

MENTAL HEALTH ORGANISATIONS AND THE PROBLEM OF “MANAGEMENT”.

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PAPER PRESENTED TO THE OPUS CONFERENCE:

ORGANISATIONAL AND SOCIAL DYNAMICS:

International perspectives from Group Relations,

Psychoanalysis and Systems Theory.

21st & 22nd November 2003

at The Ambassadors Hotel, 12 Upper Woburn Place, London WC1H 0HX.

In 2001 I directed a group relations conference for the Australian Institute of Socio-Analysis specifically for professionals who self-identified as “psychotherapists”. Some managers of psychotherapists also attended the conference. An exchange was reported in the Small Study Group System that goes to the heart of this paper:

A manager observed an “aggressive” altercation between two psychotherapists, one of whom accused the other of attacking him. The manager was reported to say, in rather languid tones, gaze fixed on the couple, “You call that an attack? That’s like a fight between two dead sheep!”

Admittedly this may be a uniquely Australian form of expression – somewhat droll and laconic – but it captured quite vividly, the difference between aggression as perceived from a “management” perspective and from a “therapeutic” one. It is perhaps qualities associated with forms of “aggression” that characterize inter-personal relations between those in management roles and those in caring or therapeutic ones. The tougher stance mobilized in making management decisions may require

qualities of aggressiveness which may be interpreted by those with a more caring orientation in a negative way; in contrast, the qualities of nurturance required for the caring function may be interpreted by those with an executive stance as lacking in strength. I will consider this later.

This paper explores the relationship and relatedness of the "management" functions (which I will hereafter call "executive" functions) and therapeutic functions in mental health services and practitioners, which I will call the caring functions. I will provide evidence from consultancy work for the *hypothesis of a split that organisations and clinicians precipitate between the executive function and the caring function. This split occurs both between the two organisational sectors and within them. An aspect of this hypothesis is that the caring function is idealized and the executive function demeaned by clinicians and a reciprocal attitude is held by management who may demean the caring function.. The obstacles this presents to the proper management of such organisations and to the proper management of therapeutic work will be considered.*

The executive functions required for the management of both mental health organisations and clinical practice, and those mobilized in the provision of care evoke organisational and individual tensions. Obholzer (1994) describes the task of "management" as "a form of conduct by those in authority that is intended to keep the organisation functioning and on-task." (p43) It is a "boundary regulating function" (p45). The "hard-edged" or tough "executive" functions involve regulating certain boundary conditions essential for good management practice: that is task, territory, time, role and resources. This applies, in practice, to both organisational functioning *and* to individual clinical work. The "soft-

edged" or sensitive caring functions provide deeply empathically based responsive intervention. I would suggest that the caring function is identified as "nurturing" and the executive function as "uncaring".

This poses a paradox for organisations and individuals since both functions are required in both roles. The terms "hard-edged" and "soft-edged" convey the quality or feel of the boundaries of these functions.

I will firstly explore the organisational realm and then make briefer comments about the relevance of these issues to the individual clinical setting.

Mental health organisations to which I have consulted over the past decade and from which I draw my data have come from a wide spectrum of settings, age groups, health and mental health problems, and were from the public, private and non-government sectors. These include services for psychiatrically ill non-mainstream youth, community psychiatric services, counselling services for war veterans, counselling services for health-related conditions and professional associations for clinicians.

Each has sought consultancy for different reasons. However, the data that emerged from the AISA conference referred to above has produced an hypothesis, which if supported, illuminates a theme common to all these organisations. This hypothesis noted the split between management and caring functions, and would seem to have implications for many organisations providing services in the mental health and health domains.

The primary task of the AISA conference was:

To explore the dynamics of identity, role, authority and task as they emerge in the conference and

To apply the learning to the organisation of psychotherapy: that is service provision, professional practice and training.

Perhaps the most notable themes that emerged from this conference were:

the identification of the therapeutic role with that of "saviour,"
the identification of "Management" by the membership with corruption and perversity. During the institutional event of the conference the conference "Management" was ignored almost entirely, and in the "Praxis Event" was overtly regarded in this way.

This led the staff of the conference to develop an hypothesis that established the foundation for the premise underpinning this paper, of a split between what the conference staff called the management and therapeutic function, and the idealization of the latter.

Data from Consultancies

To support the argument of this paper, I will provide data from some of the consultancies referred to above. I will offer more detail though from one consultancy for the purposes of this paper. This theme, however, was consistently present in many of the organisations referred to above and briefer evidence from a few others will also be provided.

Consultancy 1

For 18 months I have consulted to an organisation providing early intervention for young children and their families. This consultancy had two elements: a focus on the dynamics and considerable tensions of the therapeutic team, and the application of Organisational Role Analysis to the leadership role of the team leader..

The team defined its primary task as: working as a psychodynamic team to provide psychodynamic therapeutic services to young children and their families.

Considerable exploration occurred around what it meant to be a "psychodynamic team" and what "working psychodynamically" meant. This was a most unusual task since working "psychodynamically" was inimical to the kind of services valued in the domain in which this team operated. The creation of this service had been the passionate goal of the psychiatrist who led the team and who held both the executive "team leader" role as well as being the principal clinical consultant. The broader mental health environment which was hostile to intervention that was not so-called "evidence-based" is important to appreciate, since it impacted on the external boundary management by the team leader and on the internal relationship of the team to its leader.

One of the regular concerns of the team related to their need for a robust leader who could defend them against the perceived and actual attacks of the health system in which they operated. This was indeed a difficult boundary to manage. The attacks were broadly seen as emanating from the executive function of this health system (despite support from the

head of the hospital department within which this team fell). Gaining commitment from the health service to my ongoing consultancy was a key achievement of the team leader, since this was neither understood nor valued by the external executive and was associated with being “psychodynamic” and also “touchy-feely”, a term of contempt in these management circles. The team valued the consultancy since it helped in the containment of very serious tensions that had been difficult both to understand and to manage. (The hidden nature of these tensions resulted in the “fight between two dead sheep” quality, though at the start of the consultancy concern had been expressed that there could be “blood on the carpet”.)

These tensions had a number of hidden causes. Two key sources of tension were the team’s fear of the leader’s anger; and covert professional rivalry around the capacity for “working psychodynamically”. I think it could be understood too that the desire for robust leadership was also about the wish for the team leader to manage these covert rivalries. This presented a problem because of the actual and phantasied expectations she had of the team’s capacity to “work psychodynamically”. For example when the team tried to define what “working psychodynamically” meant, there was a lengthy silence and clear unwillingness to offer suggestions for fear one would be “wrong” or one would be criticized. As these rivalries surfaced, the team leader and the team members were able to reconsider more realistically her and their expectations of the team members’ capacities to work in this way.

The team leader described the executive dimensions of her role (as opposed to the clinical dimensions, about which she was passionate) as the “shit work”. Indeed management functions were generally felt to be

the shit work. This was further evident in another role, that of "Team Coordinator". The clinician in this role was expected to perform various team management functions like data collection and intake management. The role was eventually dismantled because of its dysfunctionality.

However, as the collaborative climate within the team increased and as the team leader and the team began more realistically to reassess the expectations of "working psychodynamically" a crisis occurred which cemented their phantasies of "management".

The management of the health system as a whole had to make serious budgetary cuts and decided to terminate this programme. Naturally the decision was a terrible shock (although in some ways not entirely unexpected) and a very painful experience for the team. However what was particularly notable was the way this occurred. No consultancy with the team or its leader occurred; nor was any alternative explored. The Chief Executive Officer of the whole service was moved to a different health system so that there was absolutely no way of challenging him, of his being held accountable by the team nor of any further negotiation with him about this decision.

Management was seen as ruthless, aggressive and uncaring – both of the team and of the team's patients. Of note at this time though, was the way the team leader demonstrated significant robust leadership in demanding successfully that my consultancy with the team be resourced to work through the dynamics of this sudden termination. Note too that one of the team's concerns had been their fear of the team leader's anger.

I think this material clearly demonstrates the split and mutual demeaning of the executive and caring functions. The executive could demean the clinical approach because it did not meet its quantitative and “evidence-based” requirements and was associated with the undesirable “touchy-feely” quality. The caring function also delved into the unconscious, and worked with serious psychic pain in children, which was not easily countenanced. The executive, in managing its resource limitations behaved in ways that did indeed seem uncaring and ruthless (in some ways not unlike some of the problematic parents in the families who used the service). The ultimate decision and manner of terminating the programme supported the therapeutic team’s phantasies of an aggressive management. The individual work with the team leader enabled her to recognize her own attitude to the more difficult executive functions she needed in her role. In her clinical role she already appreciated the critical role of the executive function of boundary management; through consultations she came to appreciate – with some ambivalence - the requirements of a hard-edged executive function. This helped her to try to deal more effectively with difficult staff issues when they arose, and which required a tougher stance.

In the next vignette I will demonstrate what could be understood as a struggle to come to grips with this tougher stance, and the accompanying diminution in managing requisite boundary conditions.

Consultancy 2

I was asked to consult to an organisation that provided community support and counselling services for people with serious psychiatric illness.

The presenting problem was a serious conflict between two senior managers, which had descended into a vitriolic personal and public fight. A diagnosis of the culture of the organisation revealed some deeper tensions. The organisation had been re-structured not long before, from having only a Director (who was a clinician) in the head office with self-managing field units, to one in which area coordinators joined an executive team in head office and managed their regions from a distance.

This shift brought into sharp focus the difficulties that the Director had in leading and managing the executive team. As is all too common in mental health organisations, I have noticed clinicians take up management roles but bring to those roles primarily clinical, not managerial experience and expertise. What often results is a dysfunctional attempt to manage using clinical and empathic skills with a soft-edge, rather than executive ones, which demand tough, hard edged management decisions (that are often neither liked nor understood by subordinate clinicians).

In this organisation the Director had consistently failed to address management problems in the region coordinated by one of the senior managers and also in the managerial collaboration of senior staff. Gossip,

backstabbing and rumour mongering became the alternative and dysfunctional vehicle for managing. One way the Board of Management tried to deal with the problem was by sending the director on stress leave. In this process a variety of boundaries were transgressed by the Board and by managers – notably those of confidentiality, due process and appropriate authority relations. It was during this time that the conflict erupted publicly.

In my report to the Board I made observations about what I considered to be serious deficits in the executive functions at Board and senior management level. I indicated my concerns about the management capacity of the Director, and the Board's collusion in this through its consistent failure to hold him accountable; and to itself conduct its business by covert personal relationship rather than organisational accountabilities. My report was rejected. While I am willing to entertain the possibility that I was wrong, I believe that there was considerable evidence (which I won't present here) to support my observations.

I suspect that the organisation's executive functions mirrored the failure of the clients of this organisation to manage themselves. Indeed there seemed to me at times to be psychotic-like boundary failures. (For example, the least professionally qualified or trained staff member - who had the longest employment history in this organisation – the office administrator – seemed to be both the major communication switchboard as well as the principal influence on decision-making.) In this organisation (which had grown from a grass-roots community organisation) the "personal" was valued far more highly than the "managerial", which was regarded as unkind, in much the same spirit as my report was regarded. My attempts to engage with the Board to work

through my report and my offers to work collaboratively with them to explore the management culture of the organisation were declined.

This material demonstrates how devaluation of the executive functions was deeply embedded in the culture. The consequences of such perceptible demeaning of this function were significant and destructive breaches in some management boundaries. These boundaries were needed to properly contain an organisation dealing with clients in much pain, and the staff who had to supervise them. Most notable were breaches in the authority boundary, resulting in management by personal relations rather than by appropriate delegations and accountabilities. The impact on the personal was quite evident in the degree of illness and unhappiness among the executive team. The valuing of the "personal" here originated in the organisation's grass-roots origins and was more closely linked with caring functions. I think that paradoxically, the executive failures led to quite uncaring personal relations.

I have tried to demonstrate in both of these examples how the split between executive and caring functions manifests at a system-wide level. In this next vignette I look more closely at the individual experience.

Consultancy 3

In my private consultancy I have developed a service that I call "Intervision", a term that I was unaware had other usage in some therapeutic contexts. The junction of one's professional role, the work of "psychotherapy" and the dynamics of the workplace are the focus of what I call "intervision". This form of consultation with clinicians/managers draws on systems thinking and psychodynamic approaches to

understanding and working at this critical junction and addresses *both* organisational and clinical issues.

In a series of action-learning based consultations, manager/clinicians present vignettes or process notes about their organisation which illustrate its culture and dynamics: e.g. its "Primary task"; their role in the organisation and their professional work – both managerial and clinical. Using an iterative, facilitated model of exploration, reflection and hypothesis building, the intersection of professional role and organisational dynamics and their influence on the clinical work is analyzed.

I also work extensively as a clinical supervisor with psychotherapists. Intervision differs from clinical supervision because it focuses on how personal and contextual dynamics *affect the way people take up* their organisational and clinical roles and the way they go about their work tasks. Among other things, boundary management of task, time, territory, role and resources are attended to in intervision.

I have provided intervisory consultation to individuals from some of the organisations referred to earlier. The material I am presenting is from a consultancy with a clinician and manager of the Counselling Division of a government-funded organisation providing support, educational, advocacy and counselling services for people with a specific health problem. The management of health-related boundaries was critical in this health condition.

The material we worked with was drawn from two sources: the client's organisational experience as well as from process notes from my client's

counselling sessions with patients. The clients of the organisation came from a social group that responded well to peer-based intervention and the organisation itself had, over two decades, developed a peer-group culture. Structurally, it comprised a community-based Board, an Executive Director and senior managers with their staffs, in the areas of service delivery. This included a major component of volunteers. The managers did not function as an executive team.

Two inter-related areas become apparent that are relevant to this paper. They emerged from the personal and organisational spheres.

1. At the personal level my client grappled with two related problems. In his personal life he was undergoing serious personal crises, which were fairly chronic. Firstly, tears and distress quite often disrupted the presentation of the clinical material he brought, as his personal issues invaded the professional arena. This was an important clue to the internal problem of managing the boundary between that which belongs in the personal psychotherapy realm (the "soft-edged caring function"), and that which belongs in the self-management area of the professional role. He was able to seek out personal psychotherapy that helped him to contain these problems in the appropriate space.

Secondly, he often brought clinical material about cases he was ill equipped to work with. He found it almost impossible to resist a request for counselling help from even the most unsuitable and complex and sometimes decompensating clients. This would regularly lead him into therapeutic trouble with demanding and acting-out clients. He developed considerable insight into this deficit, but remained in constant difficulty about turning away such

clients. This difficulty related to his feelings of guilt about depriving such clients of his help and the accompanying feelings of being unkind and unhelpful. To refuse cries for help would be uncompromising and heartless.

2. At the organisational level he struggled to find the authority he needed for his role, in the face of a rather unconnected Executive Director whom he felt did not seem to appreciate or understand the counselling work.

As his appreciation of the helpfulness of managing boundaries with his clients increased, so did his capacity to apply this to his organisational role, where boundaries of task, territory, time, role and authority were regularly transgressed in the organisation.

These are examples: He was able to take up more authority with his subordinates and require that certain policies be adhered to. He put a good deal of energy into challenging the Director who had developed a new primary task for the organisation without consulting managers. The revised task itself was a clear example of task-boundary violation. It expanded the brief of the organisation to "improving the health of the community" from one which targeted a specific population and health-related concern. He applied this to re-defining the task of his own Counselling department to limit its brief to counselling people having or affected by the particular health condition, instead of open house to any members of this particular community. He decided to write monthly detailed reports to the Director providing statistical and other information

that emphasized the extent and importance of the work of his department. While his increasing success in these endeavors increased his sense of competence and improved his role performance, he continued to struggle with turning away unsuitable clients when he associated this executive function with aggression and heartlessness. He acknowledged this struggle with some humour!

There was some evidence of the breaching of boundaries in his supervision with me: frequent introduction of personal material demonstrated this. However he began to manage this better and demonstrated his recognition of these breaches, when he requested and took up a referral for personal psychotherapy.

These examples illustrate the split between the hard-edged executive functions which helping professionals experience as unkind, and the soft-edged caring functions which managers demean. They also illustrate some of the challenges of repairing this split. The organisational difficulties of reparation would require the taking back of projections into the "other" by both groups. It would also mean working through the difficult experiences that these re-introjections elicit. Managers would need to engage with their soft-edged caring functions in a way that does not obstruct the performance of their executive functions. Clinicians would need to engage with their hard-edged executive capacities without their caring capacities being compromised by feeling these executive functions to be overwhelmingly heartless and aggressive. An illustrative example from the AISA conference I have mentioned was the way in which executive role-relationships were affected by conference staff struggling to make appropriate challenges to management decisions I made, opting instead for being "nice" to me or non-confrontational.

Relevance to the individual clinical setting

The tension in the relationship between the caring and executive functions as well as the operation of these functions has significant applicability to the work of the individual clinician not only in their organisational roles, but also in their clinical ones. Group relations and socio-analytic frames provide very useful applied constructs.

Many clinicians have a keen appreciation of the importance of boundary management in their therapeutic work. Holding the therapeutic frame and providing adequate containment for the work are the primary boundaries that these clinicians attend to. These include managing time, task, territory, role and confidentiality. This applies particularly to psychoanalytically trained clinicians. However I have observed that while some boundary conditions are managed, in my experience others that are more “managerial” in nature – such as administration of finances and marketing are not well handled. For many other non-psychoanalytic clinicians even those core boundary conditions are either not well managed or are regarded as unimportant. I have observed this particularly in the management of task, role and time boundaries.

While those clinicians can often effectively apply these executive functions to their *clinical work*, when they take up organisational management roles, their applicability to that domain is often unhelpfully superseded by the caring functions. This is evident in a number of arenas, including managing committee work in professional organisations, in running training programmes, and especially when their work roles hold the two components of both clinician AND manager.

I will focus here briefly on the clinical arena. Management of the boundary conditions of task, role, time, territory and resources is a critical function for clinicians, yet this executive function is often devalued. Boundary violations in any of these areas are sensitive clues to dynamic issues in the therapeutic relationship: in some areas more obviously than others. However to be able to attend to these boundary violations and maximize intervention, both executive and caring functions have to be applied, and the tension between them managed. They are needed for optimal containment.

As previously indicated, the tension seems to emerge from the high value placed on the caring capacity, while the executive one is often demeaned and associated with forms of "aggression". In the AISA conference I mentioned earlier the theme of the psychotherapist as "saviour" emerged strongly. The omnipotence associated with this role denies the need for the mobilization of the executive functions that set clear limits on many aspects of the therapeutic relationship. When clinicians I have supervised have engaged with a fuller realization of this and of the value of the executive function, they have found not only a very useful instrument in their therapeutic work, but a more secure, bounded therapeutic container. When such clinicians also held the role of manager, the increased recognition of the value of the executive functions also facilitated their managerial competence. The difficulties encountered by the clinician I described previously are clear examples of this.

Comments and Conclusions

Thomas Gilmore presented a paper at the Annual Symposium of the International Society for the Study of Organizations (2002) entitled "Dilemmas of Physicians in Administrative Roles: Dealing with the Managerial Other Within" in which he explored similar notions to these, as they apply to physicians. Two phrases he uses resonate with my own thoughts.

My notions of "caring" and "executive" functions" are echoed in his opening statement that: "Health care settings have been characterized as "church-state" organizations in which physicians and administrators collaborate to produce the organization's services". The association to "church" particularly strikes me since the idea of clinician-as-saviour seems to play such a critical role in the identity of mental health clinicians. Gilmore in fact refers to physicians as "the priestly class".

He suggests too that the integration of "clinical" and "administrative" aspects of their roles is a challenge for physician-executives. He talks of the need for a productive "working alliance" between physicians and administrators and adds that physicians "need to discover ways to value both aspects of their leadership roles, rather than holding the managerial at a distance." In so doing, Gilmore's exploration of medical physicians parallels in important ways my own observation of mental health and other health professionals generally. Gilmore seems to be recommending very similar reparative processes. These reparative processes, or the integration of the clinical and administrative aspects – at individual as well as organisational levels are the challenging arenas for development in this

field. Reparation is a cornerstone of Klein's idea of "depressive position" functioning. "Depressive position" organisation of mental processes involves the experience of guilt and the capacity for love, concern and repair; and the tolerance of ambivalence. The more primitive mental organisation of the "paranoid-schizoid position" mobilizes projective identification and splitting in a persecutory ethos. Applied to organisations (Obholzer and Roberts, 1995) it can be appreciated that splitting and projective identification are operational mechanisms mobilized in the alienation of the executive and management functions. Ambivalence about their relatedness would need to be tolerated by both managers and clinicians, in different ways.

I drew attention to the relevance of "executive-caring" integration and also to the value to clinicians of applying concepts of boundary management to their clinical work. Gilmore adds (and I think this is equally relevant to mental health practitioners) that: "It is as if the skills exercised in the context of their primary work—medicine—are not generalized to resemble management and leadership skills, even when there are many similarities." Gilmore also provides evidence of the denigration of formal administrative leadership within the medical culture.

The second term that Gilmore uses that I found intriguing, is the application of "aggression" to the drive and achievement of physicians, aggression which is much less evident when they take up administrative leadership:

"...might this lack of aggression for taking on the role be related to the difficulty of exercising socialized aggression or power in the role?" I noted at the outset of this paper, a manager's comments on the lack of real expressed aggression between two psychotherapists. In the spirit of

Gilmore's observation I would suggest that a similar cultural identification operates in mental health professionals.

And finally, drawing parallels between Gilmore's description of physicians, and my own regarding mental health professionals: "Given that the "managerial other" within the physician is held in low regard, when others attack them it is easy to collude with the contempt. Does this ambivalence become what Fairbain (Trist, personal communication) termed "an internal saboteur" relative to the challenges they face"?

Organisational splits may be located in groups, and particularly in stereotyped groupings (Shafer, 1999 and 2002) where the identification of the whole "other" is confounded by the part-object qualities of the stereotype and kept at a distance to maintain their "useful" otherness. The use of "fusion words" (Turquet, 1975) such as " 'management' has decided." or "...touchy-feely" which are used against each other by both sides of the split serve to maintain the attenuation of the value of the "other".

It has been my experience that when organisational dynamics are too hot to handle "publicly" or consciously, they may also be projected into individuals who carry the conflicted split on behalf of the organisation and act it out. The second consultancy I presented illustrated this, when a public conflict emerged between two individuals. When in my consultation I surfaced the underlying dynamics, my observations were rejected.

At the individual level, and in parallel, the internal split between the "executive" self and the "caring" self mirrors these dynamics. My example

of the client who consulted me for intervision reflected this. The disavowed hard-edged "executive" self was disowned because it conflicted with her "saviour" identification.

What in mental health organisations might be the source of these dynamics? In a previous paper (Shafer, 1997) I proposed that the primary task of an organisation infuses its culture. While the organisations to which I consulted were varied, they all provided caring services for adults and children with mental health or health related problems. Obholzer and Roberts (1994) state that a "major source of stress for staff working in the helping professions is their constant proximity to people in great pain" (p49). They indicate how aspects of the clients' inchoate experience can be projected into staff and the whole system can be mobilized into the same dynamic as its clients. To manage this, systems evolve social defences (Menzies-Lyth, 1990). Splitting and projective identification seem to be social defences which characterized many of the organisations to which I consulted and paralleled the dynamics of many of the clients of these organisations. I draw on these notions in particular, since the work of mental health organisations is essentially about depressive capacity – concern, reparation, love – yet the organisational dynamics are characterized by splitting of the executive and caring functions and projective identification into the "otherness" of managers by clinicians, and the "otherness" of clinicians by managers. The title of this paper could well have been "The problem of 'caring' in mental health organisations"!

Moylan (in Obholzer and Roberts, 1994) provides examples of some of her own intense emotional experiences as a consultant to organisations working with people in emotional pain. My own predominant experience as a consultant – and perhaps particularly because I also work as a

psychotherapist – was the frequent enticement to respond to the *clinical* issues of the organisation, rather than the *managerial* ones. In my work with the team that I described in my first example, I often found myself either drawn into helping the staff think about the clinical issues they were working with, or being drawn towards a group therapist role, and I had regularly to bring my attention back to the management ones.

What assisted me in doing this, as Moylan describes, was “Awareness of these [processes] opens up the possibility of choice. Instead of denial and projection, there is room for ...developing conscious strategies that support healthy growth and development”. (p59) And these capacities are what may assist managers and clinicians to work towards appropriate integration and balancing of executive and caring functions.

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