to be endorsed. After Flavia Donati did the first observation (Chapter 3), the development of interest amongst trainees in doing such observations was astonishing: for many years I regularly had trainees coming forward for this experience voluntarily. I realised that psychiatrists in training remain sensitively enquiring people; they wanted to attune themselves more directly to the suffering that was under their noses, despite the cultural demands their training seemed to make. So maybe the 'hardening' process didn't go as deep as I had thought.

WS: We have stressed the role of human sensitivity in medical and psychiatric work, but I want to add something: that is, the role of thinking – not just having feelings. When I started an observation as part of this project, some six years ago, it was a fascinating experience – not just to observe the ward and what happened around me and in myself but at least as much to think afterwards in the seminar about what might be underneath all that went on. And that process of thinking and making sense of what I had observed didn't stop there, it went further when I sat down to write a paper and again when I showed what I had written to others like Isobel Menzies who then helped me again to see things I hadn't seen up until then and have further thoughts.

RDH: I agree with that. There is more to the observation process than simply to have a set of feelings. It is important to reflect upon them, 'as opposed to discharging them like the patient', as Paula Heimann said. In some ways this thinking process is as active as giving drugs. Again it is so easy to make an opposition between the kind of thinking that we psychoanalysts support and the prescribing of more active treatments that psychiatrists rely upon, but probably both are 'active' interventions. Thought and reflection is nowadays seen as the core ingredient in a psychoanalytic treatment, but that role for thinking can also be transported outside the psychoanalytic setting – to one such as ours.

WS: An important part of the experience for me was also the process of writing a paper about it, in which your seminar was very helpful. That step from registering the pressures and atmospheres of a culture to clarifying and formalising one's reflections involves quite a process, even a struggle, as Judith Edwards (Chapter 6) described.

What fascinated me about editing this book was that I could then take another step by further reflecting on the papers of others (those who hadn't yet published their papers but were in the process of writing them) and helping them to develop and formulate their own thinking. Is this where you think the research dimension comes in?

RDH: Yes, I think there is a smooth transition from observational reflections to research findings. As psychiatry moved on during the course of my career there was an increasing demand on trainees to carry out research and publish papers. These were usually drug trials, but some were keen to publish their observational experiences. They felt that they had seen things in their wards that they had never imagined or only had a vague inkling of, and so thought that this was true research whose discoveries were well worth communicating.

And when I became more involved in higher training and worked with those specialising in psychotherapy, such as yourself or Mark Morris (Chapter 7), I was more strongly challenged to formulate clearly the ideas that I was intuitively working with in the supervision seminars. And I also needed to clarify in what way such a project does actually contribute as research to the understanding of health care institutions.

The editing of this book has involved a very considerable process of further clarification which you have continuously pushed us relentlessly towards.

WS: Well, our struggle has actually produced a result that we are both pleased with. Let's hope our readers will be too.

In producing this book we have had to combine a record of an educational intervention in the training of psychiatrists whilst also entering a more research-oriented set of attitudes where the effort is to grasp some specific and valid method in the human sciences, the science of human subjectivity. The reflective process that has been generated between us in producing this book, in confronting each other's ideas and in struggling with our rather different writing styles, has formed, however small, an institution in itself. As you, our readers, observe your own reactions to the way we have worked, you may have some access into the stresses that are involved in jointly producing a book, and how we have coped with or evaded them in a manner we are now more accustomed to understanding.

Bob Hinshelwood
Wilhelm Skogstad
January 2000

Acknowledgements

The following chapters have been published before and are reproduced here in an adapted form with permission by the publishers:

Chapter 3 from: F. Donati, 'A psychodynamic observer in a chronic psychiatric ward', *British Journal of Psychotherapy* 5, 3: 317–329.

Chapter 4 from: J. Rees, 'Psychotherapy training: food for thought', *International Journal of Therapeutic Communities* 8, 1: 47–56.

Chapter 5 from: M. Chiesa, 'At the border between institutionalisation and community psychiatry: psychodynamic observations of a hospital admission ward', *Free Associations* 4, 2: 241–263.

Chapter 8 from: W. Skogstad, 'Working in a world of bodies: defensive techniques on a medical ward – a psychoanalytical observation', *Psychoanalytic Psychotherapy* 11, 3: 221–241.

Chapter 10 from: N. Ramsay, 'Sitting close to death; observation on a palliative care unit', *Group Analysis* 28: 335–363.

Part I

General introduction

Chapter 1

The dynamics of health care institutions

R.D. Hinshelwood and Wilhelm Skogstad

This book is about an attempt to understand health care institutions through the eyes and mind of a participant observer. The approach adopted by the authors is based on psychoanalytic thinking and ideas, and has developed under the influence of the tradition of the Tavistock Clinic and the Tavistock Institute of Human Relations.

Various trends have developed there for applying psychoanalytic ideas outside the consulting room. In the 1940s Esther Bick pioneered infant observation (Bick 1964), and this is now a customary method used in the training of psychoanalysts, psychotherapists and child psychotherapists.

The Tavistock Institute, a branch that grew out of and later separated from the Tavistock Clinic (Trist and Murray 1990), then established a tradition of applying psychoanalytic ideas to commercial and government organisations. Increasingly they deployed those ideas within the context of an overall framework from systems theory (Rice 1963; Miller 1993). This conceptual complex is widely used in consultancy work with large and small industrial and other commercial companies, government organisations, small temporary conferences (the Group Relations Training Programme), and applied to society at large (Khaleelee and Miller 1985). This tradition now has a strong influence in this field of work (de Board 1978; Palmer 2000).

Obholzer and Roberts (1994) from the Clinic have produced a body of work, which we shall refer to later, that seeks to redress the balance and to give psychoanalytic ideas a greater part to play. Their work has been largely directed at particularly anxious institutions in the health and social service organisations.

The present book also deals with health and social service organisations, but more specifically we have reinforced the psychoanalytically oriented method further, and started from Bick's original observation method for the mother–infant organisation. Therefore, it harks back to the founding ideas of the Tavistock tradition (Trist [1950] 1990; Jaques 1953; Menzies [1959] 1988).

The adaptation of this method to the observation of large organisations which form the basis of the studies in this book, will be described in

DOI: 10.4324/9780203135150-2