

Exploring team dynamics in psychotherapeutic milieux

and their impact on clinical outcomes:

A critical review of the literature

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Attestation of authorship

I hereby declare that this submission is my own work and that to the best of my knowledge and belief it contains no material previously published or written by another person nor material, which to a substantial extent, has been accepted for the qualification of any other degree or diploma of a university or institution of higher learning, except when acknowledgement is made in the acknowledgements.

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Date:

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Abstract

This dissertation provides a critical review of psychodynamic literature exploring the dynamics of psychotherapeutic teams in residential and milieu settings. The review synthesises and critiques psychodynamic literature regarding the influences upon, and effects of, staff relationships in these settings. In particular the review includes consideration of the impact of staff relationships on clinical treatment and outcomes. The implications for clinical practice and opportunities for further research are also considered.

Chapter 1: Introduction

To practise psychotherapy in an institutional setting is to walk a tightrope whilst having both feet on the ground — the art of the impossible. (Bell, 1997, p. 17)

Many years ago I had the privilege of living in a therapeutic community. At a crossroads in my life I sought sanctuary and found myself in a strange, intense, and rich world of emotional and psychological exploration; a community of people facing their pains and hopes together. I had never experienced such honest communication. I became deeply engaged with the processes there and found the connectedness I had long wished for. Immersed in the client group dynamics, I had an idealised fantasy of the all-seeing, all-knowing staff group, protecting us as we went through our ordeals.

Several years later I re-entered the world of the therapeutic community as a trainee therapist. I found myself very challenged by the intense countertransference I experienced on a daily basis. I was also in the position of being a new member of the staff group, essentially an outsider in the group, and I had the brief experience of observer. I found myself deeply affected by the intensity of the relationships between staff, the strong undercurrents of emotion in the group and the sensitivity of staff to each other. My illusions of the loving, superhumanly calm staff body were shattered. Often I felt anxious or overwhelmed and wondered if I had made the right decision. But I stayed, my passion and curiosity winning over my fear. After some time I was well embedded in the staff team, no longer an outsider, but part of the group dynamic. It has taken a long time to realise that the intense emotions I experience working in the milieu relate to the interplay between many layers of conscious and unconscious dynamics. The nature of the work means that unconscious enactments and strong emotions are aroused constantly, and for me a sense of equanimity has to be relearnt each time I find myself in the middle of an unconscious enactment.

As I begin this work I sit with several years' experience as a member of a multi-disciplinary psychotherapeutic team in the dynamic and challenging environment of a therapeutic community. Over the years I have become increasingly curious about the antecedents and effects of staff psychodynamics in such an environment, as well as the complex interplay between the staff as a group, and the client group. I have often wondered whether others' experiences in this realm have been explored or narrated in the psychodynamic literature and how a deeper understanding might better serve the people with whom we work.

The above experiences and the deep curiosity they engendered, have led to me undertaking the research which is the subject of this review. Below is an outline of the therapeutic settings out of which the literature reviewed in this dissertation has emerged. I also briefly outline the nature of the client groups who attend these therapeutic settings. This is followed by a brief outline of the content of each of the chapters contained in this study.

Context: Treatment settings

Asylums were established in England in 1813 as a response to inhumane conditions in private madhouses, prisons and workhouses (Jones, 1979). Initially conceived as safe havens for the mentally ill, by the end of the 19th century these asylums were exposed as cruel institutions with staff relationships characterised by sharply defined hierarchy and impersonality (Wilson, 2012).

In the early 20th century psychoanalytically informed residential treatment was developed in the United States and Europe. Its theoretical orientation was in stark contrast to the 'scientific' and medical domination of treatment received in asylums (Jones, 1979). These hospitals provided four to five times weekly psychoanalysis, with the hospital functioning as physical container to safeguard the patient and the analytic framework. This gradually led to

the integration of social rehabilitation which used “the living together opportunities as treatment tools” (Chiesa, Fonagy, & Holmes, 2003, p. 638).

In World War Two England, the tradition of therapeutic communities arose from psychiatric hospitals. In 1947 Tom Main established a therapeutic community at the Cassel Hospital. At the same time Maxwell Jones established another at the Maudsley Hospital, later to become known as Henderson Hospital (Jones, 1979). Main (1989a) is reported to have coined the term ‘therapeutic community’ in 1946 for the psychotherapeutic milieu in which patients maintained their adult roles and responsibilities, working alongside psychiatrists and nursing staff (Rayner, 1989; Whiteley, 2004).

In the United States a parallel tradition of therapeutic community arose from Alcoholics Anonymous meetings and developed into the first therapeutic community, Synanon, in 1958. Here, recovering addicts in a model of mutual self-help gained recovery through shared responsibilities and intense ‘encounter’ processes. This tradition of American therapeutic communities came to be known as ‘concept communities’ (Jones, 1979). A number of prison therapeutic communities also evolved from the Synanon model.

The settings in this review range from psychoanalytically informed long and short-term inpatient hospital wards, acute and long term mental health wards or units; therapeutic communities for addiction, eating disorders, personality disorders and prisoners; and residential services for the treatment of disorders in adolescents and children. There are clearly philosophical and structural differences as well as differences in clinical practice among the various settings in this review. However, the essential elements of psychotherapeutic milieu, team dynamics, and complexity or severity of patient psychopathology within these services are similar.

The literature is eclectic in its terminology of treatment settings and this is reflected in this review. I use the terms ‘milieu therapy’, ‘treatment milieu’ ‘therapeutic milieu’ and

psychotherapeutic milieu' interchangeably to refer to the various settings included in this review. I also refer to inpatient hospital treatment, therapy or psychotherapy, therapeutic community or residential treatment when referring to the treatment contexts discussed in the literature. Milieu therapy can be defined as therapy that "utilises the social milieu in an environment for therapeutic benefit" (Morris, 2006).

Aotearoa New Zealand context

In general terms, the history of mental health services in Aotearoa New Zealand has been similar to that of England and the United States. After the first lunatic asylum was opened in 1854, large asylums were built throughout the country. Mental illness was regarded as incurable and treatments such as tying up uncontrollable patients were used (Brunton, 2012). From 1911 attitudes began to change; asylums became mental hospitals and treatment became somewhat more compassionate. Psychodynamic concepts were used in 'talk therapy' for shell-shocked soldiers after the First World War. From the 1950s the use of medication became commonplace and mental hospitals became known as psychiatric hospitals (Brunton, 2012).

As with other western countries New Zealand saw wide changes in the mental health system from the 1970s, particularly deinstitutionalisation which involved the transfer of care from hospital wards to community based services. However, approximately 4,000 people each year are currently committed each year to treatment under compulsory detention, assessment and treatment orders on the grounds of mental disorder (Brunton, 2012). In addition, many more seek treatment in residential services voluntarily.

In recent years Maori models of treatment have been included in residential services in response to shortcomings of Western-based treatment for Maori clients. Outcome data for Maori programmes show reductions in key mental health indicators and reduction in

recidivism for offender populations (Adamson, Deering, Moana-o-Hinerangi, Huriwai, & Noller, 2010).

However, the authors of a literature review on Aotearoa New Zealand's residential treatment of substance dependent, mental health and offender populations note that the published work relating to New Zealand is limited (Adamson et al., 2010). The paucity of psychodynamic literature regarding milieu therapeutic settings means there is only very minimal literature available for review in regard to treatment settings in New Zealand.

Context: Client groups

It is noted that the common factor in the client groups described in the literature included in this review experience complex and often severe psychopathology. They include people with personality disorders, addictions, eating disorders, co-existing disorders, psychosis and severe behavioural problems (Adamson et al., 2010; Chiesa, 1989). Clients may have been unresponsive to other treatments such as general psychiatric management (Chiesa et al., 2003) or no longer able to function in their psycho-social environment (Chiesa, 1989). They are considered unsuitable for outpatient psychotherapy due to the frequency and severity of destructive behaviour, their great difficulty in forming a therapeutic alliance, and inability to tolerate without support the stress evoked by psychoanalytic therapy (Chiesa et al., 2003).

Outline of the chapters in this study

In Chapter 2 I discuss the methodology of this review, detailing the epistemology, theoretical perspective, methodology and methods. I define the research question, determine the types of research required to answer the question, and detail the literature search process and my rationale for inclusion and exclusion of material.

In Chapter 3, I outline key psychodynamic concepts relevant to the review. I then review the literature on team countertransference to clients in milieu settings including case

material referring to individual clients, client groups as a whole, and countertransference relating to specific client groups.

In Chapter 4 I review the literature on the contribution of team members and teams prior to the interaction with clients such as personal history and motivation for the profession.

In Chapter 5 I review the literature on the contribution to team dynamics of the wider context of the therapeutic milieu: the organisation or institution itself and other agencies or forces that impinge on the milieu.

In Chapter 6 I synthesise the literature and discuss the findings of the review. Implications for clinical practice are considered, recommendations made and suggestions given for future research.

Chapter 7 provides a brief summary of the study.

Summary

In this chapter I have discussed my motivation for choosing this research topic, outlined the historical context out of which the literature emerges and outlined the content of each chapter in the review. In the following chapter I discuss the epistemology and theoretical orientation, methodology and methods of the review.

Chapter 2: Methodology

The clear-cut indicators of ‘true’ or ‘false’ which the natural and medical sciences insist upon are not readily available in a practice that depends on impressions, subjective judgment, intuitively generated interpretations and intense personal work with individuals. All these factors make our ‘science’ different from what is usually expected by the public - and indeed by the managers of care. Nevertheless, in my view we must stick to our guns and re-affirm the subjective, inductive nature of our work. (Hinshelwood, 2004)

In this chapter I discuss my research approach to this review, detailing the epistemology, theoretical perspective, methodology and methods. I define the research question and explain why I chose a critical literature review as the methodological approach. I then detail the literature search process and my rationale for inclusion and exclusion of material (Petticrew & Roberts, 2006).

Crotty (1998) proposes four elements to describe the research process: epistemology, theoretical perspective, methodology and methods. He suggests that a thorough examination of these four elements “constitutes a penetrating analysis of the process and points up the theoretical assumptions that underpin it” (p. 6). I utilise this framework to discuss my project.

Defining the research question

As discussed in the introduction, my initial impetus for this research project arose from my experience as a psychotherapist in a multi-disciplinary team within a therapeutic community. My observation of the various teams I have worked with and my own emotional and psychological experience in this workplace setting made me increasingly curious about the antecedents and effects of staff psychodynamics in such an environment as well as the complex interplay between the staff as a group and the client group.

A preliminary literature search revealed a significant amount of literature spanning many decades which related to staff relationships in residential mental health settings. Three main themes in particular became apparent in a diverse range of literature: countertransference responses to clients; clinicians' unconscious material; and organisational factors. This research project therefore suggested an opportunity to draw these topics together. The preliminary literature search helped to formulate my research question: What are the influences of team dynamics in psychotherapeutic milieu teams and how do these dynamics relate to clinical outcomes?

Epistemology

Epistemology "is a way of understanding and explaining how we know what we know" (Crotty, 1998, p. 3). It articulates the underlying assumptions and worldview that pertain to the work. Thus, epistemology is the foundation for the way research is conducted; theoretical perspective, methodology, and methods must be consistent and flow naturally from the epistemological position.

Crotty (1998) contrasts the worldviews or epistemological paradigms of objectivism and constructionism. Objectivism is the view that "things exist as meaningful entities independently of consciousness and experience" (p. 5). In this paradigm it is possible for research to discover objective truth by careful scientific method; this is the paradigm that informs the research of the natural sciences, exemplified by the randomized controlled trial.

However, in the constructionist paradigm informing this dissertation, while external reality can be said to 'exist' independently of the observer, "truth, or meaning, comes into existence in our engagement with the realities of the world" (Crotty, 1998, p. 8). In this worldview the subjective and the objective are brought together; reality is constructed between the observer and the subject being observed.

A constructionist paradigm assumes that there are as many realities as there are participants and meanings are co-constructed between researcher and participants (Morrow, 2007). This worldview is in keeping with the constructionist nature of psychotherapy which depends upon the intersubjectivity that arises between patient and therapist. It is also in keeping with my topic regarding the influences and effects of team dynamics in the therapeutic milieu, where many ‘realities’ are at work.

Theoretical perspective

According to Crotty (1998), the theoretical perspective is the philosophical stance or set of assumptions lying behind a methodology. The interpretivist approach to research “looks for culturally derived and historically situated interpretations of the social life world” (p. 67). This research project, which draws mainly from qualitative data within the psychotherapy literature, holds an interpretivist perspective which explores and seeks “to understand what it is to be human and what meanings people attach to the events of their lives” (Grant & Giddings, 2002, p. 16). This is in keeping with this topic which is concerned with how we can make sense of clinicians’ relationships with each other and with clients in the therapeutic milieu. From this perspective “the researcher ... interprets the significance of [the participants’] self-understandings in ways the participants may not have been able to see” (Grant & Giddings, 2002, p. 16).

My intention in this research is not simply to describe or summarise but to engage critically with the subject. My approach to this research, also paralleled by the body of literature I will review, is underpinned by interpretivist assumptions. Thus I will examine the multiple meanings and interpretations within the literature about clinicians’ relationships with each other and with clients.

I acknowledge that the findings I draw from this review will represent only one set of meanings. I believe they will provide a useful and interesting viewpoint, but they will not be

the only possible conclusion. Other researchers may examine this body of literature through a different lens and draw different conclusions about it.

In keeping with a constructionist epistemology I will not be seeking to validate the concepts with empirical data; to do so would privilege positivist values which would be at odds with the constructionist paradigm (Crotty, 1998). I do discuss some research that approaches the topic from a positivist framework. However, I do not place the value of these contributions above case study or clinical experience. In this respect I do not share the positivist worldview that reifies the randomised controlled trial in the hierarchy of evidence. I suggest that controlled trials, outcome studies, qualitative studies, case material and clinical opinion can all offer valuable contributions to clinical practice. This aligns with the interpretivist paradigm which sees these types of evidence as complementing each other (Crotty, 1998; Morrow, 2007).

It is consistent with the interpretivist paradigm and with my own values that I recognise that my role as a researcher inevitably impacts on the research process (Finlay & Evans, 2009; Morrow, 2007). As Morrow suggests, understanding the social location of the researcher enables the reader to make decisions about the relevance of the findings to their own context. As discussed in my introduction, I have the experience of being both a client and a therapist in a therapeutic community. I believe this dual lens is a strength that assists me to identify certain assumptions in the literature that may not otherwise be apparent. My position as a therapist in a therapeutic community has helped me to identify an interesting and relatively little researched area within psychotherapy and in this regard it is also a positive factor. However, given my closeness to the topic I am researching, I am also in a position of potential bias which could become problematic in terms of selectiveness of research, or having pre-formed conclusions.

In order to make my research as useful as possible, rather than it being a reflection of my pre-existing assumptions, I adopt Aveyard's (2010) guidelines for undertaking a review with a systematic and critical approach. She highlights the deficiencies of the narrative review, which does little more than handpick a few supporting statements from related literature to back up a hypothesis. My intention therefore is to utilise a systematic approach, carefully outline my methods, detail the literature search process, and be thorough and transparent in my analysis and critique of the data.

Methodology

As Petticrew and Roberts (2006) suggest, the methodology for this review arises directly from the research question. It must also be consistent with the epistemology and theoretical perspective (Crotty, 1998).

The purpose of this study is to present a detailed and in depth view of the phenomenon of staff relationships in residential psychotherapeutic settings. As Morrow (2007) states, a qualitative approach is able to "delve into complex processes and illustrate the multifaceted nature of human phenomena" (p. 211). Another consideration is the receptivity of my intended audience to the research outcomes; in this case therapists and counsellors who tend to be receptive to human experience and feelings and may find the narrative style of a qualitative study more accessible and convincing than, for example, a scientific analysis of data.

As previously mentioned, it is apparent from a preliminary search of the psychodynamic literature that a significant number of works refer to staff or team relationships. These tend to focus on different aspects or determinants of staff relationships, such as client countertransference, organisational countertransference and unresolved issues of individual staff members. The literature relates to different types of psychotherapeutic residential settings for a range of client groups. This preliminary review suggests that this

body of work has not previously been brought together in order to examine staff relationships as the central theme. It is therefore appropriate for this research to collect and assess all available research on the subject in the form of a literature review (Cooper, 1998).

There are many types of literature review. A systematic literature review, as epitomized by the Cochrane Collaboration lies within a positivist theoretical framework, with a hierarchy of evidence seeking to discover a knowable reality. This type of review does not fit within the theoretical framework of the constructionist paradigm that instead seeks to explore the construction of meaning (Crotty, 1998). At the other pole, a narrative review, with no predefined method or systematic approach, may support the preconceptions of the writer (Aveyard, 2010).

Within an interpretivist framework, a critical literature review utilises a systematic approach with a well-focused research question, and an explicitly stated search strategy (Aveyard, 2010). As Morrow (2007) suggests, criteria for quality are paradigm bound and standards of trustworthiness or rigour emerge from the interpretivist theoretical framework rather than positivist standards such as validity and generalisability. In this case the adequacy of data in both type and amount, researcher reflexivity and “thick descriptions”, which are rich descriptions of the literature supported by examples (Morrow, 2007, p. 219) are indicators of rigour. Aveyard (2010) states that “a literature review that is carried out systematically is a research methodology in its own right” (p. 16). I have therefore selected a critical literature review as my methodology as it is consistent with my theoretical framework and is an approach that will most usefully answer my research question.

This review aims “to uncover new insights on a topic by reviewing the literature in a systematic way” (Aveyard, 2010, p. 21). I utilise methods that aim “to identify, appraise and synthesize all relevant studies in order to answer a particular question” (Petticrew & Roberts, 2006, p. 9). I identify formative and other works, summarise and critique the literature,

identify relationships and themes, and draw conclusions. I consider the strengths and limitations of the review and identify gaps in the literature. (Aveyard, 2010). By synthesising the various strands of literature on staff dynamics in psychotherapeutic teams, my aim is also to shed new light on the clinical practice of such teams as well as suggesting avenues for future research (Aveyard, 2010).

Method

Method is the application of the particular methodology selected and includes the techniques of research (Hart, 1998, p. 28). The method undertaken in this review follows Aveyard's (2010) guidelines for a critical literature review.

Determining the types of studies to be located to answer the question

This research topic pertains to the psychodynamic literature and other literature dealing with psychodynamic themes such as literature from the counselling and sociology fields, and literature related to organisational dynamics. The initial search revealed that the literature did not form a discrete body but spanned the topic areas of countertransference in therapeutic milieux, staff psychological makeup, and organisational dynamics. The types of literature that needed to be located included theory, clinical material, case studies, and possibly, qualitative studies on relationship factors.

Literature search process

The AUT electronic databases Psychoanalytic Electronic Publishing (PEP), PsycINFO, and ProQuest Dissertations and Theses were searched for all articles, dissertations and theses relating to team dynamics within psychotherapeutic milieu as well as texts referencing "The Ailment" (Main, 1957) and *The Mental Hospital* (A. H. Stanton & Schwarz, 1954), which my initial search had identified as seminal works in this field.

PEP is a database of psychoanalytic literature, highly relevant for my topic but limited in terms of its search functionality (Psychoanalytic Electronic Publishing, 2013). PsycINFO

was chosen as it provides peer-reviewed literature from the psychological, social, behavioural and health science literature and captures an extensive range of psychodynamic literature (American Psychiatric Association, 2014).

ProQuest Dissertations and Theses was chosen as a specific database of material which may not be found elsewhere and which may provide reviews or other analyses of relevant topics (ProQuest, 2012).

In addition to an initial ‘brainstorming’ process and scanning keywords of preliminary articles, I used the PsycINFO thesaurus tool to establish appropriate synonyms for my key concepts. I quickly discovered that the search process would be complex for this project as all three concepts within the research question are broad and have many synonyms, some of which are ambiguous or too wide ranging to yield a useful body of literature. On the other hand, many studies evaded capture if fewer synonyms were used. It was therefore difficult to find one search that contained a large enough amount of relevant literature and very little irrelevant literature.

My initial search was an experimental search of the keywords “therapeutic milieu” in PEP, with the limit of English language. This revealed 195 results. I refined the search by combining “therapeutic milieu” with “staff”; this yielded 129 results. I then skim read the abstracts to determine relevance and found 36 articles of interest. I checked references of these articles to discover other articles of interest. I also used the “who cited this” and “find similar articles” functions to further search the database. This in turn revealed several more articles of interest and yielded keywords for a more refined searching process. My first systematic search combined key words “milieu” and “team” and their synonyms, as Table 1 illustrates.

Table 1

Searches for “milieu” and “team” and their synonyms

<i>Psychoanalytic Electronic Publishing (limits: English, Articles, All Journals)</i>		
<i>Search terms</i>	<i>Results</i>	<i>Relevant articles</i>
milieu OR residential OR hospital OR institution OR “therapeutic communit*” AND staff OR team OR “staff group” OR “staff team” (in article)	1610	Refined search
“Therapeutic communit*” OR “therapeutic milieu” OR “milieu therap*” OR milieu treatment OR “inpatient therap*” AND staff OR team OR “staff group” OR “staff team” (in article)	263	26
“Therapeutic communit*” OR “therapeutic milieu” OR “milieu therap*” OR milieu treatment OR “inpatient therap*” AND staff OR team OR “staff group” OR “staff team” (in para)	73	37
<i>PsycINFO (limits: English Language, All Journals)</i>		
<i>Search terms</i>	<i>Results</i>	<i>Relevant articles</i>
"Therapeutic communit*" OR "therapeutic milieu" OR "milieu therap*" OR milieu ADJ5 treatment OR "inpatient therap*" AND team OR "staff group" OR "staff team"	395	Refined search
"Therapeutic communit*" OR "therapeutic milieu" OR "milieu therap*" OR milieu ADJ5 treatment OR "inpatient therap*" AND team OR "staff group" OR "staff team" (limit to PsycArticles)	35	12 + duplicates
<i>ProQuest Dissertations & Theses Global (limits: Full text, English language)</i>		
<i>Search terms</i>	<i>Results</i>	<i>Relevant articles</i>
((“Therapeutic communit*”) OR (“therapeutic milieu”) OR (“milieu therap*”) OR (milieu N/5 treatment) OR (“inpatient therap*”)) AND (team OR staff team)	5775	Refined search
((“Therapeutic communit*”) OR (“therapeutic milieu”) OR (“milieu therap*”) OR (milieu NEAR/5 treatment) OR (“inpatient therap*”)) AND (team N5 (conflict OR tension) OR staff N/5 (conflict OR tension))	646	Refined search
ab((“Therapeutic communit*”) OR (“therapeutic milieu”) OR (“milieu therap*”) OR (milieu NEAR/5 treatment) OR (“inpatient therap*”)) AND (team N5 (conflict OR tension) OR staff NEAR/5 (conflict OR tension))	41	3
ab((“Therapeutic communit*”) OR (“therapeutic milieu”) OR (“milieu therap*”) OR (milieu NEAR/5 treatment) OR (“inpatient therap*”)) AND ab(team OR "staff group" OR "staff team") AND (conflict or tension or split* or relationship* or dynamic)	6	2 + duplicates
ab((“Therapeutic communit*”) OR (“therapeutic milieu”) OR (“milieu therap*”) OR (milieu NEAR/5 treatment) OR (“inpatient therap*”)) AND ab(team OR "staff group" OR "staff team")	7	duplicates

The initial search process captured a number of articles which although related (in that they discussed countertransference phenomena with complex clients in psychotherapeutic milieu) were not relevant to this review as they focused on staff-patient dynamics rather than staff-staff dynamics. Results were improved to some extent by using proximity specifiers in search terms.

As these searches began to return a similar set of core articles I began to gain a sense of the emerging body of literature. While these searches revealed some very useful articles, it was apparent that relevant works were likely being missed in such a broad search for the topic. These searches also threw up a lot of irrelevant material and non-psychodynamic material.

It became apparent that the relevant literature almost certainly contained reference to one or more psychodynamic concepts such as “countertransference”, “projective identification”, “splitting”, and “basic assumption group”, and to theorists such as Melanie Klein, Wilfred Bion, D.W. Winnicott, and Thomas Ogden. These keywords were used in addition to “milieu” and its synonymous terms. To further refine this process, terms relating to the client group such as “borderline”, “complex”, “disturb*”, “patholog*” were used in combination with the other keywords. These searches can be seen in Table 2 below.

Table 2

Searches for “milieu” and key psychodynamic concepts

<i>Psychoanalytic Electronic Publishing (limits: English, Articles, All Journals)</i>		
<i>Search terms</i>	<i>Results</i>	<i>Relevant articles</i>
“Therapeutic communit*” OR “therapeutic milieu” OR “milieu therap*” OR milieu treatment OR “inpatient therap*” AND countertransference OR “projective identification” OR split* (in para)	177	29
“Therapeutic communit*” OR “therapeutic milieu” OR “milieu therap*” OR milieu treatment OR “inpatient therap*” AND borderline OR complex OR disturb* OR patholog* OR “special patient” (in para)	225	37
“Therapeutic communit*” OR “therapeutic milieu” OR “milieu therap*” OR milieu treatment OR “inpatient	166	33

therap*" AND Klein OR Bion OR Winnicott OR Ogden OR Main (in para)		
"Therapeutic communit*" OR "therapeutic milieu" OR "milieu therap*" OR milieu treatment OR "inpatient therap*" (in para) AND Klein OR Bion OR Winnicott OR Ogden OR Main (in references)	104	24
"Therapeutic communit*" OR "therapeutic milieu" OR "milieu therap*" OR milieu treatment OR "inpatient therap*" (in para) AND Klein, M OR Bion OR Winnicott OR Ogden OR Main, T (in references)	33	22
<i>PsycINFO (limits: English Language, All Journals)</i>		
<i>Search terms</i>	<i>Results</i>	<i>Relevant articles</i>
"Therapeutic communit*" OR "therapeutic milieu" OR "milieu therap*" OR milieu ADJ5 treatment OR "inpatient therap*" AND countertransference OR "projective identification" or split*	75	21
"Therapeutic communit*" OR "therapeutic milieu" OR "milieu therap*" OR milieu ADJ5 treatment OR "inpatient therap*" AND countertransference OR "projective identification" or split* (limit to PsycArticles)	6	4
"Therapeutic communit*" OR "therapeutic milieu" OR "milieu therap*" OR milieu ADJ5 treatment OR "inpatient therap*" AND borderline OR complex OR disturb* OR patholog*	499	Refined search
"Therapeutic communit*" OR "therapeutic milieu" OR "milieu therap*" OR milieu ADJ5 treatment OR "inpatient therap*" AND borderline OR complex OR disturb* OR patholog* OR "special patient" (limit to PsycArticles)	42	17
"Therapeutic communit*" OR "therapeutic milieu" OR "milieu therap*" OR milieu ADJ5 treatment OR "inpatient therap*" AND Klein, M OR Bion OR Winnicott OR Ogden OR Main, T	132	21
<i>ProQuest Dissertations & Theses Global (limits: Full text, English language)</i>		
<i>Search terms</i>	<i>Results</i>	<i>Relevant articles</i>
ab(milieu OR residential OR hospital OR institution OR "therapeutic communit*") AND ab((team OR staff)) AND ab(("projective identification" OR splitting))	8	duplicates
ab(("Therapeutic communit*") OR ("therapeutic milieu") OR ("milieu therap*") OR (milieu NEAR/5 treatment) OR ("inpatient therap*")) AND ab((team OR staff)) AND ab(("projective identification" OR "splitting"))	2	duplicates

These searches revealed the main body of literature that was reviewed. Eventually, my searches would consistently return the same key articles which indicated that the search process was near completion (Aveyard, 2010).

My final searches were for texts that referenced “The Ailment” and *The Mental Hospital*. As many of the previous relevant search results had referenced these articles I hypothesised that if my previous searches were on target there should be few new results obtained by searching references for these seminal texts. I found indeed that there were some new texts but most of the results were duplicates or not actually relevant to the study. These searches are illustrated below in Table 3 and Table 4.

Table 3

Texts referencing “The Ailment”

<i>Psychoanalytic Electronic Publishing (limits: English, in references)</i>		
<i>Search terms</i>	<i>Results</i>	<i>Relevant articles</i>
“The Ailment” AND Main	86	20
<i>PsycINFO (limits ‘All journals’ and ‘English’)</i>		
<i>Search terms</i>	<i>Results</i>	<i>Relevant articles</i>
"The Ailment".cv. and Main.cu.(cited title reference, cited author reference)	84	15
<i>ProQuest Dissertations and Theses (limits: English)</i>		
<i>Search terms</i>	<i>Results</i>	<i>Relevant articles</i>
CTI("The Ailment")	10	duplicates

Table 4

Texts referencing “The Mental Hospital”

<i>Psychoanalytic Electronic Publishing (limits: English, in reference)</i>		
<i>Search terms</i>	<i>Results</i>	<i>Relevant articles</i>
“The Mental Hospital” AND Stanton Schwartz	42	4 + duplicates
<i>PsycINFO (limits ‘All journals’ and ‘English’)</i>		
<i>Search terms</i>	<i>Results</i>	<i>Relevant articles</i>
"The Mental Hospital ".cv. and stanton schwartz.cu. (cited title reference, cited author reference)	10	duplicates
<i>ProQuest Dissertations and Theses (limits: English)</i>		
<i>Search terms</i>	<i>Results</i>	<i>Relevant articles</i>
CTI("The Mental Hospital ")	10	1

The majority of literature found was in the form of articles from the database. However five books were also located. As my topic spans 60 years of literature many articles were unavailable from the databases and several journals were out of print. I used

the AUT library interloan system to request 17 articles that were unavailable on the database and checked them for relevance.

As I searched, I continued to find other key texts through reference lists, as well as texts suggested by my supervisor and colleagues.

Selection of studies for inclusion

The goal of this part of the process is to gather data that is rich and descriptive and illustrates my topic intensely (Morrow, 2007, p. 216). In contrast to a systematic literature review which aims to exhaustively search every piece of literature on a topic, an interpretivist approach to the data set uses the criteria of “redundancy of data and theoretical saturation” (Morrow, 2007, p. 217). This implies that while systematic searches are employed, new data is not added when all categories or themes are accounted for and the complexity of the topic has been illustrated.

This study reviews psychodynamic literature as the purpose of the review is to identify and synthesise the diverse but related literature on staff relationships within psychotherapeutic milieux, the various determinants of them, and the interrelationship with treatment practices and client outcomes. This body of literature is informed by psychodynamic perspectives. The review also considers research on systems theory, and organisational and social dynamics where this is integrated with the psychodynamic literature and meets the other inclusion criteria. However, a full review of the literature linking neuroscience or systems theory with psychodynamic literature is beyond the scope of this project. Although most of the literature in this review is theoretical or clinical material, some contemporary psychodynamic writers have conducted qualitative research or outcome studies, or have integrated psychoanalytic theory with empirical research. This literature was also included.

Other inclusion criteria were that the literature must pertain to an inpatient, residential, therapeutic community or therapeutic milieu setting; that it must pertain to a complex client group within such a setting, including addictions, eating disorders, personality disorders, forensic inmates, prison inmates, trauma survivors, disturbed children and adolescents; and that the literature refers to a team of clinicians within such a setting.

It can be argued that these same dynamics are relevant to any mental health service, including community mental health teams (Griffiths & Hinshelwood, 1997). However, as these services do not involve a residential therapeutic milieu as such, they are not included in this review. Similarly, literature related to individual therapy, despite some useful material in terms of countertransference and projective identification, was excluded as it yielded a body of literature too large to be realistically dealt with in this review.

Literature in languages other than English was excluded from this study. Within the field of organisational and social dynamics, texts were limited to those that dealt explicitly with residential mental health organisations or psychotherapeutic milieu settings.

Texts were excluded when one of the main search concepts (staff relationships, milieu setting, complex client group, patient outcomes) was absent. For example, where the text focused on a therapeutic dyad or focused on staff-client relationships but did not discuss staff-staff relationships it was excluded.

Texts which did meet the criteria but only gave a passing mention to staff relationships or communication were excluded as they do not contribute anything new to the discussion.

Articles returned in the search process, after being refined to reasonable numbers by reading the abstract, were then read to determine relevance. The final result was that 87 articles, books and book chapters were included in this review.

Critical appraisal of included studies

As discussed above, a preliminary reading and re-reading of the material was undertaken to determine the relevance and quality (Aveyard, 2010), as well as to become familiar with the body of literature as a whole and its broad subject threads and themes. This reading also assisted in formulating the structure of the review. The next step was a close and detailed reading of each paper and book chapter. Throughout this process I took detailed notes utilising software designed for note taking and archiving. Many of the articles pertained to only one chapter of the review, while others were relevant to more chapters.

The articles were then reviewed to explore in detail the various determinants of staff relationships and the interface of staff relationships with client care. As I became more familiar with the literature the array of topics within the broad chapter areas emerged and the various sub headings of the chapters were arranged thematically.

Bringing the literature together

In reviewing the literature it became apparent that there was a great deal of material relevant to Chapter 3, team countertransference to clients. Some of this material helped define the key concepts and some added to the wealth of case study material on this topic. The literature was arranged thematically to show the range of issues that emerge from team countertransference to clients within the therapeutic milieu. Significantly less material was retrieved for Chapter 4 relating to the unresolved psychological material of teams. However, again the material was reviewed thematically as a number of areas of interest emerged. Chapter 5 followed the same pattern, with several topic subsets relating to the main topic of organisational factors impacting on team dynamics.

Throughout the review process it became apparent that some of the topic areas related to more than one of the chapters; for example literature which discussed clients' projective identifications triggering latent conflict in teams was clearly relevant to both

Chapters 3 and 4. Similarly, the interface between client and organisational pathology related to both Chapters 3 and 5. It became clear that the final chapter would include a discussion of these areas of interface.

Finally, Chapter 6 synthesises the three bodies of literature and evaluates the significance of the research for psychotherapeutic milieux. It evaluates and synthesises the literature related to the topic as a whole, showing overlaps and gaps, implications and limitations. This includes an exploration of how the findings could be useful for current services. A set of key recommendations related to education, training and clinical supervision was developed. Future research opportunities were also identified (Aveyard, 2010).

Technical issues

I will use the first person form throughout this research as recommended by *The Publication Manual of The American Psychological Association* (American Psychological Association, 2010).

Many therapists and writers today use the word ‘client’ to describe the person who receives psychotherapy or counselling. Others use the word ‘patient’, particularly in the psychoanalytic literature. In addition, much of the literature in this review dates from the mid-20th century where the term ‘patient’ was the norm. I therefore use the words ‘patient’ and ‘client’ interchangeably in this review.

The words psychoanalytic and psychodynamic are also used interchangeably throughout the review.

Summary

In this chapter I have discussed the underlying theoretical foundations of the review in terms of the epistemology and theoretical position. I have outlined my process of identifying the research question and a critical review of the literature as the appropriate

methodology to answer this question. I have detailed the rationale and process involved in selecting databases, searching key words, including and excluding literature, and reviewing the literature.

In the following chapter I review the literature relating to team countertransference within psychotherapeutic milieu settings. This will include a brief outline of key concepts and reviewing the theoretical literature on the general topic as well as the literature relating to countertransference to specific client groups.

Chapter 3: Team countertransference to clients

The therapist's dictum to 'monitor one's countertransference' becomes a more daunting enterprise when the 'therapist' in question may be a hydra-headed treatment team with innumerable countertransference reactions in the heads of each of its members. (Eisenberg, 1997, p. 237)

In this chapter I describe the context of this review in terms of the key psychodynamic concepts which underlie this body of literature. I then review the literature relating to staff countertransference in psychotherapeutic milieux, including that with specific client groups, and I explore the effects on clients.

Conceptual context of the literature

The key concepts informing the literature reviewed in this chapter were originally developed by Melanie Klein, Wilfred Bion and Donald Winnicott. Central to these concepts is the idea that the internal world of the person can create a distortion of both the self and of the outer world (Heede, Runge, Storebø, Rowley, & Hansen, 2009).

Below I provide a succinct summary of these core concepts in order to set the scene for my review of a body of literature in which these concepts are explored in relation to staff dynamics in residential settings.

Transference and countertransference

Transference can be defined as: "the displacement of patterns of feelings, thoughts and behaviour originally experienced in relation to significant figures during childhood, onto a person involved in a current interpersonal relationship" (Blum & Goodman, 1995). Due to the severe psychopathology usually treated in milieu settings intense transferences naturally occur there, and staff are the external objects available to patients "whose internal object constellations are contradictory, untenable and self-alienating" (Whalley, 1994, p. 458).

Countertransference was originally conceptualised by Sigmund Freud as the therapist's unconscious reaction to the patient's transference. This concept regards countertransference reactions as arising from the therapist's unresolved conflicts and as problematic to the therapy (Blum & Goodman, 1995; Kernberg, 1975). Contemporary psychoanalysis regards countertransference as an interpersonal, jointly created phenomenon. The task of the therapist is, therefore, to assess which aspects relate to his or her own personality and which to the patient's internal object world (Blum & Goodman, 1995; Gabbard, 2000). Countertransference is generally regarded as a valuable technical instrument that may give "the most meaningful understanding of what is central in the patient's chaotic expression" (Kernberg, 1987, p. 40).

This also applies in treatment milieux where countertransference is characterised as "the strongest tool available to the treatment team" (Whalley, 1994, p. 458). Norton and Bloom (2004) illustrate countertransference in terms of the difficult part of therapeutic community work that includes dislike of clients, disappointment with oneself and disagreement between staff members over clients, "all of which, if sought to be understood, can shed light on the internal world of the client" (p. 257). Collie (1996) adds that milieu staff frequently go to work with a feeling of dread, wondering what, of their patients' traumatised feelings, they will be "forced to feel" (p. 131). Eisenberg (1997) cautions that "when one adds to the multitude of emotional reactions to any patient the multitude of staff reactions to other staff members, one has an exceedingly complex web in which treatment is to take place" (pp. 237-238).

Splitting

Melanie Klein (1946) states that "object relations exist from the beginning of life, the first object being the mother's breast which is split into a good (gratifying) and bad (frustrating) breast; this splitting results in a division between love and hate" (Klein, 1946, p.

99). Klein proposed that, as a developmental necessity, the infant needs to keep good experiences of other apart from the bad in order to preserve the good, around which the ego can develop and become able to integrate the good and the bad into whole objects (Gabbard, 1989; Klein, 1946). Severe psychoses later in life may occur if this cannot be achieved (Klein, 1946, pp. 99-100).

Gabbard (2000) describes the therapeutic milieu as advantageous for patients who use splitting as a primary defensive operation, where the patient's self and object representations are externalised simultaneously onto various staff members. This dynamic serves as a "superb diagnostic and therapeutic tool for understanding the process of splitting" (p. 156). Another key feature of splitting in the therapeutic milieu, and linked with the concept of projective identification, is that staff members respond to the patient as if they "actually were the projected aspects of the patient" (Gabbard, 1989, p. 446). As a result, staff assume highly polarised positions in discussions about the patient, defending these positions vehemently.

Gabbard (1989) highlights the misuse of the term 'splitting' in recent times, citing its use as a pejorative term for ascribing blame to the patient for conflict among staff, for example, referring to a patient as a 'splitter'. He argues that this has weakened an extremely valuable concept and emphasises that the term 'splitting' should be reserved for situations in which intrapsychic and interpersonal splitting occur simultaneously, recreating the patient's internal object world in the milieu.

Projective identification

The concepts of splitting and projective identification are interrelated; projective identification is "the vehicle that converts intrapsychic splitting into interpersonal splitting" (Gabbard, 1989, p. 446).

Melanie Klein (1946) introduced the concept of projective identification as being of "vital importance for normal development as well as for abnormal object relations" (p. 103).

In this psychological process “the infant’s ‘bad’ parts are split off and projected into another person in an effort to rid the self of one’s ‘bad’ objects which threaten to destroy oneself from within” (Ogden, 1979, p. 364). The bad parts can be kept at a safe distance where the infant maintains contact with those projected aspects as well as with the person he projected them into.

In Ogden’s (1982) definition of projective identification, the projector projects a self or object representation into another person then exerts interpersonal pressure on the recipient to experience feelings congruent with the projection. If the recipient can psychologically process the projection it can be reintegrated by the projector in a modified form.

In the projective identification process in the therapeutic milieu a team member may take the role of the patient’s self or object representation, evoking either a complementary or concordant countertransference to the patient (Gabbard, 1986; Kernberg, 1973). At any given time, projections may be taken up by some members of the team and not others; hence the importance of the entire staff group paying attention to countertransference responses within the team (Bateman, 1995).

Stamm (1995) uses the term ‘countertransference madness’ to describe the effect of projective identification on teams whereby splits in the patient’s psyche are transposed into patient-staff and staff-staff relationships. He cites the patient’s different perceptions and responses to different team members as a result of split or fragmentary object relations, and staff members subsequent ‘living out’ of projected aspects of the patient.

Akhtar (1991) points out that due to the patient’s experience of having internalised the objects of a disturbing and cruel family of origin, projective identification is commonly viewed as involving only “undesirable self-representations riddled with anxiety, anger, inferiority, inadequacy, confusion etc.” (p. 1407). However, a patient may also project endangered, healthy aspects of himself into the therapist, such as love, vigour, hope and

authenticity, admiring and idealising the therapist who in turn, may feel alive, competent and hopeful for the patient (Akhtar, 1991, p. 1407).

I now commence my review of the literature that utilises the above core concepts in exploring staff relationships in therapeutic milieux. I begin this with Tom Main's (1957) article "The Ailment", the seminal paper on this topic.

"The Ailment"

In "The Ailment", Main (1957) describes in detail the types of psychological phenomena that were evoked in the staff of a psychiatric therapeutic community, Cassel Hospital. Main's work necessitated a close examination of what was occurring in the wards and an honest inventory from the staff of their thoughts and feelings regarding their patients.

Main (1957) found that certain treatment practices and staff conflicts were the product of staff members' unbearable and previously unspoken feelings aroused by working with the most complex and disturbed clients. He gives the example of sedation of patients which occurred "*no matter what the rationale was* [italics added] when the nurse had reached the limit of her resources and was no longer able to stand the patients' problems without anxiety, impatience, guilt, anger or despair" (p.13). When the nurses became aware of this pattern and allowed themselves to voice their negative feelings toward patients they became more able to tolerate these feelings and the incidence of sedation "slowly dropped almost to zero" (p.14). Concurrently, the patients' reported feeling more understood and calmer, and they asked for sedatives less often.

Main (1957) describes several "special patients" treated at Cassel Hospital, most of whom had received a number of previous treatments and had not improved, but got worse. Their treatment at the Cassel had closely coincided with experienced nurses experiencing severe strain, almost to the point of breakdown. Each of the nurses had nursed one of these patients, going beyond the duty of care, and had felt that the patient's lack of progress was

her failure. The nurses also experienced a desire to blame a colleague for the patient's lack of progress. In order to investigate this phenomenon Main and his team agreed to meet twice weekly to discuss all the nursing failures, slowly discovering "the potency of group discussion as an instrument of research into relationships with patients" (p. 16). After speaking of patients' psychopathology the team began to speak of their personal feelings regarding these patients. The group stayed with the difficult process for over a year to eventually reveal "private ambitions, omnipotent therapeutic wishes, guilts, angers, envies, resentments, unspoken blamings, alliances and revenges, moves towards and against other nurses, doctors, and patients' relatives" (p. 16). Main names the team being astonished at the amount of feeling and social interaction that was evoked in the staff caring for these patients. He articulates the clear gain of the exercise for his team, who "arrived not only at an increased capacity to recognize insincerities in their daily work, but at personal easement in it. They became less afraid of difficult situations and surer at their craft" (p. 19).

Much of the associated literature since 'The Ailment' (Main, 1957) explores similar themes in which "a high degree of collusion with the patient's psychopathology by the therapeutic team determines first a therapeutic stalemate and then a malignant escalation of disturbance in both patient and staff, which leads to negative and sometimes dramatic outcomes" (Chiesa, 1989, p. 156). Stanton and Schwartz's (1954) early research also revealed that unacknowledged conflict between staff can induce and perpetuate patient disturbance, which would then dissipate when staff conflict was acknowledged and resolved.

Power of the milieu setting

Several features of the milieu can be seen to magnify countertransference, and may either foster or work against its use as a therapeutic tool. These include: the requirement of 24 hour care; a number of patients living together; a high degree of psychopathology; new mental structures evolving more quickly than in individual therapy; that milieu therapists

often receive less training and less recognition than individual therapists; and that 'action' is a primary therapeutic modality in the milieu, putting more demands on the therapist's observing ego (Szajnberg, 1985). Szajnberg also cites patients' greater dependence on the milieu therapist and feelings of greed, guilt and fear of disappointment as contributing to more intense countertransference. Corresponding feelings in the therapist include rescue fantasies, guilt, depletion and emotional distancing.

Chiesa (1989) regards the milieu as providing a strong container for patients' disturbances but also as confronting the patient with "conflictual situations in his everyday life, in addition to the dynamic work in the formal psychotherapy in which early anxieties and fears are unburied" (p. 162). In this climate, the patient's responses to anxieties are likely to include the primitive defences of intrapsychic and interpersonal splitting and projective identification.

Action instead of thought

Skogstad (2006) identifies that a common feature for clients with serious personality disorders is the use of action instead of thought: "the mind is actively being rid of thoughts or feelings that, if kept inside it, are experienced as too painful and intolerable" (p. 162). Often the thoughts and feelings are manifested as violence toward self or others but may take the form of projective identification, where not only is the belief held that the thoughts or feelings belong to the other, but real actions are taken "whose unconscious aim is to push disturbing thoughts and feelings into other people who are used as receptacles for the disturbing contents of the patient's mind" (p. 162).

Skogstad (2006) argues that the tendency to use violent projective identification and destructive behaviour correlate with very low ego strength which necessitates greater containment than can be provided by most outpatient settings; thus, residential treatment is often indicated. The aim therefore is to help patients translate action into thinking and feeling.

In a milieu setting different staff groups are experienced differently by patients (Skogstad, 2006). For example nurses in a psychosocial role in a psychiatric hospital may encourage patients to rise to their adult parts of themselves, challenging and confronting behaviour, and are often resented by residents who wish to regress and withdraw. The literature emphasises that staff working in a psychosocial role need considerable support to contain the despair, anxiety and fury they routinely encounter in their work and to understand the mutual enactments into which they are drawn (Griffiths & Hinshelwood, 1997; Hinshelwood & Skogstad, 2011; Skogstad, 2006).

Skogstad (2006) gives the example of a suicidal client who had primary therapeutic relationships with a psychotherapist and a nurse on the team. In supervision it emerged that the nurse had for some time felt unable to help the patient who relentlessly verbally attacked her. The nurse felt so ashamed of her 'uselessness' she had not spoken about it to anyone and had avoided contact with the psychotherapist. The psychotherapist reported feeling extremely anxious about the client's graphic, sadistic reporting of suicidal thoughts and about the patient's extreme fears that the psychotherapist was talking about her with the nurse. In supervision both clinicians were able to make sense of their intense feelings in terms of the client's early object relations. The nurse was identifying with a split off fragment of the client's younger self, traumatised and despairing that anyone could help her, while the psychotherapist was experiencing his patient's early anxiety and helplessness when faced with the cruelty of her parents. The psychotherapist's and nurse's lack of communication was understood in terms of the patient's terror at her parents coming together where they would mock her or fight with each other. This case study attests to the powerful feelings experienced by clinicians in such a situation as well as how difficult it is for clinicians to individually make sense of what is happening.

The inevitability of team members participating in clients' projective processes is highlighted by Griffiths and Hinshelwood (1997). They describe working with splitting and projective identification in the therapeutic milieu as "a set of cycles, moving from action, to reflection and understanding, and then back to actions – a form of psychodynamically informed action learning" (p. 12). They argue that this repetitive cycle of enactment and making sense may gradually help patients towards integration and the ability for self-reflection.

The Oedipal couple

Client response to a therapeutic couple within a therapeutic milieu, and subsequent enactment of an Oedipal dynamic, is a theme in the literature as in the example of the suicidal client given by Skogstad (2006) above. Hinshelwood and Skogstad (2011) observe that in the case of two staff members working closely with a patient, some patients will phantasise that everything about them is passed between the two and feel omnipotently in control of this process. Others will feel excluded from the 'intercourse', arousing hatred and envy. The pressure for certain things to be kept confidential may represent the patient's need to keep things away from an enquiring part of his own mind. It may also represent a wish to keep the Oedipal couple apart if the link is unbearable to them. Others behave as if there is no link at all between the therapists in denial of the Oedipal configuration and can experience it as a catastrophe if the link comes into awareness (Hinshelwood & Skogstad, 2011, p. 68).

Bateman (1995) also refers to the Oedipal couple in describing Winnicott's (1971) concepts of 'being' and 'doing' as the key theoretical concepts in work with borderline clients. He conceptualises the 'being' and 'doing' aspects as the parental couple, and links this concept with the idea that patients with severe personality disorder, especially borderline patients, tend to "split the creative parental couple through their enactments with therapists, groups and institutions" (p. 13). He highlights the importance of a "third object" to maintain a

balance between 'being' and 'doing', envisaging this as structures within the organisation such as supervision, liaison with other staff groups, and liaison amongst the team as a whole.

Client transference to the organisation as a whole

Dr Stuart Whitely (1969) identified that the therapeutic community as a whole can be conceptualised as a "corporate transference figure" (p. 147). He discusses the difficulty young, sociopathic residents face in forming relationships with individual therapists and notes the tendency of such patients to both idealise and devalue the community. For example, initial idealisation of the community is apparent in the taking up of the culture and language, but this may soon give way to protest, hostility, disregard for rules, and devaluation of staff and other clients. At this point the beginning of a more real relationship emerges between patient and the community (Griffiths & Hinshelwood, 1997; Whiteley & Foulkes, 1969).

Hinshelwood and Skogstad (2011) discuss this more deeply, exploring the role the hospital takes in the mind of a patient and how this is played out in the hospital. They suggest that "the patient projects his internal objects and object relationships into various parts of the hospital and by way of re-introjection creates a 'hospital in the mind' which reflects his own inner world" (p. 61). The functioning of the hospital is, therefore, interlinked with and influenced by the 'hospital in the mind' held by both staff and patients. The patient develops phantasies about the relationships between staff members who may represent, for example, the Oedipal couple, or the splits in the patient's mind. Actual relationships between staff may be influenced through projective identification of the patient's internal objects and the relationships these internal objects have with each other (p. 67). The authors emphasise that the integrating function of the staff is vital; that they first need to integrate the split off projections in their minds as a team in order to enable the patient to do the same.

Services on the brink of destruction

Unconscious dynamics in milieux may, if they remain unnoticed, hidden or unresolved, escalate to the point of total breakdown of a service. Several more contemporary authors refer to consultation services being requested near the point of service collapse (Briggs, 2004; Collie, 1996; Novaković, 2002). Briggs (2004) describes a typical experience of a team at a boys' home which was almost at the point of closure when he began working with the staff. The clinical team was in a siege mentality and no longer able to think in terms of their training. The boys' behaviour was increasingly out of control and they had begun setting fires on the premises. Briggs worked with the multidisciplinary team who did not have a background in psychodynamic theory and who were extremely resistant to his approach to exploring unconscious dynamics in the team and between the team and patients. It took the group many months of painful, resistant, angry work to understand that their enactments were in a parallel process with those of the boys, who were communicating their painful experience of deprivation to the staff (Briggs, 2004).

Team countertransference with different client groups

It is hypothesised that the central affect constellations of various character organisations leads to various characteristic countertransferences as a result of projected self or object representations. For example, Akhtar (1991) observes that narcissistic patients project inferiority and shame laden self-representations onto others, causing them to experience the same feelings. On the other hand, schizoid individuals commonly project "optimistic and sane attributes into the other for safekeeping, mobilizing optimism, hope and rescue fantasies" (p. 1407).

Colson et al. (1986) found that different forms of psychopathology elicit different emotional reactions among different disciplines, contributing to conflict in multidisciplinary teams. Violence and agitation in patients was associated with helplessness for psychiatrists,

fear for social workers and nurses, and anger for activity therapists. An extra complication is that working with severely disturbed people tends to generate “intense psychotic like anxieties” (p. 923), further contributing to difficulties for teams.

Borderline patients

Much has been written about countertransferential reactions to patients with borderline personality disorder (BPD). It can be argued that most of the literature reviewed here refers to client groups with a borderline personality organisation (Kernberg, 1967) whether or not they are diagnosed with BPD. Much of what has already been written concerning the effect of intrapsychic splitting and projective identification in teams refers to such clients. Kernberg (1965) observes that borderline or psychotic patients tend “by their intense, premature, and rapidly fluctuating transference, to evoke intensive countertransference reactions in the therapist” (p. 40).

Gabbard (1989) outlines a common dynamic of splitting in a residential treatment for patients with BPD, where the primary therapist is idealised by the patient and other staff viewed as punitive figures. The patient withholds information from the therapist, who is not aware of the patient’s problematic day-to-day interactions and reacts with disbelief when told about them by other staff. The staff may in turn view the therapist with disdain, excluding him from the group, projecting “badness and incompetence” (p. 447) onto him. If the process continues, the split, as with the patient’s internal objects, cannot be integrated, leading to disastrous consequences for both patients and staff.

Brown (1980) highlights both the usefulness of the milieu for borderline patients as well as its potential iatrogenically destructive effects if countertransference reactions are not properly addressed. McCready (1987) specifically discusses the collective countertransference phenomenon that he terms ‘milieu countertransference’ with borderline patients, describing how the team as a whole, mirroring the internal processes of the clients,

regresses in functioning, taking on the functional characteristics of borderline personality organisation itself. The task of the inpatient team, therefore, to utilise the countertransference for the patient's benefit is "an intricate and complex task unparalleled in outpatient treatment" (McCready, 1987, p. 720).

The VIP syndrome

Weintraub (1964) contrasts what Main calls the 'special patient', who evokes contrasting countertransferences within the team, to the VIP patient. This type of patient tends to be regarded negatively by the whole team who resentfully hold management responsible for the patient gaining entry to the service under special privilege. Often all involved act only out of a sense of obligation, using the client "as an object to be bartered for future favours" (p. 188). The VIP patient seems to be of primarily narcissistic character pathology and the common countertransference of the staff team is the desire to expel the client. Therefore, the re-enactment of the client's early experience of being used as a narcissistic extension is frequently played out. The client usually leaves the service prematurely to the relief of all concerned, and is often at high risk of suicide.

Similarly, Kernberg (1987) refers to the unsuccessful treatment of two patients who were "surrounded by a VIP quality climate" (p. 176). They both came from wealthy and influential families who exerted pressure on the hospital system. He discusses the concordant and complimentary countertransferences evoked in different members of the hospital system, resulting in large group processes including conflict between members of the hospital hierarchy and between the hospital and another agency involved in the care of the patients. He concludes that the hospital milieu strikingly replayed the pathological family dynamics of the patients, eventually resulting in their leaving the hospital without improvement, their object relations and family relationships having been recreated in the drama between staff groups or between clinicians and managers.

Adolescent client group

A typical countertransferential dynamic in an adolescent unit is described by Halton (1994) where staff play out the conflicting needs of the adolescent for independence and for limits. This manifests in a parallel process of staff breaking the rules and challenging management's authority.

Similarly, Cregeen (2008) discusses the guilt, helplessness and fury that staff experience in working with adolescents who have experienced familial and societal failures. Staff often see themselves in a rescuing role but the transference of the patients recreates them into failed parental figures. He notes that often the staff will split off this aspect and project it outwards to the patients' parents, their own colleagues and managers, to social services and to the team consultant.

Substance dependent clients

Moylan (1994) discusses addicts' inability to tolerate the reality of the damage caused by their use of drugs and the lifestyle needed to maintain their addiction. The internal and external chaos is defended against by an "assault on truth and reality" (Moylan, 1994, p. 56) which in turn affects the staff who constantly experience doubt, uncertainty, guilt, anger and internal chaos, mirroring the internal state of the client. She notes the extreme difficulty involved in being aware of these emotional states, understanding them and remaining professional.

Moylan (1994) observes that staff are frequently pulled to use the same defences as the clients. She gives the example of the staff at a drug dependency clinic who projected feelings of helplessness and incompetence onto the management, blaming and resenting them for their difficulties. She describes staff as being "angrily dependent" (p. 58) on management. As staff became aware that they were caught up in a projective identification with their clients they were able to assume more self-responsibility and function more efficiently and

creatively. Similar issues are discussed by Kaufman (1992) who observes parallel process, co-dependence, denial, enabling, burnout, and family of origin issues among staff working with substance dependent clients.

Suicidal clients

Working with suicidal patients inevitably arouses strong feelings in clinicians. Hamilton (2004) describes staff experiences in a therapeutic community during and after a patient completed suicide, with a particular emphasis on the shifting and unprocessed nature of their feelings and an unwillingness to talk about them; like the patient wanting to escape uncomfortable feelings rather than talk about them.

Similarly, in their discussion of hate in the countertransference with suicidal patients, Maltzberger and Buie (1974) argue for clinicians processing their feelings, in this case by bringing hate into consciousness, as unconscious hate may generate “well rationalized but destructive acting out by the therapist” (p. 625). They encourage therapists to become comfortable with countertransference hate by acknowledging it, bearing it and putting it into perspective.

Psychotic patients

Jagarlamudi, Portillo, and Dubin (2012) discuss countertransference responses to violent and psychotic patients in the residential setting, noting that they may induce feelings of inadequacy, helplessness, anxiety and anger. They give the example of a psychotic patient whose behaviour was misinterpreted as defiance leading to a misdiagnosis of personality disorder rather than psychosis. The authors relate this to countertransference reactions of helplessness, fear and anger in the psychiatrist which went unchecked by the team. They conclude that a psychodynamic perspective is necessary in order to temper unchecked countertransference among clinicians and other staff.

A case study by Bell (1997) also illustrates the strong countertransference evoked by psychotic clients. In this case, a group of nurses of a suicidal psychotic patient “pursued, trapped her, and then watched her every movement in an atmosphere of increasing malevolence and hostility” (p. 12). The behaviour of the primary nurse was interpreted as a defence against her belief that she was totally responsible for the patient and would be condemned by the organisation if the patient harmed herself. Bell describes the internal world of the psychotic patient is typified by a mafia-like superego, omnipotent and persecutory, which “knows no doubt and opposes thought and development” (p. 11). The primitive dread of ‘not knowing’ can pervade the environment around the patient whereby staff members may respond with increasingly authoritarian and irrational interventions.

Intense Team Dynamics

Main (1957) originally explicated conflict in teams in detail, showing how splits in the patient's mind are relived as divisions among the staff. Bell (2001) writes of one ‘saintly’ group of staff who see the patient as a victim of early relationships, being drawn to soothe him, and a counterpart group who see the patient as manipulative and attention seeking, believing he should be confronted.

Kernberg (1973) however, suggests that if the staff team can stay neutral they can gradually reduce intrapsychic conflict by clarifying and modifying the client’s primitive object-relationships. His concept of a ‘neutral’ hospital atmosphere derives from Anna Freud's (1946) concept of the technical neutrality of the psychoanalyst which implies a potential alliance with the patient’s observing ego. However, this possibility of neutrality has been critiqued by Auerhahn and Moskowitz (1984) who view it as unachievable and as preventing a realistic examination of the complex patient-staff interactions that are inevitable in inpatient therapy. Griffiths and Hinshelwood (1997) also discuss the inevitability of

countertransference enactments between the team and the client and that these enactments, when they can be examined and resolved within the team, are a vital part of the clinical work.

Kurtz and Jeffcote's (2011) work also explored the enmeshed and highly charged relationships between staff in residential settings. They examined the relationship between aspects of staff experiences influenced by the organisation and aspects resulting from the nature of the clinical task and contact with patients. Support within the team was named as extremely important and the absence of support felt to be "almost unbearable isolation" (p. 253). Lack of emotional safety in professional relationships was a major theme; staff members feeling unsafe to speak in meetings, along with fear of losing a positive team image or support system.

Lakovics (1985) and Lindbom-Jakobson and Lindgren (1997) also explore responses to transference dynamics. For example, Lakovics suggests that staff burnout and apathy can be a result of unchecked countertransference reactions while Lindbom-Jakobson and Lindgren name that clinicians can unconsciously use patients in their relations with one another. Savage (1961, cited in Jagarlamudi et al., 2012) notes that clinicians may try to avoid countertransference feelings through a number of means including withdrawal, acting out, excessive mothering, and application of authoritarian measures. Jagarlamudi et al. (2012) also cite work by Rumgay and Munro (2001) who list other defensive reactions to countertransference, including distancing from or discharging a patient, withholding help or direction, and attributing all the patient's behaviour and problems to the patient.

Healing conflict in teams: Education, supervision, reflective space

Many writers emphasise the importance of staff having the training and space to explore their personal reactions to clients and the ways in which team dynamics can shed light on client dynamics. Moylan (1994) suggests that any member of a team can develop their capacity to stand back from a situation and use their feelings to understand what is

happening within the team. In contrast, Cregeen (2008) emphasises the role of the supervisory consultant who can be like a therapist to the staff group. He identifies this as process consultancy, as does Obholzer (1994a), and contrasts this with consultation oriented to case-based advice which remains separate from the team's relational processes. Cregeen (2008) emphasises that "the team need the consultant in order to understand the nature of their anxieties and conflicts, bear the negative transference and retain a sense of hope" (p. 174).

Establishing a team environment where such reflection is possible is not necessarily easy. In "The Ailment" Main (1957) describes the process of developing staff meetings to discuss the team's feelings about patients as extraordinarily difficult. The staff group took several months to develop trust in each other and some staff members refused to take part. Eventually, painful splits were brought into the open and resolved. Stamm (1985) supports this, arguing that the sine qua non of milieu treatment is a climate where staff members feel comfortable enough to risk self-disclosure (p. 435). He suggests routine review of countertransference in staff meetings, highlighting that the more emotionally toxic a patient is, the more important it is that staff can neutralise their feelings through team discussion. For example, at the Cassel Hospital, daily team meetings allow the clinicians to "understand the internal drama instead of being caught up in an external one" (Skogstad, 2006, p. 163). Hinshelwood and Skogstad (2002) and Dowling (1998) also stress the importance of these meetings at Cassel.

Colson et al. (1986) argue that inpatient treatment should always include educating staff members to help them to identify and understand the array of work-related personal reactions, and how to use these reactions to understand patients. Similarly, but more specifically, Book et al. (1978) suggest employing a psychoanalytic, object relations framework for understanding patients and putting in place an in-service teaching programme

to keep up to date with psychoanalytic understanding of borderline personality organisation. Brown's (1980) strategies for working with countertransference in a team include daily multidisciplinary meetings to discuss countertransference with all staff involved in patient care, and similar weekly meetings between primary staff working with a patient.

Main (1989a) sees the maintenance of a "culture of enquiry" (p. 136) as central to the therapeutic community. He describes this as a process of thinking in an ongoing way about the dynamics of the whole culture of the hospital, as represented by patients and staff. This culture of enquiry is difficult to sustain against the constant pressure of mutual projections and the tendency to turn creative thoughts into ritualised practice.

Discussion and critique

The premise of the literature reviewed in this chapter was of team conflicts originating with the patient and being played out by staff groups, via the primitive defence mechanisms of splitting and projective identification, with often highly destructive results for the teams and for patients. Initially expressed by Tom Main in *The Ailment* in 1957, similar types of experiences have been described in the clinical literature over the last 60 years. This has been further refined and added to by later writers, for example, further conceptualisation of "action vs thought" (Skogstad, 2006), parallel process (Briggs, 2004) and in terms of different client groups (Cregeen, 2008; Moylan, 1994).

The idea of unconscious processes being at the heart of life in the therapeutic milieu would not in itself be a surprise for psychotherapists today. However, it should not be taken as a given that psychotherapists and especially non-psychodynamically trained members of a multi-disciplinary team would be familiar with the phenomena of splitting and projective identification in milieu environments. I would suggest that few people are exposed to such phenomena before being employed in a milieu and most people would be underprepared for the experience. In addition, Szajnberg (1985) highlighted that milieu work has increased in

intensity in recent years and the relative lack of training of milieu therapists as compared to individual therapists, and Briggs (2004) discussed the difficulty faced by multidisciplinary milieu teams. Therefore, the conceptualisation and discussion of such clinical experiences remains immensely valuable to milieu clinicians. It is apparent from the literature that no matter how experienced the clinician, the phenomena of splitting and projective identification remain powerful and distressing. Further, teams are required to make extraordinary efforts to preserve their cohesiveness in such environments.

A critique of the literature reviewed in this chapter is that the contribution of the psychic material of the clinician and the teams was notable by its absence. Staff were seen to live out aspects of their patients' inner worlds and their own psychological material and unresolved conflicts were minimised in the countertransferential enactment (McCready, 1987). This conveys a quality of separation on the part of the clinicians, which is reflective of the object relations theoretical position in the literature which holds to the view of the self as individual and discrete. This could be critiqued from an intersubjectivist stance which argues that rather than the individual, isolated self the emphasis should be put on the "fully contextual interaction of subjectivities with reciprocal mutual influence" (Mitchell & Black, 1995, p. 167). Nevertheless this chapter provides an important piece of the puzzle of staff relationships in the milieu and the effects on clients. The clinical implications of this will be discussed in Chapter 6.

Summary

In this chapter I have reviewed the literature that considers team countertransference to clients in psychotherapeutic milieux. In Chapter 4 I review the literature on the contribution of team members and the team as a whole to unconscious dynamics in the milieu setting. These include unconscious aspects and psychopathology of the treatment team.

Chapter 4 – The team unconscious

The sufferer who frustrates a keen therapist by failing to improve is always in danger of meeting primitive human behaviour disguised as treatment. (Main, 1957, p. 129)

This chapter explores how the intrapsychic material that the clinician brings to the work influences the team dynamic and consequently, the clinical work. In doing this I focus on material that clinicians bring prior to the interaction with clients such as personal history and motivation for the profession. As clinicians' psyches inevitably interact with clients' material, some of the literature reviewed in this chapter discusses this interaction; however, this chapter's primary focus is on the team members' and team's contribution to the relationship dynamics in the milieu.

Clinician's intrapsychic material

Motivation for psychotherapeutic professions

Underlying the conscious motivation for therapists to enter the field and to work in specific areas are the unconscious motives for doing so. Roberts (1994) regards the unconscious motivation for choice of profession, client group and setting as stemming from unresolved issues from clinicians' pasts. In mental health the worker's self is regarded as the main tool of the work and Roberts (1994) suggests that in this respect clinicians hope to confirm that they have "sufficient internal goodness to repair damage in others" (p. 116). He suggests that this contributes to the ideals of individuals and organisations, but is also the source of much anxiety. Roberts suggests that the drive to effect reparation, mostly unconscious, is at the heart of creative, productive and caring activities (p. 115). He describes the Kleinian theory of the normal developmental process of splitting, which gradually leads to the depressive position where the child begins to integrate good and bad objects, feels guilt for its destructiveness and has the desire to repair. Where reparation is unsuccessful (i.e. the caregiver abandons or retaliates), depressive anxieties heighten and give way to primitive

splitting defences. These can include the paranoid defence of denial and projection of aggression; the manic defence, which denies that damage has been done; omnipotent fantasies of repair; and obsessional defences which attempt to control and master anxiety. He suggests that in their work with damaged and deprived clients, therapists often experience failure and, like the infant, may resort to these primitive defences “in order to maintain precarious self-esteem and to defend themselves against the retaliation anticipated for failing to heal” (Roberts, 1994, p. 116). In the milieu setting, with its added intensity of long term, intensive care, with many patients who do not get well quickly, these dynamics are inevitably magnified.

Hinshelwood (2010) also discusses clinicians’ reparative motivations, omnipotent fantasies to save, unconscious phantasies of repair and atonement, and the consequent unrealistic expectations from both staff and patients that staff live up to these expectations. The reality of mental health work, however, is “a considerable gap between what we require and the actual lived experience in the work” (p. 209), leading to a deep sense of inadequacy which is experienced in unconscious phantasy. He suggests that “a majority of any team may be suffering these experiences at work, and can unconsciously collude as a team in reducing the level of confidence, job satisfaction and morale, on a group basis” (p. 209).

Roberts (1994) stresses that in order to increase their capacity to tolerate depressive anxieties clinicians need to have some insight into their motivation for choosing their particular profession and/or professional setting as well as their valency for defences and vulnerability to particular kinds of projective identification. He recommends this be done with colleagues, which also has the benefit of the group becoming aware of collective defences. He also suggests personal therapy to help clinicians “disentangle one’s past from the present, and to find alternative ways of resolving unconscious conflicts, rather than needing to do this entirely through one’s work” (p. 118).

Disavowal of aggressive impulses and fear of conflict

Disavowal or denial of aggression may also be a significant feature for people who are drawn to the mental health professions. According to Billow (2003) therapists who are uncomfortable with their own aggression may defuse patients' aggressive transference reactions by keeping the therapy loving and 'nice', preserving themselves as a good object. However it is unlikely that negative or hostile transferences can be kept at bay in the milieu. As Grotstein (2003) observes, group therapy, which is widely used in milieu treatment, "acts like a poultice to summon bad demons from inside to the surface to be experienced" (p. 17).

Unconscious or disavowed aggression on the part of therapists may express itself in a variety of ways in milieu teams including the inability to set appropriate limits with patients or conversely, retaliatory reactions against them (Book et al., 1978). Whalley (1994) argues that staff often have strong biases regarding anger and hostility relating to their own backgrounds. He emphasises that milieu staff must become familiar with the meaning and function of their anger and hostility. He cites Miller (1979) who discusses the narcissistic deprivation at the heart of the unconscious motivation of many therapists and the potential danger this poses for patients. Miller (1979) names that characteristics common to therapists, such as empathy and emotional responsiveness can develop from having to adapt, early in life, to the needs of caregivers, the primary narcissistic needs of the child going unmet. She suggests that if, as adults, the therapist's despair and resulting narcissistic rage has not been worked through it may be unconsciously brought to their work: "It would not be surprising if our unconscious anger should find no better way than once more making use of a weaker person to take the parents' place" (p. 54). Whalley (1994) adds that clinicians' lack of insight into their own narcissistic deprivation may prevent their ability to help patients integrate split off fragments of themselves.

Work groups and basic assumption groups

Milieu settings are fertile ground for primitive dynamics to evolve; collective anxieties among people with similar internal needs and propensities give rise to collective defences. This is referred to by Wilfred Bion (1961) as valency, the propensity in people for spontaneous, unconscious, group sharing of thoughts, feelings and behaviour.

In considering how people tend to behave in group situations, Bion (1961) distinguished between the 'Work Group' and the 'Basic Assumption Group'. The work group is characterised by co-operation, vitality and the wish to focus on the primary task of the group. The basic assumption group requires no training, development or mental capacity; the group depends upon members' valency; the capacity to share and act unconsciously on basic assumptions. These groups act on the wish to evade reality when it is painful or causes conflict between members (Bion, 1961; Stokes, 1994b).

The literature builds on this distinction, elaborating the ways teams move in and out of these modes of being. When a team is under stress it may revert to one of the coping strategies of the basic assumption group, for example, the members may become dependent on the illusion of an all knowing, powerful and benign leader (dependency group); they may become overly concerned with self-preservation and view anything external as an enemy, fighting or fleeing from it (fight-flight group); or seek rescue in the formation of dyads within the group (pairing group). In a basic assumption group the primary purpose becomes the gratification of staff needs rather than the primary task of the group (Stamm, 1995).

Kernberg (1973) highlights the power of the milieu setting and the potential for anyone within it to regress: "Even highly trained, relatively healthy, and mature professionals ... present activation of primitive emotional processes in unstructured group situations" (p. 370). This becomes evident in teams, which are usually held together by their structure of

primary task and role definitions, when their task structure fails and the team regresses to basic assumption mentalities.

Stamm (1995) discusses the sometimes bizarre behaviour that teams can become locked into. For example, he describes a staff team who grew increasingly agitated when three young patients locked themselves in a room saying they just wanted to smoke cigarettes and be left alone. The sense of urgency to “do something” grew among the team members who called numerous other staff as “reinforcements” (p. 124) and then called the fire brigade who were prepared to enter the room using the jaws of life, at which point the girls asked for five more minutes and came out of their own accord. Stamm (1995) describes the response of the staff as indicative of an unconsciously driven, basic assumption group in the fight-flight mode, where staff “had shifted from being benign caretakers to viewing the patients as an enemy to be conquered” (p. 124). Cregeen (2008) and Godwin (2011) liken this type of group to a ‘gang’, referring to several examples of consultation with staff groups who, in a paranoid state, collude against patients. The similarity is noted, to a group operating in a paranoid schizoid mode.

In contrast to the patient-induced dynamics discussed in the previous chapter, Stamm (1995) discusses patient-group basic assumption behaviour evoked by staff team dynamics. He describes an inpatient unit in which a very high number of client romances began at the same time. Only after some time was this occurrence linked to an increasingly stressful time on the ward where patients were witness to high staff turnover. The patient response was interpreted in terms of Bion’s basic assumption mentalities where, in response to the unconscious anxiety provoked, the patients defensively paired with each other (Stamm, 1995).

Competition, rivalry and envy

Difficulties for the therapist in collaboration with other team members can result not so much from wanting to be an ideal carer but from “a sense of being an inevitable loser in a competitive struggle” (Halton, 1994, p. 15). Halton discusses this in relation to an inter-team dynamic whereby a team that experiences “survival anxiety” in an organisation under economic stress, seeks to spoil another team’s success. It may also occur in relation to people in authority, with spoiling of the work that is done within their domain of authority. In this situation a team member may be unconsciously selected by the team to express both their own and the team’s envy (Obholzer, 1994b). Envy may also manifest in ideological debates, ostensibly well-intentioned but gratifying unconscious, destructive motives and working against the organisation’s primary task. In these situations it is vital, according to Obholzer (1994b), that groups have enough thinking space to differentiate between defensive processes associated with envy and constructive contributions about areas that need reform.

Envy may also be part of the complex mix of team dynamics according to Cardona (2010) who explores the tendency for teams to retreat, withdraw or avoid competition out of fear of envy. She argues that when faced with internal or external rivalries, team members or whole teams can “experience a sense of paralysis or hatred evoked by the competitive environment” (p. 214). As groups and organisations are intrinsically interdependent the potential for envious destruction is enormous. Cardona presents case studies of teams that withdraw from healthy competition with other teams or organisations, maintaining a defensively narcissistic position where “need is denied and the threat of the other is responded to with attack” (Britton, 2003, as cited in Cardona, 2010, p. 209). Cardona also discusses a staff member who expressed contempt for senior members of the organisation; they represented her unconsciously wished-for authority, arousing her sense of failure, envy

and hostility. The fear of her own envy was interpreted as a block to engagement in healthy and open competition with her peers.

Therapists may become preoccupied with who gets the bigger share of emotional supplies; of the group's affection, appreciation and recognition, status, popularity, creativity, sensitivity, understanding, and parental functioning (Berger, 2002). While Berger does not give weight to how much such envy is related to sibling transferences or an experience of devaluation in the family of origin, it inevitably plays a part in such rivalry.

Although some splits amongst staff may be triggered by specific clients, staff members who are unconsciously singled out as recipients for projections are not randomly selected (Gabbard, 1989). For example, people with borderline personality disorder have an "uncanny ability to detect pre-existing latent conflict among various staff members, and their projections may be guided accordingly" (Gabbard, 1989, pp. 446-447). Likewise, Lindbom-Jakobson and Lindgren (1997) emphasise the complexity of such dynamics, asserting that splits in teams are not simply a one-way path from patient's intra-psycho disturbance to staff relationship disturbance, but also relate to existing conflicts and tensions between team members. Patients will unconsciously use these conflicts to split staff members apart in their mind, exacerbating pre-existing team tensions. In addition, they suggest that a team member may use the splits evoked by patients to further his or her personal rivalry towards colleagues, essentially, using the patient "for unconscious purposes in their relations with one another" (p. 221).

Berger (2002) recognises the contribution of the client group to facilitating the envious split by seeing the staff as good or bad according to their needs. She argues that if teams can openly process their envious splits, an opportunity is created for generosity to be expressed, enhancing the capacity of other team members to risk undertaking a similar process (p. 107).

Transferences to colleagues

The issue of transferences between team members and other staff is one that is surprisingly neglected in the literature on psychotherapeutic milieux. However, Lindbom-Jakobson and Lindgren (1997) explicitly name that for psychotherapeutic milieu therapists the work is more complicated than individual work because “the others working at the institution constitute both real and fantasized objects also for the psychotherapist” (p. 219). They argue that the therapist’s own transferences to colleagues make it difficult to think about the patient’s transferences to the same people. The example is given of a patient’s anger towards a therapist’s colleague evoking the therapist’s previously suppressed negative fantasies about the colleague (p. 219).

Problems of multi-disciplinary teams

Potential problems that can arise when members of different professions are working in the same team have been highlighted by a number of writers. Herrman, Trauer, and Warnock (2002) note that members of any profession tend to see their contributions as more important than members of other professions see them. In addition, it is common for team members to interpret inter-professional differences as deficiencies in the training of the other profession (Herrman et al., 2002, p. 77). Power relationships between different professions within a team may manifest by one profession excluding other members while others may usurp or challenge the power of another group. It is observed that different rewards such as power, status and income between professionals on the same team can cause problems, particularly where discussion of issues of reward and status is avoided out of a “fear that releasing destructive feelings of jealousy and envy could break the fragile unity of the team” (Herrman et al., 2002, p. 78). The authors argue that team members who value participatory and equal relations with clients tend to emphasise equality between team members, but that “the ideal of democracy is widely recognized to be a myth that can impede members from

addressing underlying problems” (p. 78). Hinshelwood (2012) agrees that the disciplines in multidisciplinary teams do not always work well together, stating that the integrative function is often lost and the team, as in a basic assumption group, works to shift responsibility to manage workers’ anxieties more adroitly than to work creatively to respond to people’s needs. Lindbom-Jakobson & Lindgren (1997) also name that differing theoretical orientations of team members and the associated lack of common theoretical language are likely to increase the risk of rivalry between colleagues.

The interrelationship of clinicians’ and clients’ intrapsychic material

Interrelationship of team and patient disturbance

The attribution of the origin of a patient’s disturbance solely to his inner psychopathology is described by Chiesa (1989) as reductionist. He suggests that on some occasions the main source of the patient’s distress can be located within the therapeutic team, either through inadequate understanding of the patient or “uncontrolled countertransferential reactions ... which, for reasons often idiosyncratic to a particular team, become uncontrollable” (p. 159). In his case study a client’s passivity was responded to with a relentlessly confrontational attitude by staff, which led to the patient’s mental state worsening until he was discharged. He describes such teams being characterised by a lack of self-reflection, a narrowing of the capacity to think and a blind insistence in pursuing the original mistaken approach. The team’s dysfunction and the patient’s disturbance in such dynamics escalate each other to the point of an irrevocable breakdown in treatment.

The preference for cruelty over pain

Whalley’s (1994) perspective on complementary identification highlights the dynamics of pain and anger that he suggests are dominant in the emotional field of the milieu. He suggests that complementary identification occurs due to both the patient’s projective identification and the therapist’s defence against a painful concordant identification. With

traumatised patients, abusive or sadistic objects, and the projections of these, are numerous, and defences against concordant identification are likely to be operational in the therapist. Sadistic feelings provoked by the projective identifications of patients “might be preferable to other feelings stimulated, such as abandonment, hurt, powerlessness, rage or other painful affects associated with his or her own past conflicts and traumas” (Whalley, 1994, p. 460).

The dynamic of helplessness

Main (1989c) identifies the dynamic of helplessness as one of the primary dynamics between staff and patients: “the helpful will unconsciously require others to be helpless, while the helpless will require others to be helpful.” (p. 12). This dynamic can exert a powerful force in treatment milieux where staff and patients unconsciously conform to the only two roles on offer: “staff to be only healthy, knowledgeable, kind, powerful and active, and patients to be only ill, suffering, ignorant, passive, obedient and grateful” (Main, 1989c, p. 61). Hinshelwood (2010) argues that the roles are progressively reinforcing as each group “spits out” aspects of itself that do not conform to the unconscious demands of their role, and “what patients lose of their healthy side, accumulates in the staff and what the staff lose in terms of their more negative attributes resurfaces within the patients” (p. 205).

In Main’s (1989b) analysis, therapists’ unconscious demands and motivations are as significant as patients’. He observes that if the clinician does not understand his patient’s miseries and failure to improve he becomes helpless in a way that is unacceptable to him, which leads to “anxiety such as to threaten the professional ego with private feelings, and it is in defence against this anxiety that the doctor retreats from encounter and thoughtfulness” (p. 211). Bell (1997) highlights the ability for milieu teams to tolerate doubt and ‘not knowing’ as necessary to effectively working with very disturbed patients who suffer a primitive dread of not knowing and placate a terrifying superego with a demand for omnipotence. He notes a parallel process for these patients’ therapy teams who, in a more or less continuous state of

anxiety and helplessness about not knowing, develop ritualised, institutional systems in a defensive demand for omnipotence. Hinshelwood (2010) discusses the pain of helplessness, particularly among staff working with psychotic patients where “the fear of incurable madness may afflict staff” (p. 211).

It seems that staff unconsciously require patients both to stay unwell and to recover. If staff cannot tolerate their own helplessness, projecting it into patients, and, in addition, punish patients for not responding to their omnipotent phantasies of care and cure, patients may experience devastating effects of depersonalisation, helplessness, regression, and an increase in symptoms of mental illness. In addition, punitive, cruel and inhumane treatment can arise from staff frustration at the patient’s continued illness, or the belief, informed by unconscious aggression or hate, that the treatment is for the patient’s good. As Main (1957) notes “The sufferer who frustrates a keen therapist by failing to improve is always in danger of meeting primitive human behaviour disguised as treatment” (p. 129).

Staff identification to clients

Many contemporary therapeutic milieu staff members are formerly part of the client group or have had similar life experiences. For example, many addiction therapeutic communities employ staff members in recovery from addiction (Australasian Therapeutic Communities Association, 2012; De Leon, 1995). Other workers may identify in terms of a previous experience or family history of mental illness, which may or may not be disclosed.

Roberts (1994) argues that rather than necessarily increasing the capacity for empathy, the close resemblance between workers’ past experiences and their experiences at work can actually threaten this capacity, as unconscious defences are enlisted to relieve their intolerable anxieties. Some organisations defensively accentuate differences between staff and clients, often supported by rigid programmes and hierarchies and a prevalent belief that “they’ (the clients) are the sick or mad or needy ones; ‘we’ (the staff) are the well, sane,

strong, helping ones” (p. 117). In other institutions differences are denied and workers are so identified with their clients as victims they are likely to be overwhelmed by pain and despair.

A case example is discussed by Roberts (1994) of Haply Lodge, a service for homeless mentally ill people, where staff attempted to eliminate all barriers between themselves and clients by living with them permanently with no boundaries between work and leisure time, sharing all duties with clients. The staff, who nearly all had been homeless themselves, felt guilty for being better off than the clients and, according to Roberts obliterated the differences in order to reduce their guilt. However, soon the absence of limits led to breakdown and burnout in the staff, the burnout itself serving to assuage guilt about lacking enough goodness to cure their clients.

The struggle to face difficulties in the team

It is argued that if the staff can anticipate clinical supervision as a critical yet non-threatening environment, it can “expand the boundaries of their own personality structures and gives growth and satisfaction about better caring for their patients” (Szajnberg, 1985, p. 335). Much of the literature already cited highlights the importance of regular psychodynamically informed supervision. Chiesa argues that “much of the patient’s treatment will depend on the team’s ability to think critically about its own functioning, and to discriminate between the patient’s projections and problems belonging to the staff” (p. 161). Like Szajnberg (1985) maintains that this would benefit not only the patient, but also the staff, in terms of greater understanding, less reactivity and consequent guilt, increased effectiveness, self-esteem, and job satisfaction. However, maintaining this level of communication within a staff group is inherently difficult. Chiesa (1989) has identified teams’ fear of supervision, evasion, resistance, and cover-up as a key problem. He observes team members’ tendency to avoid honest communication out of fear of the pain of honest self-examination, fear of blame and guilt, or loss or a position of omnipotence. This is shown

by Polden (2010) who, in a case study of breakdown in staff relationships in a prison therapeutic community, showed, when their resistance to talk was eventually overcome, that the team members believed the dynamic revealed only their deep, personal failure and was not related to clients' processes or other contextual factors.

It clearly requires the ongoing effort of all staff to maintain a culture of enquiry. Griffiths and Hinshelwood (July 1995) identify several defences to such a culture, similar to those identified by Menzies-Lyth (1959) who wrote about nurses' avoidance of getting too close to the painful aspects of their work with dying patients. Griffiths and Hinshelwood (July 1995) list several phenomena often found in therapeutic milieu that enable and maintain this shut-down of thought and enquiry, including 'the packed timetable'; 'the projection of despair'; 'paranoid interpretations', which ascribe malevolent motives to a client; 'last minutisms', which signify a crisis-led, reactive, mentality; 'tribalism', which occurs when each team addresses only its own interests; 'inter-professional rivalries', 'pseudomutualism', which results when difference is avoided; 'ritualised interpretations' which are given as if from a list; 'competitive interpretations'; and 'interpretation as social control' which occurs when therapists are required to use interpretation to control patients (Griffiths & Hinshelwood, July 1995). Main (1957) cautions that the struggle to face such difficulties is ongoing and may continue to be so despite having processes in place to work through them.

Discussion and critique

The literature reviewed in this chapter assumed a much greater contribution from clinicians' psyches to relationships in the milieu than that reviewed in the previous chapter. The impact of therapist personal history and motivation, and therapists' part in the 'dynamic of helplessness' was examined in depth by the writers and provides great richness to the discussion about unconscious influences on staff relationships. As a result of reviewing this

literature and from my own clinical experience I believe this is an invaluable area for teams to consider.

Overall, I suggest that consideration of clinicians' and teams' psychological material is an overlooked area within the topic. The literature identified for this chapter was relatively scarce compared to that regarding patients' splitting and projective identifications. In particular, the lack of material on staff transferences to each other is notable, as is staff identifications to patients.

It could be argued that this in itself may represent, within psychotherapy as a whole, a defence; the projection of unwellness and helplessness onto patients and an omnipotent defense against not knowing, such as that examined in this chapter. For example, Chiesa (1989) named the "fear of the pain of honest self-examination, fear of blame and guilt or loss or a position of omnipotence" that commonly besets psychotherapeutic teams. This over focus on patient pathology at the expense of an examination of staff pathology can reinforce the defensive pathologising of patients as well as perpetuate the dynamic of helplessness in precisely the way that Main (1989c) and Hinshelwood (2010) have observed. In addition, as also noted in Chapter 3, an intersubjectivist critique would encourage clinicians to recognise the reciprocal mutual influence of subjectivities (Mitchell & Black, 1995). This, I suggest, is a key to any social milieu.

Nevertheless, I would reiterate that the literature that has been reviewed regarding staff's contribution to the psychodynamics of the milieu offers an immensely valuable contribution to an emerging picture of the multiplicity of influences on staff dynamics and the consequent effect on clients.

Summary

In this chapter I have reviewed the psychodynamic literature which refers to the contribution of team members to milieu dynamics. I have discussed unconscious motivations

of mental health staff for joining the mental health profession. I have also considered staff's unresolved psychological material and how this can manifest in staff teams in mental health milieu. I have discussed the scenarios of teams under stress moving into a basic assumption group mentality. Finally, I have discussed the importance of, and the resistance to, the team undertaking supervision and fostering a culture of enquiry, and the potential for harm to patients if it does not.

In Chapter 5 I explore processes that are an inherent part of institutions and how they too find unconscious recipients and participants in teams, team members and patients.

Chapter 5 – Organisational countertransference

When I got there I found the usual convention regarding all the staff as being totally healthy, and if wayward to be overridden, reprovved or disciplined; and all the patients as being totally ill, and if wayward to be tolerated as not real people and treated with charity, drugs or psychotherapy - that is to say social splitting and the projection of health and illness were part of the social order. (Main, 1989a, p. 129)

In this chapter I review the literature on aspects relating to the wider context of the therapeutic milieu, including the organization or institution itself and social and political forces that impinge on milieu function and team dynamics.

Unconscious processes in organisations

Organisational defences

We are reminded that much human behaviour is determined by unconscious phantasies, and these can be shared within groups or institutions. (Skogstad, 2004). Several authors (Halton, 1994; Heede et al., 2009; Heginbotham, 1999) refer to unconscious processes repeating themselves on a number of levels in an organisation; parallel processes permeating the whole system from clients to clinicians to management. These authors emphasise the importance of a therapeutic organisation having this recognition built into it. Halton (1994) suggests that threats to survival or self-esteem can regress an organisation, or group within it, to the paranoid schizoid position. When an organisation is not functioning well, staff groups within it begin to form and use primitive defence structures such as projective identification, primitive splitting, devaluation, and primitive idealising. Obholzer (1994a), and Mosse and Roberts (1994) point out that organisations are particularly susceptible to primitive anxieties about annihilation and fragmentation arising during times of change and reorganisation, when familiar symbols of safety and belonging break down. When primitive defences are evoked the work moves away from the primary task and also

can result in destructive dynamics being played out throughout the organisation (Heede et al., 2009). Split off aspects are often projected outwards, to patients, management, external agencies, or funders (Halton, 1994).

Heginbotham (1999) observes a range of polarities in mental health services; between strategy and operational activity, theoretical model and personal responsibility, professional and agency allegiance as well as between clinicians and management, and medical and social or psychological models of care. He frames these as the symptoms of splitting; the projection of aspects of the organisational self onto the 'other'. He observes that similar dynamics occur in all healthcare services but argues that mental health services are by nature psychodynamic; with users, clinicians and managers interrelating in complex ways. He notes that service users are often in contact with the service for long periods and therefore "have an opportunity to observe and be affected by the splitting and projections within the service" (p. 255).

Jacque (1953, as cited in Wilson, 2012) proposed that in addition to the outward form of an institution, a phantasy structure exists, with collective defences, unconscious projections and introjections between all participants. Staff members are unconsciously required to take into themselves the projected objects or impulses of other staff; thus some staff will receive only the good objects while others may have to "be a shit" and 'take all the shit'" (Wilson, 2012, p. 63). Similarly, Stokes (1994a), referring to the 'organization in the mind', hypothesises that staff may join institutions because they provide locations, in other members or departments, through splitting and projection, for difficult and hated aspects of oneself. Kernberg (1973) stresses the importance of a clearly defined primary task and clarity of roles within an organisation, and suggests that without these, primitive defences and object relationships will surface in the form of personal conflicts (p. 370).

'Deadened' is the term Hinshelwood and Skogstad (2002) use to describe the atmosphere in a therapeutic milieu when staff could not bear their anxiety. They apply

Menzies Lyth's (1959) work on anxiety and defence in health care settings to anxiety in mental health milieux, reporting that anxiety is recognisable in a felt sense of the atmosphere which is the "palpability of a defence in operation" (p. 115). They give the example of the "deadened atmosphere" of a mental hospital where on the surface nothing much appeared to happen; however on closer examination defensive processes "which actively brought about the deadening" (p. 113) were revealed. These included a pervasive defence against communication and intimacy throughout the institution, revealed in the way only cursory contact was made between people before being quickly curtailed. The defence was interpreted as a fear of life or liveliness, which had become associated with madness for patients and staff alike.

Hierarchy, power and status

Eisenberg (1997) argues that experiences of authority and dependency relationships are critical in personality formation. He views the institutional structure itself as a trigger to countertransference, and argues that "differentials of power and authority serve to reanimate emotional forces associated with authority and dependency" (p. 252) playing on the vulnerabilities and conflicts of all members of the community. The result is extensive inner and outer conflict with associated dysfunctional management of those feelings, and a resulting inability to effectively complete tasks. In his view, in some institutions, a large amount of staff time and energy is consumed by maintaining personal equilibrium in a very challenging atmosphere; "At every point up and down the institutional ladder one can observe the tell-tale signs of threatened narcissistic balance" (p. 253). This can be observed in expressions of grandiosity amongst staff, denigration and devaluation of others, staff feeling powerless and guarding against impending humiliation, chronically resentful staff, and those who try and avoid narcissistic injury through cynicism and withdrawal. He suggests that "no one functions in this type of close knit and stratified milieu without having to adapt to, defend

against, or all too often act out the legacy of earlier conflicts that are brought to the surface in such a setting” (Eisenberg, 1997, p. 253). Stokes (1994a) adds that authority figures may become transference persecutory figures for staff. He suggests that unless the organisation is able to act as a reliable container for the ambivalence of its members toward its authority then interpersonal disorder will result among its members.

Hinshelwood (2012) observes that human beings function best collectively “but a collective is also the most horrendously destructive of things” (p. 202). He cites Goffman (1968) who observed that people with the best of intentions work in mental health institutions and end up contributing to a system that harms the patients and themselves. Hinshelwood attributes this to the effects of hierarchical institutions “which seem to transform even the profession of psychotherapy into a neutralised, prescriptive, top-down profession when practiced in an institution” (Hinshelwood, 2012, p. 201). Jones (1968) argues that the ‘hospital as a whole’ approach demands that professional staff must be willing to be subject to scrutiny just as patients are. Both Jones and Main (1989a) observe that the ‘hospital as a whole’ approach is especially difficult for authority figures to face. However, while Jones was an advocate of flattening the hierarchy, Main argued against it. In Main’s view, the hierarchy in therapeutic milieux provides an opportunity to explore a patient’s relationship with authority as well as to be not too much at odds with the dominant social order outside of the hospital. But perhaps more importantly, he argues that authoritarianism has less to do with social structure than as a specific way of relating. He suggests that it is a defence of appeasement against persecutory anxiety to do away with uncomfortable roles of authority rather than to bring to light the hidden fears of being in an uncomfortable role.

Similarly, in his discussion of hierarchy, Wilson (2012) argues that hierarchical structure is important precisely because the payoffs are continuity and stability for all, and it offers a protective factor for employees whose employers are constrained by a mutually

recognised set of rules. He argues that, even while purporting to be democratic, therapeutic communities have tended to cling closely to a hierarchical structure. He highlights the success of many of these communities, the impossibility of overcoming the formal medical hierarchies of hospitals and the danger of becoming a “pseudo-therapeutic community” where there is a “facile, over-enthusiastic acceptance of ideological principles without the ability to genuinely apply them” (Wilson, 2012, p. 60).

Complex interpersonal dynamics relating to authority and power are naturally intensified when one profession holds itself above others. In a paper examining the roles of psychiatrists within teams, Herrman et al. (2002) observe that “psychiatrists are still socialized to assume the central role and overall responsibility for the treatment of their patients, and to expect unchallenged leadership of mental health services or facilities” (p. 77). Tobin (1996, as cited in Herrman et al., 2002) alludes to the narcissism inherent in the historical status and privilege of psychiatry and cautions that the leadership of a team should be earned, not bestowed. Taking this even further, Heginbotham (1999) advocates for challenging and modifying the power of certain professional groups within an organisation, saying clinicians must be willing to examine their roles and negotiate with others to achieve the most appropriate set of power and professional relationships.

Scapegoating

The concept of scapegoating has been applied to institutions in an effort to understand why individuals come to carry the blame for systemic or institutional problems. Halton (1994) argues that problems related to institutional dynamics are often attributed to an individual. This person becomes an unconscious recipient for a difficult group feeling, like a ‘sponge’ for the group’s anger or depression, resulting in him or her carrying or expressing the feelings, for example, in conflicts with managers or by becoming depressed and leaving. Obholzer and Roberts (1994) discuss the culture of blame in institutions arising from

unconscious fears about the lack of certainty, order and safety in the world and in our organisations, and the defensive belief that all will be well if “the evil ones, the troublemakers” (p. 129) are expelled. In this situation the conflict becomes forced down to the individual and interpersonal level and the institutional issue becomes impossible to recognise or address (Stokes, 1994a).

Interrelationship of client and institution pathology

In his discussion of difficulties in organisational life, Halton (1994) suggests that projective processes originate with the client group but become organisation wide. Halton names that this splitting and projecting is as normal in the defensive processes of disturbed adults as in the play world of the child. However, when an organisational group remains unconscious of the projections they are carrying and retain their self-idealising illusion, a culture of blaming, envy, hostility, refusal to co-operate, active sabotage, and avoidance of communication results in “a ricocheting of projections back and forth across groups and organizations” (Halton, 1994, p. 17).

Kernberg (1987) discusses the interrelationship between patients’ regressive ego states and regressive large-group processes. He observes that these large-group processes tend to result in a group that is “self-satisfied, leaning towards a narcissistic leadership or producing a dynamic ‘mob’ moved by aggressive impulses toward external enemies, led by a paranoid leader” (p. 185). He notes the corruption of moral values that typically take place in organisations when these processes occur, concluding that a dramatic and dangerous potential exists for the replication in the hospital’s social system of patients’ specific superego pathology (Kernberg, 1987). Similarly, Bell (2001) has identified that “the functioning of a primitive cruel superego ... comes to operate not only at the individual level but also at the level of the institution” (Bell, 2001, p. 21).

Socio-political influences on milieu

In a process similar to the defensive operations of teams described in Chapter 4, Bell (1997) imagines that the ever increasing requirement for data, documentation and accountability from funders and monitoring agencies represents these organisations having become caught up in a mutual projective enactment with clients and organisations.

In their work on acutely disturbed patients, Jagarlamudi et al. (2012) discuss the effects of drastically shortened hospital stays in recent decades. This has coincided with a shift away from psychodynamically informed inpatient treatment to the medical model as the prevailing approach to inpatient treatment. Whereas transference dynamics played a central role in the life of the inpatient therapeutic community, despite these dynamics still being present, the move away from psychodynamic training means this thinking no longer informs hospital care.

Likewise, Bloom (2005) discusses the growth of right wing, religious conservatism from the late 1970s as an extremely negative influence on therapeutic communities. She argues that therapeutic communities' focus on psychodynamic principles and social change are democratic processes which are essentially subversive to authoritarian, hierarchical socio-political structures. She argues also that an increasing 'biological fundamentalism' in psychiatry has seen the biomedical model displace psychodynamic training and treatment. She cites the implications of "managed care" for therapeutic milieu, which are devalued in the new neoliberal economic paradigm, and which face increasing restrictions on services. She emphasises that with increased restrictions and stress on organisations, their resultant inability to provide 'containment' for staff teams in turn impacts on teams' ability to provide this function for clients. Stokes (1994a) too, cites the constant change and reorganisation that has become a feature of mental health services in current times. He argues that because of this, the institution can no longer provide the same level of containment for the projected

parts of its workers as it used to; this leads to increased anxiety and increased tensions between workers, rather than the ‘worker vs management’ dynamic of past generations.

Effects of organisational dynamics

Defensive Practice

Stanton (2013) highlights the swift movement to defensive practice when staff feel unsafe, highlighting the fight-flight response for workers under stress. The implication for patients is authoritarian and restrictive treatment, particularly in acute inpatient units where staff may frequently feel unsafe and insufficiently supported by the organisation or wider system: “It is always easier to justify more paternalistic, restrictive, biological practice ... than more collaborative, psychological, less restrictive practice” (J. Stanton, 2013, p. 1). Stanton argues that defensive practice has a high risk of being spirit breaking for both staff and patients. She emphasises that the leadership team needs to visibly support training, supervision and reflective practice and stresses that if the organisation can provide a containing function for staff they in turn will be better able to contain the anxieties of the patients.

Burnout

A study on burnout amongst psychotherapists found that those who work in agencies have higher rates of burnout than those working individually (Hardiman & Simmonds, 2012). This is hypothesised to be a result of the emotional pressure associated with intense involvement with people over long periods of time. Increased administration, frequent staff meetings and the nature of the client group were also considered factors. Effects on staff can include loss of energy, idealism and purpose, and less trust and sympathy towards clients. In the context of this research project, it is noted that high rates of burnout amongst clinical staff necessarily impact on clients through high staff turnover and the multiple effects of stressed,

under-functioning clinicians. Similarly, Morante (2005) highlights the toll on staff of the stresses of under-funding, over management and continuous service changes.

Effects on clients

Stanton and Schwartz (1954) argue that in large institutions, long chains of command block genuine communication between staff and exacerbate covert disagreements and conflicts. They also argue that rigid and impersonal job descriptions suppress openness and flexibility, and result in low staff morale. This process, they say, rather than mental illness itself, causes much apparently 'disturbed' behaviour in patients (A. H. Stanton & Schwarz, 1954; Wilson, 2012, p. 59). Similarly, Rosengren (1967, as cited in Wilson, 2012) noted how institutional pathology can impact on patient health. In a three year study of a therapeutic community he observed that patients were unconsciously encouraged to "act out" in order to fulfil staff expectations; crises were created which served the function of enhancing staff consensus and emphasising traditional staff-patient roles.

Heginbotham (1999) notes that provision of a nurturing culture seems to be extraordinarily difficult for mental health services to achieve and cautions that without this nurturance, "mental health teams will continue to fuel the psychotic processes of mental health care and offer a psychotic organisational response to the disintegrated patient" (p. 257). Heginbotham creates a powerful metaphor to describe the interaction between the mutual fragmentation of the patient and the team, where the patient's projection of his good or bad self on to the team will be reflected back "as if from a fragmented mirror (literally a 'crazed mirror') which creates a multiplicity of responses" (p. 257). If the team is not well nurtured itself it is unlikely to be able to contain the anxiety of the client and such a fragmentary response may occur, perpetuating the disturbance in both. This may not be catastrophic for staff members but certainly could be for patients.

Towards Solutions

The containing and reflective space

Hinshelwood and Skogstad (2002) highlight that changes in psychiatry, as were observed in the process of deinstitutionalisation, can be very damaging when they do not take into account “the unbearableness and destructiveness of mental illness and the need for containment for both patients and staff” (p.118). The concept of the organisation as ‘container’ is derived from the work of Bion (1962) who discussed the ‘container’ as the maternal function of receiving and understanding the emotional states of the baby, returning them in a more bearable form. In the view of Heede et al. (2009) the organisation’s relation to its members is analogous to this function: “The organisation must be capable of including, containing and detoxifying its members, so that members can feel and reflect upon the task at hand” (p. 278).

Heginbotham (1999) argues that management need to provide the containing space in which team members and the team as an entity can grow and develop. He emphasises the need for “nurtured co-ordination” (p. 258); to spend time understanding and aligning the values, models and theories each member brings to the team. He highlights the need for expert facilitation of this containing space for staff members. Similarly, other writers (Griffiths & Hinshelwood, 2001; Main, 1989a) stress the centrality of maintaining a ‘culture of enquiry’ in psychotherapeutic milieux, “into the meaning of individual symptoms and actions as well as group dynamics” (Skogstad, 2006, p. 166). If the culture deteriorates the reasons within both the patient *and* staff groups need to be explored. As Tom Main described in “The Ailment” (1957), once the nurses started talking about their hidden thoughts and feelings toward patients and the splits in the team, outcomes for patients improved.

Halton (1994) describes a group functioning in the depressive position as one in which “every point of view will be valued and a full range of emotional responses will be

available to it through its members” (p. 18). It will be evident in the group discussing and thinking about the projections they carry from the client group, rather than acting them out. Halton adds a caveat, that as with the individual, the depressive position is never achieved once and for all and future perceived threats to survival or self-esteem will once again invoke the paranoid schizoid position.

Resistance to the reflective space

Halton (1994) names the conflicting feelings of hope and fear staff experience when a consultant is called in to address organisational problems. He describes the group’s resistance to becoming conscious of their ‘bad’ parts, which can manifest in projections aimed at the consultant. Similarly, Moylan (1994) identifies a huge amount of ambivalence and hostility to supervision. The resistance against really knowing one’s problems is strong – “the wish ... is to have the problems eliminated, not clarified” (Moylan, 1994). Halton (1994) names as crucial the consultant’s willingness and ability to contain the projections of the staff group until they are ready to use an interpretation.

Organisational resistance to a containing or reflective space is also highlighted in several case studies showing that services in crisis called in consultants only as a last resort (Bolton & Roberts, 1994; Briggs, 2004; Collie, 1996; Novaković, 2002). Bateman (1995) also observes how the reflective space can be impeded by organisational pressures and lack of understanding on the part of the organisation or elements of it.

Eisenberg (1997) suggests that even if a reflective space is created, the organisational structure tends to profoundly compromise the self-disclosure which could make it effective:

The unequal status of treatment team members, the fact that some will speak with the imprimature of authority and others will not, that some may have supervisory authority over others, that some may be dependent on others for certain privileges or

opportunities – all of these phenomena have a chilling effect on the sharing of personal material. (p. 240)

Training for milieu staff

Like many of the authors cited below, Heede et al. (2009) suggest that organisational and team splits be dealt with through “supervision and training of personnel and through a clear decision making structure within the organisation” (p. 279).

In observing the high stress of residential care which involves being at close quarters with “harrowing and disturbing human agonies and predicaments“ (p. ix), Hinshelwood (1997) notes the lack of experience and training of many staff, often because of high clinician turnover or senior staff moving away from the stress of ‘coalface’ work (p. ix). He suggests that the most effective support for practitioners is to be trained to think in terms of a “a model they carry in their minds of what residential care consists of” (p. x), based not simply on procedures but on working actively with their emotional reactions when carrying them out. He emphasises that “the human feelings of the staff can be used professionally – and this stops those feelings from being an impetus to strange, disordered or unethical responses” (p. x). He suggests that working consciously with emotional reactions increases resilience of each person in the team and strengthens the team as a whole.

Herrman et al. (2002), recommend that multidisciplinary teams receive training about team dynamics, structure and function, in the context of contemporary understandings about organisations. They emphasise that training programmes should aim to produce a conscious shift in attitude toward teamwork. They particularly emphasise the importance of collaboration and suggest that professional bodies give credit for collaborative activities, and that organisations make clear their expectation that staff collaborate.

In light of the intense transference and countertransference relationships that are likely to occur in therapeutic milieux, Whalley (1994) too advocates for greater emphasis on

education and development. He recommends multidisciplinary staff meetings, private meetings between key staff, and group supervision meetings, stressing the containing function of these meetings. He emphasises that these meetings should support the development of relationships that are secure enough to assist members to openly discuss, and work through countertransference.

Kahn (2012) criticises the tendency for many writers to identify significant problems in organisations and then simply make vague concluding comments on the necessity of group supervision. He describes ‘functional analysis’, a method of identifying the social needs served by dysfunctional patterns in groups. Change involves identifying patterns, then altering structures so that members can more openly satisfy their needs. Firstly, observation, interviews and feedback meetings identify what members find most emotionally difficult about their work. Patterns of behaviour in and across groups are also identified; this is followed by an analysis of the functions these patterns serve for members. Interventions involve the creation of ‘holding environments’ in which staff can temporarily regress in intentionally nurturing environments (Winnicott, 1965); these structures provide both containment and interpretation, enabling members to make sense of their experiences. Kahn suggests that before deeper emotional processes can occur, especially in inter-team groups, a process of working from the outside in needs to occur. This includes acknowledging shared goals, working together on joint tasks, and having a clear, shared understanding of roles and authority. He suggests, as do Obholzer and Roberts (1994), that members must be “educated, trained, reinforced and led toward engaging one another in ways that offer compassionate understanding” (Kahn, 2012, p. 232). Furthermore, organisation leaders are integral to the process, and interventions are developed from the top of the hierarchy downwards, beginning with senior management, then department leaders, before working with individual teams and across teams. Cross-team projects are initiated and training held for all staff on topics such as

client-staff dynamics and parallel process which enable members to better understand the emotional material triggered in their work. Kahn suggests that education and training can help staff overcome their resistance to the concept of unconscious behaviour, and to participating in group process.

Depathologising and collaboration with clients

Griffiths and Hinshelwood (1997) stress that staff need to recognise the value of the psychosocial dimension of care rather than regarding care as a “one to one curative act” (p. 15) determined by the skill of the clinician acting on a passive patient. The authors caution that clinicians “can hold on to hope and hopefulness only if they can own and contain their own omnipotent phantasies of absolute cure and its converse, total impotence or failure” (Griffiths & Hinshelwood, 1997, p. 8).

Maxwell Jones (1979) tracks his own learning over 30 years of working in therapeutic communities, moving from typical psychiatric thinking about diagnoses, to eventually avoiding the labelling of clinical conditions and using the term ‘social learning’ instead of ‘treatment’. He argues that the major contribution of therapeutic communities in psychiatry has been to humanise hospitals, and professionals generally, so that they identify with the patient as a person, and realise the power of the peer group and the opportunity of each patient or potential patient to achieve fulfilment (Jones, 1979).

Likewise, Hinshelwood (2012) states that in order to counter the dynamics of institutionalisation and helplessness, organisations and staff must attend to the healthy side of the patient as much or even more than the unhealthy, symptomatic one. This entails “working alongside” (p. 207) in which carers do not care for patients but engage with them. He lauds the development of consumer rights but cautions that genuine collaboration can easily give way to lip service which could see it swallowed up in “a top-down diktat that prescribes user involvement” (Hinshelwood, 2012, p. 207). This view is echoed by Heginbotham (1999) who

advocates not only levelling of hierarchy but also for patients to be involved in determining which models and theories should underpin the therapeutic approach. Hinshelwood (2012) cautions organisations to hold a dialectical position: “It is not that bottom-up initiative is good and top-down control is bad. What is good is to keep aware of that dialectic between top-down and bottom-up...No single individual, group or level knows best; that is the ethical requirement” (Hinshelwood, 2012).

Discussion, findings and limitations

Organisational dynamics as a specific feature of staff relationships in psychotherapeutic milieu have been eloquently expressed by a few writers as reviewed in this chapter and bring useful and thought provoking material to the discussion about milieu psychodynamics and the effect on client treatment and outcomes.

However, I am left with the sense of many gaps in this body of literature. It is clear that there is a dearth of literature which explicitly discusses the sociocultural and political influences on psychotherapeutic milieu team relationships. This is a concern given the location of therapeutic milieux as entities which contain within them a multiplicity of sociocultural and political contexts from clients and staff, as well as the engagement with the sociocultural and political context of the wider community.

The value of a cultural perspective to the discussion on staff relationships cannot be overstated in terms of the Aotearoa New Zealand context which involves an ongoing discussion between Maori and Pakeha practitioners in milieu teams and organisations regarding culturally appropriate services for Maori. (Adamson et al., 2010; Durie, 1998). The influence on relationships in milieu teams in this context is a topic of considerable interest and worthy of research in its own right.

The political perspective seems to have been taken up by few writers, particularly Sandra Bloom (2005), a feminist critical theorist, who, as cited above, argues passionately

that the political landscape and contemporary social and economic paradigms have a profound effect on psychotherapeutic organisations, the people working in them, and ultimately and most seriously, the clients. I contend that the overall picture of influences on relationships between staff in milieu settings is incomplete without this perspective.

Summary

In this chapter I have reviewed the literature on aspects of milieu dynamics relating to the organization or institution itself and other wider social, cultural, and political forces that influence milieu function.

In Chapter 6 I synthesise the literature reviewed in Chapters 3, 4 and 5 and discuss the findings of the review. Implications for clinical practice are considered, recommendations made and suggestions made for future research.

Chapter 6 – Findings, Clinical Implications and Recommendations

The human feelings of the staff can be used professionally – and they are thus stopped from being an impetus to other, strange, disordered or unethical responses.

(Hinshelwood, 1997)

In this chapter I identify the findings revealed in the literature review and discuss key themes. I consider the implications for clinical practice and make recommendations. I then discuss the strengths and limitations of this review and make suggestions for further research.

Overall Findings

The literature shows that conflictual team dynamics are ubiquitous in psychotherapeutic milieu settings. They operate at the level of countertransference to clients and client groups in the milieu (Briggs, 2004; Chiesa, 1989; Gabbard, 1989; Griffiths & Hinshelwood, 1997; Kernberg, 1987; Main, 1957; Skogstad, 2006; Szajnberg, 1985) and they occur in relation to transference and countertransference between team members (Eisenberg, 1997; Lindbom-Jakobson & Lindgren, 1997). Team dynamics are influenced by systemic forces within the institution (Eisenberg, 1997; A. H. Stanton & Schwarz, 1954) as well as social and political forces (Bloom, 2005; Jones, 1979). Dysfunctional teams may regress to the paranoid schizoid position or act primarily as a basic assumption group (Cregeen, 2008; Stamm, 1995; Stokes, 1994b). Conflictual dynamics may be manifest in hostility and division within teams, and blame and resentment toward other parts of a service, management or other services (Halton, 1994; Heginbotham, 1999). They may also manifest in excessive insularity of teams (Cardona, 2010), low morale, burnout (Briggs, 2004; Hinshelwood, Pedriali, & Brunner, 2010) or in a felt sense of the atmosphere of a milieu (Hinshelwood & Skogstad, 2002). Most crucially, teams affected by unconscious dynamics may act punitively towards clients (Cregeen, 2008; Main, 1957) with tragic consequences.

The literature suggests that an optimally functioning team would relate to patients in such a way as to avoid being unconsciously provoked into a customary response. This would provide the patient with a different form of interpersonal relatedness that facilitates the internalization of healthy object relations (Gabbard, 2000). A number of writers name the inevitability of countertransferential enactments; that they are not necessarily destructive in themselves but it is the lack of thinking about them and resolving them that creates problems for clients (Book et al., 1978; Griffiths & Hinshelwood, 1997; Skogstad, 2006).

Earlier psychoanalytic literature discussing therapeutic milieux in the 1950s, 60s and 70s explores the development of democratic principles and seems to accept as a given the importance of the 'total community' approach and a 'culture of enquiry' (Jones, 1979; Main, 1989a; A. H. Stanton & Schwarz, 1954). More recent writers use terms such as 'consultation' and 'supervision', articulating in general or specific ways how this should be conducted. However, all the writers without exception name the vital importance of teams being able to think about unconscious dynamics in the milieu (Cregeen, 2008; Main, 1957; Moylan, 1994; Skogstad, 2006; Stamm, 1995). A number of writers identify that organisational influences can impede this process (Bateman, 1995; Eisenberg, 1997; Halton, 1994; Heede et al., 2009; Heginbotham, 1999; Jones, 1979).

Whereas the literature revealed by this review finds many problems with residential mental health treatment, none argues for abandoning it. On the contrary the literature points to the potential of the therapeutic milieu to be curative, not only for the individual's problems, but also as an example of society's democratic ideals in action (Bloom & Norton, 2004). The necessity of a reflective space to facilitate the potential of milieu treatment is discussed below. Following this, clinical implications are discussed and a set of recommendations made.

Reflective space – making sense and avoiding clinical chaos

I suggest that the key theme emerging from the literature is the potent impact of organisations' and staff teams' interpersonal relations and unconscious material on the disturbed inner worlds of the patients who are their service users; and as importantly, the impact of the socio-cultural, and political contexts within which these clinical interactions take place. While many have written about aspects of this material before, this review brings together wide-ranging literature from varying perspectives, and highlights the necessity for clinical staff and their managers to have reflective spaces in which they can make sense of these complex interrelationships. If reflective thinking does not occur, not only at the clinical level, but at all levels of organisational structure, including management and governance levels, the consequences can be clinically disastrous.

The literature reveals that the reflective space should be a space to explore not only the client's intrapsychic world or the microcosm of the relationship between client and clinician but also the many other layers that impact on this. These layers include the therapist's personal history and motivation for the work; the make-up of the particular clinical team and its manner of operating; clinicians' intrapsychic material in relation to patients' intrapsychic material; the phenomena of splitting, projective identification and transference/countertransference enactments between clinicians and clients and within teams; the particular client groups; the nature of the organisation and type of treatment setting, and the socio-cultural, and political contexts of the treatment setting. These layers, from microcosm to macrocosm are illustrated in figure 1 below.

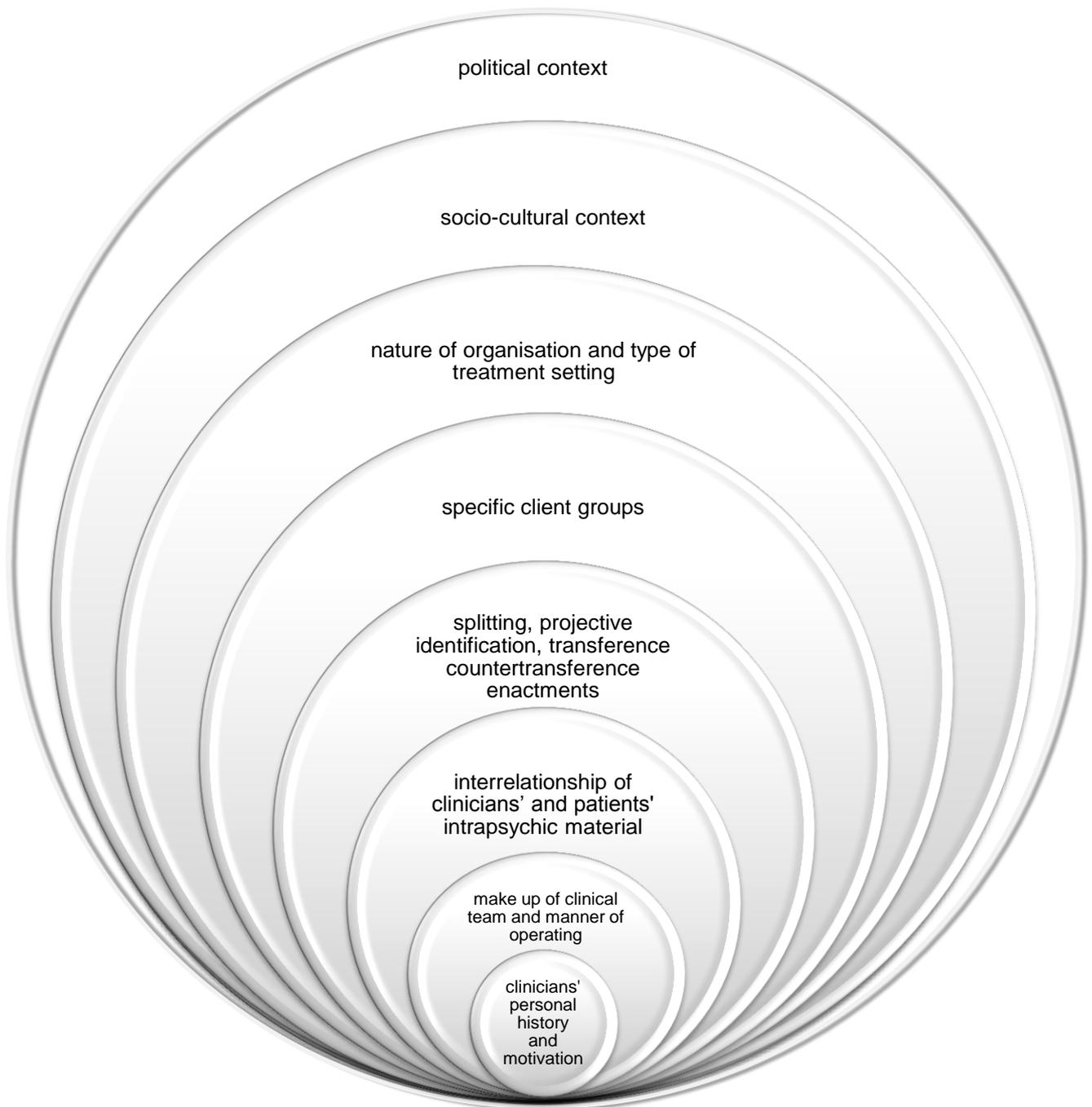


Figure 1. Layers of influence upon team dynamics within psychotherapeutic milieu

Below I will discuss the layers of influence upon team dynamics in therapeutic milieu, identified from the review and outlined in *Figure 1*, and their clinical implications.

Discussion and clinical Implications

Clinicians' personal history and motivation

Beginning at the micro level, the literature reveals the significance of individual clinicians' personal histories. The literature reviewed in Chapter 4 describes some of the elements that clinicians bring to their work including narcissistic injury, adapting to the needs of others, defending against aggressive impulses, depressive anxieties, and guilt. In addition, as also explored in Chapter 4, some clinicians have backgrounds similar to those of their client population, for example, addiction (De Leon, 2000). When a team of clinicians comes together a great deal of complexity is immediately involved. The literature contains relatively little material about the personal histories of clinicians working in treatment milieux. I suggest this is an under researched and very significant influence on team behaviour in this particular field. It would be useful to consider other aspects such as character styles and attachment styles of therapists and how these interact in the team and with patients.

In addition, the literature suggests that clinicians need to think about their personal motivation for the work and how this interacts with their personal history as well as with other staff and with clients. The literature reveals that reparative motivations, omnipotent saviour phantasies, phantasies of repair and atonement, and consequent unrealistic expectations of success are typical constellations of therapist motivation. Again, when clinicians come together to work as a team these become powerfully magnified in the staff relationships and in the work with clients. As both Main (1957) and Hinshelwood (2010) point out, their own high expectations and those of clients, and the resulting sense of failure and inadequacy can lead to reduced confidence, job satisfaction, and morale among staff, and disturbingly, the potential for staff to act out of their unconscious aggression and rage.

Clinicians who are unaware of their unconscious motivations for working in their profession risk acting out, for example, punishing clients for not getting well or suffering depletion in the face of their guilt-driven need to effect reparation. In particular the literature revealed that many clinicians come to therapeutic milieux underprepared for the intensity of material there (Szajnberg, 1985).

The make-up of the treatment team and its manner of operating

The literature referred in particular to the potential problems faced by multi-disciplinary teams in regard to relationships among staff, highlighting difficulty integrating paradigms (Hinshelwood, 2012), a lack of common theoretical language leading to increased rivalry (Bloom, 2010; Lindbom-Jakobson & Lindgren, 1997) and resistance to exploring unconscious dynamics (Briggs, 2004). The differences between status, reward and perceptions of value among professions was discussed and associated issues of competition, rivalry and envy were explored (Berger, 2002; Cardona, 2010; Halton, 1994). The difficulty for teams in general to face honest discussion was highlighted, as was the necessity of them learning to do so.

The clinical implications of a dysfunctional clinical team has a great bearing on clients and organisations given that the clinical team operates in the centre of a psychotherapeutic organisation, subject to powerful influences from all sides. In any team the importance of exploring the make-up of the particular clinical team, (multi-disciplinary or otherwise) in light of the aforementioned factors is important information for considering team relationships. In addition, the team's manner of operating regarding hierarchy is also relevant. Team members would ideally be able to observe and explore the health of their particular team at a given moment; whether it is a place of receptivity and honest feedback or whether the team has moved into defensive practice, a basic assumption group, or a paranoid

schizoid mode of operating. The contribution of all team members would assist members or sub groups who are experiencing difficulty.

Interaction of clinicians' and patients' intrapsychic worlds

The literature reviewed in Chapter 3 revealed the complex interplay of clinicians' intrapsychic material and the intrapsychic world of patients. However, a critique of this literature is that at times it emphasises the clinicians' identification with patients' projected material but minimises the personal history clinicians might bring to such identifications. I would argue that as revealed in the literature reviewed in Chapter 4 there is a danger that this repeats a pathologising of the patient as 'sick' and the clinician as 'well'. The dynamic of helplessness has been shown to be a crucial unconscious enactment between carers and patients in psychotherapeutic milieu (Hinshelwood, 2010; Main, 1957).

Teams' latent conflicts are evoked by projective identifications from patients (Gabbard, 1989; Lindbom-Jakobson & Lindgren, 1997) and it was shown that some team members believe that dynamics are indicative only of their personal failure and not related to clients or other contextual factors (Polden, 2010). Obholzer (1994a) cautions organisations to ensure that group problems, sometimes expressed by an individual for a group, are not attributed to individuals as this may prevent necessary organisational reflection and change taking place. I suggest clinicians need to be encouraged to reflect upon how the clients' and organisation's material relates to emotional states that can feel entirely personal, whilst also reflecting on their own personal contributions to the dynamics (see *Figure 1*).

Splitting, projective identification and countertransferential enactments

The interplay of staff and patient unconscious dynamics is most easily seen in the phenomena of splitting and projective identification and the enactments that result, for example, conflicts and rifts evoked between staff. Clearly, Grotstein's (2003) statement that "the group experience brings out dimensions of a patient's character that all too frequently

escape detection in individual treatment” (Grotstein, 2003, p. 15) also applies to staff. The literature points strongly to the interrelatedness of unconscious processes of clients and team members (Gabbard, 1989; Lindbom-Jakobson & Lindgren, 1997).

Without exception, the literature highlighted the importance of teams becoming aware of the unconscious dynamics assailing them from multiple directions as unchecked transference dynamics inevitably affect patients. Clinicians may experience intense feelings of inadequacy, hopelessness, anger, and hostility to colleagues, clients and employers (Cregeen, 2008; Hinshelwood, 2010; Jagarlamudi et al., 2012; Moylan, 1994). They may feel flooded, overwhelmed or immobilized with affect from the multiple, strong and often conflicting emotions that patients and colleagues evoke (Colson et al., 1986). Other effects include collegial rifts that become entrenched and irresolvable, sometimes leading to people resigning (Briggs, 2004).

Manifestations of unchecked countertransference include punitive or rescuing behaviour from staff (Main, 1957), ‘ganging up’ on the patients (Cregeen, 2008), scapegoating of a patient or staff member (Halton, 1994; Obholzer & Roberts, 1994), distancing, and withholding care from patients (Jagarlamudi et al., 2012). Some of the effects on patients are a hypothesised perpetuation of fragmentary internal object relationships (Heginbotham, 1999), failure to improve (Kernberg, 1987; Weintraub, 1964) premature discharge from services (Chiesa, 1989), and suicide (Weintraub, 1964).

Specific client groups

The literature highlighted, along with aspects of clients’ individual character styles, typical constellations of defences, and countertransferences and enactments which client groups tend to evoke. This literature was explored in Chapter 3. For example Moylan (1994) describes the characteristic dynamics present in addiction services where clients deny reality, experience doubt, uncertainty, guilt, anger and internal chaos, and manifest angry

dependence. Clinicians often use the same defences as clients (Moylan, 1994) which may then be enacted with other staff, managers and consultants (Cregeen, 2008; Halton, 1994; Polden, 2010). Added to this may be a similar background to the clients amongst some clinicians (De Leon, 2000; Roberts, 1994).

Training in the dynamics of specific client groups is essential, both within training programmes and as part of ongoing training within milieux, particularly in relation to unconscious dynamics that typically occur between clients and staff. Consideration of personal identification with clients is also an important topic for training as well as for personal therapy, for example, for a recovering addict working in an addiction therapeutic community.

Whilst considerations of the unconscious dynamics of the first three layers in *Figure 1* may be familiar for many clinicians, this review highlights their importance, and to some degree I suggest the literature reveals these layers of material remain under explored in most milieu settings. Moreover, the literature reviewed in Chapter 5 highlights that there are additional influences to which most clinicians pay scant attention when it comes to clinical outcomes

Structure and culture of the organisation

The structure and culture of the organisation, as discussed in Chapter 5, represents the layer that intersects the interpersonal processes between staff and clients and the wider societal context of the organisation. The literature reveals that an organisation's culture contains many unconscious elements (Hinshelwood, 2012; Hinshelwood & Skogstad, 2011) including aspects of hierarchy, authority and status. Unconscious processes repeat themselves on a number of levels and thereby permeate the whole organisation (Eisenberg, 1997). As discussed above, clients are inevitably affected by the effects of the organisational structure and culture on staff relationships, including the passing down of anxieties through the

hierarchy and the lack of strong provision of containment for clinical teams (Bloom, 2005; Heginbotham, 1999; J. Stanton, 2013). Change and reorganisation involves the arousal of primitive anxieties and defences in groups within organisations (Kahn, 2012), and reflective thought easily gets lost. This points to defensive behaviour at an organisational level and presents a strong argument for reflective spaces for management as well as clinical staff to untangle the multifaceted influences on the organisation's emotional state.

Social-cultural context

It is apparent that the wider social-cultural context of therapeutic milieu is greatly overlooked in the literature. I expected to find material related to diverse cultural contexts of team members as well as underlying assumptions of the dominant cultural context and how this impacts on staff relationships. However, no literature was found on these topics. This layer includes the assumptions that underpin the philosophy of an organisation and how these interact with the cultural contexts of each member. These assumptions may relate, among other things, to issues such as power, privilege, gender, ethnicity, sexual and gender orientation, and religion. The milieu is likely to unconsciously privilege the assumptions of the dominant culture which is a matter of concern for the organisation as a whole as well as for teams, clinicians and clients. This has particular relevance to Aotearoa New Zealand where the assumptions underlying the dominant western culture have been identified as at odds with a Maori model of health and potentially detrimental to work with Maori clients (Adamson et al., 2010; Durie, 1998).

The absence of literature about the cultural context carries clinical implications in itself. I suggest that the lack of discussion about this layer - both in terms of the diversity of individuals in a milieu and in respect of the wider cultural context - reflects the ease with which people remain unconscious to, and privilege, assumptions of the dominant culture.

The cultural layer of meaning has considerable implications for services which today have an increasing diversity of participants. Neglect of this layer has the ability to cause a great deal of dysfunction for staff relationships and for the clinical work, influencing outcomes for clients. I contend that this is an area which should not be ignored in the reflective space.

Political context

Only a few writers had a particular interest in how the political context affects therapeutic milieux. Bloom (2005) discusses the change in paradigm during her decades in the field, particularly the devastating effects of the change in political context from 1980 onwards which resulted in privatisation of health services and the move to ‘managed care’ and competitive funding. These changes have become the status quo within which therapeutic milieu of all types have to operate, or perhaps more accurately, to survive. The literature revealed that political forces, both conscious and unconscious, are at work in the milieu. For example, as highlighted by Bloom (2005), the biomedical model, evidence based practice, postmodern paradigm, eclecticism, neoliberalism, new conservatism and managed care “have crept into our systems and we have seen the devaluation of psychodynamic concepts as well as the culture of enquiry” (Bloom, 2005, p. 347). There is a strong need for management and staff to consider the implications that these factors have as organisational stressors, and consequently, as influences on teams, clinicians and clients.

The unconscious is multilayered

Overall themes suggest that many clinicians going into milieu work are naïve to their own personal psychopathology and how this relates to their motivation for the work (Billow, 2003; Miller, 1979; Whalley, 1994), as well as the potent ways in which clinicians’ intrapsychic material interfaces with clients’ intrapsychic material, and certainly to organisational and social, cultural and political influences upon team dynamics and treatment

processes. Literature suggests that workers in milieux are often the most inexperienced (Szajnberg, 1985) and that people leave either because they suffer burnout (Hardiman & Simmonds, 2012; Roberts, 1994) or move away from stressful frontline work (Hinshelwood, 1997). This leads to a precarious situation for clinicians and consequently for clients. Insufficient awareness of influences on the work when working in staff teams can have powerful and detrimental consequences for clients, staff teams, and individual clinicians themselves.

As has become clear, the layers of unconscious material present in therapeutic milieux are not discrete but move outwardly - affecting the layers beyond - and inwardly from the political, socio-cultural and organisational context; all intersecting in the work with clients. In addition the layers also relate not only directionally but in a complex interweaving. I suggest that it is essential the reflective space is available to make sense of the complex interweaving of this material. When clinical teams come together to talk about their 'special patient' all of the above layers are influencing the clinical moment and if not thought about, this material is unconsciously enacted, by individual clinicians, teams and organisations. The literature shows clearly the unconscious lengths to which teams and organisations will go to avoid honestly discussing staff relationships (Chiesa, 1989; Griffiths & Hinshelwood, July 1995). It is clear from this review that the unconscious life in milieux needs to be carefully and respectfully thought about and that this does not occur with sufficient regularity or depth.

It was notable that while each piece of literature seemed to explore one or even several pieces of the puzzle, none of them discussed all of the layers explicitly. For example, while Main (1989a) discussed the dependency-making system of the hospital he did not refer outwards to the cultural and political assumptions inherent in the hospital structure. On the contrary he considered that the criticism of hierarchical structures, such as Jones' (1968) "flattening of the hierarchy" to be defensive, suggesting that it was not necessarily the

authority inherent in hierarchical structures that is problematic; rather, an authoritarian way of relating is the problem. However, while his position holds considerable wisdom, I suggest that to not think about the social, cultural and political order which provides the wider context of the milieu is to avoid a set of powerful forces that influence how organisations and staff conceptualise and experience team and organisational dynamics, in turn potentially affecting work with clients. In contrast, Bloom (2005) pays a great deal of attention to the wider social and political context of organisations but does not give consideration to the personal histories or motivation of clinicians.

The incapacity to think on all of these different levels is particularly reflected in multidisciplinary teams, which have become the typical configuration of teams working in psychotherapeutic milieux. In these teams the problems arise as each profession conceptualises clinical material from within its own paradigm, and is often unable to perceive clinical matters from alternative team members' paradigms (Hinshelwood, 2010). While the multiple modalities of a multidisciplinary team offer potential enrichment for the team, the lack of a coherent theoretical basis is more often problematic (Bloom, 2005). In particular, psychoanalytic concepts can be seen by non-psychodynamically trained staff as elitist and inaccessible. However, when used in a non-defensive and non-pathologising way and offered as part of the human condition, understanding of unconscious dynamics can be a powerful tool for promoting understanding in therapeutic milieu.

Intersubjectivists propose that we are not isolated individuals but are co-creations of each other; that the self is a construct, inseparable from its social context (Mitchell, 1991). This, I suggest is a useful lens from which to view the therapeutic milieu, and provides a lens for exploring the ongoing intersubjective co-creations unconsciously created within the layers of psychic material outlined in *Figure 1*.

As Bloom (2010) notes:

Complex interactions among traumatized clients, stressed staff, pressured organizations, and a social and economic climate that is often hostile to recovery efforts recreate the very experiences that have proven so toxic to clients in the first place. Healing is possible for these clients if they enter helping, protective environments, yet toxic stress has destroyed the sanctuary that our systems are designed to provide. (Bloom & Farragher, 2010, p. 151)

With this multi-layered view of the influences revealed in the literature on staff relationships in milieu settings, I now outline some key clinical recommendations.

Recommendations

Creating a culture of enquiry – reflective spaces

The literature reveals that we have moved a long way from Tom Main's recommendation that the whole therapeutic community "needed to be treated as a troubled larger system in a "total culture of enquiry" (Main, 1989a).

How can we become better able to reflect on ourselves as individuals, teams and organisations? The literature emphasised facilitation provided by an external consultant (Cregeen, 2008; Halton, 1994; Moylan, 1994; Obholzer, 1994a). Various writers recommended team reflection on valency for the profession, on countertransference to clients, as well as organisational reflective enquiry (Dowling, 1998; Hinshelwood & Skogstad, 2002; Main, 1989a; Skogstad, 2006, p. 163). Writers emphasised that this space should be used to candidly identify and deepen understanding of dynamics between staff that point to intrapsychic processes in clients (Brown, 1980; Stamm, 1985). Many writers identified that while this can be a difficult process for staff and may be resisted by management, it is vital for healthy team functioning and patient outcomes (Jagarlamudi et al., 2012; Lakovics, 1985; Main, 1957; Skogstad, 2006; Stamm, 1985). An intersubjective perspective could also assist the culture of enquiry by supporting the members to consider

how the multiple and overlapping layers of influence, including their own contribution, combine to co-create the total environment. Indeed it is not only clinicians but also managers and boards that need to have the space to consider the multifaceted layers of unconscious material that permeate organisations. As Main (1989a) notes, management and governance also have the potential to enact transference and countertransference, to be reactive rather than reflective. Obholzer (1994a) adds that the absence of systems for managerial support can increase loneliness and potentially lead to unhealthy collusiveness, undermining their ability to fulfil their leadership and containment functions.

Personal therapy

The literature highlights the need for clinicians to become aware of their own unresolved conflicts, motivations and valency for the work via personal therapy or with colleagues in supervision groups (Roberts 1994). I would argue that a baseline for entering milieu work is that clinicians have experienced meaningful personal therapy and have the capacity to think in an ongoing way about how their personal histories and unconscious motivations impact their work, both individually and with their teams.

Training on Therapeutic Milieu

There is very little training for staff entering therapeutic milieux; most learn on the job. Further, even amongst psychodynamically trained clinicians there is a lack of training on how unconscious material manifests and plays out within milieu settings. For multidisciplinary teams the problems are greater, with lack of understanding of, or conflicting beliefs about unconscious processes. Clinicians come trained from their various perspectives and have little or no training in working in teams, let alone working in a therapeutic milieu. They have not considered what may arise working with a team of clinicians, let alone a community of residents. Often clinicians approach the work as if it is individual therapy in a community situation and later, group therapy in a community (Main, 1989a). This is

problematic for staff and clients. This review highlights the need for a training programme or programmes to be developed for milieu staff in New Zealand, which would need to have as a core consideration the layers of influence on milieu relationships, as outlined in *Figure 1*.

Training on unconscious processes

Many writers emphasised the importance of staff, especially in multidisciplinary teams, receiving training on unconscious dynamics in the milieu, particularly countertransference, splitting and projective identification (Heede et al., 2009; Herrman et al., 2002; Hinshelwood, 2010; Kahn, 2012).

Gabbard (1989) suggests that more conscious causes of conflict (such as philosophical differences and differences in training and orientation) can be differentiated from the polarisation caused by projective identification by determining whether the group's differences occur along lines that parallel the client's internal object world. This highlights the extraordinary usefulness of an awareness of unconscious dynamics among team members. Such training would ideally be ongoing as powerful unconscious processes easily overwhelm the ability to draw on historic training material. Training in this material is, I suggest, essential for therapeutic milieu teams.

Strengths and limitations of this review

It was notable that while each piece of literature in this review discussed aspects of unconscious processes affecting team dynamics in therapeutic milieux, none discussed all these aspects. This review provides a summary and critique of literature from disparate areas of a topic that affects clients, clinicians and communities. It identifies the range of unconscious dynamics that affect organisations, teams and clinicians. It also provides a set of recommendations which I suggest could represent a baseline for best practice for such organisations.

A limitation of this review is its focus on psychodynamic literature specific to milieu settings. It may have been useful to examine some issues more broadly even within the psychodynamic literature. For example, the psychodynamic literature on therapist personal history and motivation could have provided more data which could have then been applied to milieu settings. Additionally, a broader review could have extrapolated literature related to other organisational settings, to psychotherapeutic milieu settings.

It could be argued that the interpretivist methodology is a limitation of the review in that it requires that I interpret the literature. My view of the data is embedded in the world of psychotherapy and my own experience of the therapeutic milieu. However, I suggest that the literature clearly identifies the various levels of intrapsychic, interpersonal, organisational and societal dynamics and another researcher's findings may not be greatly different from my own. Moreover, my subjective position could equally be argued as a strength given it provides an additional lens through which to understand the data.

Suggestions for further research

This review has highlighted the need for further research about three aspects of unconscious dynamics in milieux – therapists' personal histories and how this affects their work, the socio-cultural context, and political forces influencing therapeutic milieux. Such research could take various forms. I envisage an ethnographic study of milieu clinicians to discover their experiences of unconscious influences in their work. This would be particularly useful in the context of current day milieu therapy in Aotearoa New Zealand. A range of staff from different milieu services could be interviewed for such research.

Additional valuable research method might be an observational study of psychotherapeutic milieux as discussed by Hinshelwood and Skogstad (2002). This type of study can bridge the gap between psychoanalysis and scientific study and again would provide research that is specific to the Aotearoa New Zealand context.

Summary

In this chapter I have detailed the findings of the review, discussed key themes and implications for clinical practice. I have made four recommendations that milieu staff: undertake their own personal therapy, undertake training in therapeutic milieux, participate in ongoing training about unconscious processes, and that teams at all levels of milieu participate in reflective spaces in which they are enabled to explore all aspects outlined in *Figure 1*, as they impact upon teams, team dynamics, and clinical work.

Chapter 7: Conclusion

Chapter 1 provides an account of my motivation for engaging in this topic. The context of the review in terms of settings is given and an outline of the chapters provided.

Chapter 2 outlines the methodology of the review. The epistemology and theoretical orientation of the work are outlined as is the method for collecting and examining the data.

Chapter 3 locates the review in the context of the key psychodynamic concepts pertaining to the relationship between team dynamics and client groups.

Chapter 4 explores the contribution of unconscious material from the individual clinician in the team, and the team as a collective, to the dynamics of the team.

Chapter 5 explores the unconscious dynamics of organisations that contribute to team dynamics in milieu settings. Social and political forces that contribute to team dynamics are also discussed.

Chapter 6 contains a summary of the findings from this literature review and a discussion of themes that emerged from the review. One of the key themes was the interrelationship of client, staff, organisational and social pathology in the milieu setting. The literature pointed to the necessity of a strongly held reflective space or culture of enquiry in order to examine team dynamics in terms of countertransference and 'organisation as a whole' dynamics. Four recommendations were made regarding personal therapy, training in both milieu therapy and unconscious process, and the provision of reflective spaces.

Finally, I recall the deep curiosity which led me to this research. My curiosity has enabled me to enrich my understanding of the influences upon staff relationships in milieu settings, and the implications of these influences for clinical practice and outcomes. My hope is that through this research, others may also be enriched by these understandings.

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