Exploring Space in Workgroups

Susan E. Barbour

Dimensions of Psychotherapy, Dimensions of Experience

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INTRODUCTION

The concept of psychological space in workgroups is not widely discussed in the psychoanalytic literature. There has been especially little discussion concerning how a leader or consultant might understand and utilize space to facilitate group cohesion. A. Kenneth Rice and Eric Miller used the

Tavistock model, a convergence of psychoanalysis and social science in the study of group relations (Obholzer and Roberts 1994). The A. K. Rice Institute adapted the model in the United States (Colman and Bexton 1975; Colman and Geller 1985) to consider authority and social systems. Neither, though, discusses space in relation to their concepts.

In this chapter I focus on space in a small workgroup (ten members or less) and define the elements that facilitate group cohesion. I review theory

relevant to the creation of workgroup space including; group mentality and the basic assumption group, primary task, the concept of the group-as-a-whole, workgroup boundary and the mechanism of projective identification within groups. My example illustrates, first, the different ways that leaders conceptualize their roles and, then, with or without the group's involvement, delineate the primary task and manage the workgroup boundary. Second, I examine how leaders might structure workgroup communication and think about

workgroup relationships in ways more conducive to cohesion and productivity.

SPACE APPLIED TO WORKGROUPS

I had begun a consultation to a small workgroup when I had a dream about space. I dreamt that I was a therapist in a mental hospital. I was in a group room where psychotic or otherwise disturbed folk shuffled in and out. I was trying to bring some cohesion to the group. Tables formed a square in the middle of the room with

an inaccessible open space in the center of the tables. I was inviting one person and then another to take a seat at the table where they could talk to each other, but my effort was useless, and the patients would shuffle out of the room. I felt that my efforts were ineffective and futile. There was no group per se, and no group cohesion. Everyone was lost in their own world.

The inaccessible space struck me. The tables, where the group might gather together, served to block, rather than to facilitate space. The world of

the individual took precedent over the interaction of the group. Upon awakening, I thought of Ogden’s (1997) concept of reverie in relation to therapeutic space. Object relations theory considers the internal (intrapsychic) world as a space into which affects (associated with various identifications with people, groups, etc.) can be taken in or expelled. Reverie has to do with the containment of those affects within a shared frame, one that allows meaning to gradually evolve, and become crystallized, cognitively known and later articulated

in the experience between analyst and patient. Reverie is a state of being, being with, and being in. Reverie presumes internal space, as well as an interpersonal space made possible first by the analyst’s receptivity and then via the maintenance of the therapeutic frame. The idea is similar to Winnicott’s concept of ‘potential space’ (Winnicott 1971: 41, 107) in which the analyst, like a mother, maintains an ‘unconscious receptivity to being made use of’ (Ogden 1997: 9). Ogden describes several ingredients fundamental to reverie: the

analyst's creation of internal space that gradually fosters the possibility of space between analyst and patient, reflection in lieu of action or reaction, and an attitude that there is 'time to waste' (Ogden 1997: 161). An unhurried atmosphere allows meaning to emerge in an integrative way and is qualitatively quite different from speedy action prone to concretize and produce results.

Connected to beginning the organizational consultation, my dream communicated my resonance with

those from this workgroup who felt incompetent and ineffective. Similarly, Ogden describes the analyst's 'emotional tumult of reverie' (Ogden 1997: 162) as the feelings of uncertainty, confusion and incompetence experienced when sitting with a patient. Identifying with Ogden's comments, I began to think about staff members' discomfort as a venue to understanding this workgroup. The other members of the workgroup, while concerned for their colleagues, felt confident. However, almost all staff members felt less like

members in a group than isolated individuals. The dream conveyed the affective disconnect of a crazy ward where preoccupied individuals came and went in their own world. The essence of their shared subjectivities, the cohesion of the 'group-as-a whole' had shattered (Wells 1985: 109).

GROUP STRUCTURE AND CONTAINMENT

Groups operate on two levels, according to Bion (1961): (1) the workgroup, which is reality-oriented and carries out the task, and (2) the

basic assumption group or group mentality. The workgroup's primary task is its mission or that which is most central to the survival of the workgroup (Miller and Rice 1975). However, task completion in and of itself is only one aspect of workgroup life.

> The internal world of a group is made up then, first of the contributions of its members to its purpose and, second, of the feeling and attitudes the members develop about each other and about the group, both internally and in relation to its environment.
>
> (Miller and Rice 1975: 55-56)

Members pair with each other as they resonate with each other's conscious and unconscious interests, needs, values, and convictions. Wells, basing his ideas in part on Bion’s (1961) concepts of dependence, pairing and/or fight-flight, describes the internal world of a group as the network of relationships that form through the ‘lattice of projective identifications shared among group members’ (Wells, 1985: 116). These pairings may result in scapegoating or marginalizing some members of the group.

Organizational changes can have dramatic effects on the internal life of a workgroup. I shall refer to two in particular. When there is a change of leadership and/or when there is a shift in the primary task, the unconscious life of the workgroup shifts. A change in the primary task may arouse anxiety and affect conscious and unconscious pairings between individuals which in turn, may heighten the ‘irrationality’ (Shapiro 1985: 354) of the workgroup. The cultivation of shared potential space, on the other hand, may contain the anxiety of the basic assumption

group and allay counterproductive forces that otherwise impede group cohesion and task completion. Just as the potential space between mother and infant provides a receptive holding environment that modulates the infant's anxiety, so too, shared potential space becomes the 'third area of human living', (Winnicott 1971: 110) made up of the shared subjectivities of workgroup members and may provide a holding environment in which group members relate to and accomplish the workgroup task.

Klein first considered the phenomenon that occurs between mother and child in the intersubjectivity of potential space (Klein 1946 (in Scharff 1996)) and introduced the concept of projective identification, now recognized as occurring in relationships throughout our lives. In projective identification, disliked, undesired or indigestible aspects of one's self are unconsciously projected onto someone else. Projective identification is also active in groups and is both an intrapsychic mechanism and an interpersonal

transaction that affects individuals in unspoken ways. Individuals' perceptions, reactions, thoughts and feelings may be impacted, leading to a transformation in behavior (Horwitz 1985: 22). Wells comments that group life cultivates 'strong, conflicting, ambivalent feelings of love and hate' in its members and that individuals in groups bond together in unconscious tacit agreements that express the 'group Gestalt' as they respond to the 'group-as-mother' in ways that parallel the 'infant-in-relation-to-mother' (Wells 1985; 114-117). Therefore,

anxiety is generated by group life and how the good-enough leader and the good-enough organizational structure contain and manage that anxiety is of utmost importance in forming a more cohesive workgroup.

While Wells describes multiple levels of organizational life, for the purpose of this discussion on space I focus on his concept of the group-as-a-whole, or the supra-personal level of organizational life and the interorganizational level of relations between institutions and the

environment in which they exist (Wells 1985). Individuals and sometimes entire subgroups within organizations share an unconscious consensus. Subgroups blame other subgroups as they unwittingly distance themselves from their disliked projections and in so doing, exacerbate defensive posturing that ricochets back and forth between subgroups through blame and rebuttal (Halton 1994). Splitting occurs in groups as it does intrapsychically and members identify with and become receptacles for each other's projections as a result of the

splitting used to manage anxiety. Shared patterns of projective identification lead to repetitive behaviors and predictable responses between subgroups.

Wells names some of the most common dichotomies that form in workgroups around defensive positions: ‘affective vs. cognitive, hero vs. villain, process concerns vs. task concerns, fight vs. flight, hope vs. despair, competence vs. incompetence’ (Wells 1985: 120). In health organizations, we commonly find

dichotomies such as: medical vs. psychological, administrative vs. applied, scientist vs. practitioner, doctor vs. nurse, etc. As a consultant, I too became a receptacle for the split-off aspects of the workgroup's unconscious and through reflection (psychological space) on my dream I could begin to define the meaning of the communication from and about the disruptions in this workgroup's cohesion.

Furthermore, a workgroup is an 'open system' that survives by

'exchanging materials' with its environment like a 'biological organism' (Miller and Rice 1975: 43). It has a region of regulation around the activities of the system and this region has two boundaries, an inner boundary between the internal activities of the system and the region of regulation and an outer boundary that separates the region of regulation from the activities of other groups or from the organization (Miller and Rice 1975). The inner boundary has to do with how the workgroup perceives and manages its activities and the outer

boundary with how the environment perceives the workgroup’s activities. Regulation involves modulating what comes into and goes from the workgroup and distinguishes the workgroup’s distinctive tasks and contributions. Those outside the workgroup perceive the roles and functions of the workgroup in one way, and the workgroup may perceive its roles and functions in another, thus the region that is most functional is the shared frame of reference. Without the shared frame of reference, communication, expectations and the

relationship itself can break down (Szmidla and Khaleelee 1975).

A workgroup is continually negotiating its role in systemic relationships; projections are continually put into the group and accepted or expelled by the group across the semi-permeable boundary area. The leader is primarily responsible for the definition and negotiation of ‘boundary control functions’ within and from outside of the group based on the definition of the workgroup’s primary task (Miller and

Rice 1975: 47). Boundary regulation is a continuing process and offsets the unconscious migration of workgroup roles that can occur through the non-verbal impact of projective identification described earlier. Turquet points out, therefore, that structure and primary task are intricately and dynamically related and that the boundary control is key. ‘Only by drawing clear boundaries between conflicting primary tasks can a group resolve tensions and confusions’ (Turquet 1985: 72).

Therefore, workgroups need ways to talk about complex or conflictual issues. A workgroup benefits from a framework for communication—regular forums for meetings on different topics. Like the environmental mother (Winnicott 1963) who holds the infant, the leader creates a structure for the group to come together as a whole. A network of relationships forms and may become a holding environment for the workgroup, one in which staff members feel safe. Heifetz and Linsky

describe the workgroup holding environment as follows:

> A holding environment is a space formed by a network of relationships within which people can tackle tough, sometimes, divisive questions without flying apart. Creating a holding environment enables you to direct creative energy toward working the conflicts and containing passions that could easily boil over.
>
> (Heifetz and Linsky 2002: 102)

Within the communication structure, consideration of the more deeply embedded patterns of shared identifications facilitates group cohesion. Groups benefit from the perspective that they exist as an entity,

a ‘radical view’ (Wells 1985: 124) for leaders to hold. If there is a problem in the group, leaders typically focus on the individual who expresses the problem, rather than considering how the group is putting something into the individual via projective identification and by ‘shared splitting’. A group-as-a-whole perspective assumes that ‘when a person speaks, he/she does so not only for themselves, but in part, speaks via the unconscious of the group’ (Wells 1985: 124). At times, an individual’s expression may in fact be

an accumulation of unconscious forces from the workgroup.

Cognizant of these interpersonal forces, a leader may begin by considering how these forces impact the leadership role, what feelings are stirred up, what the group is doing and ‘how he feels the group inside himself’ (Turquet 1985: 73). A leader’s receptivity cultivates an atmosphere in which group members can also explore their experience in relation to the workgroup. Thoughtful reflection of one’s experience creates

space for speculation, a playful yet purposeful arena facilitated by the leader and made possible within the holding environmental structure. In addition, staff members need to feel that there is ‘time-to-waste’ for some period, without pressure to concretize the reflection into decisions. I illustrate in the next section.

CREATING THE SPACE FOR WORKGROUP CHANGE: WHAT A LEADER CAN DO

A leader can cultivate space in a workgroup in four interrelated ways: (1) delineation and maintenance of the

workgroup's task and boundary, (2) establishment of a consistent structure for workgroup discussions, (3) creation of a precedent for reflection and engagement, and (4) implementation of a perspective that considers the group-as-a-whole. In the first two, the leader and workgroup structure the holding environment, the third has to do with the leader's thoughtful role management, and the fourth with a focus on the group rather than on disparate individuals. The latter two also involve the leader's capacity for psychological

containment of the group. To address the group-as-a-whole, Wells proposes that a leader ask the following questions:

> (1) What have the group members been asked to carry on behalf of the group, (2) what may be being deposited into each member on behalf of the others, and, (3) is a group member who is identified as incompetent, inept, too aggressive, or too passive merely unconsciously being asked to carry these projected split-off parts and attributes for the group-as-a-whole?
>
> (Wells 1985: 125)

Case illustration—background

The ten-person, mostly male, health clinic staff group had held a long, stable and positive reputation in the community. The clinic operated independently providing outpatient services, but was affiliated with a research and teaching hospital. The staff had worked and aged together for many years and then experienced a number of retirements. Agreeing that diversification of the staff was beneficial, as positions became available, the openings were filled with younger female physicians. Two women were hired over a several-year

period, but within a couple of years, first one, then the other, left. Their vacancies were also filled with women. A year later, a young man was hired, became unsettled but ultimately did not leave his position. New staff members said that they had difficulty feeling part of the established workgroup. Tensions increased when the Medical Director, Robert, retired after many years in his position and was replaced by a younger man, Kevin. I shall discuss each Medical Director's role vis-a-vis the four areas

instrumental in forming space in a workgroup.

Delineation and maintenance of the workgroup boundary

Robert and the workgroup developed together over many years. They focused on providing direct patient care as the clinic's primary service and as their medical expertise. The Medical Director and the workgroup considered requests from the community for other services (e.g. emergency, public health services) on a situation-by-situation basis. By so

doing they defined and negotiated the workgroup's priorities. When they believed outside constituents held perceptions of their work contrary to their views, they defined the pressures they experienced and addressed them through education about the importance of direct patient care and the value of their service to the larger organization and to the community. At times, they initiated reports about their services, written in an experience-near way to explain what they offered and its value. While at times they provided other services, for instance they ran an

immunization program for a period of time, the prioritization of services was clear to staff members and was consistently maintained.

Kevin came to the Medical Director’s position with a model of providing health care based on efficiency and outcome; a conception that differed from Robert’s. He believed that the clinic’s image was passé and that they needed to provide a wider range of services and better demonstrate its usefulness to the affiliated hospital and to the public.

His view was breadth for many versus depth for a few. Initially, Kevin engaged the workgroup in a discussion about the clinic’s primary mission but was met with a mixed response. The discussion was inconclusive and Kevin moved forward without consensus. Energetic, in a way the former director was not, Kevin roused staff to expand community programs, delegated assignments to staff members and set a precedent for services he thought would raise the visibility of primary care health interventions. To offset a potential threat of layoffs and reduced

staffing, he wanted to reshape clinic services to conform to what the community most needed and valued. He encouraged grant writing as a way to subsidize the clinic. Demands on patient care time increased as some staff members' time was applied to research coordinator roles, affecting tasks that Robert and the older members of the group would not have considered central either to the clinic's mission or to its members' expertise. Gradually, the workplace atmosphere shifted from one that was more contemplative to a more proactive

culture. Kevin, philosophically speaking, defined patient care in terms of efficacy, a perspective new for the clinic.

In contrast to Robert, Kevin's vision of the workgroup's activities, the inner boundary of the region of regulation, became more closely aligned with how constituencies perceived the clinic's services and in so doing he won external favor. The boundary around workgroup activities shifted, as did the prioritization of tasks, to accommodate what Kevin

understood as the needs of external constituents, but the shift occurred without the engagement of the group. As the primary task changed, confusion in the workgroup increased, and the possibility to think about change and to discuss it, was replaced by frenetic activity and resistance.

Structure of workgroup discussions

Robert wanted to promote ways for the staff to interact. He had maintained a regularly scheduled formal and informal meeting structure:

administrative meetings, medical case conferences, in-service training and a once-monthly leaderless staff group meeting to discuss issues related to work raised by staff members. The informal leaderless group offered a reflective opportunity for staff to talk about their work and sometimes about workgroup relationships. Robert participated in this group in the role of staff member, not as medical director. Newer staff members were uncomfortable and wary of conflict that did occur at times. In addition, staff gathered informally for morning

coffee although new staff members were uncomfortable about these gatherings as well. They believed that they should get to work and were not appreciative of the way story-telling about the clinic’s history was a way of passing on the torch.

Believing that discussion tends to expand to consume the time available, Kevin revamped the meeting structure. Consistent with his utilitarian focus, he increased staff meeting time to discuss business items and eliminated medical case conferences until staff members

spoke up. He also discontinued the informal leaderless staff meetings because newer staff members were uncomfortable. There was no space for the uncomfortable affects to be discussed and, interestingly, it was a number of these same staff members who left their positions. The informal coffee gatherings became infrequent, sporadic, and then ceased altogether.

Creating a precedent for reflection and similarly engaging staff involvement

Robert modeled quiet thoughtfulness and engaged others in joint problem solving and program building. His reflective, exploratory and engaging style, as well as his punctuality, dependability and consistency, framed a reliable holding environment for workgroup communication. He was receptive, curious about staff members' lives, supportive and grateful for their ideas and contributions. He invited consultation and collaborative work. He confronted others when they did not consider their own contribution to

a problem, warning them not to impugn motives. He encouraged more experienced staff to mentor, teach and support new staff, and he did so as well. He welcomed feedback and adjusted his actions accordingly. Some believed Robert was too laid back. Others experienced him as receptive and felt empowered by him. While the group struggled to retain new staff members, he was able to open the door for change and renewal.

Kevin also supported staff members but in a different way. He attempted to

engage and rally staff members' enthusiasm by making suggestions and encouraging action. Some were responsive; others felt intruded upon. He took time to listen to individuals and often responded with an action-focused reply, rather than a reflective comment. Good-natured and proactive he maintained a fraction of the patient load of his predecessor or other physicians. Admittedly extroverted, he spent long periods of time outside the office responding to situations as they occurred, thinking on his feet and doing it well. However, group

members sometimes wondered where he was and felt uninformed about the clinic's projects and issues. Staff joked that he was manic, and Kevin in turn, experienced the group as brittle and reactionary, aware that friction during group meetings seemed to have little to do with the topic at hand. His focus on the efficient utilization of time preempted reflection to address the underlying discord and ambiguities.

Group-as-a-whole

What was interesting about the evolution of this group is that, while

Robert's personable management of the system's structure facilitated a predominately cohesive workgroup, that cohesion broke down as the group changed. Newcomers felt marginalized by the intense group loyalty and by comments that the group was a 'family'. Robert created a warm and conversational holding environment, but newcomers' discontent was not understood as symptomatic of the group-as-a-whole. Newcomers carried the despair of the dying group and the younger females felt ineffectual and intimidated as a counterbalance to the

sense of sufficiency possessed by the men in the group that had been around a long time. Ultimately, the impact of these pressures led them to depart. Kevin, like Robert, viewed problems as individual ones, and group members' insecurities were further exacerbated with an implicit change in the primary task and, even more so, by the absence of a forum to discuss what was happening. Both Robert and Kevin, in their different ways, brought noteworthy competencies to their jobs as leaders. However, it was striking that they both focused on individual

staff members' tasks and issues and were not mindful of the perspective of the group-as-a-whole level of functioning. There was little space in them or in the workgroup to process at that level.

CONCLUSION: WORKGROUP SPACE

In this example, a once-cohesive workgroup was dramatically affected by staff turnover and leadership change. In spite of a clearly defined primary task, a reliable framework for communication and Robert's warm,

supportive style, group anxiety was roused by change. While the holding environment helped the group communicate, group members did not consider what the group-as-a-whole was asking new staff members to contain for the group. Aspects of the group experience were projected into new staff members who became uncomfortable and left their positions, only for the process to begin anew.

The group's anxiety was further roused by the change in leadership and staff members' shifting identifications

with the leader, by the new leader's different vision of the group's tasks, by the workgroup's lack of involvement with the development of this new vision, and by the dismantling of the structure for communication. As anxiety intensified the group fragmented and two camps solidified. Competition and envy intensified as individuals withdrew into solipsistic work patterns, represented in my dream as the patients shuffling in and out across the boundary of the room. Some in the workgroup rationalized that their colleagues had left because

they had better offers elsewhere. Others reflected on how these staff members felt double-bound, ineffectual, and depleted and were unhappy about the change in leadership. No one attributed staff members' discomfort to the atmosphere of the group-as-a-whole. This workgroup was similar to workgroups of any kind that experience staff turnover or business failures, or that eventually seek organizational consultation.

The concept of a holding environment and the psychological space for containment of anxiety is central to object relations theory. The mother’s empathy or the analyst’s reverie make it possible for the infant or patient respectively to integrate unrealized aspects of oneself. The mother and infant are both affected in the shared experience of the potential space as they adapt to each other's change, vulnerable and different, but attuned. The mother’s/analyst’s holding and containing make it possible for the infant/patient to

manage anxiety and find better ways of interacting with the world. The leader in organizations serves a similar function for workgroups.

The application of the concept of space to workgroups is inherently complicated, if for no other reason, then because of the number of personalities involved and the exponentially larger number of ways that people resonate with each other and, through projective identification, impact each other. Workgroups that lack an adequate way to manage the

ubiquitous experience of a group's underlying anxiety, form defensive patterns to that anxiety that may ultimately and unknowingly impede task completion. The group atmosphere becomes brittle and symptomatic through, for instance, the potential for accidents, absenteeism, staff turnover, scapegoating, reduced productivity or lower morale.

Groups benefit from a way to reflect on their patterns of interaction. The creation and maintenance of space naturally implies the utilization of an

internal structure of relationships that links group mentality to task completion. Winnicott points out that with overwhelming anxiety, an individual becomes ‘cluttered up with persecutory elements of which he has no way of ridding himself’ (Winnicott 1971: 103). Such is the case in group-life as well; a workgroup must have some way of ridding itself of the clutter of persecutory elements that are projected into members or into its environment. Otherwise entrenched repetitive patterns can lead to

fragmentation, traumatic interaction and individuals' withdrawal.

My dream was about the lack of potential space in this workgroup. When an organization is in such a state of mind, a consultant can help the leader and the workgroup in a variety of ways. First, the consultant can work with the leader and/or the workgroup to consider the frame, group communication structure and address ambiguities in the primary task. Second, the consultant can, in part through the use of self, work with the

leader to create a space in which to examine the structure of conscious and unconscious communication in the group. In so doing, a consultant can introduce the perspective of the group-as-a-whole. Third, and most importantly, the consultant can help the leader think about his or her experience with the group as a communication from the group-as-a-whole and help the workgroup explore individuals' valencies (Bion 1961) for what they contain for the group. All of these interventions can be carried out by the consultant leading meetings

with the individual leader, with the workgroup or, frequently with a combination of such meetings.

From a psychological perspective, the consultant performing the above tasks provides holding and containing for the leader and workgroup as well as space for thinking about the experience of the group-as-a-whole. My reflection on my dream as a communication from the workgroup was the beginning of a space in and for this workgroup and for this leader. By understanding the group-as-a-whole a

consultant can help workgroups cultivate space, evaluate their strengths and vulnerabilities, and form a more cohesive system able to respond to the competitive demands of a changing world.

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