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A Psychoanalytical Perspective on Social Institutions*

Psychoanalysis has made many contributions to our understanding of social institutions. It has done so through extending the understanding derived from exploration of the one-to-one relationship in clinical psychoanalysis to the larger and more complex relationships in groups and institutions. This is widely recognized. Less well recognized is psychoanalysis' other contribution, the derivatives from the psychoanalytic method in work with institutions and how this illuminates understanding of their content and dynamics. Wallace's view, quoted by Almansi (1986), that Freud's most valuable gift to anthropology was the clinical method of psychoanalysis and the unequalled insights it provides, is equally applicable to work with social institutions.

This paper is concerned with the second type of psychoanalytic contribution to institutional practice. Central to this approach is a deep conviction about the existence of the unconscious such as most easily comes through having an analysis oneself. This was how it came to Freud as he pursued the difficult course of his self-analysis. A useful alternative experience is membership of a group where the work is based on psychoanalytic principles as applied to group phenomena and directed towards increasing insight into group process (Bion, 1961). There is no harm in having both. They are different and complementary, the latter leading more directly into work with institutions. Such experience develops the capacity to recognize and understand the unconscious mind, both content and dynamics, and its manifestations in the conscious thoughts, feelings, speech and behavior of the people one is working with—and in ourselves. One also learns to recognize its presence in the institution itself—its structure, sub-systems and culture.

In institutional practice psychoanalytic understanding is extremely useful in orientating oneself to the nature of the situation, even if it is unlikely that one would interpret deep unconscious content directly to the client, as a psychoanalyst might to a patient. Perhaps more important than content are the dynamic psycho-social processes that go on in institutions at both conscious and

*A new paper.

unconscious levels. Of particular significance are the defenses developed to deal with anxiety-provoking content and with the difficulties in collaborating to accomplish a common task. These defenses appear in the structure of the institution itself and permeate its whole way of functioning.

People do not say what they really mean even when they honestly and sincerely say what they consciously think, let alone when they do not. Neither patients nor clients are likely to be absolutely sincere and honest, although they become increasingly so if work is going well and trust in the analyst or consultant is growing. In the institutional setting it is not only the unconscious thoughts and feelings one needs to understand, but also the implicit; what is not being said. Thoughts conscious in some people, or even shared in two's and three's, are not openly shared with everyone in a work situation where they could be realistically and constructively used. The ability to see behind what is being said or done to what is unconscious or implicit, to understand it, to open it up and explore it with the client is a focal skill for the institutional consultant. This implies recognizing the defenses that are holding the content unconscious or implicit and helping the client to give them up or modify them. Such an approach is familiar to the psychoanalyst and the methods he uses to accomplish this task are in many ways directly transferable to institutional practice.

The approach of the consultant to the client institution that facilitates the elucidation of such situations strikingly resembles Freud's recommendations about the way the psychoanalyst may best gain access to his patient's mind (Freud, 1911–15). Freud recommends "evenly suspended attention," not directing one's attention to anything in particular, not making a premature selection or pre-judgment about what is significant, which might distract one's attention from whatever might turn out to be significant. If one can hold to this attitude something will—hopefully—evolve that begins to clarify the meaning of what the patient is showing the analyst. Bion developed this point further (Bion, 1970). He recommends eschewing memory and desire, not consciously summoning up memories about the patient or what has previously happened; previous understanding about the patient; desires for him or for the progress of the analysis, or for that matter for oneself.

Bain (1982) stresses the value to the institutional consultant of ignorance and adds that, even if one is not ignorant, a "cultivated ignorance" is essential to the role of the social consultant. In a paper on work done in the Royal National Orthopaedic Hospital (RNOH) in London, I talk of the need to take a fresh look at the situation, to set aside habitual ways of looking at things, to blind oneself to the obvious, to think again (Menzies Lyth, 1982). It is beneficial if the client too can foster these attitudes so that consultant and client together can work towards the emergence of new meanings and appropriate action. In other words, the consultant may—indeed should—encourage the members of the client institution to speak as freely and widely as they can about

their work situation, relationships and experiences, something akin to psychoanalytic free association. In the initial exploratory survey of the nursing situation in a general teaching hospital I invited nurses to talk about the presenting problem—difficulties in the deployment of student nurses in practical training—but also invited them to talk about anything at all that seemed to them significant in their experience of nursing (Menzies, 1960; Vol. I, "Social Systems as a Defense Against Anxiety"). This invitation evoked much of the material that led to our deeper understanding of the work and training situation, particularly the anxiety patterns and the socially structured defenses developed to cope with them.

The strain of this way of working is considerable for the consultant, as it is for the analyst. One does not have many props since one has at least temporarily pushed to the back of one's mind such conventionally useful things as memory, consciously set objectives and theory; they are not to be directly used for guidance in the field. One exists most of the time in a state of partially self-imposed ignorance which may feel profound, frightening and painful. One needs faith that there is light at the end of the tunnel even when one does not have much hope.

If one can hold on to ignorance and evenly suspended attention, meaning will probably emerge and one will experience the reward of at least one mystery or part of a mystery solved, uncertainty and doubt dispersed. But this will not last, especially if one communicates one's understanding to the client who accepts one's interpretation and is prepared and able to proceed again into the unknown. One is thrown back on ignorance, uncertainty and doubt and must experience the process all over again. One may need to give a good deal of support to the client to go along with the process, especially a client who is accustomed to using the "expert" and expects him to produce a definitive answer quickly. If one resists this pressure, one may be bitterly attacked as though one is delinquently withholding goodies to which the client is entitled. Failing that, the client clutches at straws and magical unrealistic answers.

I have often had the experience while consulting with a group that I was the only person in the room who did not know what was going on. The group members "knew," that is, had abandoned ignorance. Fortunately, clients can identify with the model presented by the consultant and learn to work this way so that collaboration in the process becomes progressively easier and more rewarding to both parties. Patients are similar. A new patient may ask an analyst to tell him or her what to do about a problem or how to use an interpretation; experienced patients know, even if they may not like it, that they must take responsibility and work out what to do for themselves.

This introduces another way that psychoanalytically oriented consultancy runs in parallel with psychoanalysis—the initiative for taking appropriate action as insights and meaning evolve lies with the client. Just as patients make

their own life decisions without advice or suggestion, so clients make their own decisions about change and are responsible for implementing them. Ultimately they must take the responsibility and face the consequences. The analyst's or consultant's responsibility lies in helping insights develop, freeing thinking about problems, helping the client to get away from unhelpful methods of thinking and behaving, facilitating the evolution of ideas for change, and helping the client to bear the anxiety and uncertainty of the change process. This latter feature is notable in psychoanalytically orientated consultants and others whose work has been influenced by them. They stay around. Other consultants without that orientation are more likely to do their investigations and send their report to their clients—a blue-print of what they should do about their problems and leave the clients to do what they can on their own. This seems to happen surprisingly often, as for example, in the repetitive attempts to re-organize the British Health and Social Services. It is unlikely to be effective: clients are left on their own with what may well be the most difficult part of the task—the implementation of change. It would be unthinkable to give patients a detailed report on their psycho-pathology, instruct them as to what to do about it and send them away to do it.

I find it as unthinkable to leave a client institution in a similar situation. Serious change in a social institution inevitably involves re-structuring the social defense system, and this implies freeing underlying anxieties until new defenses or, better, adaptations and sublimations are developed (Jaques, 1955; Vol. I, "On the Dynamics of Social Structure"). There is a sense in which all change is felt as catastrophic even when it is rationally recognized as for the better, since it threatens the established and familiar order and requires new attitudes and behavior, changes in relationships and a move into a comparatively unknown future (Bion, 1970). Some of the changes that institutions make actually bring their members into more direct and overt contact with difficult tasks and stressful situations than before. This is a potentially maturational experience for the members who "learn" to confront reality and deal with it more effectively. But while the change is taking place the problem of containment is central: the presence of someone who can give strength and support, help manage the anxiety, continue the process of developing insight and help define the exact nature of desirable changes.

I am indebted to Bain for helping me formulate my ideas on the function of the consultant who follows a dynamic approach to institutional practice (Bain, 1982). He states that the institutional consultant must concern himself with three kinds of analysis: role analysis, structure analysis and work culture analysis.

Of these work culture analysis appears the most closely related to psychoanalysis. It considers such things as attitudes and beliefs, patterns of relationships, traditions, the psycho-social context in which work is done and how

people collaborate in doing it. A second look, however, may show that both roles and structure are infiltrated and partially determined by dynamics familiar to psychoanalysis. For example, the content of roles is partially determined by projection systems which contribute to the view taken by themselves and others of the incumbents of the different roles and of the roles themselves. Anxieties about one's capacity to do one's job may be projected downwards into subordinates and their roles. This is linked with a tendency to arrogate their capacities so that the subordinates' capacities are underestimated and their roles diminished. Projection of one's capacities upwards also takes place along with an expectation that one's superiors will take over one's responsibilities, so that anxiety about one's capacity to do one's job properly is relieved. Anxieties about whether one's subordinates are capable and trustworthy—partly arising from one's own projections—may lead to unduly narrow and rigid prescription of their roles and to unnecessarily close supervision. The effects of such attributions can be seen in roles at all levels in a structure as was found in the nursing service of the general teaching hospital the author studied (Menzies, 1960; Vol. I, "Social Systems as a Defense Against Anxiety"). But they are probably most obvious in the lowest rung of the hierarchy where the role content may be well below the capacity of the workers. Bain found this strikingly in his work in Baric, a computer processing company, as I did among student nurses in the general teaching hospital. Similar factors influence structure: diminution of the content of roles may lead to too many levels in the hierarchy with people doing jobs that people below them could easily do, and to too many supervisors.

This three-pronged analysis may seem very different from what goes on in psychoanalysis, which may appear to be more analogous to work culture analysis. I do not think this is so, however. Psychoanalysis is directly concerned with the patient's internal world as he or she shows it to the analyst. This internal world consists of images and phantasies—conscious and unconscious—of other people, the self and inter-personal relationships, of roles and role relationships, all of which exist within a structure. It is a social system, an imaginary institution. Psychoanalytic exploration of this internal world changes it, that is, the patient's personality. The internal changes are reflected in changed relationships with the external world. For example, analysis of internal role systems leads to changes in the roles the patient operates and how he or she operates them. Fenichel (1946) writes that social institutions arise through the efforts of human beings to satisfy their needs, but social institutions then become external realities comparatively independent of individuals that affect the structure of the individuals themselves. Participation in a psychoanalysis, like participation in other social institutions, changes the structure of the personality.

There are also differences between psychoanalytic practice and institutional

practice which limit the full and direct transfer of method from the one to the other and require variations and modifications. For example, patients take action in the external world themselves, and cope with the way they and the changes within them affect and are affected by real people and situations that facilitate or inhibit these efforts. If and when an institution uses a consultant to facilitate institutional change, individuals or even small groups with whom the consultant is working cannot usually take decisions or initiate action on their own. Other people and groups need to be involved if understanding and insights are to grow and relevant action take place. The work must usually range fairly widely throughout the institution. Significant changes in the designated problem area require counter-balancing changes in surrounding areas if they are to be effective and lasting.

Bain found in Baric that the level of the operators' role could only be raised if the structure and other roles were also changed, with less supervision, fewer supervisory roles and so on (Bain, 1982). Similarly in the RNOH a significant change in the nursery nurses' role had to be balanced by change in the roles of the staff nurse and ward sister. They delegated more patient and family care to the nursery nurses and themselves became more involved in management, technical nursing, support and training. The nursery nurses took over certain aspects of the social worker's role in family care, while the latter did less work directly with families and trained and supported the nurses. Work was done with other wards and departments both to help develop attitudes consistent with those in the Cot Unit itself and to assist in desirable role and structure modification.

Role analysis, structure analysis and work culture analysis need to be explicit and related to one another at all stages of the work if real and lasting progress is to be made. Too often in my experience in institutional consultancy one or two types of analysis are neglected and the consultant concentrates on the others. Psychoanalytically orientated workers may, and often do, concentrate exclusively on some form of work culture analysis oriented to achieving significant attitude change. They go into an institution to conduct sensitivity or support groups, usually for "carers" like nurses or social workers. Their aim is to increase the sensitivity of the carers to their clients and themselves and to help them bear the stress of their work. It is not difficult to achieve such changes within the group itself. The carers want to be sensitive and less stressed. The problem is that the carers often return to a work situation where roles, structure and work culture are changed minimally, if at all, and this may make it impossible for them to deploy their changed attitudes in changed behavior. The danger is that people become disappointed, frustrated and disillusioned. Attitudes change back in defense against these feelings, and in line with the demands of the institutional system. Or people can no longer

tolerate the system and leave. The consultants and what they stand for may be discredited.

The author's role in two therapeutic communities caring for delinquent and deprived children illustrates this point. I was a management consultant. My task was continuously to explore with the staff the therapeutic impact of the roles and structure in the institution and help modify them so that the institution as a whole would become more therapeutic. Therapy was understood by the staff and by me as the impact on the children of the whole institution and not only activities more usually regarded as therapeutic or developmental, such as counselling or education; staff sensitivity was not enough. Work culture analysis was not neglected but was carried out mainly by another consultant, who particularly handled staff attitudes and relations to children, their own feelings and distress. The division was not rigid and, perhaps strangely, it worked. Too many therapeutic communities appear to lack sufficient awareness of role and structural factors; their therapeutic impact, therefore, is diminished because these are inadequate (Menzies Lyth, 1985).

By contrast, consultants who lack a psychoanalytic orientation may well confine themselves to role and structure without sufficient understanding of the contribution to them of unconscious content and dynamics. They may suggest changes in role and structure without the backing of the requisite changes in work culture. Indeed, attention to work culture might not support these ideas about role and structure. Consequently nothing effective may happen. For example, there seems to be an urgent need for more work-culture analysis if real improvement is to be effected in the British Health and Social Services.

Psychoanalytic practice and consultancy differ in ways that mean the consultant may not be able to follow Freud's precepts fully. The psychoanalyst refrains as far as possible from contact with the patient outside the analysis and with his or her relatives and friends. The analyst is to be as much as possible a mirror that reflects the patient back to him- or herself and shows nothing about the analyst. This practice is recommended for the protection of both patients and the analysis, to give freedom for fantasy and to help the patients follow their own directions. Desirable as this is in institutional consultancy, it is possible to a much more limited extent. One usually has to function in the client's territory so that one shares activities and places in a perfectly ordinary way: coffee, drinks, meals, canteen, lavatories and so forth. It is inevitably more sociable and it may be difficult to fend off ordinary human curiosity about oneself without seeming, or even being, offensive. One can hardly avoid contact with spouses or relatives especially in residential institutions. But, one has to try to keep one's distance, not to get too drawn in, and, of course, not to let one's own or one's clients' social feelings interfere with the work. Holding the balance of one's social and work relationships is often a problem. One may

be perceived as being too much in the pockets of certain people. Who does one eat with in the canteen, and why? Does one mix enough socially with the lowest level workers? It is conventional for higher managers to entertain outside consultants—dinner in the Matron's flat, not the student nurses' canteen. One has to wend one's way carefully through these intricacies, noting that they are likely to have an effect on the transference and counter-transference and on one's own transference to the client. It is important to understand what that effect is.

Transference is still an important concept, even if it gets a bit cluttered by the greater real presentation of oneself to one's clients and the wider view one has of clients than of patients. To further the work, it may be essential to draw such transference phenomena into work culture analysis, especially if they lead to suspicion of bias. This will not necessarily be easy or welcome. Careful attention to the counter-transference is also necessary, one's own bias may make careful observation and deduction more difficult.

Here another difference between psychoanalysis and consultancy is helpful. One need not work alone. An institutional consultancy may, in any case, be too big an undertaking for one person. The advantages of having at least one colleague are inestimable. It is not really advisable to work alone. It is an old Tavistock Institute principle that it takes a group to study a group. At least, a person working alone needs his or her own consultant "to come home to." As regards transference and counter-transference, two people can be very useful in helping each other sort them out, check and re-check them and disentangle each other from relationships that interfere with work or from attitudes inconsistent with consultancy. Several times after I had done a long continuous spell of work in the RNOH I would become too possessive of the children and too identified with the hospital. I would begin to talk about "our children." My colleague, Tim Dartington, said, "They are not our children, you know." That was all that was necessary to remind me of my place. Two or more people give added richness to interpretation of the data. Their perspectives are different, their field experiences are different since they do not always work alongside each other. Their relationships with different members of the client institution are different. Two people are much more than twice one in my experience. I have done a great deal of useful work in cars, buses and trains going to and from the field with colleagues, and am grateful to them for the insights they have helped to develop.

Note-taking and keeping of records are another example of differences. Freud discouraged the analyst from making notes during sessions since it would involve selection of data and would interfere with evenly suspended attention. Having a colleague in the field allows other possibilities. One can split the roles, one person conducting the discussion with evenly suspended attention while the other takes notes, inevitably selectively. But selective notes

may be useful afterwards in conjunction with memory from evenly suspended attention in recording significant aspects of what went on and keeping track of the vast amount of data one collects in the field.

Then there is the question of reports. I have already criticized the practice of sending the blue-print type of report to clients. However, reports are useful in certain forms and in certain settings. A written report may be a useful mnemonic. It would never by choice, however, be my first report. Its contents would initially be reported verbally in a face-to-face situation where one could work with the effect of the conclusions on the client, tackle resistance to their acceptance as a means to further understanding, stand corrected and amend them if one was wrong. The final document would probably be a distillation of joint work between the client and oneself. This was done regularly in one of the children's communities, the Cotswold Community. I worked there on two consecutive days a month and sent a "field-note" outlining where I thought we had got to and giving them something to work on by themselves until my next visit. I had trust and respect for that particular client and felt this was a safe and profitable way of working.

A complication is that one may be obliged to write reports, for example, if one is being financed by a research grant. In the RNOH we had to submit annual and final reports to the Department of Health and Social Security who financed the study. The same principle applied. The reports crystallized discussions with the Project Steering Committee and other people in the hospital and were approved by them before being sent. The question of confidentiality is implicit in this and also affects wider publication. As a rule one cannot effectively disguise an institution. One's clients are literate and interested in themselves and entitled to be told where the work will be published. Results can only be professionally and ethnically published when contents have been agreed and consent given for publication. Sometimes one cannot publish.

The end of a consultancy is rather like the end of an analysis. One needs to work through termination to ensure that the patient or client will be able to manage alone. For patients this means more than simply sustaining the gains that have been made or solving the problem originally brought. It means that they can continue to make progress on their own, through having "learned" a method of tackling problems which will survive the departure of the analyst or consultant and facilitate creative developments in the future. In the RNOH after we left the ward sister* and her staff re-organized the care of latency children in a unit separate from the Cot Unit where we had worked together. The exciting thing was that this was not a slavish copy of the model we had developed together but a different model realistically related to the needs of latency children and taking into account the differences in resources, notably

*The head nurse in a ward.

that while all Cot Unit staff were permanent the latency unit was mainly staffed by transitory student nurses.

The institutional consultant like the psychoanalyst evolves principles—or theories—about healthy functioning. Principles for the individual and the institution have much in common: avoidance of the use of regressed defenses, more adaptation and sublimation, full deployment of the individual's capacities and creativity. Such principles act as a useful guideline when one is diagnosing the nature of the problem in an institution. They give some indication of the direction beneficial change might take. Objectives to work towards are joint exploration of the current situation, sharing the results of the exploration, helping the client accept the reality of his situation, working through resistance and helping the client move towards appropriate action.

An example of consultancy which used such background principles for diagnosis and objective setting and which resulted in successful moves towards change in the directions indicated by the principles concerns the care of children up to 4 years old in the Cot Unit of the RNOH (Menzies Lyth, 1982). The problem was to develop care methods which would sustain and develop in a healthy way the child patients' capacity for making attachments and satisfying relationships. The principles used derived from the work of Bowlby (1969). Briefly, the capacity to develop lasting and meaningful relationships develops in accordance with the opportunity the child, particularly the very young child, has to form secure attachments.

The good ordinary family provides an excellent opportunity where the young child is likely to form a focal intense attachment, usually, but not always, with his or her mother. Additional usually less intense attachments are formed with others including father, siblings, grandparents, other relatives and friends, the attachment circle expanding as the child gets older. Moreover, the people in the circle of attachment are attached to each other, and so provide models of attachment with which to identify. A child not only loves his or her mother as she is experienced but identifies with father loving mother, and extends the concept of the male loving the female. Fortunately for our joint work, these principles were also accepted by most of the hospital staff, especially those with whom we worked most closely, and who were most directly concerned with the care of the children—nurses, teachers, social workers, the pediatrician and the surgeons. They showed a degree of concern and understanding of children's needs which in our experience was quite unusual in children's institutions.

We defined a mutually acceptable objective for change in the Cot Unit as being to establish a care-situation as close as possible to that provided by a good ordinary home. There was, of course, an "easier said than done" aspect to that and it took a long time to work out in precise detail what could

practicably be done in the hospital setting. Attention had to be given to a great deal of hostility and resistance to the changes especially from people outside the Cot Unit but affected by it.

The unit was as near to the size of an ordinary family as possible. The Cot Unit was already as small as practicable in staffing terms: twelve cots of which occupancy on average was about 7–8. The fairly low cot occupancy was due partly to the policy of one surgeon who quite rightly believed, before any objective developed with us, that the best place to nurse a child was at home whenever the physical condition permitted it, and that was for a good part of the treatment. The resident staff on the Cot Unit consisted of only one staff nurse, three nursery nurses, a nursery teacher and a social worker. As hospital wards go, this one was excellent. Ward furniture could also be moved around at the discretion of the staff and families to create semi-enclosed still smaller units.

The major sub-objective was to sustain the basic attachment to the mother as far as possible by helping the mother to optimize her presence with the child. We set the objective as "optimize" because in the long-stay situation and often very far away from home, it was not possible for the mother to be present 24 hours of every day as is usually possible in a short-stay setting. Hospital staff came to accept as part of their duties the need to work out with each mother, child and family what was best for them. The hospital was open to all family members, relatives and friends, and this helped to sustain other important attachments. Very importantly, the mother could bring other children to the hospital with her which certainly increased her presence, and could bring other adults who helped while away the often dreary hours in the hospital. Her presence was also sustained through the careful exploration of the mother's role with her child in the hospital, keeping her as much in her normal role as possible, the child's main caretaker, protector, authority, playmate, comforter. This was quite hard for the nursery nurses who had gone into their profession to look after children and who now devoted a great part of their time to sustaining and supporting mothers who were looking after their children themselves. But it was not too difficult to work with their resistance and to teach and support them while they developed a new, more demanding and more rewarding, role as the main support for the family's own care of its hospitalized child.

However, all that could be and was done to sustain maternal and family presence was not enough completely to avoid times when no close member of the family was present. At worst, there were some children from overseas whose mothers were never present and other family members rarely if at all. For all children, but especially for those children, it was important to provide an alternative attachment figure from the hospital staff. A case-assignment system was developed whereby each patient and family were assigned their own nursery nurse who worked with the family to care for the child when they

were there and took over the sole care of the child when they were not there, or in parts of the hospital where family were not allowed to be present such as in operating theaters just prior to operations or in the early stages of care in the post-operative recovery ward. Careful plans were made for re-assignment when the assigned nurse was off-duty or absent on escort duty. The secondary assigned nurses were part of the close attachment system of the unit and were already well known to the child and family. Care-taking never became indiscriminate, a care method only too common in children's institutions and fatal to the development and maintenance of the capacity for attachment and making healthy relationships.

One last point on attachment. The small size of the Unit and the permanence of its staff set up a situation rather like that of the good ordinary family; staff developed strong attachments among themselves which not only provided good models of attachment for the children but facilitated their becoming secondary attachment figures when necessary. It was quite like the ordinary family circle where father, grandmother, aunts and friends provide good secondary attachment figures and care-takers in the absence of the mother.

Boundary control is another matter of great importance in children's institutions which too often seem totally unaware of its significance. The good ordinary family usually guards its physical and psychological boundaries quite carefully, regulating both entry and exit and particularly protecting its children from unwarranted intrusion and from excessive freedom to go out. A system of boundary control was gradually developed whereby no-one came into the Unit who did not have business there. This move by the ward sister provoked perhaps more hostility and resistance than any other single move; people took as a personal criticism or even an insult the general view that too many visitors, often strangers, were not good for the children, however kindly they were. Careful boundary crossing procedures were also developed for those staff from outside the Unit who did have business with the children. For example, when a doctor visits a child in an ordinary home, the mother or another family adult accompanies the doctor to the child and stays with them; so in the hospital anyone coming in to do something for a child made contact through his mother, another family care-taker, the assigned nurse or all of them.

The objective of this paper has been to show that it is possible to help institutions to develop ways of working that embody some of the principles of healthy institutional functioning, and that this can be done by consultancy that embodies both psychoanalytical principles and an understanding of institutional functioning. This possibility gives cause for some optimism that institutions can be helped to better ways of functioning that make them more healthy and rewarding environments for their members and also contribute to their personal maturation and development.

References

Almansi, R.J. 1986. Review of "Freud and Anthropology," Psychological Issues Monograph 55, by E.R. Wallace. *Journal of the American Psychoanalytic Association,* 34:725–28.

Bain, A. 1982. *The Baric Experiment.* London: Tavistock Institute Occasional Paper No.4.

Bion, W.R. 1961. *Experiences in Groups and Other Papers.* London: Tavistock Publications; New York: Basic Books.

———.1970. *Attention and Interpretation.* London: Tavistock Publications.

Bowlby, J. 1969. *Attachment and Loss.* London: Hogarth Press.

Fenichel, O. 1946. *The Psycho-Analytic Theory of Neurosis.* London: Routledge and Kegan Paul.

Freud, S. 1911–15. *Papers on Technique.* Standard Edition Vol.12.

Jaques, E. 1955. "Social Systems as a Defence Against Persecutory and Depressive Anxiety." In *New Directions in Psycho-Analysis,* edited by M. Klein, P. Heimann and R.E. Money-Kyrle. London: Tavistock Publications; New York: Basic Books.

Menzies, I.E.P. 1960. "A Case-Study in the Functioning of Social Systems as a Defence Against Anxiety: A Report on a Study of the Nursing Service of a General Hospital." *Human Relations,* 13:95–121.

———. 1970. *The Functioning of Social Systems as a Defence Against Anxiety.* London: Tavistock Institute of Human Relations, Pamphlet No.3.

Menzies Lyth, I. 1982. *The Psychological Welfare of Children Making Long Stays in Hospital.* London: Tavistock Institute Occasional Paper No.3.

———. 1985. "The Development of the Self in Children in Institutions." *Journal of Child Psychotherapy,* 11:49–64.