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GROUP RELATIONS, PSYCHIATRY AND CONSULTATION: THREE INTERACTING SYSTEMS - A SWEDISH PERSPECTIVE

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1. Introduction

The AGSLO, the Swedish Work Group for Leadership and Organisation, was formed in 1974 as an association with the primary task to introduce Group Relations Conferences in the Tavistock tradition in Scandinavia. These are working conferences with titles such as "Authority, leadership and organization" and with the primary task to provide opportunities to learn about social and psychological processes in groups and organization in the here and now and by experience. The conferences put a heavy emphasis on application of the learning.

The AGSLO has later, in the 80:ies been transformed into a non-profit foundation. I would like to point out that the foundation does not pursue any other tasks such as consultation, research or clinical work.

Still there exist close links with consultation, research and pychiatry due to historical and personal reasons in the history of the foundation. I intend to highlight how the three systems of Group Relations, psychiatry and organizational consultancy have been interacting.

Clearly this is a complex system of dependencies, counterdependencies, alliances and splits, negotiations and political struggles that is impossible to delineate in detail. Therefore I will present my rather impressionistic experiences on a few points without any aspirations to be complete.

Group Relations work in Sweden had its' roots within psychiatry, rather than in industry, research or consultancy. This fact has had a series of consequences for psychiatry and group relations, as well as for consultancy work in the mental health system.

The situation in Sweden in the early seventies was that sensitivity training had failed to achieve its' goals and ran aground surrounded by a heavy public suspicion that spread over to almost all attempts of experiential learning about social processes from a psychological perspective.

A couple of years ago, during a general meeting with the members of the AGSLO, a question was posed. The question , voiced by one of the founding members - a Swedish psychiatrist- raised the issue wether it would be of interest to the AGSLO to try to assess the impact of the Swedish Group Relations Conferences on Society. As an example - obviously not haphazardly chosen - he mentioned the impact on Swedish psychiatry. To be more explicit: important changes had taken place within psychiatry the last fifteen years and it was known that quite an impressive number of members of group relations conferences had been recruited from psychiatry. Did we know the reason why they took an interest in attending conferences? Did we know anything at all about how they applied their learing? If so, did we know anything about how this application had affected the change process that was going on inside the mental health system? The psychiatrist added that there may be some

indications that the reform of psychiatry was not always a happy and successful venture. The issue was noted for further reflection and consideration and initiated a renewed interest in the social benefits of the work.

What was perhaps not noted then was that the psychiatrist who raised the issue was one of three founding fathers of the Group Relations work in Sweden as well as as one of three founding fathers of the reform of the Swedish mental health system. All together they were four psychiatrists in two partly overlapping groups, three of them psychoanalysts, two of them social psychiatrists and three of them so committed to group relations work that they worked on the staff in the first Swedish Group Relations Conference in 1975. Three of them made up the leadership troika of the first project clinic for a new and reformed Swedish social psychiatry in 1974.

The personal union between the two systems in the early stages of their existence certainly is important. My hypothesis though is that what they symbolize is of even greater importance for the understanding of the system relations which are the topic of this paper. My aim is not to evaluate the Swedish development, but rather to try to learn from our experience of the relations between the three systems in order perhaps to avoid future collusion over these boundaries.

At the same time as the AGSLO was formed the Swedish mental health system was preparing for radical changes:

- firstly as a result of a new law in 1968 that transferred the system from state to local government
- secondly as a result of the heavy criticism levelled at psychiatry by radical students, consumer groups, psychoanalysts and anti-psychiatrically oriented professionals
- thirdly as a result of the interest a few professionals, influenced by the social psychiatric movement and psycho-analysis, had paid in president Kennedys Community Mental Health Center Act of 1963
- fourthly as a result of the interests parts of the psychoanalytic movement had to establish a power base within Swedish psychiatry through differing alliances and coalitions with among others psychologists and social psychiatrists.

I intend to present

1- an overview of the development of AGSLO and its conferences
2- the main objectives of the changes in the Swedish mental health system from1974 and onwards
3-the possible consequences of these changes for the system and the individuals serving it I will illustrate these consequences with some findings from consultancy in similar institutions and
4- connect these two developments in order to explore how the two systems may have interacted on a covert level

2. Group Relations in Sweden - AGSLO

The AGSLO - The Swedish Work Group for the Study of Leadership and Organization was formed in 1974, mainly with the initiative and support coming from professionals in psychiatry.

In Finland the corresponding work since the late seventies has been sponsored by PohTo (Pohjois-Suomen Teollisuusopisto) - The Industrial Further Training Institute of Northern Finland in Oulu and thus has a different tradition with its' roots in industry and close links

with the Tavistock institute. The AGSLO on its' hand had early organizational links with the AKRI, or A. K. Rice Institute, which has sponsored conferences from 1965 and onwards in the U S. Corresponding conferences and institutes operate in Norway, India, Ireland, Israel, France, Germany and Australia among others.

The AGSLO in its' early days actually had an internal discussion as to the primary task of the foundation where fractions of the group wanted the work to be carried on in the three areas of Conferences, Consultancy and Research. Eventually only conferences became the task, which does not prevent members of the AGSLO from engaging in research and consultancy as individuals.

Since its' beginnings the AGSLO has sponsored 36 conferences with almost 1800 members from all areas of work in Sweden. The number of applicants has almost always exceeded the number of available places on the conferences (Table 1). One may also note that we have staged a main 6- to 7-days residential conference and at least one shorter, non-residential conference every year.

Table 1
AGSLO-CONFERENCES 1975 - 1990

Type of conference	No of type	No of applicants*	No of members*
Main 6 days conference **	16	1 500	950
Intergroup, 3-days, non-resid.	10	800	640
Training conference	3	50	36
Small group	2	60	48
Large/Small group	1	70	50
Large group	1	70	53
Social dreaming	1	18	18
Sum:	36	2 570	1 795

Notes: * Approximative numbers ** Two of which 7 days A and B conferences

Of greater relevance to my topic today is, from what areas applicants and members have been recruited and what the development has been in recruitement.If you first look at the proportions (Table 2) of members from public and private sectors of the working life, you clearly see that public service dominated in the pioneering years but has decreased since then. This is partly the result of a successively clearar policy of the Foundation to recruite more actively from sectors other than the public services like psychiatry and health organizations.

Table 2
PERCENTAGES OF *MEMBERS*, MAIN RESIDENTIAL CONFERENCE 1975 - 1990
PUBLIC SERVICE / PRIVATE SECTOR

Sector	Percentage for period					
	75 - 77	78 - 80	81 - 83	84 - 86	87 - 88	89 - 90

Public	86	90	81	70	65	57
Private	14	8	16	24	33	40

If one looks at the main areas of work of the applicants in three-year intervals (Table 3), one will find that psychiatry dominated during the first nine years whereas governmental administration has increased its' shares during the last eleven years.

Table 3
PERCENTAGES OF *APPLICANTS* , MAIN RESIDENTIAL CONFERENCE 1975 - 1990
MAIN AREAS OF WORK

Area of work	Percentage for period					
	75 - 77	78 - 80	81 - 83	84 - 86	87 - 88	89 - 90
Psychiatry	38	45	32	23	10	23
Local & state governm.	14	20	14	23	23	34
University	22	9	9	7	8	3
Social work	5	9	11	3	13	3
Others	21	17	34	44	46	37

This can also be demonstrated in the shares of members accepted for the main conference. (Table 4) Here psychiatry dominated during the first three years and industry and commerce have increased their participation over time.

Table 4
PERCENTAGES OF *MEMBERS* , MAIN RESIDENTIAL CONFERENCE, first 3-year period and last two three year periods
MAIN AREAS OF WORK

Area of work	Percentage for period		
	75 - 77	85 - 87	88 -90
Psychiatry	39	19	9
University	21	9	4
Lo. & st. government	15	18	10
Industry & commerce	4	13	21
Others	21	41	56

This shift can also be illustrated by the changing frequencies of professions represented among members of the main conference (Table 5) . Here the most striking tendency is the decrease of psychologists, university teachers and researchers. Increases can be seen for personnel managers and consultants from the first to the second last period.

Table 5
PERCENTAGES OF *MEMBERS* , MAIN RESIDENTIAL CONFERENCE, first 3-year period and last two three year periods
PROFESSIONS

PROFESSION		Percentage for period		
		75 - 77	85 - 87	88 -90
Psychologists	31	7	15	
Psychiatrists	13	4	3	
Social workers & PSW		8	2	6
Administrators	1	12	6	
Consultants	1	13	5	
Personnel managers		0	6	1
Univ.teachers & resr.s		10	5	3
Others	36	51	61	

The composition of staff certainly mirrors the competence available, but it also affects what profesional groups will be attracted by a conference. In this table (6) one can see how psychiatry almost totally dominated the staffs during the six first years, with a rather quick decrease during the following six years and a stabilization over the last four years with rather evenly distributed shares of other areas of work.

Table 6
PERCENTAGES OF *STAFF*, MAIN RESIDENTIAL CONFERENCE 1975 - 1990
MAIN AREAS OF WORK

Area of work		Percentage for period					
		75 - 77	78 - 80	81 - 83	84 - 86	87 - 89	1990
Psychiatry	96	80	68	50	49	62	
University	4	17	21	20	17	23	
Consultancy, health, industry and church		0	3	11	30	34	15

Interesting is also to note (Table 7) how the domination of psychiatrists' on staffs steadily has decreased in favor of psychologists. it should be observed then that psychologists on staff only to about 50% are active in psychiatry

Table 7
PERCENTAGES OF *STAFF*, MAIN RESIDENTIAL CONFERENCE 1975 - 1990
Professions

Profesion		Percentage for period					
		75 - 77	78 - 80	81 - 83	84 - 86	87 - 89	1990
Psychologists	29	43	40	47	53	85	
Psychiatrists	46	34	21	11	3	0	
Others*	25	23	39	42	44	15	

* Clergy, managers, nurses, psychotherapists, secretaries and social workers a.o.

I have presented these numbers and tendencies in order to demonstrate one general tendency; from the beginning the work of AGSLO was heavily influenced by psychiatry, performed by psychiatrists and other professionals active in the mental health field and attracted members from psychiatry and the health professions. This occurred even though it was clearly stated that the work should cater for all areas of working life and for all professions.

Therefore I will give a condensed picture of what went on in psychiatry during the early history of the AGSLO.

3. The Psychiatric Reform

The main ideas of the psychiatric reform were to make a shift from a system based on mental hospitals and psychiatric clinics in general hospitals to a community oriented, sectorised system. This was to be done from an ideology which could be called social psychiatry. In this context psychiatry would be seen as a service system in close interaction with the population in well defined, rather small catchment areas. Hopes were that on opening up the big, heavy institutions towards the population psychiatry would be affected and develop also as to the quality and type of services offered. Mental health should be seen in a social context rather than as illnesses afflicting individuals. The resources should be reorganised from care on the ward to interventions in the community. Multi-professional teams would form and work cooperatively to serve the population's need for support, treatment and consultation. Generally the idea was to establish Community Mental Health Centers, but still based in the hospital system.

The work began in 1974 when three project teams were formed out of a large mental hospital in Stockholm, the so called Nacka-project. In the second half of the 70:ies - followed the project in the psychiatric clinic at the General Hospital of Ängelholm, where I worked at the time. It is worth noting that both projects were headed by the psychiatrist who moved most activeley to introduce Group Relations work in Sweden and also was one the founding fathers of the AGSLO. At the end of the 70:ies and in the early 80:ies most of Swedish Psychiatry followed suite and changed into so called sectorized psychiatry.

In short this change meant
- that the change in the beginning stages was partly of a revolutionary nature as it sprang from the professional rather than from the political levels
- that old patterns of work, cooperation and management were dissolved for new ones
- that established lines of authority were abandoned
- that established work roles also were given up
- that the personnel of psychiatry were more directly exposed to the needs and cravings of the population

To sum up: the whole system was put under extreme pressure to work responsibly within new frames. The situation was one of joy over a new freedom, mixed with a sense of insecurity and loss.

As the enthusiasm for the new freedom faded away symptoms of a crisis became evident. Some examples:

- professional rivalry increased over issues of power, influence and professional autonomy
- ideological disputes frequently turned into entrenched wars
- schisms that had not been worked through in the open developed into silent but threatening splits
- opposition and differences of opinion could not be managed except by inquisition and accusations of heresy
- teams were ultimately paralyzed by strong feelings of lost control and a hostile passivity evolved

This was the time for consultation and many units engaged in long sequences of consultation and internal scrutiny which drained time and energy from the encounter with the client system; the population.

I will now outline some possible causes for the crisis that grew out of the reform. My hypothesis is that the new goals for psychiatry actually forced the system to reorganize structural arrangements that had served as social defences against collective anxiety. In my ,perhaps not very original experience, organizational defence plays a crucial role in times of organizational change.It is, as if our clever and conscious strivings are often met by strange, and hard to define, counterforces. These are forces that we may perceive most clearly in times of institutional crisis. At times when the need for change, development and innovation is at its' peak.

In my experience as a consultant I have at times been able to grasp these forces as parts of the unconscious life of the organization. Eliot Jaques and Isabel Menzies Lyth demonstrated how this unconscious life at times has been shaped by an anxiety basic and common to the individuals of the organization at hand. An "Angst" that in parts belongs to the individual and which is handled by him or her more or less successfully through defence, symbolization, activity and other means. In parts this anxiety also is a collective concern.

Jaques and Menzies also demonstrated how organizations seemingly tend to develop common, often ritualized, defences as a support for their members' strivings to preserve their cohesive selves, their relative freedom from anxiety and their competence. These collective defences are often described as what "sticks to the walls of the organization ". In his analysis of the system for wage negotiations at a factory Jaques explained how certain social systems evolved as defences against paranoid and depressive anxiety. Menzies showed how the work of nurses was organized as a defence against castration anxiety, death anxiety and the anxiety of being overwhelmed by primitive aggressive and libidinal whishes.

The ideas of Jaques and Menzies have been applied in research and consultation by several Scandinavians. So, in Norway Harriet Holter has studied social defences in families and Poul Moxnes in psychiatry. The Swedes Kjell Granström and Dan Stiwne have applied the model to the school system.

In work with representatives of a computer business, a small-arms factory and a nuclear power enterprise I have met expressions of anxiety for schizoid break-downs, uncontrollable violence and physical destruction that permeated the organizations to such a degree that collective moves were institutionalized in order to fend off their burdens. I will soon relate a few glimpses from an action research project in a religious order of sisters where I was confronted with the basic anxiety around dependency/rejection which this female organization had bound in its organizational rituals and then been forced to let free.

On a deeper level you may assume that organizations develop and form both to handle a realistic primary task and to handle primary anxiety sources in a defensive way. Eliot Jaques even formulated the hypothesis: **"one of the primary cohesive elements binding individuals into institutionalized human association is that of defence against psychotic anxiety. In this sense individuals may be thought of as externalizing those impulses and external objects that would otherwise give rise to psychotic anxiety, and pooling them into the life of the social institutions in which they associate."**

I believe that every one who have experienced the chaos and isolation of a large group or the opening minutes of an inter-group exercise have been in close contact with the mighty longing for belongingness, order and orderliness that according to Jaques gives birth to institutions and organizations. Clearly organizational defences share with individual defences the quality that they appear as from behind a mask of Janus. The relative freedom from anxiety is the face looking ahead. Backwards stares the frozen face of routine, lifelessness and petrification.

4.Organizational defences during change and development

I would like to illustrate the impact of changes in the social defence system with some observations from a piece of action research with a religious Order of Sisters that I took part in in the early 80:ies. I have choosen this example, rather than one of many from consultation with health organizations, in the hope that the phenomena will stand out even clearer in a culture that is related to ours but still probably foreign to most of us working in secular settings.

The religious orders have an 800 year old tradition of strictly hierarchical organizations and operate in the tradition of care. They are also female organizations founded, developed and ideologically led by men. In these respects they share important properties with hospitals, whose predecessors they also were.

This order asked for consultation on two important issues. In contrast to other, closed and less democratic, orders they did not recruite novices and they had experienced how large segments of their primary task had been catered for by the modern welfare states. The primary task of all religious orders is "to serve God and neighbours". The first part is done through religious service and the second had in this order been dealt with by caring for children,the sick and the elderly and through education. As you all know there are three vows given by nuns:

- the vow of chastity
- the vow of powerty
- the vow of obedience

I will attend to the last one only. Certainly the church in general and the religious orders par exellence serve dependent needs. In the preparatory interviews we performed with all the sisters of the order it had turned out that they lived in a world - privately and collectively - that was permeated by conflicts around dependency and rejection - this was especially true regarding the sisters' early relations to their mothers. Thus, we had good reasons to believe that the collective anxiety, the organizational Angst, of this order and the defences against it would center around dependency. We could also make the hypothesis that this order - like probably many other authoritarian and hierachical systems - attracted entrant members with conflicts around dependency. We conjectured that the vow of obedience was part of their collective system of defence. By making the vow of obedience to Mother General and Mothers of Houses the novice confirmed a relatedness to a system through a relationship with a superior who in return promised never to fail her in her dependent wishes and strivings. It also made it easier for the young nun to manage herself in her caring roles as she received the dependent wishes and projections of desertion that were aimed at her from children,

elderly and sick people. It also helped the nuns to manage the interdependency between themselves in their daily life in the House. Through obedience to the abbess one was given distinct and strong frames for ones chores and duties and for how one should relate to other sisters and the surrounding world.

The risk that the dependency of the neighbours served should invade the net of dependencies among sisters could thus be minimized. During our almost three year long period of consultation in the different Houses of the order we learned that during the last two decades close to one half of the sisters had suffered what was termed ”nervous break-downs”. These break-downs were of varying degrees, but had strikingly often reached a psychotic intensity. Most of the sisters had regained their health without much of professional assistance, and most of those afflicted had afterwards changed positions and roles in the order. Often to roles they described as more satisfying than before the break-down.

In our efforts to grasp this phenomenon we found:

- *firstly* that break-downs of this type are usually rare in religious orders
- *secondly* that such break-downs very rarely occurred in this order before 1960 and
- *thirdly* that they began to appear from around 1965.

Successivley we were able to connect these observations with the Second Vatican Concilium in Rome 1962. One result of this conference in the catholic world was the Pope’s declaration of a new emphasis on the personal responsibility of every catholic for his or hers life on earth. Within the Order this created a conflict between obedience and personal responsibilty that for several years could be understood on a conscious level only - in a theological system of reference and without true working through and resolution of the dilemma. The former collective systems of defence broke down and each sister was left alone to handle her dependency relations and relationships as well as she could. The demand for personal responsibility was also in essence a demand for increased autonomy and this in turn exposed each individual nun to the dependency cravings of ”the clients” in a more distressing way than before. My experience is that corresponding phenomena occur in each and every organization that is reorganized in such a way that the accomomodated ways of supporting the individuals are disturbed. This means that everybody in the system during a period of change is put in the same type of marginal conflict as everyone entering an organization as a new-comer will encounter. In order to belong to an institution the individual has to achieve a good fit between individual and social defences. If the discrepancy is too great a break-down occurs in the individuals’ relationship to the institution. It usually manifests itself in a permanent or temporary break in the individuals’ membership. If an individual e g goes on to use his or hers habitual defences he or she will be perceived as a hindrance to others who adapt better to the new structures. These often choose, then , to reject this deviant member. If he or she then in turn tries to behave in a way consistent with the social defence system, rather than in accordance with the personal defence system, this will cause the personal anxiety to rise and the member may eventuallay break down or leave the institution.

Altered goals, changed policies, new roles, changes in leadership - especially in a hierarchical organization - will expose members to a new social defence system. And thus put them in the same dilemma as the entrant member in the marginal position.

So, there is a period of shedding of the shell when the organization changes its structure and before new defences have developed and began to stick to the walls. These are times of opportunities and times of perils. The opportunities are connected of course with the fact that the Janus head for a while exposes its front. It is possible to experience a new openness. Wishes, ambitions, hopes and

ideals that formerly were censured now surface. Creativity and pleasure may reign. At the same time many members are left without the support of the organization and run the risk of being overburdened on a personal level. Sooner or later however new collective defences will grow - for better or for worse. Security and stability return, but at the same time pleasure and creativity may be forced in the background. Janus has once again turned his darker face towards us.

5. Psychiatry and dependency

Let us for a moment consider what might be psychiatry's primary task!

Primary task here should be understood in the sense of Ken Rice , i e as that task which an organization has to pursue and attain in order to survive.

Thus. in a capitalist ecconomy, a production company will be organized in order to maximize profit. In any society, a hospital has to cure patients from disease and a research laboratory to produce new knowledge - et c. Thus if no profit, if no cure and if no new knowledge result, the organization will eventually die.

The definition will vary, of course, depending on our perspective, so let me present three possible perspectives - the medical, the sociological and the psychological:

a, As a branch of medicine psychiatry usually presents itself as the specialty that diagnoses, treats and if possible prevents mental disturbances. It also aims at alleviating and comforting when treatment is not possible. Somewhat willingly-nillingly - nowadays - also to protect society against the harm of a few disturbed.

b. From a rough sociological perspective you could say that psychiatry is part of the reproductive sector of the state with the objective to control deviancy and the possibilties of chaos and disarray connected with deviancy.

c. From the perspective of organizational psychology psychiatry may be described as an instititution that manages peoples' loss of relative autonomy or their incresed dependency of inner or outer factors. This is done irrespective of the cause of this loss as long as it can be defined as "psychic" in nature.

I assume that these three differing definitions of primary task to a lesser or higher degree are always present in any psychiatric organization. They may be seen not only as perspectives, but also as conflicting ideologies and thus tend to feed continous conflicts and boundary problems to be handled by the leadership. Therefore they are of importance not only in times of change, but for my topic the last definition is essential.

The objective then is to facilitate for individuals to move from low degrees of relative autonomy to relatively higher levels of independence. In order that this shall occur the patient is required to enter a temporary relationship of dependency with the institution and the therapist.

Out of the third definition - the one centering on the management of dependency in society - you may put forward the hypothesis that one part of psychiatry's basic and collective anxiety is to do with dependency (the danger of loss of self or love objects), another one clearly touches on the anxiety for madnes or psychosis (the danger of traumatic overstimulation). I will primarily focus on the former source of anxiety and how we handle it organizationally in the mental health system.

I will go on from the notion that all care is built on the ability to manage dependency. The one defined as a patient or a client is obliged to enter a temporary state of dependency in order to be treated or taken good care of. The therapists or
care-givers have to be able to respond to this by giving treatment or care, avoiding to promote excessive or prolonged dependency from the patient.

Now, when it comes to work in a group or team, which is part of the basic conditions of ”the new psychiatry”, this requires of the members of the group that they spin a web of relations among themselves, and that they are able to, as it were, attach this to the primary task of the group. This actually implies that the group members' interdependency has to be tied to the the task as well as to the surroundings of the group, the institution or the organization.

The inner situation of a psychiatric team has much in common with any working group such as for instance a construction team in a car factory or an infantry group in a regiment. There are also crucial differences regarding their tasks.

Common to the three groups is that they are formed and held together by the interdependence of the members and by their dependence on the surrounding organization. The differences are to do with the tasks. For the care giving team the situation is unique because it has as its central task to manage the dependency of patients, whereas the other two groups mainly manage construction and violence as their tasks.

Thus the inner dependency of the psychiatric group will not stand free from the primary task and it runs a constant risk of having members fall into grave difficulties in discerning dependency having to do with the relation to the patients from the dependency - the interdependency - that is the basis for cooperation in the group. When this boundary becomes blurred - individually or collectively - the group runs the risk of entering an emotionally too intense state which in turn heightens the anxiety level. This is one point where the head of Janus may begin to turn. The cooperative relation both between members and between members and their leadership is threatened. Creative development and change, emancipatory self-understanding and scrutiny are no longer pleasureable opportunities but threatening dangers. Each and everyone runs the risk of either being left on his or hers own or of being entwined in an overheated relational web. This is the point where individuals risk their capacity for mature dependency in a regression into the infantile forms.

Gordon Lawrence has suggested that we strive to manage the boundary between our ”relationships” and our ”relatednesses”. By relationships Lawrence means the relations we actually have in a group, e g between leader and led, between supervisor and supervisee, between superior and subordinate or between therapist and treated. Each one of these relations can be defined in an ”objective” way as to aim of the relationship, possible roles, responsibility involved et c. Relatedness on the other hand is to do with the notions we hold of our relations in an organization, and they are often mixed with our conscious and unconscious views of authority.

These two concepts point to the interesting and continuous interplay between relations and our notions of them, between realistic hopes and fears and those who are less realistic.

A Swedish psychologist and researcher, who is also the president of the AGSLO, Siv Boalt Boethius , has coined the expressions realistic and unrealistic dependency in order to discern two different types of dependency relationships. Those who build on real relations and those who build on - usually unconscious - notions of relations.

In her studies of nursery school personnel Boalt Boethius demonstrated how the realistic dependency builds on clear notions of the frames for the individual work. These frames may be the definition of ones own tasks, how different tasks are separated from each other - in short a good understanding of

the structural givens makes a sound interdependency possible. This also makes it possible for everyone to see the strengths and weaknesses of oneself and of each other and to use this knowledge in their work. Thus it is an important component in competence.

When this clarity of structural frames is absent dependency gets tinged with primitive elements and may show up in the wellknown Basic Assumption Dependency taking over with results such as:
- nobody will let anyone else take an initiative in the team
- or that everyone is expected to take own initiatives continuously

Whatever way results is unrealistic in that it denies the fact that work has to be done with some consequence of action and that the group must support its members such as they are.

I will give some further examples from Boalt Boethius' studies and from my own consultant experience of how difficulties in maintaining realistic dependency may disturb the functioning of work teams in the care-giving sector of society.

The personnel of the kindergartens expressed comitment and satisfaction in the work with the children, just as most people in psychiatry enjoy their clinical work. The relation to colleagues, parents and administrators was judged as more difficult to handle by most of the staff. Many avoided initiatives, to lead or to raise issues. The difficulty in an autonomous functioning generally manifested itself in an inability to hold on to superior principles and long-term goals for the work. It was hard to tease out which were main issues and which were minor. They often compromised and worked with conflicting and short-term goals. It was difficult to make priorities, and discussions often stuck on minor issues and details. Relations grew more important than real issues of work. Hidden competition and a dampened rivalry made it difficult to express gratitude and support or to grant authority, e g to lead lead work on a given issue. Norms of equality developed. The criteria of what was good work remained obscure, and that in turn led to a new kind of dependency on colleagues and management. You would leave it to colleagues and supervisors to decide on what was good work. As a consequence many teachers and nurses encountered difficulties in preserving their inner representations of good and bad work. It then became hard to think autonomously and to express differences of opinion. The trust in the opinion of others became too strong and one's own too weak. And so autonomy was lost.

Similar difficulties frequently appear in service organizations when organizational development is performed. In my experience this often is to do with the fact that new goals demand new roles. Ingrained roles usually contain well developed criteria of what is good enough, whereas new roles demand personal decisions. Decisions that are especially hard to make in a climate of dependency. It easily turns out that junior nurse knows that she has performed well when she has made the inventory of the ward's store room or fed the aquarium fish. It may be much harder to assess the quality of a group session or a crisis therapy. And certainly many a psychologist and psychiatrist has taken refuge in the psychotherapeutic setting, which is not as easy to assess as that of a team leader or of a supervisor.

6. Interaction of the systems.

Let me return now to the interaction of the two systems: Group Relations Conferences and psychiatry. So far I have noted that their appearance on the scene and their growth closely follow each other in time. I have also demonstrated that the initiators of both partly were the same individuals and that conferences recruited staff as well as members from the new psychiatry to a high degree during the pioneering years. Does this have a meaning? I think it does.

By experience and numerous testimonies I am quite convinced that conference members from psychiatry really have learnt an amazing lot about themselves, about leadership and authority and

certainly about the unconscious workings of groups, organizations and institutions. I also know that much of this learning has been widely applied on a personal level in order to be able to continue to work in times of change and upheaval, in times of progress and in times of desperate organizational regression. Many professionals in psychiatry have applied their new knowledge to increase their capacity to stay in role under stress and to defend one's work through a process of inner consultation in a dialogue between "the helping consultant self" and "the threatened therapeutic self" - just in order to point to one example. Many have increased their understanding of themselves as leaders in psychiatry and enlarged their capacity to receive, carry and contain the massive projections they often meet.

Certainly an amount of professionals in psychiatry have learnt in such ways that they decided to leave psychiatry for good. Some left for private practice, others left in order to return as consultants and others again left for wholly new territories.

Clearly some also applied their learning in defensive ways. In consultancy work I have, at times, noted tendencies to create a permanent interpretative atmosphere - resembling conference culture - in certain of the units of the new psychiatry. I venture the hypothesis that this atmosphere of illegitimate interpretation may have been the result of retaliatory tendencies that have not been worked through during conferences or perhaps have not been given the chance to be worked at due to collusive alliances beteween staffs and members coming out of the same institutions.

I find it fairly easy to understand that individuals turned to Group Relations Conferences with much hope as they were exposed to the strong forces I have outlined in my sketch of the psychiatric reform. But at times it seemed as if membership of at least one conference was part of the requirements for work in the new psychiatry - at least for psychologists, psychiatrists and psychiatric social workers. Certainly in reality it was not a requirement, but it became part of the relatedness to psychiatry for quite a few people.

In my experience this may have mirrored an unconscious collusion between the two systems. It is possible that the originators of both actually with some unconscious guilt foresaw the forces they would release in the mental health system and that the creation of the AGSLO in ways was their premature and unconscious penance for this "sin". Even if further exploration of this interpretation would prove it unfounded, it still seems quite obvious to me that the AGSLO in the beginning years in practice actually served as a consulting support system for the new psychiatry. It also seems obvious that it served as part of the leadership training for the new psychiatry. The relatedness may have been an institutional one, but the relationship was on a personal level. I am convinced that this mode of relating invited to a perversion of aims in both systems which it may prove worthwhile to explore further than has been possible here.

Provided these institutional strivings had been conscious, they could have been managed in the open. One obvious possibility could have been to set up a formal training and consultation institute for the new psychiatry. Such an institute could have had the advantage of relating to psychiatry and its organizations on an institutional rather than on an individual level as it now occurred. This would have meant that individual consultants from one institution would have consulted to individuals, groups and organizations in the other with focus on the system. What happened now was the obverse: individuals sought consultation in the conferences and may have lost the system perspective. My opinion is that had intersystemic consultation been possible, it would have strengthened the psychiatric reform.

The AGSLO certainly would have been more free to define and pursue its' primary task had this collusion been worked through earlier in the foundations' history. As it now evolved much good, necessary and painful work was put into the efforts to clear up the boundaries between the trustees and the Board, between the Board and the conferences and so on. Not much attention could be given to the boundary I have tried to illuminate today. As the foundation matured through work on other boundaries however, policies were slowly changed in order to free the conferences for learning by all sectors of society. The results of this are obvious in the ways the composition of conference members have changed during the last decade. Consequently the work of conference staffs and memebers, in my opinion, has become more profound and mature.

One conclusion for the future may be: when the mental health system needs a consulting and supporting system (and it does, especially in times of change!), then build one, but let Group Relations' work develop without any covert institutional ties, political or psychic, conscious or unconscious!