

THE FUNCTIONS OF DYSFUNCTION: IMPLICATIONS FOR ORGANIZATIONAL DIAGNOSIS AND CHANGE

William A. Kahn
Boston University

Organizations are often marked by dysfunctional patterns of group and intergroup behavior that make little sense, given organizational purposes. Such patterns stubbornly resist change by leaders and consultants. They remain in place, often enough, because they serve irrational functions for system members of which they are often unaware. Such irrational functions involve defending system members from the conscious experience of painful affect and anxiety that gets triggered by their tasks and environments. In this article I offer a theory of intervention and a diagnostic methodology for analyzing and altering irrational patterns of intergroup conflict. Using a case study of a consultation in a residential treatment center, I show how consultants can intervene in organizations whose members have created and maintained patterns of behavior that undermine rational organizational purposes.

Keywords: intergroup relations, intergroup conflict, organizational diagnosis
irrationality

Far too often organization members operate at cross-purposes. This is particularly true with organizational structures enabling division of labor: members are grouped into divisions, functions, and departments, and then further split into groups and teams, in order to create specialized functioning on behalf of the larger system (Mintzberg, 1992). Such structures heighten systemic efficiency and effectiveness; ideally, members complete particular tasks, and their efforts are seamlessly joined together to complete their collective mission. In practice, structures that divide labor and expertise are marked by more profound divisions as well, as members too often come to identify with the parts rather than the whole to which they belong (Diamond, Stein, & Allcorn, 2002). Organization structures that divide people from one another thus press toward the fragmentation of larger systems, with predictable misalignments in purpose, activities and relationships. Such dysfunctional patterns frustrate organizational members and leaders alike, given how little sense such patterns make in achieving stated goals.

A typical response to members operating at cross-purposes is reorganization (Gulati & Puranam, 2009). Leaders merge or further split divisions. They create or dissolve matrix reporting relationships. They change reporting relationships and replace leaders. They tinker with reward systems. They introduce programs—focused on excellence, quality, teamwork, and the like—to shift practices. Through such efforts, senior leaders try to engineer alignments across divisions. They bring in consultants to fix problems with communication, operations, conflict, or leadership. The guiding

logic is this: If only people were organized correctly, rewarded appropriately, taught teamwork and collaboration, and led wisely, they would work well across their divisions.

The results of these changes have often been less transformational than leaders might have wished (Steele, 1969). Dysfunctional patterns remain, as if welded to the skeletal frames of organizations. Members continue to act in spite of, not with, those identified with other parts of the larger system. The irrationality is twofold. First, in working at cross-purposes, members are less able to achieve the missions and purposes for which their organizations exist (Kahn, 2005)—and thus, threaten the very existence of those organizations, and by extension, their own jobs. Second, individuals are acting against their own rational self-interests when formal reward systems and informal cultures press them to collaborate (Mintzberg, 1992). They risk sanctions. Why? What forces move individuals to take such risks, to themselves and their organizations?

In this article I offer a way for consultants to look carefully at this question. The underlying premise is this: *Ostensibly dysfunctional behaviors that continue to occur over time are maintained because they serve certain functions for those performing those behaviors.* In other words, behaviors that seem on the surface patently dysfunctional can also be understood as functional, beneath the surface. Based on this premise, the consulting task thus becomes identifying those underlying functions—and then helping organization members create ways to serve those functions in more rational ways. Absent this focus, consultants will continue to help make structural shifts and realignments that might well become compromised by dysfunctional patterns of behavior that serve hidden needs (Stein, 1996; Steele, 1969).

Consultants need to become comfortable with the logic of the irrational in order to work with the idea that behaviors can be simultaneously dysfunctional and functional. Psychologists offer a window into such logic, showing how dysfunctional individual behaviors need to be understood in terms of irrational interests. Irrational behaviors are driven by motives of which individuals are often unaware—their unconscious impulses, demands and needs (Cramer, 2000; Freud, 1936). The psyche exerts its own press: if individuals unconsciously wish, for example, to remain isolated in order to protect themselves from experiencing the pain of loss, they will do so, even as it subverts their stated goals to work closely with others, create loving partnerships, and create strong family units (Cramer, 2000). This is logical, even as it is rooted in irrationality.

This process occurs in organizational life as well. Robert Kegan and Lisa Lahey describe how individuals at work routinely undermine their own efforts to change ineffective work patterns (Kegan & Lahey, 2001; 2009). Their work shows that although individuals can have compelling visions of what they would like to achieve, they sabotage those visions through their own hidden attachments to psychic needs. The manager who wants to develop her team, for example, has difficulty delegating to others. The manager might say that she does not yet trust her team and wants to bring them along slowly. Yet she makes little effort to actually develop them to become trustworthy. In such cases, people defend some hidden parts of themselves (Kegan & Lahey, 2001). The manager does not develop others because she fears being dependent on others, which she equates with weakness. Her previous experiences with dependency have been painful; she thus organizes her life in ways that protect her from the anxiety associated with dependency on others. The behaviors that on the surface are dysfunctional, subverting her stated goals, are actually functional, enabling her to avoid that which makes her anxious (Kegan & Lahey, 2009).

This logic applies to social systems as well. Family theorists have mapped how families maintain behavior patterns that impede members' development (Walsh, 1998). Their resistance to altering those patterns is usually rooted in how those patterns serve psychic functions for one or more members, as when an overly enmeshed relationship between a parent and a child serves the parent's need for intimacy in the context of a disengaged marriage (Minuchin, 1974). The underlying anxiety about the marriage itself drives the parent to maintain the dysfunctional relation with the child. Indeed, the wish to avoid that anxiety affects the family system as a whole, with all members arranging themselves in ways that support the dysfunction. The dysfunctional patterns serve collective functions for the system (Bowen, 1978; Minuchin, 1974).

Groups, teams, and organizations more generally can create and maintain similarly dysfunctional patterns. Such patterns are *social defenses*—the collective arrangements (e.g., organizational

structure, work method, prevalent discourse) that members use as protection against disturbing affect or anxiety (Long, 2006). Lyth's (1988) classic study examined social defenses in the nursing service of a teaching hospital. Nurses restricted contact with any one patient, limiting their abilities to attach to specific patients. Patients were discussed as disease categories, not individuals with names and histories. The nurses rushed about the unit, limiting intimate contact with patients and one another. Their patterns of behavior made little sense given the task of caring for patients. Yet the patterns make a lot of sense when understood as a defense against nurses feeling emotionally attached to and anxious about dying patients.

Social defenses complicate the work of consultants. The consulting task becomes deciphering the defensive functions embedded within ostensibly dysfunctional patterns of behavior and helping system members create and enact ways to contain and manage their anxiety. A number of theorists have been trained in the tradition of the Tavistock Institute to decipher social defenses (see Gould, Stapley, & Stein, 2004; Obholzer & Roberts, 1994). Their writings describe the action and implications of social defenses. Yet there is little concrete guidance for consultants not fully trained in that tradition to diagnose and change seemingly dysfunctional patterns. Moving from a conceptual understanding of social defenses to an effective diagnostic and intervention process has been a bit of a mystery.

In this article I seek to demystify the process. I do so by describing and illustrating the use of *functional analysis* as a method to integrate the outcomes of interaction patterns with the hidden needs they serve. Functional analysis was developed by Coser (1956) to identify the social needs served by conflict in and between groups. Coser's insight was that conflict, usually perceived as destructive, served positive functions implicitly desired by system members. For example, he noted that conflicts between groups increase internal cohesion within groups and prevent group dissolution. Coser's analysis led to a more general proposition: system members engage in seemingly destructive patterns of behavior because they need what those patterns do for them. This proposition leads to the functional analytical method shown here.

In this article I use the case of a long-term consultation with a residential treatment center to illustrate theory about diagnosis and change in the context of groups working at cross-purposes. The theory contains two primary components. First, seemingly dysfunctional patterns are actually quite functional, in terms of enabling organization members to collectively avoid surfacing anxiety triggered by their work. Second, dysfunctional patterns wrap themselves around existing organizational structures, as diseases attach to host organs. Diagnosis thus involves isolating the patterns, although change involves altering structures such that members are able to move openly toward satisfying hidden needs. Taken together, these two theoretical elements offer consultants a conceptual tool for enabling organization members to disentangle work behavior from defensive behavior. Although the theory is developed in the context of a long-term consultation, its key tenets are useful for briefer consultations with organizations.

Diagnosis

The residential treatment center provided educational, residential, and clinical services to approximately 100 at-risk boys with emotional and behavioral difficulties severe enough to interfere with their abilities to remain in their schools, homes, or communities. The clients, ranging in age from seven to 18 years, typically had disorders that manifested in aggressive, withdrawn, or self-injurious behavior. Center staff worked with these clients in the context of three primary programs. A day school helped students improve academic and social skills, develop more appropriate behavior controls, and enhance self-esteem. A clinical department provided diagnostic evaluation, individual and group psychotherapy, and case management. A residential department oversaw teaching social skills and using group interaction, consistent daily routines, and behavioral management programs.

The three departments—education, clinical, and residential—were each managed by a department head. The residential department was responsible for the clients before and after the school days and weeks, during which the education department was responsible. The clinical department was responsible for the clients at specific, relatively limited points during school days, when therapy,

medication, or case management was required. An administrative team led by an Executive Director oversaw the departments and ancillary services and set the strategic direction of the Center, reporting to a Board of Directors whose actual oversight was nominal.

The organizational diagnosis, developed via observations and interviews, culminated in a series of feedback meetings. The diagnosis involved identifying patterns of behavior within and across groups, and then analyzing the functions that those patterns served for Center members.

Systemic Patterns

The overarching theme was the Center's interdepartmental dis-integration. The education, residential, and clinical departments each pursued its own agenda. Each department operated on a different set of principles rooted in beliefs about what ultimately would best serve clients. The educational department focused on behavioral outcomes. The clinical department focused on cognitive and emotional processing of past and present events. The residential department focused on teaching life skills. Although each departmental focus was integral to the clients' development, the differing beliefs and premises translated into a struggle for primacy. Incidents would occur—a child ran away, another stole a van, a third had drugs—and staff members would often immediately look to blame other departments. They were also disrespectful to other departments' members. Rather than inquire about their experiences, perspectives, and approaches in specific situations, they circulated rumors or confronted them in a bullying or disrespectful fashion. Or they simply ignored one another rather than seek out one another to provide crucial information necessary to put client actions in context.

The lack of integration among the three departments was reinforced by relations between the three department heads. The Center needed the heads to be the primary integrators. Ideally, they would confer, advocate, and find consensus as a daily practice. No judge was needed as long as the three heads acted in concert for the good of the Center and its clients. These conditions were not met. The clinical department head withdrew from the advocacy process, leaving the others to battle for prominence. These two women did so with a vengeance, taking every opportunity to weaken the other's stature in the Center. The Center was rife with rumors about their latest battles, waged publicly in meetings and privately through back-channels. Their battles were treated largely as interpersonal—they simply "couldn't get along," or "hated each other." The education department head was widely perceived as "ambitious," and the residential head as "a bully." These women acted in ways that confirmed such projections.

There was often inconsistency in the Center's collective treatment of clients. A teacher might "consequence" a child for acting disruptively in class, putting him on isolation once he was back in the residence, but the residential staff might well reverse the consequence because they distrusted the teacher's motives and rationale. Or the residential staff might ask for extra support during transition after school and be rebuffed by teachers who said they needed to finish preparing for class. Such transitions—students leaving school for the residences, or on Fridays, for the weekend—were flashpoints. The three department heads sought to protect their staff from being "on the floor" during those times; each argued that their people needed respite.

The senior administrative team largely abdicated from the work of managing relations among the three departments. They did not provide a set of principles to guide department heads' advocacy and consensus. Nor did they serve as arbitrators. The lack of administrative presence was clearest when it came to the lack of accountability. A staff member yelled at another, to the point of verbal abuse, with little repercussion. A residential supervisor forgot to pass out medications and was barely reprimanded. Reports of such infractions were routinely made to the senior leaders, and just as routinely resulted in little observable disciplinary action.

The senior leaders were not, in practice, much of a team. They did not meet as a unit per se, joining instead the department heads in an all-purpose monthly meeting. Each of the five senior directors found other places of support outside the Center, in another department or in an administrative subgroup. The senior administrative team did not exist as such, its members sliding out of the group to find support elsewhere. They abandoned one another as much as they did the rest of the Center. In doing so, they colluded with the system's fragmentation.

Functional Analysis

The analysis of the functions served by these patterns proceeds from the question: Why would Center members *want* those patterns to exist? On the surface, the patterns go directly against the goal of integrated therapeutic services for at-risk youth. Instead, Center members created a system marked by fragmented territory with little overlap. They made few attempts to alter that landscape. Previous work on irrational behavior in groups (Smith & Berg, 1987), families (Minuchin, 1974), and organizations (Gould, Stapley, & Stein, 2004; Stein, 1996) suggests that Center members must have found that landscape particularly useful. Given group and intergroup patterns not in the rational service of the Center's tasks, the analysis needs to begin with a focus on the irrational needs met by those patterns (Obholzer, 1994).

This analysis was grounded in a series of interviews and observations focused on what members found most emotionally difficult about their work. Previous work suggests that when powerful emotions triggered in such settings are not perceived as important and thus expressed, people create defenses against the conscious experience of those emotions (Braxton, 1995; Mawson, 1994). In practice, this might mean, for example, avoiding situations that trigger further emotion or discharging emotions onto others without being aware of doing so (Cramer, 2000). Thus, functional analysis begins with identifying the strong emotional experiences prevalent in a social system.

The significant emotional experiences within the Center included sadness (from working with clients whose lives have been marked by abuse, neglect, abandonment); guilt (at not being able to save clients from painful lives); anger (at those who have abused or neglected the youth); hopelessness (at the limits of what can be done to help the youth); and fear (of the possibility of physical assault from clients). Members also privately spoke of their anxiety about becoming emotionally attached to clients and the loss and hurt when clients left, did poorly, or were returned to unhealthy situations. Table 1 summarizes these underlying experiences.

Several key theoretical tenets create the bridge between the presence of these emotions and the creation of dysfunctional intergroup relations. First, powerful emotions demand expression (Frijda, 2007). When people talk directly with others about what they feel in the moment, emotions dissipate. They may wreak havoc like a particularly unruly visitor, but they leave. People are then able to look at and deal with their situations dispassionately. Second, as Freud (1936) first noted, if emotions cannot be admitted to conscious awareness and verbally expressed in relevant settings, they will be expressed in less direct and appropriate ways. That is, they will be *acted out*—a process by which emotions generated in one situation give rise to behaviors in other situations that indirectly express those emotions (Shapiro, 1982). In such instances, the emotions themselves will not, however, dissipate but remain even as they are pushed down and away from conscious awareness (Shapiro, 1982). The emotions take up residence; the demanding guests move in indefinitely. At that point, deeply seated emotions grip people; they have people rather than the other way around.

The functional analysis thus proceeds from the premise that certain emotions, bootlegged from their originating settings, develop and hide within certain patterns within and between groups in organizations. The analysis involves tracking how interactions within and across groups are in the service of expressing, discharging, and in other ways reacting to emotions triggered by work. In the residential treatment center, four primary functions were served by patterns of acting out.

- The anger that Center members expressed toward others distracted them from other emotions—sadness, guilt, hopelessness—that tend toward despair rather than action (Frijda, 2007). The anger was directed at other Center members as an acceptable substitute for anger at clients and their families, schools and communities.
- Anger and frustration directed across departmental lines increased cohesion within departments (Brewer, 2001). The cohesion provided members with a sense of safety (in the context of potential assaults by clients) and attachment (to replace more difficult relations with clients).
- Interdepartmental conflict enabled members to discharge painful emotions. Members would treat others in ways that would cause them to feel those unwanted emotions; to disavow guilt, for example, they would act in ways that led others to feel guilty about what they were

Table 1
Center Members' Significant Emotional Experiences of The Work

Recurring experience	Sources	Illustrative quotes
Sadness	Sustained contact with clients whose lives have been marked by abuse, neglect and abandonment.	"I catch myself sometimes at the end of a shift on the verge of tears and have no idea why. Then I realize that I have spent eight hours with kids who have been through such hell. It makes me so sad." <i>Residential supervisor</i> "I hear story after story, each one sadder than the other. I hold it together for the kids—there is no other way I can help them. But if I ever stop to think about it, I get down. So I don't stop much." <i>Clinician</i>
Guilt	Enduring sense of remorse about the gap between members' own lives and opportunities, and those of the clients.	"I feel guilty about all the opportunities that I have had in my life, all the great people that have been there for me, compared to the lousy deal that so many of these kids got in life. It just rips at me." <i>Teacher</i> "Lots of these kids got a raw deal. It wasn't their fault. And here I am, with all that I have in my life. It makes me feel badly, like I got away with something, that I could have been them. And there they are." <i>Residential worker</i>
Anger	Identification with youth leads to antagonism toward those who have hurt, betrayed, abused, or abandoned them—including their families, communities, and schools.	"Look, I care about these kids. I find myself getting furious at the people who did this to them. Some of these parents have no right at all to be parents, and these kids are suffering from that. I hate having to try and reunite them with the families. But I have to keep my mouth shut, don't I?" <i>Residential worker</i> "So much of my job involves running around to the kid's school, the kid's neighborhood center, wherever, trying to get someone to care about him. And they just don't, a lot of them. It upsets me, gets me really mad. I keep it in, though, just do the job." <i>Case manager</i>
Hopelessness	Experiences of seeing youths fail after they leave the Center, given the relative lack of time in a therapeutic environment and the lack of external support.	"It does get hard to keep doing this job, when you hear about kids who really started to make progress here being pulled out of here and sent back to horrible situations. You wonder why you even keep going." <i>Teacher</i> "I work so hard with some of these boys. But I know—I can just tell—when there's not much difference we're going to make. I can see it in them. It's like they're too far gone or something. I would never admit that to anyone here. But it makes it hard to keep going around here." <i>Residential worker</i>
Fear	Physical assaults from clients who lose control of their higher-order cognitive abilities, become violent, and require physical restraint.	"Some of these kids are huge. They can get really terrifying. I won't admit it around here, but sure, I get scared when I see a kid revving up. I look around for help pretty quick, and even when it turns out okay, it takes me a while to breathe normally afterwards." <i>Clinician</i>

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Table 1 (*continued*)

Recurring experience	Sources	Illustrative quotes
Anxiety	Distress about feeling deep sense of loss when clients about whom Center members cared left, did poorly, or were returned to unhealthy situations.	"I've been attacked here. A lot of us have. It's just part of the job. But there's still fear. We don't talk about it; it's a pretty tough place, and you're expected to just get in there, do what you have to do, not be afraid. But we are." <i>Teacher</i>
		"I can get really jammed up about certain kids, maybe those who remind me or something or someone. I really struggle with these kids—not with them, really, but with myself, in how close I allow myself to get to them." <i>Case manager</i>
		"I just want to shut off from some of these kids. Not because I don't care about them. But it's like I don't want to care about them, you know? Some of them just make me really anxious, 'cause I know that they're in for a rough time. I feel for them but don't want to." <i>Residential worker</i>

not doing for clients. The Center's fragmentation thus enabled members to locate painful emotions elsewhere (Moylan, 1994).

- Center members used interdepartmental gulfs to justify how clients' lack of progress lay with other departments' techniques, training, competence, and efforts. Center members thus avoided experiencing their own guilt and hopelessness in relation to at-risk youths' failures to thrive (see Roberts, 1994).

These four processes became woven into the fabric of the Center's group and intergroup relations. Implicitly, members subscribed to the tenet that emotions were to be acted out against rather than expressed with one another. They thus did not have to admit painful emotional experiences triggered by their work. Their conflicts created the terrain for discharging and defending against emotions (Brewer, 2001; Cramer, 2000; Kahn, 2005).

Interventions

The Center case illustrates how intergroup conflict may be driven by unacknowledged needs that system members have to deny, avoid, export, and in other ways move away from potentially painful emotions triggered by their tasks. Interventions that take seriously these defensive processes need to be guided by a useful theory of consultation.

Theory of Intervention

The basic theoretical premise is that system members require structures and processes to surface, verbalize and acknowledge emotional material triggered by their work. As this occurs they will no longer need to use their intergroup relations as settings in which to act out and defend against such emotional material. The key intervention is thus the creation and maintenance of such settings, which function as *holding environments*. The holding environment concept was developed by British psychoanalyst Donald Winnicott (1965) to describe the nature of effective caregiving relationships between mothers and infants, and in the analytic setting between analyst and patient. Subsequent applications of the concept broaden the notion of holding environments into other types of settings. Residential units whose occupants require the experience of reliable caregiving have been examined as holding environments, for residents (Cohen, 1984) and for staff members

(Braxton, 1995). More recently, holding environments have been noted as important in other sorts of organizations (Kahn, 2001; Petriglieri & Petriglieri, 2010). The premise is that adults who experience strong emotions often need settings in which to safely express and interpret their experiences, that is, to temporarily regress to intentionally nurturing environments.

The holding environment is defined as “a social context that reduces disturbing affect and facilitates sense making” (Petriglieri & Petriglieri, 2010, p. 50). Holding environments provide two key actions: containment and interpretation (Petriglieri & Petriglieri, 2010). *Containment* occurs when people absorb, filter, and manage difficult emotional material that can then be effectively worked with; *interpretation* involves working with ideas and meanings in ways that enable members to make sense of their experiences (Kahn, 2001; Shapiro & Carr, 1991). It is through the joint action of containment and interpretation that organization members are able to manage potentially painful affect and anxiety triggered by their work or environment.

Holding environments are key interventions into intergroup conflicts whose staying power derives from the discharge of misplaced affect and anxiety. The consultant’s task is to work with members to create and maintain settings in which they contain and interpret their experiences. Relevant research and theory suggests certain processes useful for consultants in establishing effective holding environments. These processes (summarized in Table 2) trace a movement from the outside to the inside: system members need goals and structures that join them together, and over time, hold them together well enough to allow self-expression (Kahn, 2001). When members make that movement, they generate mutual empathy (understanding based on similar emotional experiences), normalization (placing distressing events in appropriate perspectives), and validation (enabling members to feel justified in their perceptions and experiences; Braxton, 1995).

Table 2
Processes of Creating Holding Environments in Intergroup Relations

Process	Rationale
Shared tasks and superordinate goals	Structure that enables members to work together across groups, departments, functions, and other divisions that inevitably press for their disconnectedness from one another. As initially demonstrated by Sherif (1958), and confirmed by various other researchers (see Brewer, 2001), groups turn away from antipathy and conflict in the context of superordinate goals.
Specific structures that hold people together as they work on joint tasks	While superordinate goals and joint tasks provide the impetus for groups to convene across existing divisions, maintaining their alliance requires structural shifts (Kotter, 1996). These structures include joint meetings led by leaders authorized to focus on the superordinate goals, reward systems that support collaborative behavior and outcomes, and hierarchical structures and reporting relationships that press toward expansive collaboration (Gulati & Puranam, 2009; Kotter, 1996; Mintzberg, 1992).
Role clarity	Clearly specified roles, responsibilities, and authority in the context of newly configured collaborative work enables members to have shared understandings of the rules by which they need to engage one another. The lack of such clarity enables individuals to act upon their own biased understandings, self-interested agendas, assumptions and beliefs, politicized relationships, and historical precedents (Kegan & Lahey, 2009; Steele, 1969).
Containment and interpretation	Members need to develop the capacity to verbalize, directly and appropriately, their emotional experiences to others, and join with them to make sense of those experiences. This is the action of the holding environment—containment and interpretation—that substitutes for the defensive actions of group members acting out against those defined as “other.” While shared tasks and superordinate goals, buttressing structures, and clarity about the newly configured system help re-define the nature of the “other” in the organization, members must be educated, trained, reinforced, and led toward engaging one another in ways that offer compassionate understanding (Kahn, 2005; Obholzer, 1994; Roberts, 1994).

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This theory of intervention involves consultants enabling system members to make these movements—and thus, turn toward rather than away from one another. Senior leaders support is crucial, leading to system members' willingness to invest, as signals that leaders send about the patterns of behavior they are no longer willing to tolerate (Kotter, 1996). The illustration below thus begins with the senior leaders and moves through the hierarchy. At each level, the process involves creating meaningful boundaries around a group, enabling members to remain focused on what occurs within rather than outside the group; and then naming the patterns in which members are caught, in order to bring to conscious awareness the choices that they have made and their unintended consequences. It is when people become consciously aware of how their own behaviors undermine their stated goals and objectives that it becomes possible for them to change those behaviors (Miller, 1993).

Developing the Senior Administration Team

The Center's senior leaders as a group paralleled the dis-integration of the larger system. They were not a team, joined around a shared task. We began by creating a meaningful boundary around the group that would enable the leaders to collectively address the issues of the Center (Alderfer, 1980). The boundary involved having them meet regularly in a conference room, door closed, without the department heads. In these meetings we clarified their purpose as a team (as distinct from their individual operating responsibilities). The team's purpose: to create and maintain integration across departments on behalf of a therapeutic environment for clients.

In order to fulfill this purpose, the senior leaders needed, first, to understand how and why they had allowed the Center's dis-integration to occur, and second, to create a structural foundation for integration. In the course of those conversations we created a holding environment, in which the senior leaders were able to publicly acknowledge emotions and anxieties that they had previously only acknowledged privately. In so doing, they began to understand how they had avoided acknowledging those experiences by focusing so much attention—and blame, anger, and frustration—on the department heads.

The senior leaders were then able to openly struggle with the role that they had played, individually and collectively, in the Center's fragmentation. The Executive Director took the lead in acknowledging his guilt in letting the Center fall into the patterns. Other leaders followed suit, trying to understand rather than blame. My role was to help them understand how, in not taking up their authority, they had protected themselves from the rage, frustration, longing, and hope that staff members held as a parallel process with their clients toward figures of authority (Obholzer, 1994). The senior leaders were the objects of transference in the system (Hinshelwood, 2001). By not taking up the authority to lead and discipline, the senior leaders deflected the disturbing emotions. The senior administrators explored the nature of the transference in the Center, the choices that they had made in the face of that transference, and the consequences of those choices. They decided to make a different choice: to join together to take up the senior leadership of the Center. In so doing, they created three key mechanisms (summarized in Table 3) by which to move the Center toward interdepartmental integration.

The senior leaders' work created the foundation for the integration of the Center in several ways. Their movement from loosely connected individuals to a team with a shared task and purpose symbolized exactly the movement that the Center as a whole needed to make. In turning toward rather than away from one another, they were able to create a container for tolerating the difficulty of their work (Gould et al., 2004)—and thus, reduced the need to maintain their own dysfunctional patterns as a senior team.

Engaging the Middle

The Center's middle layer consisted of the directors of the residential, educational, and clinical departments. Their antipathy, lack of collaboration, territoriality, and disjointed communications maintained the lack of integration among their departments. They had rarely been held accountable for their inability to effectively collaborate. Indeed, the directors acted not as middle managers,

Table 3
Senior Leaders' Integrating Mechanisms

Integrating mechanism	Structural change	Holding environment
Treatment oversight	The leaders created the role of Director of Treatment, enabling one of them to assume responsibility for treatment across all departments. The Center as a whole became the site of therapeutic treatment. The Director convened regular treatment meetings with the department heads to create shared principles and measures of effective treatment.	The Director of Treatment encouraged treatment team members to express their own feelings about what they were doing. They spoke of their uncertainty about treatment options, fear of making wrong assessments, sadness and guilt about kids not improving, and moments of joy when they did improve. These leaders began to see the similarities in their common experiences of the work.
Case management	The Center's fragmentation was symbolized by clients having distinct files in each of the three departments, with little overlap. The senior leaders created a case management department, charged with maintaining oversight of the client's progress through the Center. Case managers were trained as liaisons with referring and state agencies as well as monitors of client progress in residential, educational and clinical settings. The Director of Case Management met regularly with case managers to discuss their work. They designed practices together and developed processes to integrate effectively with the other departments.	The case managers learned to name and explore the emotions triggered by their work. As they grew more comfortable with one another, they increasingly shared their anger and frustration with client families and community agencies, sadness over the children who were all but abandoned by parents, and gladness at the moments of their connection with clients.
Administrative Review Group	The senior leaders created a forum in which they would meet regularly as a team with each department head. The forum required the leaders to meet together to prepare shared concerns, lines of inquiry, and strategies for holding accountable and supporting each department head. At the Administrative Review Group sessions themselves, senior leaders heard the same questions and issues—the better to remain integrated with rather than split off from one another.	The senior leaders began to speak candidly of their guilt and frustration of letting problems go unaddressed and not holding others accountable, anger at being taken advantage of, apologetic about letting one another down, and trepidation about whether they would truly back one another up as they held middle managers accountable.

integrating on behalf of larger purposes, but only as the leaders of their respective departments, leaving no one to pursue such integration. This pattern held in place the agency's intergroup conflicts.

The senior leaders pressed the directors to more effectively assume the roles of the integrating middle. They began by defining the directors' roles *as* middle managers, charged with coordinating efforts not only within but between the departments. The senior leaders changed the middle managers' titles, from Directors to Coordinators, signaling the importance of coordination tasks. Over the span of several months I facilitated meetings among the senior leaders, and among the senior and middle leaders together, in which they worked to clarify the latter's roles and responsibilities, many of which involved them working together rather than separately. Expectations were set, coordinated tasks described, and metrics agreed upon.

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These structural changes set the stage for coordinators to function as a group to support cross-departmental work. The dynamics among the middle managers made this difficult. The Center's patterns had for some time depended on heightened levels of animosity between the department heads. I worked with the department heads to help them make a shift similar to that of the senior leaders, from a disintegrated group to an integrated team. I thus clarified for them the pressures in the Center for them to split away from one another: how as long as they squared off against one another, members across the Center could justify their distracting anger at one another. We reviewed the Center dynamics that cast them into roles that maintained these patterns, and how and why they went along with those patterns. The hope was that such understanding would help release the coordinators from those roles; they could choose to act differently. This did not occur with all of the coordinators. The residential coordinator continued to believe that she was simply a victim, constantly set up by her peers and leaders. She was unable to accept her own collusion.

We attempted to create shared tasks. The coordinators tackled the issue of paperwork, which was a struggle across the Center. The different departments reported events differently, were unable to easily coordinate or share their reports, and had different timetables for reporting events. They tackled as well the issue of staff development. Each department had different ways of conceptualizing staff development, resulting in inequitable and confusing processes that fed animosity between Center members. In working on these issues, the coordinators struggled to move away from their well-worn habits of protecting their own departments and toward developing solutions that prioritized the Center as a whole.

These struggles were only partly successful. The coordinators were not able to put differences aside and work together to create, invent, and collaborate. This symbolized their inability to move completely away from dis-integrated patterns more generally. The coordinators held onto those patterns as long as they could. Why? There was the force of habit: they knew far better how to pull away from rather than work well with one another. Their prolonged struggles had also disturbed their abilities to trust one another. There was also the power that they garnered: as long as the Center was fractured, those who were at the forefront of the warring factions—the coordinators—were the focal points.

If the Center was to move away from its fragmented patterns, the coordinators would need to create integrated ways of working and relating. The senior leaders stepped in to exert their authority on this issue. They placed the residential coordinator on probation. Her inability to adapt to the Center's shift became increasingly apparent, as she repeatedly failed to collaborate with her peers and senior leaders. Her subsequent firing was a significant event in the Center—a symbol that the senior leaders were no longer willing to tolerate divisiveness. The residential coordinator had played a significant, polarizing role in the Center's fragmentation. As Center leaders and members began to develop the capacity to articulate rather than defend against the emotional experiences of their work, there was less need for her polarizations. Center leaders and members began to authorize those who could lead toward integration. The residential coordinator could not make that shift. In this respect she was a casualty, used by the Center to sustain social defenses (see [Taylor, Kurlioff, & Smith, 2004](#)).

The residential coordinator role was then divided into three roles which were filled by three staff members chosen as much for their collaborative abilities as for their technical knowledge. It was, finally, in the context of this new structure that the middle managers began to share and examine their own experiences of the work. They talked of their responsibility for contributing to the agency's fragmentation, and their guilt about having colluding with splitting the agency apart; of their sense of abandonment by the senior leaders; of their sadness about the staff harmed by the pattern; and of their hopes that the newly configured structure would enable them to truly help staff and clients achieve their goals. They were increasingly able to articulate how they had turned against one another in order not to feel overwhelmed by those experiences.

Involving the System

The consulting task thus far involved helping to restore the integrity of the organizational structure, such that senior leaders oversaw the Center's collective work on its mission and middle managers

integrated their departments. In both cases we worked from the external (developing structures, clarifying roles, creating boundaries around work groups) to the internal (exploring group and intergroup dynamics, collusions with dysfunctional patterns, individual choices to push away or move closer to others). The leaders began to surface and bear painful affect together. We created the “containers,” bounded settings such as Senior Administrator Team and Coordinator group meetings, in which they could safely verbalize and put in proper context their emotions and behaviors. In so doing, they reduced their needs to split away from one another in order to avoid becoming aware of (and pained by) those emotions.

A similar movement needed to occur for the rest of the Center members. We began by creating small, well-bounded groups with particular tasks that would help integrate members. Each group was composed of members from different departments. The intervention was twofold: to join members together across the Center to solve joint problems; and to create productive patterns of interaction within the groups that could spill over into other intergroup settings. This occurred in the context of the three task forces summarized in Table 4.

The three task forces integrated treatment efforts across departments. They created structural interventions into the problem of agency fragmentation. These interventions were intertwined with relational interventions: as agency members worked to develop new models to guide the agency’s practices, they modeled new ways of relating. They joined together, integrating ideas and perspectives, and in doing so, knit together the departments they represented. This integration occurred

Table 4
Interdepartmental Task Forces as Systemic Integrators

Task force	Purpose	Holding environment
Treatment oversight	Develop a treatment philosophy to guide how clients were worked with across the Center. The group developed overarching principles and measures of treatment that would then be translated into the particular work of the different departments.	Task force members developed the capacity to reflect together on the difficulty of their work, the decisions they made, the assumptions they carried about one another, and the conflicts they enacted across departments.
Therapeutic milieu trainings	Develop an integrated training curriculum for creating the Center’s therapeutic milieu. Working from treatment principles set in place by the treatment oversight group, the group analyzed the practices that helped create the therapeutic milieu across the departments, identified the skills necessary to enact those practices effectively, and designed relevant trainings.	Task force members shared their initial misgivings about working across departments. In naming their distrust of one another, and the ways in which they had felt let down and undermined by one another, members were able to identify the barriers to their working effectively together. These conversations created a bridge between members, enabling them to join around their shared task.
Treatment teams	Create new structure by which members of different departments who worked with the same clients would join together to make treatment recommendations. The task force developed the purposes, processes, and outcomes for treatment teams. They puzzled through the logistics for treatment team structures, selected treatment team leaders and members, clarified roles and responsibilities, and designed problem solving and decision making processes, and treatment team ground rules.	Task force members increasingly shared their own difficult experiences of making treatment decisions and the pain and anxiety of the outcomes of those decisions.

partly at a deeply human, emotional level, as members of each task force—like senior leaders and middle managers before them—acknowledged the emotional terrain that they shared. In mapping the common ground of the pain, sadness, anger, and hope endemic to their work, they opened the space between them as a place of connection rather than struggle (Roberts, 1994).

There was also a larger shift that needed to occur. The Center's intergroup patterns had enabled disturbing emotions and anxiety to remain under the surface. It was only when that material was able to be systematically excavated and more consciously experienced and understood that Center members could shift from those patterns. Put another way, the structural interventions that had been created were unlikely to resist the constant tug of Center members' wish to suppress the pain of their work. Unless members were provided avenues in which to articulate their experiences, they would likely try to use the departmental structure as the setting in which to act out (and thus avoid) those emotions. This would undermine the senior leaders, middle managers, treatment teams, and other groups dedicated to the Center's integration.

We thus created Center-wide trainings to enable members across departments to understand and work with emotional material triggered by their work. It is in naming those experiences that Center members could reduce the need to act out against one another. The trainings brought Center members together to learn about secondary trauma (Figley, 1995), caregivers' "soaking" of clients' emotions (Kahn, 2005), and parallel processes in organizations (Alderfer, 1987)—each of which offered a window into the dynamics of the relations between clients and caregivers. The trainings gave Center members the opportunity to make connections between their own affect, cognition, and behaviors and that of the clients that they served.

The trainings were followed by monthly cross-departmental forums in which Center members shared experiences, identified and solved problems, acknowledged emotional reactions, and supported one another. The forum involved a revolving fishbowl: members from different departments would rotate in and out of a circle of chairs (surrounded by a much larger circle containing the full staff), engaging in conversations about their experiences. A facilitator in the fishbowl helped participants connect the experiences they shared—with clients, coworkers, administrators—to the emotions and anxieties triggered by their work. Over time, Center members learned to make those connections themselves, and understand how, what, and when they were acting out against others. As this occurred, members began to have less need for such acting out.

From Madness to Method

The center case illustrates a particular theory of diagnosis and intervention. The theory has the following components.

- Unproductive patterns of intergroup conflict held in place by organizational structures, leadership behaviors, and member interactions can serve important underlying needs of which members are unaware. The patterns exist because members have consciously or unconsciously chosen not to alter those patterns. They do so because those patterns implicitly serve their interests (Miller, 1993).
- The underlying needs are, by definition, irrational, in that they undermine the given tasks that members are employed to complete. Irrational behavior is often associated with defense mechanisms (Cramer, 2000): Individuals defend against the conscious experience of potentially painful emotions and anxiety. The case illustrates how organization members use conflicts between departments to avoid acknowledging the emotional distress triggered by their work.
- Altering structures, changing leaders, and developing integrating mechanisms are necessary but insufficient for creating rational, sustainable, and productive intergroup relations. The pulls to use intergroup conflicts as devices for acting out emotional distress triggered by work are powerful enough to undermine new structures, leaders, and forums (Brewer, 2001). Such changes need to be accompanied by parallel efforts to reduce members' needs to use divisions between groups as the context for acting out against disturbing emotion and anxiety.

- People need to become aware of what seemingly dysfunctional patterns of group and intergroup relations functionally *do* for them (Miller, 1993). They need to learn how they use those relations to discharge unwanted emotions. The case illustration shows how Center members need one another in order to discharge anger, guilt, sadness, and the like. Center members use one another, badly rather than well, in the face of distress.
- A functional analysis points to the presence of emotional experiences that members need to consciously acknowledge, claim as their own, and verbally express so as to lessen the need to act out those emotions in destructive ways. Changes in organizational structures, reporting relationships, integrating forums, and leaders will then be supported rather than undermined.
- Subsequent interventions maintain a focus on creating and maintaining settings in which members are supported in naming, reflecting on, and making sense of their emotional experiences. These are holding environments, marked by containment and interpretation (Kahn, 2001; Petriglieri & Petriglieri, 2010; Shapiro & Carr, 1991). In such environments, members find common ground in their experiences of their tasks.
- As system members discover common ground, they are able to bring themselves more fully into their collaborative work (Kahn, 2005). Members turn toward rather than away from one another; they learn to use one another well rather than badly. They become focused on rational tasks and purposes, no longer needing the functions served by irrational patterns of interrelating.

These components are grounded in insights from researchers and theorists from different disciplines, working at various levels of analysis. Psychologists note the importance of individuals excavating, acknowledging, and giving verbal expression to disturbing affect and anxiety when navigating difficult transitions, repeatedly stuck in dysfunctional relationships, or recovering from trauma (Figley, 1995; Shapiro, 1982). Otherwise, such individuals remain caught in defensive maneuvers that undermine stated goals and purposes. Group theorists focus on appropriate boundaries, effective group leadership, and healthy rules of engagement that enable members to use their groups as settings in which to safely examine and interpret difficult work experiences (Smith & Berg, 1987). In the absence of such factors, groups cannot contain their members' affect and anxiety, which then gets expressed elsewhere (Smith & Berg, 1987), particularly in the relations between groups (Diamond et al., 2002). Organizational researchers have shown how structural interventions are effective only to the extent that they have members' full engagement (Gulati & Puranam, 2009). When members are engaged in using current structures for defensive purposes, interventions that alter those structures are unlikely to be effective. Members are otherwise engaged in self-protection.

Methodological Implications

The theory described above is the foundation for functional analysis—the method by which to diagnosis and alter the “madness” of dysfunctional patterns of behaviors. The analysis begins with the charting of relations within and across groups. These patterns are analyzed as to whether they are rational (i.e., serve stated systemic purposes) or irrational (i.e., undermine systemic purposes). Irrational patterns become the primary focus. Their functions are analyzed by associating them with specific emotions and anxieties that system members share privately but not publicly. Subsequent interventions are based on the notion that irrational patterns thrive when system members cannot safely examine, share, and develop insights about their experiences (Miller, 1993). The consulting task is thus to work with system members to develop settings—holding environments—in which they feel contained enough to name painful affect and anxiety (Kahn, 2001, 2005).

The theory holds that irrational patterns lose meaning and momentum when system members are able to speak of what they are defending against. Testing this theory empirically involves action research with organizations marked by dysfunctional intergroup conflict. Action research methods enable researchers and consultants to develop, implement, collect data about, and refine concepts of theory-driven interventions (Somekh, 2005). The action research necessary to test out and refine this theory begins with a functional analysis of the affect and anxiety being discharged and defended against, and the ensuing consequences for intergroup relations. The action researcher then helps organization members create integrating structures that press for collaboration across groups. The

test of the theory comes in developing those integrating structures into holding environments—settings in which members can openly express, contain, interpret, and work with potentially disturbing affect and anxiety. To the extent that intergroup relations become more healthy and productive, theory linking integrating structures and affective containment are useful. Further development of the theory involves identifying the conditions under which holding environments are created or undermined in practice (Kahn, 2001).

A key issue is the applicability of the intervention theory. The functional analysis of the Center occurred during the course of a relatively lengthy consultation. It was during that consultation that the importance of the expression of affect and anxiety in reducing the amount of dysfunction in intergroup relations became increasingly apparent. Structural interventions were ineffective, as members kept reverting to ineffective relations across groups. It was only in those unplanned moments of emotional honesty, when Center members spoke openly of what they felt in their work with clients and one another, that they were able to join together to do work. In noticing this, I began to develop both the theory and the practice presented in this article. Nevertheless, this theory may guide consultants working with client systems in relatively brief time spans. Consultants can thus use functional analysis in the initial stages of diagnosis. They can frame interventions at multiple levels simultaneously, aware of how the affect and anxiety that disturb system members gets discharged and disrupts intergroup relations. They can work in parallel on structural shifts that integrate various groups, and on creating settings in which system members can safely express affect and anxiety. Even in brief consultations, it is possible for enough trust and safety to develop between consultants, leaders, and members to allow for open communication (Fincham, 1999).

Leaders are integral to this process. The case study illustrates how irrational patterns are held in place because those who have the power to change them do not move strongly enough to do so. The Center's dysfunctional patterns protected the senior leaders from their own experiences of guilt, shame, sadness, anger, and hopelessness. They too were caught up in the compelling distraction of department head warfare, to the point that they were unaware that their own disengagements had given the department heads outsized influence. Consultants need to confront senior leaders with their own participation—passive or active—in dysfunctional patterns that have been allowed to exist. It is only then that leaders can make conscious choices about maintaining or interrupting those patterns. Those choices are crucial. Leaders can model, set the stage for, and reinforce either primitive defenses or higher-order rationality. Others will inevitably echo their movements (Gulati & Puranam, 2009; Kotter, 1996).

The limitations of the theory offered here are related to the willingness and ability of people, consultants, and members alike, to consider unconscious defenses against affect and anxiety and create holding environments. Functional analysis requires the acceptance of, comfort with, and analytic skill in tracing how patterns of work relationships are influenced by people's unconscious movements away from painful affect and anxiety. Absent this, functional analysis is unlikely to be an effective diagnostic tool. Similarly, the creation of holding environments requires consultants, leaders, and members to admit to, become comfortable with, and develop skills in working with the expression of affect and anxiety. When people are not comfortable acknowledging and honoring such emotional material as an integral part of their work experiences, the interventions they create to interrupt and alter dysfunctional intergroup conflict will likely prove insufficient.

Conclusion

The theory of intervention presented here points to the consultant's role in developing people's capacities to work well amid affect and anxiety, reducing their need to turn away from their given tasks and purposes. This involves helping members learn to examine how group and intergroup patterns facilitate or undermine system purposes. The consultant helps members identify irrational patterns and guides them through the process of discovering why they are tolerated. The discovery process is driven by the question: What do those patterns and conflicts *do* for system members? Consultants help people develop their shared capacities to ask and answer this question. The functional analysis method thus presses the consultant to look carefully beneath stubborn patterns

of group and intergroup behavior. Such patterns are often ascribed to the force of habit, entrenched interests, key stakeholder resistance, cultural indoctrination, misaligned reward systems, and the general lack of comprehension, competence or training. Although such factors surely contribute, dysfunctional patterns also need to be examined in terms of the irrational functions that they serve.

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Received January 8, 2012

Latest revision received July 25, 2012

Accepted August 1, 2012 ■