

Competition and Coherence: Creating a New Balance Between Economic Change and Organizational Identity in Mental Health Care Organizations

Mathias Lohmer*

Abstract

Rapid changes in the basic economic conditions of the health care system have, over the years, led to a generally apprehensive climate in health care organizations: the endeavour to provide high quality therapy conflicts with economic dictates to reduce costs and ensure a good rate of return.

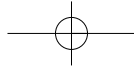
Looking at the recent development in Germany, this article tries to analyse how the health care system has to tackle these contradictory demands. It uses for this purpose the central dimensions of competition, which is one of the basic moving forces of market economy, and of coherence, which highlights one of the central necessities of the work of dealing with mentally ill individuals.

Competition demands rapid change, which in turn collides with the distinct need for stability in health care organizations; this corresponds to a structural dilemma: because of the nature of work in helping professions, which may be defined as 'stabilization of destabilized systems', and because of many helping professionals' personal history and psychological structure, we can frequently observe that the prevailing values in health care teams are continuity, stability, and orientation *within* the organization. This relates to the fact that people working in organizations have a basic need for coherence: to identify sufficiently with their own role, task, and organization. Primarily, they may try to fulfil this need by maintaining the stability of familiar structures and processes. However, they often underestimate the necessity of orientation to the demands of the environment, that is, to context and change.

The institution's economic context, the mechanisms of the market, and the increasing influence of competition, on the other hand, appear to be an annoying and irritating factor in the face of the 'real' helping activity. A one-sided economic orientation, which does not take into account the specific way of working in 'helping professions', has an equally destructive effect by breaking up meaningful work coherence.

An earlier version of this paper was first presented at the ISPSO-Symposium in Amsterdam in 2006.

*Address for correspondence: Dr Mathias Lohmer, Feilitzschstr. 36, 80802 Muenchen, Germany. E-mail: lohmer@t-online.de; website: www.lohmer.info



Yet, when an organization succeeds in balancing the necessity of developments driven by competition with the need for coherence and social identity, and in bringing both together in a shared vision, taking financial concerns as well as its own tradition into account; that is, keeping both the client and the staff in mind, then a new balance for the dilemma described above can be achieved.

This paper outlines the conditions for such an integrative organizational attitude, which tries to balance the various factors at play. The shift of values within society and its influence on the culture of organizations is discussed in a historical perspective. A case study from the author's consultation work with mental health care organizations illustrates the working hypotheses of the paper.

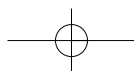
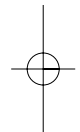
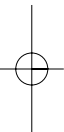
Key words: Mental Health care system; competition; coherence; change; helping professions; organizational culture; organizational consultation; organizational identity.

ECONOMIC CHANGE AND ORGANIZATIONAL IDENTITY

Rapid changes in the basic economic conditions of the health care system in Germany have, over the years, led to a generally apprehensive climate in health care organizations: the endeavour to provide high quality therapy conflicts with economic dictates to reduce costs and ensure a good rate of return. The general consolidation of tasks threatens familiar free spaces and leads to increased stress; the work relations between management and staff become more and more strained.

The demand for rapid changes collides with the distinct need for stability in health care organizations: this corresponds to a structural dilemma: because of the nature of work in helping professions, which may be defined as 'stabilization of destabilized systems', and because of many helpers' personal history and psychological structure, we can frequently observe that the prevailing values in health care teams are continuity, stability, and orientation within the organization. This relates to the fact that people working in organizations have a basic need for coherence; to identify sufficiently with their own role, task, and organization. Primarily, they may try to fulfil this need by maintaining the stability of familiar structures and processes. However, they often underestimate the necessity of orientation to the demands of the environment: that is, to context and change.

Seen in terms of organizational dynamics, increasing competition in the field of health care and not-for-profit organizations accelerates a development that has been observed for years: economizing the health care system. A field formerly characterized by communal,



public, church, or welfare institutions and their specific logic – no striving for profit, high awareness of tradition, secure status of employees, little attention paid to cost efficiency – is increasingly determined by the market economy and its logic. This generally implies: a clear necessity to make profit, otherwise termination of services; higher efficiency; shorter in-patient treatment; streamlined processes; specialization on profitable fields of medical care; deference of medical heads of staff to administrative directors; fewer and less well-paid employees confronted with an increased work load.

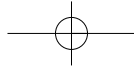
The impact of these changes in Germany has meant that a system that previously functioned more or less on a welfare model is increasingly forced to conform to market pressures.

This development cannot be arrested or reversed; it can only be influenced and steered *within* the framework of economic logic: that is, in a way that fulfils the demands of profitability while taking into account the quality of medical care and the employees' satisfaction with their work.

The challenge facing medical and administrative management on the one hand, and employees of mental health care organizations on the other, consists in accepting this development and understanding it as a process dependent on their own formative efforts. The danger is that, instead of the mutual development that is called for, it can come to a split between medical and economic necessities and logic. In this case, the task of resolving the tension through mutual effort in divided roles is not addressed. Instead, the situation regresses to a paranoid–schizoid state of organizational development, in which polarization, projection, and projective identification lead to one-sided argumentation of both extreme standpoints. This is enacted, for example, in chronic, irresolvable conflicts between medical and administrative directors or between employees and management (cf. Lohmer and Lazar 2006).

This can result in a serious threat to the institution: if the economic point of view is overly dominant, then employees lose the focus of their identification with the organization and thus lose their social and organizational identity. Inner resignation takes hold, morale suffers, and the employees' commitment to their work at the institution is dramatically reduced. Qualified personnel leave their jobs, and the quality of care and service diminishes noticeably.

If, however, the opposing standpoint takes the upper hand (an organizational identity dependent on security and familiar processes, with insufficient attention to economic necessities), the existence of the institution will be threatened over time in the face of steadily growing competition.



Acceptances of the necessity of development, accompanied by willingness to change, thus are a guarantee for survival: every system, whether an individual or an organization, only remains viable if it permits a constant process of development and growth, thus achieving an active adaptation to its changing environment. Active adaptation implies adjustment to shifting circumstances, but also exertion of influence on the organizational conditions and environment, wherever possible.

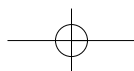
In my systems–psychodynamic perspective, based on the *Tavistock-Modell* (cf. Lohmer, 2004a), such systems with learning abilities are defined as open systems: that is, open towards their environment, capable of absorbing information, developing it further, and producing altered forms of action. Through this process the primary task of an organization, which defines its central interaction with the environment and particularly with the market and which consequently has direct bearing on its survival, is repeatedly adjusted to current developments. Open systems, meaning individuals or groups with functional borders or filters towards their specific environment, are capable of learning from experience (Bion, 1962). Persons within such systems are capable of anticipatory thinking and maintaining a high level of attention to the external context of their work. This context, or the framework in which their work activity takes place, is constituted by the relevant economic, social, and political environments of the organization – for example, the competitive market.

COMPETITION AND COHERENCE

Economic competition in the marketplace involves constant pressure to adjust; therefore, it requires such an anticipatory approach to external circumstances and also demands swift responses to new developments. But, for these very reasons, competition also promotes an institutional culture in which curiosity, creativity, and high motivation are desirable and encouraged.

In my view, competition at least initially has a ‘bright’ side: it forces individuals, groups, and organizations to make comparisons, providing a social impulse for them to distinguish themselves from one another and to develop the ‘best’ of their own abilities and potentials.

However, an exclusive orientation towards short-term maximizing of profit can cause an institutional culture to ‘turn sour’, and thus lead to the destruction of its social and organizational identity. In this case, the ‘dark side’ of competition prevails. In recent times, this is often to be observed in health care institutions whose policy is



then solely orientated towards cost reduction aimed at improving returns quickly (it may also boost the owners' opinion of the management!). In the long run, however, quality suffers, and with it, the competitive status of the institution. Instead of excessive cost cutting it would, alternatively, often be better to improve returns by expanding services and attracting new clientele.

The process of learning and adaptation that is mobilized by competition and directed towards change stands, by its very nature, in conflict with the change-resistant conservative forces of every system, be it an individual, a group, or an organization. These forces dictate that energy be conserved and that solutions, once found, are conformed to. In terms of the systems theory, that makes good sense: not every minimal oscillation or change in the surroundings should suffice to place a system in question; it should rather be sturdy enough to accommodate slight irritations.

The ability to conform to established processes and rituals gives rise to the identity of a system: individual, group, or organization. Identity is generated by the experience of continuity over time and in varying situations. We can speak of an organizational identity when the members of an organization share a mutual organizational culture and, in their role and person, feel attached to the organization and their task within it: that is, when sufficient overall facets of their person can be bound into their role in the organization (cf. also Ashforth and Mael, 1989).

In order that such an identity can be experienced, expressed, and brought to bear, it is necessary that patterns be established: through repetition of business processes, in communication on core values, and in the organization of everyday work. These recognizable patterns provide a secure expectation, a base orientation, and a functional boundary towards the surroundings: 'we, the team' or organization, as opposed to the environment. Such a social identity, which gives its members a feeling of security with regard to roles and expectations, ultimately leads to a feeling of coherence.

The concept of coherence, originally coined in individual psychology, refers to the inner cohesion of a person's self, meaning that the various instances (the ego, the id, and the superego) and facets of a person are experienced as balanced and complementary to one another. Even when confronted with burdens or conflicts, the person feels "whole" and consistent, and is able to apply his or her ego functions (such as stress tolerance, reflection, planning, and decision making). Thus, coherence is the prerequisite for a successful ego identity on the individual level, for a social identity on the group level, and for an organizational identity on the organizational level.

Coherence on the group and organizational level implies that the members and subgroups of an organization experience themselves and one another as belonging together, united in a common task and a mutual organizational culture, and, under stress, as loyal, predictable, trustworthy and able to function.

Coherence, therefore, lends the system a centripetal dynamic, thus performing a consolidating function by emphasizing equality, whereas competition has a centrifugal function, which promotes development but at the same time threatens to dissolve the boundaries of a system, because of the emphasis it places on differences among persons and sub-systems.

Particularly in health care teams, stability is often more highly valued than the necessity or the ability to change; certainly an expression of the central goal of many teams working to help destabilized persons or systems, that is, to re-introduce a new stability into a dysfunctional system.

Due to its nature, this helping work requires a high degree of stability and continuity in a team whose members must be able to bear and deal with the emotional upheaval and extreme tension often imported by the clients' system into the therapeutic system. Stability is significant for the work itself, and this also accommodates the need of many helpers to regard the members of their team or organization as a stable and reliable 'family' in which they feel sheltered and secure. Many helpers have emotional difficulty in dealing with separation, to the extent that the departure of a team member can often result in a severe sense of loss. This vulnerability of many helpers becomes comprehensible when seen in relation to their life experience, which frequently includes a history of separation and loss or of insufficiently secure attachments. In sum, this type of work thus supports the pronounced 'family sense' of many helpers.

The predominant internal orientation in mental health teams – where the continuity of personnel and established, secure processes are highly valued – does, indeed, feed the illusion of being protected from the demands of the environment. Teams sometimes tend to behave as though the market situation did not really apply to them, believing that their 'mother institution' would completely shield them from harm! This attitude makes active adaptation to shifting demands of the environment even more difficult.

HEALTH CARE ORGANIZATIONS AND CHANGING VALUES

In addition to the dilemma just described (stability vs. orientation to change), we encounter particularly within *mental health care*

organizations certain indications of a conflict of values that is significant for the whole of society. In accordance with a study by Barz et al. (2001), it can be asserted, in short, that the shift of societal values from an external orientation in the 1950s and 1960s to an internal orientation in the 1970s and 1980s has now yielded to a balancing out of internal and external value orientation and, consequently, to a need for mediation between the self and the environment.

Whereas the first phase emphasized aspects of self control in the face of conventions, institutions, and rules that went unchallenged, the second phase, in the 1970s and 1980s, was characterized by a veritable explosion of individuality – associated with values such as emancipation, autonomy, individualism, and breaking with traditions. The maxim was one of self-realization.

Contemporary experience instead highlights the importance of mutual reliance, the limitation of resources, the reality of reciprocal dependence, and the need to handle multiple demands simultaneously. In this third phase of the value shift, the maxim is self-management – managing boundaries in the face of a variety of tasks, a new social consciousness, and tenets such as balance, consistence, circumspection, and synergy.

Applied to our question of the integrative power of an organization, this would imply the need for ongoing efforts to balance out market demands over against internal culture: to combine flexibility with stable organizational structures providing security and support.

But mental health care organizations, in their emancipatory self-image, identify strongly with phase two, often with the result that external demands – such as economic challenges or policy innovations relating to care – are perceived as negative or threatening, while existing practice is defended as positive and beyond question.

Seen against this backdrop, some institutional conflicts become more comprehensible. On the one hand we have the tendency of teams to be solely inward looking, asking questions like: ‘with whom would we like to work? What feels good? Which standards of psychiatric care or psychotherapy do we want to uphold?’ At the same time, the subjects of strategy, finance, market pressures, and competition are disregarded.

In that sense, we might say, they are primarily concerned with issues of coherence rather than competition.

Weighing against that is the context orientation of management representing the whole organization, asking, for example, ‘How can we optimally deploy our resources in order to maximize profits while maintaining good enough quality standards?’ Thereby, they might disregard the needs and wishes of their employees.

This frequently leads to a dynamic of splitting between administrative and clinical management and employees, whereby the management is identified with the irritating and unpopular external demands and regarded as 'pawns of the owners and their profit orientation', while the employees form a huddle to protect their previous practice, from which they glean their identity.

Another effect of identification with values of the second phase is the pronounced aversion of many mental health care teams to standardization, regulation, and set procedures for making decisions: clearly, this can only result in a massive conflict with business logic over the proper handling of tasks and processes.

Here, an overall hesitance to assume responsibility and to accept restrictions or requirements is coupled with ideologically articulated convictions about the superior value of individuality, authenticity, and the concomitant refusal to 'submit' to rules considered to be dictated from without or from above. This applies particularly to demands arising from the economic logic of profit orientation.

This ideologically underscored refusal to integrate economic logic can be interpreted as a rationalization for an incomplete step toward maturity on the part of the individuals and groups in question: it is a refusal to accept and deal with the demands of reality. Instead, regression takes place on the group level; the economic point of views is split off and projected on to medical and administrative management. As a correlate, it can occur that the administrative management splits off its commitment to quality, social identity, and therapeutic logic, delegating it to the employees and medical-therapeutic management and, in so doing, marginalizing it.

SELF-MANAGEMENT AND INTEGRATIVE ATTITUDE

Due to this danger of polarization and splitting, it is all the more pressing to develop the self-steering abilities of a 'learning organization': the skills of self-management corresponding to the third phase of the shift in values.

In the Tavistock tradition, Gordon Lawrence (2000) formulated the concept of 'managing oneself in role' making it clear that every member of a work group and/or team is confronted with the necessity of managing him- or herself within his or her given role, and that this responsibility cannot be passed on to an external or a higher instance.

Managing oneself in role thus includes the active management of boundaries relating to the diverse tasks and the contradictory demands and logic to be served: as Medical Director, for example,

how do I enact my role on the boundary between the medical and economic realms? Do I protect my staff against 'tall orders' from the administration, or do I work towards integrating the divergent and counteracting perspectives within myself? As Administrative Director or CEO, am I interested in the specific circumstances and demands of 'helping work', or do I disqualify such considerations as 'luxuries'?

The concepts of the open system, the primary task, and managing oneself in role help to maintain a perspective on the whole organization and its further development, even though the individual worker in his or her individual role is primarily responsible for the workings of one subsystem only.

Managing oneself in role could mean, for individual members and an entire team, balancing out and integrating the various factors influencing them simultaneously: the external challenges relating to care policy with their feeling of identity arising from their internal culture; the standardization of procedure with the value placed on individual and creative fulfilling of tasks; and the active perception of risks and responsibilities with an open approach to micropolitics, power, and authority.

THE TASK OF THE 'HELPING' PROFESSIONAL: PASSIONATE ENGAGEMENT

There is, however, among helpers, a peculiar hesitation when it comes to applying such aspects of organizational dynamics to achieve a balance among the various factors influencing their work. Instead, members of mental health care teams often rely on the same skills they use in their dealings with clients: they demonstrate their empathy, reflect on problems extensively, mistrust swift action, and prefer highly individualized approaches. The result is an overtaxing of the standard social and clinical repertoire in dealing with group and organizational problems: helping professionals behave as if there were no distinction between their direct contacts with clients and those with their colleagues and directors in an organization.

Behaviour that is desirable in the helping professionals role – reticence, technical neutrality, and so forth – is inhibiting in the organizational context, and referring to it positively as 'restraint' is a mere rationalization. It seems as though working in helping professions for many years leads to a weakening of the ability to engage passionately in the ongoing development of the organization!

It can hardly be denied that cultivating a predominantly receptive–reflective approach to other persons ultimately weakens expressive and vital forms of entering into relationships. A more serious

problem arises, however, from the fact that many psychotherapists and other helping professionals themselves have been formed by childhood patterns and family dynamics which required that they, for their own emotional survival, keep a low personal profile in order to adjust as well as possible to difficult, unpredictable, impulsive, or extremely needy parental objects. This attempt to give subtle emotional support to the parents, to guide or care for them, can later lead to a preference for indirect forms of control, rivalry, and the exercise of power, which are then perceived as successful and amenable to the ego. Open competition on internal and external levels is thus avoided. Another manifestation of this defensive strategy, which is acquired very early and can be observed frequently among helping professionals, is the seemingly naïve search for zones free of dominance and conflict, accompanied by a refusal to address the topic of 'constructive and destructive use of power' (cf. Lohmer and Wernz, 2005). Aggression, envy, the desire for power, and mutual competition are taboo in such a context: they are denied and projected upon the 'evil, profit-oriented management' - which itself often presents a suitable foil, possessing a 'valency' (as Bion calls it) to identify with these attributes.

A CASE STUDY

In the field of inpatient health care for patients with neurotic and personality disorders, psychosomatic and burn-out disturbances, but not psychiatric illnesses, which need to be treated in psychiatric clinics, Germany – almost unique in worldwide comparison – has a large number (about 3000 hospital beds) of psychotherapy inpatient clinics. These are both public and privately owned, catering to a broad spectrum of the patient population, with services reaching from acute care to rehabilitation, meant to enable patients to enter professional life again.

The particular inpatient clinic that I am going to use for my case study has about 120 hospital beds and competes on a regional and national level with other clinics in maintaining a high level of customer satisfaction and minimal costs.

In terms of finance, this clinic has managed through the intense marketing work of the medical director to achieve special contracts with one major insurance company, which guarantees it the position of the primary service partner for the insurance.

The particular profile of the clinic is defined outwardly by offering tailor-made treatment to each individual patient, paying much attention to the patient's own wishes, such as wanting to exchange

one psychotherapist with another one. This can be understood as a sign of strong market orientation, treating the patient more as a customer than an 'ill person'. Inwardly, it is characterized by a liberal climate, a great deal of self-determination of the staff in their work, and by the option of ongoing Internet consultation with former patients outside of work hours, which improves the quality of service and also enhances income for the psychotherapists.

The medical director has repeatedly positioned the clinic as 'avant garde'. This refers to the testing of new models of financing with public and private health insurance companies, and to the integration of modern communication techniques, such as consultation via the Internet.

At the time of the incidents reported in the case study, I had been working for some time in the role of consultant for the clinic. I had been consulting to three subsystems – for the staff, the interactions of staff and clinical management, and for the clinical management.

Between the CEO, who is also the owner of the clinic, and the medical director there is constant conflict over 'who decides what': each of the two having the impression that the other is interfering in *his* area of responsibility, the medical–therapeutic field or the administrative–business aspects.

The introduction of a new IT system in the clinic leads to the culmination of various tensions and to massive conflicts. All treatments, daily therapy plans, and the documentation of the course of each and every therapy were to be entered on the PCs that each doctor had in his or her office. At the same time, a new system for recording work hours was to be implemented; it was supposed to document when an employee entered or left the clinic.

Various motives and expectations converge in the introduction of these new systems. The medical director wishes to prepare a response to a demand for transparency which may be made by the health insurance, requesting details on its clients' therapy plans ('are they getting what the insurance pays for?'). He also hopes that documenting work hours will assuage the employees' complaints: either it will emerge that there is time enough for documentation and writing physicians' reports, or he, as medical director, will be able to prove to the administration that more positions need to be filled. The owner and CEO is similarly interested in more transparency, but also in control over the work processes of the staff: he constantly has the impression that their work hours are determined by their personal needs, that they 'come and go when they feel like it'. But he is prepared to create new positions if it emerges that overtime is unavoidable. He hopes that the introduction of IT will streamline

procedures, standardize them, and make them more effective, while giving him more insight into them. The staff members are ambivalent about IT and the documentation of their work hours: they want their work load reduced, but are concerned that there will be more control exerted over them and that they will lose flexibility in timing and shaping their own work activities. They hope that clocking their work hours will lead to more recognition and to paid overtime, and, at the same time, they worry about a loss of self-determination and familiar niches.

The conflict between these diverging interests is exacerbated dramatically by two factors.

An incidental audit shows that many of the therapists have pursued Internet consultations (which are paid additionally) during work hours: the medical director and the CEO are incensed and threaten to initiate legal measures. Meanwhile, the introduction of the IT system turns out to be premature, with no test run and a number of programming errors. The IT consultant responsible for the system is a relative of the owner: he does not deal well with the team, tending to insult staff members when they ask questions.

The atmosphere at the clinic reaches breaking point, with mistrust and reciprocal threats increasingly taking hold. The accusation of 'usurping payment' (the extra fees for Internet consultations) stands against the threat of 'inner resignation' among the staff due to the 'mistrustful and controlling, disrespectful behaviour of the management'. There is a dramatic swell of insulting e-mails with cc's being exchanged between staff and CEO.

In two team consultations, the dynamics of polarization and splitting become apparent. Both sides (the 'cheated management' and the 'mistreated employees') see themselves as victims of the other party; everyone is indignant and tries to mitigate and rationalize their own failings ('we just wrote a few mails during work hours by mistake, it was in the interest of the patients!' vs. 'the IT system is working pretty well'). Defence strategies typical of the respective roles and social group identity are activated. The medical director begins to vacillate between the fronts: should he back the CEO or the staff?

The chief resident, who is part of the clinical management, sides with the staff and assumes the role of advocating their concerns.

The CEO, now perceiving the medical head of staff as an obstacle, increases the pressure. He raises his voice and attempts, more and more urgently, to 'assert' his 'matter-of-fact' point of view. The staff members, in a complementary development, become more and more passive, complaining that they cannot stand to listen to the CEO any more: they shift from the level of debate on content, which is painful

for the group, to the relational level of 'how we deal with one another', a displacement on to a secondary conflict which is typical for mental health care teams!

It becomes clear that an attitude conducive to integration on the group level will be difficult to achieve; there is a collision between enthusiasm for innovation and the wish for control on the one hand, and overtaxing and the fear of a loss of familiar freedoms on the other. The economically motivated innovation threatens the cohesion of the team and its co-operation with the administrative and medical management.

In a subsequent consultation of the medical management, including the chief resident and the medical director, another facet of the splitting comes to light: the medical director has been having 'secret talks' with the CEO, while the chief resident has been 'left out' and thus identifies with the staff.

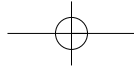
In sum: the management wishes to employ a new IT tool for economic reasons, but has overlooked the difficulties associated with its introduction and the resulting cultural changes that are of central significance for the organizational identity of the members of the organization. As a consequence, problems are played down, and an IT project group that includes staff members never convenes.

The team consultation of the medical management comes to the following conclusions: the medical director has to stop polarizing ('everything is working fine'), so that the staff members can give up their posture of refusal ('we will stop collaborating!'). He needs to mediate between the perspectives of the staff and those of the CEO and to translate the economic logic into the logic of therapeutic activity in a manner comprehensible to the team and vice versa. The chief resident has to be included in the management meeting, and the project group must be given factual authority so that the IT system can be introduced at an acceptable pace. The IT expert who has been insulting to staff members needs to be barred from direct contact with the team.

Concentration on the common task can then strengthen coherence again and make it possible to continue in being successful in taking on external competition.

DISCUSSION OF THE CASE STUDY

Looking at the case in its entirety, one could say that management introduced a significant structural change (the IT system) in order to pursue a clearly more market orientated business strategy of optimizing internal processes in order to be fit for competition. The



intended effect was to reduce costs, increase efficiency, and allow more transparency for the insurance companies.

Staff in return felt controlled and robbed of their niches, to a large degree ignoring the strategic context in which these structural changes were taking place. Instead, they were solely concerned with restoring their state of coherence. Thus, they were partly denying the market reality that needed to be addressed.

This problem was exacerbated by the fact that management ignored the severe problems created by the inept introduction of the IT system and by losing contact with the desires and fears of the staff.

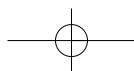
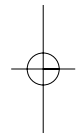
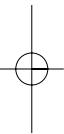
So, instead of taking the whole picture into account (market orientation and internal therapeutic climate, the need for competition and for coherence), staff and management used the social defence of splitting to have each side identify with one side of the polarity and so avoid the painstaking psychic work of integrating both.

BALANCING ECONOMIC CHANGE AND ORGANIZATIONAL IDENTITY

How can management and staff succeed in withstanding the tension between economic necessities and organizational identity, and how can they bridge these polar opposites?

Certainly it is of advantage to be conscious and highly aware of phenomena as they have been described here. Of foremost importance is a specifically integrative posture towards organizational dynamics, permitting containment (as discussed in Lohmer, 2004b, and Lohmer and Lazar, 2006), that is, reflective attention to, and open discourse on, these processes, which often occur unconsciously but have extensive ramifications for the dynamics within a group. To accompany this, an organizational consultation can be very valuable. In particular, the combination of team consultations for staff members and for management with the same consultant can help in recognizing divisive dynamics early and in resolving them whenever they arise.

Another aid can be provided by a perspective allowing for a balanced assessment of significant influences and guiding factors which bear on an organization. Although it has mostly been used in for-profit organizations up to now, the balanced score card is slowly gaining ground in health care organizations as well (cf. Eisenreich, 2002). It is applied as an instrument to measure the value and the quality of processes within an organization. This perspective emphasizes that the claim of being a learning organization (cf., for example, Senge, 1990) is only justified if four dimensions are *simultaneously* addressed when realizing a vision and a strategy: first, innovation



and learning, second, finances, third, the customer, and fourth, inner processes.

Innovation and learning relate particularly to the satisfaction of employees and the circumstances for containment: is there a mutual development that promotes innovation?

Do employees have access to a secure social and organizational identity that provides them with sufficient institutional coherence? Can they participate in balancing corporate interests with their own developmental impulses, through regularly scheduled one-to-one personnel talks in which goals are agreed upon?

For the dimension of finances, this involves working with clearly stated budgets and budget responsibility even at lower levels of hierarchy; for example, with flexible working hours or 'comp-time' accounts, and it also means allowing employees to participate in the financial success of an institution.

For the customer aspect, it implies accepting that health care organizations serve and must satisfy different customers at the same time: the direct clients as well as those commissioning and funding the work. This is another juncture at which polarization, as described earlier, often occurs. The team members identify with their direct clients and their needs, while the directors fall in line with funding instances, owners, and their demands.

With regard to inner processes, a tendency is often to be observed among the staff of psychosocial organizations that they have difficulty in distinguishing between different programmes for different groups of clients and patients. Teams frequently identify fully with providing comprehensive help, and thus find it hard to recognize the value of short therapies or basic health education. This also entails an important learning process: distinguishing between 'what makes us who we are' and 'how we always do things'. It implies formulating the core of one's own tradition, the specific nature differing from that of competitors – which is often a combination of particular abilities coming together to present a specific type of service. This practice should be compared – in the sense of 'benchmarking' – with that of the 'strongest competitor', so that processes in an organization can be developed further toward achieving 'best practice'. These processes must be distinguished from institutional routines and social defence strategies (cf. Menzies-Lyth, 1960; Hirschhorn, 1988), which serve to allay fears and avoid exertion.

SUMMARY

If an organization succeeds in balancing these diverse aspects and relating them to a mutually shared vision, developing a sense for

financial necessities but also for the contours of its own tradition, keeping the customer in mind and supporting the staff as well, then we have what in recent years has fashionably been described as a 'learning organization'. Then, the organization is an organism with well-developed abilities for self-guidance – or self-management in roles – that can, at various levels of hierarchy, respond to environmental challenges. Such an organization can skilfully negotiate external and internal competition, while at the same time developing and maintaining coherence and organizational identity.

Acknowledgement

I gratefully acknowledge the contribution of Ross A. Lazar, discussing this paper and giving invaluable support in formulating the English version.

References

- Ashforth, B. E. and Mael, F. (1989) 'Social identity theory and the organization'. *Academy of Management Review*, 14(1): 20–39.
- Barz, H., Kampik, W., Singer T. and Teubner, S. (2001) *Neue Werte, neue Wünsche. Future Values*. Düsseldorf: Metropolitan.
- Bion, W. R. (1962). *Learning from Experience*. London: Karnac, 1984.
- Eisenreich, T. (2002) 'Steuerung und Führung mit Kennzahlen – die Balanced Scorecard als Cockpit für das Unternehmensmanagement'. In: T. Giernalczyk (Ed.), *Supervision und Organisationsberatung. Institutionen bewahren durch Veränderung* (pp. 94–111). Göttingen: Vandenhoeck & Ruprecht.
- Hirschhorn, L. (1988) *The Workplace Within: Psychodynamics of Organisational Life*. Cambridge: MIT Press.
- Lawrence, W. G. (2000) 'The management of oneself in role'. In: W. G. Lawrence (Ed.), *Tongued with Fire. Groups in Experience* (pp. 31–50). London: Karnac.
- Lohmer, M. (2004a) 'Einführung'. In: M. Lohmer (Ed.), *Psychodynamische Organisationsentwicklung. Konflikte und Potentiale in Veränderungsprozessen* (2nd edn) (pp 7–16). Stuttgart: Klett-Cotta.
- Lohmer, M. (2004b) 'Das Unbewusste im Unternehmen: Konzepte und Praxis psychodynamischer Organisationsberatung'. In: M. Lohmer (Ed.), *Psychodynamische Organisationsentwicklung. Konflikte und Potentiale in Veränderungsprozessen* (2nd edn) (pp 18–39). Stuttgart: Klett-Cotta.

- Lohmer, M. and Lazar, R. A. (2006) 'The consultant between the lines of fire: the dynamics of trust, mistrust and containment in organizations'. *Organisational and Social Dynamics* 6(1): 42–62.
- Lohmer, M. and Wernz, C. (2005) 'Psychotherapeuten und Macht'. In: O. F. Kernberg, B. Dulz and J. Eckert (Eds), *Wir: Psychotherapeuten über sich und ihren 'unmöglichen' Beruf* (pp. 291–302). Stuttgart: Schattauer.
- Menzies-Lyth, I. (1960) 'Social systems as a defence against anxiety: an empirical study of the nursing service of a general hospital'. In: E. Trist and H. Murray (Eds), *The Social Engagement of Social Science, Vol. 1: The Socio-psychological Perspective*. London: Free Association, 1990.
- Senge, P. M. (1990) *The Fifth Discipline. The Art and Practice of the Learning Organization*. New York: Doubleday.