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This is a post-peer-review, pre-copyedit version of an article published in *Social Theory & Health*.

The definitive publisher-authenticated version
Walsh, K., Campbell, S., Ashby, M. & Procter S Soc Theory Health (2016) 14: 493. doi:10.1057/sth.2016.5 is available online at:
https://link.springer.com/article/10.1057/sth.2016.5

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Abstract

In this article, we explore how the application of organizational psychodynamic theories might improve the understanding of unconscious forces influencing apparently rational and evidence-based processes such as the generation and implementation of health policy. There is a growing body of literature using psychodynamic theories to explore discontinuities in policy-making and the containment of anxiety in organizations. In this article, we focus on the dyadic relationship between policy formation and the media/public response, in particular knee-jerk reactions that can cause 'U' turns in policy implementation, and the role of organizational leaders in containing public anxiety. We illustrate this using three contrasting instrumental case examples. Drawing on the seminal work of Isabel Menzies and the psychodynamic literature, we explore how anxiety is manifested in organizations and the role of public institutions as receptacles of public anxiety. We suggest that policy has a latent function of controlling objects into which public anxiety is projected and that we need to understand the sources of this anxiety if more rational policy responses are to ensue. We also explore the implications this has for policy development generally and for the role of senior managers.

Keywords:

psychodynamics; health policy; health services; anxiety; defence mechanisms

Introduction

As academics and clinicians who have been working in health services for many years, we have been struck by the way health policy is often formulated or changed in haste, with limited recourse to available evidence, as a response to some public or organizational anxiety about a single focusing event or exceptional experience (Majone, 1989; Michaels *et al*, 2006). Paradoxically the underlying anxiety, which we argue in this article can give rise to hastily implemented changes, and the causes of this anxiety are marginalized within mainstream health policy analyses that look to partial *post hoc* rationalizations to explain such responses. Indeed

Fotaki (2006, pp. 1712–1713) notes that policy analyses are '… generally phrased in the language of politics and economics, while insights from other disciplines are largely ignored …'. In this article, we explore how the application of organizational psychodynamic theories might improve understanding of the unconscious forces influencing apparently rational and evidence-based processes such as the generation and implementation of health policy. We do not claim a psychodynamic perspective is the best or the only useful perspective. No single perspective can explain all the complexity that is policy development. However, there is a growing body of literature using psychodynamic theories to explore discontinuities in policy-making and the containment of anxiety in organizations (Obholzer and Roberts, 1994; Fotaki, 2006; Diamond and Allcorn, 2009; Fotaki and Hyde, 2014). This literature applies psychodynamic theories to explain inherent *contradictions* in policy formation related to unexpressed and therefore unexplored individual and collective unconscious desires and fears. For instance, Fotaki and Hyde (2014) propose a theory of organizational blind spots to explain continued organizational and leadership support for failing policies and strategies. Such blind spots, they argue, are fuelled by the propagation of unrealistic public expectations and the splitting of policy-making from policy implementation enabling each to blame the other for failure while both publicly uphold unrealistic goals. Other authors have suggested that policy has a latent function of controlling objects or organizations into which the public anxiety is projected and that this frequently results in contradictory and seemingly irrational outcomes (Obholzer and Roberts, 1994). In this article, we argue that we need to understand the sources of this anxiety if more rational policy responses are to ensue.

In what follows we will explore the largely unconscious psychodynamic factors that operate at individual and group levels, and effect behaviour and therefore policy development at a meso or organizational level within health services. We will also explore the role of such organizations or institutions as receptacles of public anxiety and the effect this has on policy development and change at a macro or societal level. In particular, we focus on the dyadic relationship between policy formation and media/public response, specifically the knee-jerk reactions to media headlines that can cause 'U' turns in policy implementation, and the role of organizational leaders in both anticipating media reaction and containing public anxiety. We illustrate this using three contrasting instrumental case study examples from which to draw insights and make generalizations to other similar cases (Stake, 2000): The Australian National Emergency Access Targets (NEAT) policy, the

Australian policy response to HIV/ AIDs, and the UK primary and secondary care split. Finally, we will explore how psychodynamic processes such as containment might be used positively by leaders to contain public anxiety enabling the realization of beneficence in policy development.

The Psychodynamic Perspective

The psychodynamic perspective is based on the work of Freud (1920). Freud was one of the first to propose that human behaviour is influenced by both conscious and unconscious processes. Freud put forward the idea that many of our motivations, thoughts and desires, that is much of our mental activity, lies '… below the "surface", hidden from our conscious awareness' (Carr and Gabriel, 2001, pp. 415–420). While much of Freudian psychoanalytic theory, such as Castration Anxiety and the Electra Complex, has been disputed, much has also endured. Indeed terms such as the unconscious, the Ego, denial, regression, sublimation, transference and many others have become part of the common lexicon. Most people with a passing knowledge of psychodynamics would not dispute phenomena such as transference and countertransference and the ego defence mechanisms; the most commonly known of which is perhaps Rationalization, often referred to as the 'sour grapes' excuse, as in the fable of the fox who could not reach the grapes, so comforted himself with the thought they were probably sour (Walsh *et al*, 2011). The original theory of the Ego and its mechanisms of defence was put forward by Freud and later expanded upon by his daughter, Freud (1946). The Ego is that part of Freud's structural model of the unconscious, which mediates between the instinctual drives of the Id and the moral repression of the Superego. The Ego negotiates compromise between these two structures using Ego defences (Danzer, 2010). While much of psychoanalytic theory has been challenged and adapted, the theory of Ego defences has gained wider acceptance (Malan, 1982; Pultchik, 1995). Indeed recent neuroscience studies have uncovered brain structures, the underlying activities of which have strong similarities to those postulated by the Freudian concept of Ego (Rizzolatti *et al*, 2014).

Overall, the psychodynamic perspective can be summed up by the following points: humans adopt various defensive mechanisms in order to avoid mental pain or conflict, or to control unacceptable impulses. These mechanisms vary from being almost wholly conscious to being totally unconscious. The end product of these mechanisms is often a form of maladaptive behaviour or a neurotic symptom. The behaviour or symptom often has an expressive as well

as a defensive function, containing the avoided feelings or impulses in a disguised form and the behaviour or symptom often has damaging consequences for everyone, not least for the individual in whom the mechanisms are occurring (Malan, 1982).

If psychodynamic mechanisms are at play at an individual level then it follows that such mechanisms also operate in organizations. After all, we take all of ourselves everywhere.

Group Anxiety in Organizations

Jaques (1953 [1990]) and Menzies (1960) were some of the first to research anxiety and its defences, operating in organizations (as opposed to individuals). Menzies' seminal work, 'A Case Study in the Functioning of Social Systems as a Defence against Anxiety', was a report into a nursing service in a general hospital in London and is still regarded as one of the best studies of its kind. Over 50 years later it is still relevant (Evans *et al*, 2008; Lawlor, 2009) and it is worth summarizing Menzies' salient insights here.

Menzies' study laid the ground work for the concept of social systems as mechanisms of defence. Menzies identified numerous sources of anxiety against which the nurses adopted various defences. Nurses are the 24-hour care givers in the health system. They are faced with the suffering and death of others, which may awaken in them their own existential fears and increase their anxiety. Drawing on the work of Freud (1948) and Klein (1959), Menzies remarked that:

> Nurses are confronted with the threat and the reality of suffering and death as few lay people are. Their work involves carrying out tasks which, by ordinary standards, are distasteful, disgusting, and frightening. Intimate physical contact with patients arouses strong libidinal and erotic wishes and impulses that may be difficult to control. The work situation arouses very strong and mixed feelings in the nurse: pity, compassion, and love; guilt and anxiety; hatred and resentment of the patients who arouse these strong feelings; envy of the care given to the patient. (Menzies, 1960, p. 98)

In addition, patients and relatives project other painful emotions onto the nurses, such as the relatives' feelings of inadequacy for not being able to care for their family member at home or the patient's envy of the physical health of the nurse when contrasted with their own infirmity (Menzies,

1960).

According to Menzies, the nurses in her study used a number of defensive manoeuvres to manage the anxiety. These included: depersonalization, categorization and denial of the significance of the individual that inhibited a full person to person relationship with the patients; detachment and denial of feelings; the attempt to eliminate decisions by ritual task performance; and purposeful obscurity in the formal distribution of responsibility (Menzies, 1960, p. 105).

Not surprisingly, these socially constructed defences were sometimes entrenched in policy. For example, the socially constructed defence against the anxiety of identifying too closely with the suffering patient was backed by the task allocation policy of breaking the workload into lists of tasks. In this way patients could be cared for by any number of nurses, which restricted prolonged contact with any one patient.

Menzies makes the point that all social defences are a compromise between the implicit aims of the social defence system and the demands of reality as expressed in the need for the organization to fulfil its primary task. It is not surprising then that such compromise leads to difficulties for both the utility of the social defence and the ability of the organization to fulfil its primary task (Menzies, 1960). In Menzies' case study, the social defence of depersonalization of the patient, while fulfilling the function of protecting the nurse from identifying with the patient and the attendant anxiety, also robbed the nurse of the satisfaction of human connection and made holistic care (which the organization espoused) impossible to achieve. This situation was further exacerbated by the social defence of splitting up the nurse–patient relationship. This was entrenched in policy through the system of short allocations of nurses to ward areas that were changed regularly and often (rationalized as necessary for a flexible workforce) (Procter, 1989).

Public institutions as receptacles for public anxiety

Public institutions, in this context, are any large social system such as health, education and social services (Obholzer, 1994). These organizations are most commonly studied from economic, structural and cultural perspectives (Handy, 1993; Hatch and Cunliffe, 2006; Schein, 2010). Schein, in his theoretical discussion of organizational culture, identified a range of concepts such as group norms, espoused values or habits of thinking, shared or held in common by group members that have been used to explain regularities in behaviours observed in organizations and

captured in the concept of organizational culture. A significant amount of research has been conducted to try to understand the genesis of organizational cultures (Huczynski and Buchanan, 2013). However, as Schein (2010, p. 14) pointed out, 'perhaps the most intriguing aspect of culture as a concept is that it points us to phenomena that are below the surface, that are powerful in their impact but invisible and to a considerable degree unconscious'. So at the heart of our understanding of organizational culture is a contradiction. On the one hand, research demonstrates the puzzling conformity of individuals to regularized and shared behaviour patterns, on the other hand these conformist behaviour patterns give rise to contradictions and irrationalities that are observed on a daily basis and form the substance of most criticisms of organizational effectiveness. In order to further our understanding of this contradiction, it is to the powerful but invisible unconscious forces that Schein suggests we need to look. This article attempts to do just that.

From a psychodynamic perspective, public institutions can act as containers of unwanted and/or inadmissible societal anxieties around suffering, death and dying as illustrated above through the work of Menzies (1960) and this gives rise to defensive behaviours and functions at both an institutional and organizational level (Fotaki, 2006; Diamond and Allcorn, 2009).

Extending Menzies' work, a cornerstone of psychoanalytically informed organizational studies for the last 50 years, has been the view that not only are psychodynamic mechanisms at play in organizational life, but that public institutions constantly deal with fundamental human anxieties (Obholzer and Roberts, 1994; Diamond and Allcorn, 2009). More recently, some psychoanalytically informed organizational researchers are of the view that '… [public] institutions, and the apparatus of government as a whole, play a vital role in "containing" some of the troubling feelings which characterize citizens' lives and that anxiety seems to be the most powerful of these' (Hoggett, 2006, p. 180).

If there are, inherent in our healthcare system, anxieties that are defended against, then it follows that the sources of these anxieties (and their defences) also exist in the general population. One such source of anxiety may be death.

> In the unconscious, there is no such concept as 'health'. There, is however, a concept of 'death', and in our constant attempt to keep this anxiety repressed, we use various unconscious defensive mechanisms, including the creation of social systems to

> serve the defensive function. Indeed, our health service might be more accurately called a 'keep – death-at-bay' service. (Obholzer, 1994, p. 171)

Health services may also be called 'shield us from death' services. A remark made by a nurse to one of the authors of this article illustrates this. The nurse had been caring for a 2-year-old boy dying of leukaemia. Following the death of the child, the nurse spoke of how no one in her family would understand what it was like to care for a dying child and that in any case they would not want to know. She then stated, 'I envy them their ignorance'.

If indeed health services serve, in part, as socially constructed defences then three possibilities flow from this. First, there is likely to be a strong defensive reaction to any breakdown in the system's defensive function (if general societal ignorance is intruded upon by any perceived system dysfunction). Second, just as in the organizational example from Menzies above, the health system (at a meso level) may entrench socially constructed defences in policy and the defensive functions so entrenched may have unintended and negative consequences. Third, the first two points may perpetuate a negative feedback loop from which it is difficult to escape.

Defensive reactions to breakdowns in the system's defensive function

According to a psychodynamic formulation, any breakdown of health systems function (and therefore crack in its role as receptacle of societal anxiety) may trigger a disproportionate response on the part of the community and a knee-jerk reaction on the part of managers and policymakers at a local (meso) and nation (macro) level. We are all familiar with local and national newspapers' almost daily exposés on some actual or perceived problem with local health services. Newspaper headlines such as: 'Hospital budget blowouts, Delays and infighting …', 'Concerns over surgery cuts …', 'Doctor deficit hits …', 'Helipad delay blasted …', 'Medical professionals deny hospital mishaps …' are commonplace (examples from *The Mercury*, 2013–2014). Many of these headlines will have some basis in fact, but many also exaggerate the problem, and are based on rumour, misinformation or fuelled by internal leaks and vested interests. The consequence in our experience is often an ebbing of staff morale and knee-jerk policy reactions. For example, in one health service the authors have knowledge of, criticism of 'bed block' in the local media led to a directive for all nursing managers to ensure patients

were discharged by 10:00 each day or suffer the consequences. Issues of cause and effect and problem-solving were not considered. The headline for the coming week was obvious, ‘Sick patients forced out of hospital’.

While there is an element of rational concern about poor health service performance, much of the media reaction may also be a defensive response to the existential anxiety it provokes. Indeed, to paraphrase Menzies, the defensive response fragments the problem so that the core no longer exists in a recognizable form and parts of this core are projected onto waiting times, cost blow outs and poor management, which are consciously and honestly, but mistakenly, experienced as the problem and about which something must be done, usually by someone else (Menzies, 1960). This leaves the real problem of dealing with the realities of death, suffering and dying (and facing the unreality of societal wishful thinking that healthcare can fix these things) unexplored. In this way the behaviour serves its defensive function of defending us from confronting our existential anxiety. It serves its expressive function through externalizing the threat that the anxiety poses onto others: clinicians, politicians and executive managers, who can be blamed, while the original source of the anxiety is not confronted. This can place a great deal of stress on staff. It is perhaps not an accident that the executive turnover in healthcare in the United States is 47 per cent higher than any other industry (The Advisory Board, 2013).

Paranoid–schizoid **and** ***depressive*** **modes of reacting to stress**

The elements at work in knee-jerk policy reactions and projections of blame (from both internal and external sources) seem to mirror the *paranoid–schizoid* position described by the Melanie Klein’s Object Relations theory (Klein, 1946 [1975]; Diamond and Allcorn, 2009). According to this perspective, when anxiety is high, people manage this anxiety by splitting off the good and the bad elements of their existence. The good elements are introjected into the self and the bad elements are projected onto others (Voyer *et al*, 1997; Walsh *et al*, 2011). Hence, various groups within organizations may see others as representing something bad and themselves as something good: ‘Doctors are authoritarian, social workers talk too much … managers only think about money’ (Halton, 1994). As well as clinical professional groups, *paranoid–schizoid* projections may also be applied to other health service groups such as executive managers, planners and funders, and policymakers. The less contact these groups have with each other, the more likely such projections become (Halton, 1994).

In contrast to (but never totally separate from) the *paranoid–schizoid* position is the *depressive* position. In this mode, 'Organisational members do not feel particularly threatened (polarized, fragmented or split apart) by the thoughts, feelings and actions of others or organizational and external threats' (Diamond and Allcorn, 2009, p. 15). In the *depressive* mode, all points of view are valued and emotional complexity accommodated. Group members will discuss and think through, rather than project and act (Halton, 1994). This position is often made possible by leaders who can provide direction and can also contain some of the group anxiety and thereby delay splitting and projection. However, when there is a collapse in direction of the *depressive* mode, feelings of lethargy, stagnation and gloom may ensue (Diamond and Allcorn, 2009).

***Paranoid–schizoid* and *depressive* policy positions**

In what has been discussed so far, a psychodynamic formulation may be that unconscious forces operate at an individual, organizational and societal level. It follows that psychodynamic mechanisms (especially the *paranoid–schizoid* and *depressive* positions) may also operate at health service and governmental levels and may be expressed in policy. With this in mind we will explore a psychodynamic formulation, based on the *paranoid–schizoid* and *depressive* positions, in relation to two Australian national health policies: the 1980s policy response to the HIV/AIDS pandemic and the NEAT, and the conflict between primary and secondary providers in the United Kingdom. We believe that such a perspective may be useful in providing a different explanatory point of view to the characteristics of these three cases.

Australian HIV/AIDS policy response of the 1980s: An example of a *depressive* position

In the 1980s, the world was gripped by the HIV/AIDS pandemic. The very real existential threat this posed was palpable. Many countries took what appeared to be a *paranoid–schizoid* position of alienation, blaming and discrimination against certain groups; namely, gay men, IV drug users and sex workers. The potential for this to happen in Australia was real. In the mid-1980s homosexuality was still illegal in some states. Sydney Telecom engineers refused to carry out repairs at the Pitt Street Mail Exchange because they believed it was staffed by large numbers of homosexuals. Ansett and TAA airlines sought to ban HIV positive passengers from travelling (a move that was rejected by the Australian Flight Attendants

Association) (Sendziuk, 2003). There were also some instances of groups of men roaming Sydney looking for homosexuals to punish (Sendziuk, 2003). The potential to enact draconian policy initiatives was certainly real. There were calls for mandatory screening of high-risk groups, the quarantining of infected individuals and the closure of ‘gay’ venues (Sendziuk, 2003). Despite these issues, a positive policy response was formulated and enacted.

According to Aggleton and Kippax (2014), the Australian response was a tripartite approach, which saw State and Federal governments working with communities, together with social and public health researchers to develop an effective response. The anxiety in relation to the disease, which could have seen a *paranoid–schizoid* position take hold, was contained long enough, by enough politicians and community leaders, for pragmatic, inclusive, policy and social responses to be enacted. These initiatives included education in schools on safe sex, blunt ‘Grim Reaper’ television advertisements, and promotion of condom use and needle exchange programmes, among others. Individual interest groups worked with their communities and were supported financially by state and federal governments. Very early in the response to the epidemic most Australian governments (State and Federal) positioned HIV as a ‘problem for everyone’ (Aggleton and Kippax, 2014, p. 188).

From a psychodynamic perspective, this response appears to mirror a *depressive* position in which anxiety is contained long enough for a reasoned response to ensue. But the containment was fragile. Not all the state governments agreed with the policy positions. Nevertheless, Dr Neil Blewett, the Commonwealth Minister for Health from 1983 to 1990, and other leaders, did much to contain anxiety and prevent the splitting and projection seen in other countries. The subsequent policy response has been widely praised internationally and seen as an exemplar of HIV policy success.

However, constant vigilance is necessary as with time the *depressive* position often loses direction. This is characterized by gradual complacency and loss of energy (Diamond and Allcorn, 2009). The current waning of the response to HIV policy in Australia appears to mirror a directionless *depressive* position; HIV rates are once again on the rise and safe sex practices are declining. This loss of direction may to some extent be due to a loss of historicity. For the present generation HIV is no longer the killer it once was. Many people with HIV can now enjoy a near to average life expectancy and this generation has not had the experience of watching friends and family members die, sometimes within months of

diagnosis. However, not all policy can be characterized as taking a *depressive* position.

The NEAT policy: An example of a *paranoid–schizoid* position

Emergency Departments (EDs) are the 'front door' of health services. If health services are indeed repositories for unwanted anxieties around suffering, death and dying, as the psychodynamic literature suggests, then it is likely that leakage of this anxiety may occur at the door of the ED. In Australia, there has long been concern about ED access and waiting times. This situation is in no small measure related to complex problems, including an ageing population, rising public expectations and federal funding cuts (Crawford *et al*, 2013).

Many initiatives have been tried over the years with mixed success. Most recently the NEAT was introduced by the Australian Government in 2010. This policy requires that most patients presenting to EDs be seen, assessed and transferred within 4 hours (Australian Government Department of Health and Ageing, 2011). Western Australia was the first to introduce the 4-hour rule in 2008 following '… persistent and damaging media attention …' (Crawford *et al*, 2013, p. 2) in relation to their EDs.

In 2010, the NEAT was introduced nationally despite evidence that the 4-hour rule in the United Kingdom (on which it was modelled) had not had an altogether positive impact on the quality of care, patient outcomes or waiting times. Crawford *et al* (2013) in their literature review of access block in EDs also state that there is evidence from the United Kingdom that much of the burden to meet the 4-hour target was placed upon clinical staff, especially nurses. Other concerns about the NEAT policy have been voiced. Green (2014, p. 305) comments on the 'Dumbing down' of emergency physicians and the sacrifice of quality care in favour of timeliness. Khanna *et al* (2013) in a five year retrospective study of data from 30 EDs in Queensland, found rising access levels of NEAT non-compliance at times when corresponding access block have traditionally not been a concern. This points to a possible shifting of constraints and the need for service-level analysis and new solutions to guide workflow reform.

It is not our intent to evaluate the NEAT policy comprehensively but rather examine it from a psychodynamic perspective. From this perspective the NEAT may be seen as an example of a *paranoid–schizoid* policy position. As outlined earlier, the *paranoid–schizoid* position is characterized by projection (paranoid) and splitting (schizoid) in relation to anxiety. The

policy may be seen as an understandable response to societal anxiety about ED access. However, this concrete concern may mask anxieties of a more existential nature to do with death and dying, and societal expectations of health service delivery, discussions of which are generally avoided in the public arena. A psychodynamic formulation may be that the NEAT policy projects some of these anxieties onto what Menzies would call the 'bits of the ambience' (Lawler, 2009) of the situation (the EDs and their staff), so ED access is genuinely but mistakenly seen as the problem. In this way, we may collude not to discuss the 'elephant in the room'; the reality of our expectations, the possibility of the need for rationing of health services and the reality versus our expectations of medical advances in the light of our individual impending non-being.

In addition, there may be an unspoken assumption that simple 'carrot and stick' solutions will work in complex settings and for complex problems. This may imply a level of complicity on the part of the health service staff. It implies that they are not sufficiently motivated to find a solution and the targets will remedy this. This splitting of the management world from the clinical world may allow an 'us' and 'them' polarization where the policymakers (health managers) could be seen as active and decisive and the ED staff as recalcitrant.

Paranoid–schizoid policy positions may mitigate against finding solutions to complex problems as they split the key stakeholders required into the objects of 'Them' in relation to 'Us'. From a psychodynamic perspective, the *paranoid– schizoid* position would therefore allow the avoidance of the source of the anxiety (for which the health service is a repository) by concentrating on bits of the situation (ED access).

UK policy initiatives to improve communication between primary- and secondary-care providers: An example of a sustained *paranoid–schizoid* position

As mentioned earlier in some circumstances it would appear that some *paranoid–schizoid* positions can become entrenched in a negative feedback loop, influencing successive policy decisions.

An enduring complex problem in the United Kingdom has been the split between primary and secondary care with numerous policy initiatives introduced over the years to improve the flow of communication between clinicians in each sector. Research undertaken in the 1990s (Pearson *et al*, 2004) found that primary-care physicians blamed hospital consultants for early readmission of the patient to hospital, while

hospital medical staff expressed concerns about some of their patients following discharge but did not undertake any actions in relation to these concerns. No evidence of either party communicating effectively with each other to resolve the patient problem was found. More recent work (Procter *et al*, 2013) found that community nurses were unable to persuade hospital staff to contact them when discharging a patient from hospital despite their best efforts. Clinicians were reluctant to breach the boundaries between primary and secondary care even when it was the only way that patients' needs could be addressed. From a rational perspective such behaviour seems inexplicable, but from a *paranoid–schizoid* perspective the failure to communicate can be under- stood as the avoidance of the source of anxiety, locating responsibility for failure in another part of the system. The longevity of this problem in the United Kingdom against a background of successive reform and re-structuring to address this issue points to the need for new understandings of the dynamics of the situation to effect change.

The role of leadership and containment

As these psychodynamic formulations appear to indicate, effective leadership is important to effective policy development and implementation at all levels. In the face of group or societal anxiety, leaders can effect splitting or containment. Externalization in the form of splitting may be an effective (but ultimately destructive) way for individuals (including leaders) and groups to manage anxiety and bad feelings by relocating these feelings to other groups or to their leaders (Diamond and Allcorn, 2009). Leaders who have a capacity to avoid splitting (the *paranoid–schizoid* position) through the capacity to recognize and contain anxiety both within themselves and others will be required at all levels. When leaders can recognize the potential for splitting and act as effective containers for the anxieties of the group, they can give the group the psychological space to acknowledge emotions and work through anxieties to find effective solutions (including polices) that do not rely on splitting. According to Diamond and Allcorn (2009), the consequences of the failure of containment can be severe:

> The incapacity of organisations and their leaders to contain toxic emotions promotes a predominance of primary processes (over secondary processes) and psychological regression in groups. These psychodynamics are a direct threat to democratic practices in organizations and political institutions. More alarmingly, they represent emotional, ideological, and institutional prerequisites to a

> fascist (or totalitarian) state of mind (Diamond and Allcorn, 2009, p. 100).

Of course, not all instances of a lack of containment would be so dire. Nor are we suggesting that leaders need to be trained psychodynamically in order to be effective containers of group (or societal) emotions. However, we are suggesting that leaders need to be (in the words of Winnicott, 1965, p. 8) 'good enough' containers. Such good enough containment may entail opening the space for emotions to be recognized and named, and the opportunity for dialogue, reflection and learning to take place (Diamond and Allcorn, 2009). Such awareness and containment when applied to policy development may serve to develop policy that is well-conceived, inclusive, solves problems and turns ideas, vision and purpose into legitimate action for social reform, and sets the focus for public debate and public agreements about action.

Winnicott's model of the 'good enough' mother is also a key potential strategy for health management and leadership. He posits that the experience of the mother needing to be able to 'hold' her child who rages against the world and its frustration at unmet needs, but who, he asks, will hold the mother? So we may in turn ask 'who will hold the health worker or their institution'? This 'holding' is a vital supportive component of good management, often neglected in the 'lean and mean' public service arena.

Conclusion

At the beginning of this article, we quoted Fotaki (2006) who made the point that policy analyses are often phrased in the language of politics and economics, while insights from other disciplines are largely ignored. The intention of this article has been to posit a psychodynamic formulation of unconscious forces and their attendant anxiety that may affect individual behaviour and influence policy development at both organizational and systems levels.

Like all psychodynamic formulations they should be posited tentatively, held lightly and reformulated and refined in the light of subsequent evidence and interpretations. Nevertheless, the psychodynamic perspective may help bring to awareness and explain that which has hitherto been hidden or obscure. If indeed there are unconscious forces at work that influence human behaviour, including policy development and its execution, then a better understanding of these forces may help deliver

policy that is coherent, inclusive and more likely to bring about its purpose of improving the healthcare of the community. Failing to explore these forces may see us repeat the same mistakes and be locked into a vicious cycle from which it is difficult to escape (Fotaki, 2006).

We do not claim that the psychodynamic perspective we have outlined here is the only (or the best) explanatory framework. What is important is that as clinicians, health researchers and health policy developers we accept that people do not react and behave in 'rational and predictable' ways and that the technical, rationalist functional perspective is no longer sufficient to locate, explain or find solutions to complex health policy problems (Carr, 2000; Walsh *et al*, 2011). We hope that this work may contribute to the discussion around how policy leaders can more consciously and carefully explore the anxieties inherent in the systems in which we work, and begin a dialogue which will deepen our understanding of these forces so that they can be brought out of the shadows and dealt with consciously and openly.

As Hirschhorn and Young (1994, p. 162) put it, 'We can start to overcome our defences when we stop acting and start thinking, when instead of working to sustain normality we let go to extend and deepen our awareness'.

Acknowledgements

The authors would like to acknowledge the contribution to the initial conception of the paper made by our late friend and colleague Associate Professor Erica Bell.

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