Forensische Psychiatrie und Psychotherapie, Volume 17, 2010 (3), 6-20

Offences and defences: group dynamics in secure institutions[1]

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Summary

Freud is credited with first describing psychological 'defences' against anxiety and other negative affects. 'Defences' are cognitions, beliefs, emotions and values that operate both consciously and unconsciously; and may be manifested in interpersonal space as behaviours with meaning. Isobel Menzies described how individual defences might be manifest in groups (or social systems) of people who are interacting together; and especially when working on a task that is distressing. In this paper, I will discuss how such social defences operate in organisations and institutions whose task it is to contain and care for dangerous people; and how we need to manage maladaptive defences that make a hard task harder.

Key words

Group dynamics, social defences, secure institutions, Isobel Menzies, Forensic Psychiatry

Angriffe und Abwehrmechanismen: Gruppendynamik in geschlossenen Einrichtungen

Zusammenfassung

Wir verdanken Freud die Beschreibung von psychologischen Abwehrmechanismen gegen Ängste und negativ erlebte Affekte. Unter Abwehrmechanismen sind Kognitionen, Überzeugungen, Gefühle und Wertvorstellungen zu verstehen, die sowohl bewusst wie unbewusst auftreten. Isobel Menzies beschrieb, wie Abwehrmechanismen in Gruppen oder sozialen System auftreten, insbesondere in belastenden Situationen. Hier soll untersucht werden, wie sich soziale Abwehrmechanismen in forensischen Institutionen auswirken, und wie mit maladaptiven

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[1] Acknowledgements: This paper is based on previous work with Amanda Lowdell (2008), and published in Aiyegbusi & Clarke-Moore (2008). Thanks also to Morris Nitsun for his advice and feedback on the original presentation.

Abwehrmechanismen, die die Aufgaben der forensischen Psychiatrie noch erschweren können, umgegangen werden kann.

Schlüsselwörter

Gruppendynamik, soziale Abwehrmechanismen, gesicherte Institutionen, Isobel Menzies, forensische Psychiatrie

Introduction

The term, 'defences', has passed into a common language and understanding of how people manage difficult feelings, either individually or in groups. We understand that people who feel anxious, may get angry instead; or that angry people may express their rage by being unhelpful. The task of managing negative affects is crucial for effective group living; and therefore requires a psychosocial competency, which, like most others, is acquired during childhood.

Freud suggested that many neurotic symptoms are defences against unconscious internal conflicts that generate anxiety. The anxiety may or may not be conscious; but the symptoms usually are, and may be manifest in emotional displays, bodily signs or behaviours. Anna Freud's 'The ego and mechanisms of defence' elaborated several defences used by children faced with dreadful anxieties; and since then, there has been further study of the nature of defences, their number, and how they operate. Contemporary researchers in this field include George Vaillant, (1992; 1995) whose life trajectory research has illuminated how psychological defences are used over a life time and are a good indicator of mental health; Phebe Cramer (2006) and Michael Bond (1992) who have studied the measurement of defences, and the application to psychotherapy outcomes; and Leigh Vaillant (1997) who has developed a therapeutic intervention based on the description and reconstruction of defences.

Group theory has described similar defences operating in groups; plus some specific to group dynamics. Yalom (1975) and Nitsun (1994) have described how defences operate in therapeutic groups. Specifically in work groups, Bion (1961) described a number of defences which might be manifested by members of groups, and which impaired the execution of the group task.

There are a number of general points about psychological defences that bear reiteration. First, there are a range of defences: mature, intermediate and immature defences. All individuals will use a characteristic 'hand' of defences, which influence their personality function. Second, those individuals who chiefly utilise immature defences, and do not seem able to use mature defences, are more likely to suffer from poor mental health and psychological distress. Many psychiatric diagnoses may be understood as the result of the maladaptive use of immature defences, and the relative lack of action of mature defences. People with personality disorder, for example, tend predominantly to use immature defences in the interpersonal realm. Finally, although

everyone uses immature defences at times of stress in adulthood, this is usually only brief. The *persistent* use of immature defences by an adult suggests that they are still functioning unconsciously in a *childhood* state of mind; that the attachment systems laid down in the 'there-and-then' of childhood have been activated inappropriately in the 'here-and-now' of adulthood. Hence, the value of a mentalising therapeutic approach which emphasises reflection on the here-and-now relationship with the therapist.

Social defence systems in work groups: Isabel Menzies and the study of nursing care

In 1959, Isabel Menzies commenced a ground breaking study which has greatly influenced health care staffing and training. A psychoanalyst working at the Tavistock Institute of Human Relations, she was asked to review the allocation of student nurses and overall staffing needs of a large teaching hospital, with 700 beds. The hospital had a nurse training school and the nurses were required to work across all sites under the leadership of a matron based at the main hospital site. The work force consisted of approximately 150 trained nursing staff and 500 students.

The senior staff had encountered great difficulty in balancing the training needs of the students with the overall staffing needs of the organisation. Many students were not receiving adequate time in a specific clinical area, and some were due to qualify without having all the required experience. Senior staff felt there was a serious breakdown in their system of training allocation and asked for help in reviewing their methods.

Menzies utilised a psychoanalytic approach by viewing the difficulties of student nurse allocation as the 'presenting problem'. She interviewed many staff both structurally and informally, and carried out observational studies in some areas. She discovered that the 'actual problem' of staff allocation arose because one third of nurses were not completing their training, due to high levels of anxiety and distress: others frequently took time off due to minor illnesses so that the absence/sickness rate was high.

Menzies felt that the nature of the anxiety needed to be understood in terms of the feelings aroused in the nurses by their work with patients. Nurses were in contact with pain and suffering on a daily basis, and were required to perform intimate and distasteful tasks which might arouse negative feelings such as disgust, fear and hatred; and perhaps also positive feelings of excitement. She suggested that nurses might envy the care their patients received, or hate the patients for failing to get better; and that these negative feelings were in conflict with the positive tender values usually associated with professional care.

This conflict between love and hate resembles the conflict that Melanie Klein described in relation to children, who also struggle with conflicted feelings towards their carers. What Menzies (1961) concluded was that the nursing staff had to devel-

op defences against this internal conflict, and these defences were manifested in behaviours that made carrying out the primary work task (in this case caring for patients) difficult, if not impossible. She argued that these were unconscious defences, which would prevent negative affects from becoming conscious, and thus allowing staff to claim that they were fine.

Menzies gives various examples of defensive behaviours manifest in organisational structures. One example was how everyday work decisions were made. Each decision was experienced as life-or-death in importance; and caused enormous anxiety in the staff. This anxiety was defended against by nurses turning their tasks into rituals, such as checking and re-checking every action or decision. Student nurses were not trusted with such decisions, and discouraged from using any form of initiative or thinking; as juniors, they were the group most affected by these task rituals, and were quickly discouraged from becoming more senior.

Another type of social defence was the increasing separation of the nurses from direct contact with patients. The nursing service attempted to protect the nurse from anxiety by allocating them numerous tasks (sometimes as many as 30 in one shift) for various patients. This prevented nurses from coming into too much contact with any one patient and their illness, (hence protecting them from anxiety), but undermined their role as carers involved in a personal relationship with the patients.

Yet another example was the denial of the patient's personal identity; by labelling them in terms of their illness or the bed number. Patients were not talked about by name, but might be referred to as 'the Liver in bed 6'. Nurses were encouraged to view and treat all patients in a uniform way, regardless of their personal illness or circumstance. Patient individuality was reduced, and thereby distress about them as people, and their personal suffering. Similarly, there was an organisational emphasis on detachment as a professional skill: 'good' nurses did not have particular feelings about any one patient, but treated all patients the same. In the same way, nurses were discouraged from being individuals: the use of nurse uniforms served a purpose in that they could be viewed as "a kind of agglomeration of nursing skills, without individuality; each is thus perfectly interchangeable with another of the same skill level". This enabled 'blanket' decisions to be made and avoided any individual responsibility.

Menzies stated that it seemed to be assumed that any caring professional had to learn to detach and control his feelings, and to avoid 'disturbing identifications'. By reducing any individual distinctiveness, distressing attachments would not form between nurses and patients. Another feature of a 'good nurse' was that they were willing to move from ward to ward with no notice, leaving distressed patients behind without a thought. The implicit rationale seemed to be that a student nurse would learn to be psychologically detached if she actually experienced detachment in the form of the sudden ward moves.

The pain and distress these defensive manoeuvres caused the students was implicitly denied by the hospital system, and explicitly criticised as being 'unprofessional'.

Senior nurses would take a brusque and a typical 'stiff upper lip approach' to upsetting feelings, so that students who were exposed to much emotional strain found senior staff to be unsupportive. However, when senior staff members were interviewed by Menzies, they showed understanding towards the students, but seemed unable to handle emotional stress in any way other than by adopting 'repressive techniques'. Traditional nursing roles supported the use of discipline, repression and reprimand from senior to junior staff, and not a kind sympathetic approach.

All staff minimised their anxiety by the use of immature defences such as denial of feelings; dividing people rigidly into 'good' and 'bad' (splitting); and projection of unwanted feelings that they could not bear to feel into patients, or other members of the nursing team. For example, teams became split into those nurses who were "responsible", and those who were seen as "irresponsible". The 'responsible' nurses complained that the 'irresponsible' ones needed to be constantly supervised and disciplined, which led to more and more ritualistic checking behaviour, and prevented the 'irresponsible' staff from actually learning to do their jobs in a responsible way. Projection was not confined to fellow staff; anger and frustration of the work was also projected into patients, who were seen as endlessly demanding and troublesome.

Menzies concluded that these social defences operated to help the individual to avoid the experience of anxiety, guilt and uncertainty. However, they in fact did not relieve anxiety; staff still felt anxious and distressed, but the social defences meant that they were not allowed to know their feelings or express them. No attempt was made to enable the individual nurses confront and face their anxieties and distress, and they were therefore unable to develop a capacity to bear these anxieties more effectively. Without a capacity to manage their distress, it was inevitable that staff would drop out of training and leave; leading to the staffing problems that were the 'presenting problem'. The lack of awareness meant that it became very difficult for staff to carry out their work effectively.

Implications for professional caring systems

Menzies' study was important for a number of reasons. First, she brought psychodynamic thinking into the work place, in ways which were practically relevant for running caring organisations. Second, she suggested that group/social defences might mirror individual defences, but be intensified by the group process and organisational structures. Third, she was the first to report that professional carers might actually have negative feelings towards those they care for; that caring was not the highly idealised activity it seemed to be.

There have been subsequent studies of professional defences in different environments, (recognising that different contexts might raise different anxieties), and there developed a whole school for the study of organisational change (Miller, 1993). For example, Miller and Gwynne found evidence of social defence systems operating in dealing with their anxiety aroused by caring for physically handicapped and young

chronically ill people in residential settings (Miller & Gwynne 1972). They found two distinct approaches of care towards the residents. In some homes there was a 'horticultural' model of care, which regarded residents as having capacity to overcome their difficulties, if they could only develop skills to do so. This model defended against hopelessness by denying the true extent of patients' disabilities; and both staff and residents were encouraged to remain hopeful of physical cures and rehabilitation, even if in reality, this was unlikely to be achieved. Such a model put enormous pressure on staff and patients to show 'improvements'.

In other settings, they found a more pessimistic approach, where residents were regarded as very damaged and in need of complete care. This was referred to as the 'warehouse model'. This more parental style defended against hopelessness in patients and staff by not expecting patients to be autonomous in any way; and by a conscious emphasis on the continuous provision of good nursing and medical care. In this model, the resident was required to accept the professional diagnosis and treatment offered. Residents who passively accepted care, and did not exert any independent autonomy, were seen as 'good patients'.

Both the 'horticultural' and 'warehousing' approaches are described as social defence mechanisms that protect staff against the unbearable anxiety and frustration of caring for a group of people who would never recover health, and would always remain to some extent dependent on others. Since independence and autonomy are associated with maturity and health (at least in Western cultures), long term dependence and reliance on others are associated with child-like states, and hopeless impairment, which in turn generated fantasies of death: "The task that society assigns – behaviourally though never verbally – to these institutions is to cater for the socially dead during the interval between social death and physical death" (Miller & Gwynne 1972).

Social defences in psychiatric systems

The Miller and Gwynne study is particularly relevant to any system providing long stay residential care. Elizabeth Bott (Bott, 1976; Hinshelwood, 2001) had also applied Menzies' thinking to a psychiatric setting in a study of a long stay psychiatric hospital, using an anthropological fieldwork method. She found that the task of the hospital included a number of conflicting aims: to control the madness that society could not tolerate, to provide care for people who required respite from their intolerable difficulties and to offer treatment and cure to patients suffering from mental illness. When these aims were not compatible or achievable, this was either unrecognised or not accepted by the hospital staff.

Bott noted that staff in a long stay psychiatric hospital had a profound unease about the task they were performing: an awareness of a 'sort of dishonesty' that patients were admitted, allegedly for their own sake, but actually to relieve other people's anx-

ieties. Thus patients and staff were in a no-win situation; the patient might improve, but they were not necessarily accepted as recovered or welcomed on discharge.

Like the staff in general medical hospitals, psychiatric nursing staff were forced into contact with people who had severe illnesses that caused damage. But in the psychiatric hospital, the illness and damage was psychological, not physical; patients' personal identities were lost or damaged. Not only did patients become dependent on the staff and the hospital, it seemed that they might never recover, and staff became frightened of the chronicity of their illnesses and their handicaps. Fear of madness, and distaste for mental distress, became the norm, and staff would do all they could to avoid contact with the patients as individuals (Main, 1977).

In such long stay institutions, staff were unsure whether patients were there for long term care or for active treatment; nor was it clear who had the power to decide. Conflict and confusion lead to apathy and demoralisation on the one hand, and either manic activity or minor acts of sadistic acting out on the other.

More recent work has shown how these defences are still operative in psychiatric services (Hinshelwood & Skogstad, 2000; Campling, Davies & Farquharson, 2004). Donati (1989) observed the engagement of nurses with patients on a chronic psychiatric ward as kept to a bare minimum; as 'touch and go'. Keeping the patients at arms length was a defence against the fear of the impact of madness on the staff; where madness is symbolic for 'death of the mind' (in contrast to actual death and dying as experienced by nurses in general hospitals). She describes the chronic boredom of the patients and the staff, and the occasional manic bursts of activity by staff who visited the ward briefly but then left again, leaving it disappointed and hopeless again.

Implications for forensic mental health care

By now, it will be clear that nursing staff working in forensic settings are working in organisations remarkably like those described by Bott, and Gwynne and Miller. In general mental health settings, care has moved to the community, and there is emphasis on 'service users' or 'expert by experience', who 'live with mental disorders', and are managed at home as far as possible. However, in forensic psychiatry, there has been an expansion of residential care, with a huge increase in the number of secure beds (McCulloch, Muijen & Harper, 2000). Although it was originally anticipated that most forensic patients would stay no longer than 18 months to 2 years, it is now clear that the average length of stay in a forensic facility is closer to 5 years (Shaw, Davies & Morey 2001). In the High Security hospitals (which used to be called 'Special': Broadmoor, Rampton and Ashworth), the average length of stay remains at about 8 years, although there is a considerable range (Maden et al, 1995).

What this means is that forensic staff are now responsible for long stay residential psychiatric care; with nurses and patients, living cheek by jowl for hours of days of weeks of years. Staff in these settings will spend more time with the patients than with

their own families; and these units and hospitals can become like enclosed communities of both staff and patients. In one case known to the author, both a patient and his primary nurse had entered the hospital aged 19 at the same time, 23 years previously: they had both 'grown up' together in a high security hospital.

Nursing staff therefore have to manage the demands of long term residential care for people with severe mental illnesses. However, they also have to try and make therapeutic relationships with patients who have committed horrifying and disturbing acts of violence against humanity. Normally, people who have done such acts are shunned by others; forensic nurses have the professional task of caring for those who are normally socially excluded because of their risk to others. It is easy to imagine, using both Menzies' and Bott's formulations, that staff have to defend themselves not from *unconscious* fear alone, but from conscious fear of the patients, who have been identified as highly risky people. The emphasis on security measures means that nursing staff are being encouraged to provide a personally supportive relationship to patients, while at the same time being suspicious of the danger they pose.

Staff have to deal with unconscious fear of madness in the patients, envy of their care, and hate for their seemingly hopeless situation. Defensive manoeuvres include distancing themselves from the patients as much as possible (for instance by withdrawing into the office or kitchen); rubbishing attempts to help the patients (Sarkar, 2005), and seeing patients as either 'all good' or 'all bad'. This last issue is clearly an example of splitting, and represents both a manic defence against the reality of what the patients have done, and a cruel identification with the hopelessness of their position. They must also deal with conscious fear of the patients, disgust at their offences, and hatred when they are physically attacked.

There are three other problems peculiar to work in forensic residential institutions, which give rise to particular anxieties and defences. First, the vast majority of forensic patients not only have severe treatment resistant mental illnesses, but also suffer from moderate or severe personality disorders. The psychological impact of working with personality disorder on staff has been well described in the general psychiatric literature (Norton, 1996), but rarely applied to forensic settings. Patients with personality disorders not only relate in immature and fragmented ways; they also elicit care from professional carers in hostile and toxic ways (Henderson, 1974; Main, 1976; Adshead, 1998). In outpatient settings, staff can respond by distancing themselves from the patient (Watts & Morgan, 1994); in forensic settings, this may not be possible (Whittle, 1997).

Second, the conflict of purpose that Bott described in the old style asylums is even more intense in forensic institutions. Are the staff there to help the patients feel better or behave better? How can they work towards patient recovery and discharge when it is not at all clear that anyone wants them to be discharged? If they do not provide treatment, patients will be institutionalised and hopeless, and the 'nursing' purpose will be gone; however, if they do not provide long term care, there will be damaged patients who may end up being abandoned in the community with potentially

awful consequences for them and others. This conflict between 'care' and 'custody' is a crucial one for forensic nursing staff, and it leads to a multiplicity of unconscious behaviours that allow avoidance of thinking.

Finally, there is one anxiety that all forensic professionals try and keep as far from consciousness as possible, which is the fear of identifying with these violent and cruel patients. This can take the form of excitement over their crimes and pathology, or an excessively punitive stance towards the patients. Robert Simon, a distinguished forensic psychiatrist wrote a book entitled' Bad men do what Good men only dream' (1996); Both Simon and Mrs Klein would argue that we all have innate feelings of hatred and cruelty that we generally manage in fantasy. Very few people will ever enact their unconscious cruelty to others; but forensic patients actually have done so. In the same way people watch horror movies, staff can be voyeuristically excited by the acts that patients have carried out. They may wish that their cruel and callous feelings were tolerated and cared for; and this may be especially true for those staff members who have actual histories of childhood victimisation. Professionals like ourselves may be drawn to this work because we also unconsciously long to be cruel; or perhaps because we unconsciously seek revenge for past hurts; or because we are unconsciously anxious about our capacity for destructive anger. Whatever the reason, a variety of defensive acting out behaviours by staff may be driven by the anxiety that we psychologically resemble the patients.

Examples of forensic social defences: patients

Just as Menzies described, the social defences of forensic organisations are usually manifest in policies and procedures that keep patients and staff contact to a minimum; emphasise security and not care; or go to the other extreme of emphasising care and ignoring risk. The effects of these social defences are amplified because the patients are using similar immature defences; partly because that is their pathology, and partly in response to a mad environment, that cannot decide whether they would be better off dead or must be kept alive at all costs.

Case 1: Tom, Harry and Harry's doctor

Tom and Harry are patients in a therapy group, which has been running for a year. Tom is very difficult in the group; loud and overbearing, he acts in ways that make others uncomfortable, especially Harry. Harry complains to his doctor, who goes to the therapist and demands that Harry be protected from Tom.

What is going on here? Both Harry and Tom have histories of extreme violence; yet Harry is presenting himself as a helpless victim of Tom's aggression. He elicits a protective response from his doctor, who acts as a concerned parent for a vulnerable child. All Harry's aggression, and his fear of it, is unconsciously carried and acted out by his doctor, who is cross with the therapist. We may also wonder to what extent

Harry's doctor fears Harry's violence; and so cannot encourage him to take the complaint back to the group where it belongs.

A similar dynamic is operating in Case 2:

Kelly killed her male partner in a cruel and sadistic attack which took place over a number of days. She is referred for individual psychotherapy; and starts work with a therapist. After a number of weeks of work, the therapist is startled to get a letter from the clinical team, which says, 'Dear Dr X, could you not talk to Kelly about her murderousness because she finds it upsetting'.

It is very likely that Kelly does find the work upsetting; her situation is indeed an upsetting one. Her resistance to working is expectable, understandable and human. However, her resistance is manifest as anxiety and projected into her carers; who act on it by attacking the therapeutic process. Note too the split: the team seems to assume that the 'bad' therapist does not see the upset, or care about it, and only the 'good' professionals can care for Kelly. Unconsciously, of course, the disgust and rage at Kelly's crime is enacted in an attempt to prevent her from getting her treatment. I am sad to say that Kelly did drop out of therapy; and the therapist's efforts were described as 'ineffective' for Kelly.

Examples of forensic social defences: within the institution

Cases 1 and 2 are examples of how the patient's defences can be mirrored and amplified by staff counter-transferences and group dynamics in clinical teams. Now I want to describe some examples from processes within forensic institutions.

Case 3: The consultant psychotherapist suggests that a therapy group be set up for women who have killed someone close to them. Other professional colleagues are highly dismissive:

'You might as well set up a wearing-pink-bows group'.

The suggestion of a new therapeutic intervention apparently stirs up uncomfortable feelings in the professional colleagues; which is defended against by a denigrating comment; and an odd associative image. Only little girls wear pink bows in their hair; the implication seems to be these women could only get together over a shared hairstyle that belongs to childhood. It is also being suggested to the therapist that it is ridiculous to think that these women are adult enough to reflect together on their own histories of violence. As in case 2, no doubt there is some real concern that the process of thinking will be initially painful for group members; but this is not what is communicated. Whatever the negative affect is in the colleagues, it is defended against by a rubbishing of treatment as childish and ineffective. In supervision later, we wondered whether the colleagues were feeling particularly hopeless about these patients; and whether they might be feeling envious of the therapist's capacity to still care.

Case 4: In a supervision group, the facilitator asks Jim to present his last patient session. Jim explains that he does not have any material, because the patient did not come to therapy last week. When the facilitator enquires why the patient did not come (which was unusual), Jim replies: 'He can't come to therapy 'cos he's got a beard'.

One of the ways that defences against anxiety can be manifest is in the use of language. Linguistic analysis of insecure attachment narratives from early childhood often show characteristic lapses of thought which are then manifest in lapses of monitoring of language (Main & Goldwyn, 1994). Note that Jim did not say, 'He couldn't come to therapy because his appearance has changed'; which would have been a more coherent communication (and more grammatically accurate: using past, not present, tense, and linked to the actual cause). Instead, Jim said something which makes no sense; which perhaps indicates that he was anxious about his patient's change of face, or felt annoyed by the security procedures that mean that no-one can move in the hospital if they do not look like their security identification card. This type of minor linguistic defensive manoeuvre is widely practised: this episode stayed in my memory chiefly because when Jim spoke about the beard that stops therapy, all the other therapists in the group nodded!

Examples of forensic social defences: outside the institution

In this section, I want to explore how the social culture, in which the forensic institution resides, also uses defences that affect the hospital's ability to carry out its task. In Diagram 1, I lay out how the hospital fits into a social system of concentric groups, each with their own potent dynamics and defences against grief, rage and fear.

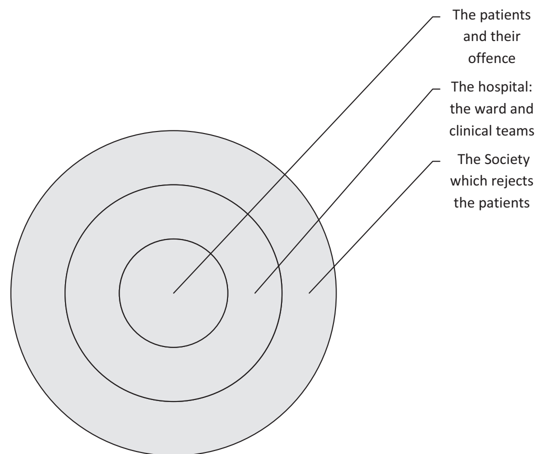

Diagram 1:
The forensic institution as part of a system of groups: defensive anxiety flows from outer group to inner and vice versa. Note how the forensic institution is caught in the middle

It is well understood by forensic practitioners that the society in which the offenders live (the ultimate Large Group, as it were) has pushed them out of the community because of the things they have done. The Large Group fears and hates the patients; but the social value of justice for the Group means that there is a need to care for them. This conflict of feelings is acted out as ambivalence towards not only forensic patients, but those services which care for them.

Case 5: Staff at a high security hospital are accused of being physically abusive to patients. There is a national inquiry: heads roll, and policies change; for example, patients are allowed free access to phones. Five years later, staff are accused of professional boundary violations and colluding with patients to break the rules. There is a national inquiry: heads roll, policies change: patients are now forbidden access to the phone. It is over 5 years since the last inquiry…

These repeated inquiries suggest that there is a profound ambivalence in the national psyche in the UK about these hospitals. On the one hand, their madness and vulnerability must be cared for properly; on the other hand, their capacity for mad violence needs to be contained. Punishment and retribution are normal features of social life in groups: the wish to hurt the person who has hurt you is all too human. Deprivation of liberty (combined with social exclusion) is the most common form of punishment now carried out in most industrialised countries; however, it is recognised that prison guards often act punitively towards prisoners (Goffman, 1961; Zimbardo et al 2000), presumably as an unconscious expression of Large Group identity, and the Large Group's revenge.

Forensic patients are not to be punished for their offences; no matter how guilty they feel. The Large Group wants revenge, but cannot have it; it projects this wish and the staff identify with the projection. The Large Group unconsciously wants staff in secure institutions to exact revenge on the patients; and punishes them severely when they do. Note how this projective dynamic can be mirrored and amplified by the same projection upwards from the patient, who projects his hostility into the staff, and then consciously becomes a victim.

What is frustrating for the psycho-dynamically informed manager in such systems is that there seems to be such an investment in not learning from experience. It could be anticipated that staff would swing from one type of boundary violation to another with patients: this is how projection and splitting manifest in groups. What would be helpful is more attention to, and reflection on, the daily examples of abuse and collusion: rather than waiting for them to be taken up at a group level. But the therapist in an institution like this needs to acknowledge that they too are part of the Large Group that sent these patients to the hospital; and are glad that they are there.

I want to end with a final example of a Large Group defence against patient dependence and need; and how this can be taken up by organisations in an unthinking way.

Case 6: The UK Department of Health decided that there should be a 30% reduction in the time patients spent in hospital. Consciously, it was hoped that this strategy

would decrease hospital infections, encourage more active rehabilitation of patients, and save money that was spent on 'unnecessary' care. Unconsciously, one might see this as a Large Group wish that the chronically and severely ill would disappear quickly; and that there were 'bad' staff who were not getting rid of the patients fast enough.

This policy was devised with medical and surgical beds in mind; and then sent out as an instruction to all hospitals offering inpatient care. It was not intended to apply to psychiatric beds. Nevertheless, the policy has been applied to a high security psychiatric hospital, and a requirement that the average length of stay be reduced from 8 years to 5 years. It is not clear what this means for the10% of the population who have lived in the hospital over 10 years.

Fifty years on, we can see the Menzies defences still being enacted at a Large Group and institutional level. We see denial of dependence and suffering, and a wish to discharge that which makes us anxious. We see the denial of patient individuality and personal history; that enables people to be treated like things; and so helps staff not to care too much. We see a mad denial of reality: what makes a man stay a long time in a forensic psychiatric hospital is probably *not* the same as that which makes him stay a long time in a surgical ward! We see manic activity to compensate for hopelessness, fear of suffering and disability. The saddest effect in the hospital so far is on those long stay 'residents'; who do not fit into the assertive rehabilitation programme and therefore are likely to end up 'out of mind'.

Conclusion

'Mankind cannot bear very much reality' (T.S.Eliot)

Defences are necessary to social living; and they form part of the variety of psychological structures that make up our self and identity. We should therefore not see them as 'good' or 'bad' but functional or dysfunctional. In the case of organisations, we may want to ask: does this defence help us to get the job done? Or is it distracting us, and making us act out something for the groups that we are members of? Perhaps the most important thing that I have learned as a psychotherapist in an institution is that we need to take our feelings about our work seriously; whether positive or negative, they may be telling us something important about others, ourselves and the society we live in. The other thing that I have learnt is that we all need to keep working on our mature defences: altruism, sublimation, suppression, humour and hope.

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