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The Opportunities and Pitfalls of Reflective Practice in an age of Austerity

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ABSTRACT *On the basis that psychotherapists are experts at reflective practice, this article explores the notion of reflection as both an individual and a systemic issue, and argues that in our present age of austerity there is an increasing tension between the two. The article begins by describing pertinent aspects of today's UK National Health Service and some of the reflective practice projects in which the author has been involved with groups of health professionals in this context. The article focuses on the anxiety that drives the organisations within which we practice health and social care, and suggests that we might help contain this anxiety, not just by working with groups of anxious staff, but by helping society better understand and articulate the problem.*

Key words: reflective practice; perversion; Schwarz Rounds; organisational anxiety; austerity

The need for reflective practice across health and social care is, I presume, self-evident to readers of this journal, but in the wider world there is a massive gap between rhetoric and practice. At the same time as the importance of reflective practice is being extolled, our attention is distracted and our time consumed by an ever-lengthening list of "must dos" that do not just distract but demand a very different mind-set. Unfortunately, reflective practice groups are rare outside mental health and hospice settings and, even in mental health settings, they are not the rule despite significant evidence that they are helpful. Jessica Yakeley's research with a randomly selected group of medical students (about a third of the year) who took part in Balint-like groups demonstrated significant positive outcomes compared to the others in the year (Shoenburg & Yakeley, 2014). Following this, several medical schools have introduced Balint groups for medical students in their first years of clinical contact and plans are underway for widespread implementation.

The General Medical Council (GMC) and medical deaneries now ask all doctors for evidence of reflective practice as part of the revalidation process, suggesting that it should be a focus of the annual appraisal discussion just as it is expected from doctors in training. It is interesting to observe how this gets interpreted: how do you show evidence of reflective practice? Inevitably documentation is required but the forms that have to be filled in never quite capture the essence of it. As in so many areas of working life, documented evidence gets confused with the real thing. We are in the process of producing a generation of doctors who can evidence their skills and

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competencies but this is not necessarily the same as being able to use and apply them. I have run a number of reflective practice workshops for local trusts and deaneries in a panic about the GMC requirement and, inevitably, the main concern of many of the participants has related to providing the documentation required for their next appraisal. Many were understandably anxious about who would have access to the documentation, and there is little available information to reassure them. I remember leading a discussion with a group of trainee surgeons where the level of antagonism was extraordinary, confirming all my old prejudices about this sub-group of doctors, and then it suddenly clicked; for this group of rather black-and-white thinking clinicians with their photographic memories and fondness for lists (I own up to the prejudice!), reflective practice was like making your confession. They felt they were being asked to list their sins and show appropriate remorse. Once I had worked this out, we were able to have a more constructive conversation. So, I learnt two important lessons: first, start where people are at, and second, do not take anything for granted.

Finding a language to bridge our very different worlds is important. I remember the professor of general practice telling us in our first week of medical school that we would learn thousands of new words and concepts over the next five years and then spend the next 40 years searching for ordinary words to communicate them to our patients. When considering the work of psychotherapists with organisations it is important to reflect on how outsiders might see us – what are their anxieties and prejudices about us and what we might be trying to do to them, and how can we help to open up their worlds rather than shut them down? It is worth putting a great deal of thought into getting the starting point right.

Of course, it would be good if the starting point was very different. The organisations we get asked to work in at the moment are often better described as "disorganisations" for reasons with which many readers will be familiar, such as:

- Reorganisations following one on top of each other, imposed from the top, not thought through, and badly implemented.
- A ruthless "more for less" philosophy stretching staff beyond reasonable limits and with a blind eye for the effects on patients.
- Increasing central control with a sustained undermining of professional agency.
- Economies of scale leading to industrialisation which leaves staff feeling as if they are working on a production line and patients feeling like a statistic rather than an individual.
- A blinkered approach to risk that sees outcome in terms of bureaucratic accountability rather than engaging more fully in the therapeutic relationship.
- A fragmented system that promotes competition over co-operation, markets over stability, consumerism over complexity.
- A culture of what have rightly been termed "pseudo-teams".
- A system that over-values the new and the quick fix, that forgets its history, and fails to learn from experience

I could go on!

THE ORGANISATION AS A REFLECTION OF SOCIETY

Much of this reflects forces at work in society at large and is directly or indirectly linked to austerity. There is little doubt that the communalism and spirit of co-operation that provided the

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value base for implementing both the United Kingdom's National Health Service (NHS) and group-based treatments such as therapeutic communities in the aftermath of the Second World War have been steadily encroached upon by individualism and consumerism in the intervening years. In her book, *The Perverse Organisation and its Deadly Sins*, Susan Long (2008) described a move in society from a culture of narcissism to one of perversion. Perversion flourishes where instrumental relations have dominance – in other words, where people are used as a means to an end, as tools and commodities rather than respected citizens and where individual gain and pleasure is promoted at the expense of the common good, often to the extent of not recognising the existence of others or their rights. It is these relations that Long described as increasingly dominating modern organisations. I should emphasise that Long was not talking about individuals but about the behaviour of the organisations as a whole, although an individual's behaviour is certainly affected by their environment.

A core aspect of perversion is the capacity of the individual or the organisation to "turn a blind eye", to know and not know at the same time. Such blindness – at least unconsciously wilful – is horribly evident in the stories of neglect and abuse from the Francis Reports that documented the cruel and neglectful behaviour at the Mid Stafford Trust in England between 2005 and 2009 (Francis, 2010). There is no doubt that the Trust "knew" at some level about the dangers of their financial efficiency drive. Despite the enormous attention given over the last 20 years to clinical governance reporting systems, Trust managers and leaders appear to have ignored, or even silenced, feedback from staff that would have alerted them to the problem.

One way to try to make groups feel safe is to determinedly turn an honest eye: to help people face the reality of their situation, however difficult; to avoid secrets and discourage information being held by elites and subgroups; to encourage transparency in the governance arrangements; to keep rules few and simple and owned by all involved; and to encourage all involved to be as engaged as possible with each other and with the organisation as a whole. That is a tall order in the present climate.

So what does it mean to work with groups of staff in such squeezed, unstable chaotic organisations? I want to discuss three knock-on effects: first the states of mind I encounter doing this work; second, what the focus of the group should be; and third, the practical issue of protected time. All of these, of course, would be issues anywhere and at any time but the present conditions are significantly amplifying any negative dynamics.

THE EFFECTS OF DYSFUNCTIONAL ORGANISATIONS ON INDIVIDUALS

My work in organisations indicates that many staff are at the end of their tether, extremely demoralised, and burnt out. Absenteeism is a preoccupation for human resources departments and finance directors but if you talk to occupational health physicians they are much more concerned with what has been called presenteeism, the people who continue to work when they should be off sick. A lot of staff are keeping their heads down, concentrating on surviving. "Getting to the end of the shift without a suicide" is a phrase that frequently comes up when talking with mental health nurses.

Space to reflect can involve people getting in touch with how bad things are, along with their anger and sense of hopelessness and helplessness. While some will find a reflective practice group a lifeline, others will approach it as yet another "must-do" amongst an ever-growing list of

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demands on their time. Yet others will feel threatened. It can be hard to move the group on from feelings about the organisation: many staff used to experience the NHS as a benign parent and now feel deeply hurt and betrayed by recent changes; many have invested deeply in building up a service only to find it being dismantled overnight – some have experienced this many times over and carry layer on layer of unresolved grief, repressing their pain as they struggle on to look after the next baby. I cannot begin to convey some of the craziness, crass stupidity, and brutality that I have observed in some of our more dysfunctional organisations over the last 10 years. For example, I have witnessed "re-engineering" that involves making all the ward managers across an organisation re-apply for their jobs and, not just demoting some of them, but quite deliberately reassigning them all to different wards and specialties – in the process, denigrating expertise and breaking up well-functioning teams, all in the name of "moving people out of their comfort zones". The systemic denigration of the importance of attachment and containment is perhaps the most startling aspect of modern health and social care and a point I return to later.

WHAT SHOULD THE FOCUS OF REFLECTIVE PRACTICE GROUPS BE?

Many reflective practice practitioners focus on the primary task, the essential therapeutic relationship between clinician and patient, which of course is hard enough as it also brings up feelings of rage, disgust, impotence, and hopelessness. Balint groups were introduced for GPs in Britain in the 1940s and modified forms of such groups continue to have a place in the training of GPs and psychiatrists. As well as providing a forum where the relationship with patients is the focus, they challenge the isolated stoicism that so often characterises medical practice.

Balint groups as originally envisaged were focused on exploring the relationship between the GP and the individual patient although GPs of that era were very aware of the importance of the family context. But we live in very different times; even in general practice settings, the single-handed practice is a thing of the past. I have just started working with a group of GPs from a surgery who wanted a supervision group to help them with their personality-disordered patients. What has emerged is a very strong fear that they are creating dependency in their patients. This seems to stem from the recent retirement of a senior partner who was a bit of a maverick with a tendency to fit in his many, very special patients at any time of the day or night. Since he has left the remaining GPs are having to pick up his patients who are hugely dependent, demanding, regressed, and hostile. familiar enough story but it immediately raised questions for me about the organisation: why was the GP not confronted, how can GPs support each other with these patients and avoid splitting, and what kind of relationship do they have with mental health services and the local Accident & Emergency Department?

The majority of patients that trouble GPs have chronic, complex problems and are working with a number of other teams from diverse professional backgrounds. Understanding and nurturing the relationships between different parts of the network is likely to make more or as much difference to the outcome for the patient as exploring in depth an individual staff member's difficulty sitting with a particular patient. On the other hand, productive links and parallels with the wider system can often arise from such an exploration; an understanding of the systemic context described above, for example, started with a GP describing her discomfort with an individual patient. The point is that it is more difficult than it was, and perhaps unhelpful, to keep the "primary task" separate from the systemic context.

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These are difficult issues for the reflective practice facilitator, although they all have parallels in other therapy situations. There is a fine line between providing a safe forum to share some of the distress, on the one hand, and a collusive moaning shop with a room full of victims, on the other. And while it is perhaps unrealistic to try to focus solely on the therapeutic relationship between patient and clinician, there is no doubt that the more successful teams and organisations are those that manage to minimize the other demands on people's time and keep staff attention focused on what is really important – the core clinical task. Even within a dysfunctional umbrella organisation like the Mid Stafford Trust, there were opportunities to create islands of good teamwork, where attention to the needs of the patients is paramount. Patient reports, for example, contrasted the excellent care on the Coronary Care Unit with that on some other wards where the reports should bring shame to the nurse's uniform. One patient, comparing the care on Ward 6 and Ward 7, likened it to two different lands (Francis, 2010). Research by Prof Michael West and his colleagues into team functioning supports the idea that thoughtful, well-managed teamwork can "buffer" the effects of a wider dysfunctional organisation (Borrill, West, Shapiro, & Rees, 2000).

So reflective practice can usefully encompass: first, the individual encounter with the patient; second, relationships with colleagues and how these are affected by the work; third, team functioning; and fourth, the individual's role within the wider system. All these categories overlap and influence each other so helping staff to make these links is an important part of the task.

THE IMPORTANCE OF PROTECTED TIME

My third issue is that there is never enough time. Personally, I find an hour of group time very short. Ninety minutes is preferable but I have rarely managed to negotiate this. People tend to rush in late looking like they have been saving lives so it is difficult to look stern and disapproving, bleeps and mobiles go off, it takes a long time for people to settle, and then someone needs to leave early. This reflects the reality of work pressures as well as – obvious to us but not to them – psychological resistance. All I can say is, "Good luck interpreting the resistance, if that's your style!"

As an aside, you can observe the same phenomenon at conferences where the accepted formula at the moment seems to be three unrelated 20 minute talks – often on very different topics – followed by 10 minutes of questions to all three speakers. As a speaker, one feels cut off mid-conversation and as a listener one suffers from severe information overload. For me, it brings on an emotional flashback to medical school, sitting through day after day of back-to-back lectures, yearning for the kind of thinking, growing space that my fellow students doing arts and humanities were enjoying. It's a while since I was a student and in the meantime most medical schools have accepted that they cannot and do not need to teach their students everything and the better ones have radically changed the curriculum to embrace the value of self-directed learning. In our modern technological world, we have internet access to more than enough knowledge and information. The point of a live lecture or seminar is to model something very positive, that is, demonstrate a relationship to the subject that inspires, enthuses, triggers curiosity and creativity, and sows a seed that will continue to grow. Incidentally, these are all good things for a reflective practice facilitator to model.

So what is it about conference organisers? There seems to be a collective resistance, even in some psychotherapy circles, to allowing time for a group to reflect on a topic. Perhaps this again links to

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austerity and a need to persuade under-funded study-leave committees that the conference is worthwhile. If so, it reflects a very distorted perspective on learning. I have recently played around with the idea of charging more for shorter talks. My point is that it seems to be harder and harder to protect the space to think let alone the space to look after ourselves.

NURTURING RELATIONSHIPS: LEARNING FROM CHIMPS

I am going to deviate a little now and describe some ethology research involving chimpanzees and baboons which illustrates some of the issues we are up against in the NHS and, indeed, many other modern work environments. Michael Chance, a researcher into non-human primates, has described two main forms of culture (Chance, 1988). Primates such as savannah baboons appear to be concerned with self-security, with warding off potential threats, and with maintaining status within a hierarchy. Individuals are dominant or subservient, preoccupied with inhibiting aggression. Levels of tension are high. Chance called this the agonic mode. Needless to say, it is not the sort of culture we want in our reflective practice groups but it does increasingly describe the relational environment that NHS staff experience.

Groups of chimpanzees in the wild and gorillas, on the other hand, tend to be preoccupied with nurturing social relations – play, tenderness, stroking and kissing, all soothing, reassuring activities that keep tension levels low. Typically, their attention is released from self-protection. Their culture – what Chance (1988) called hedonic – appears to promote self-confidence, empathic cooperation, curiosity, and reality-based intelligence. Chance observed a transient third state – the agonistic – that is characterised by individuals simply fighting things out for themselves, the violence consuming all-important group resources. This agonistic mode did not promote overall group survival and represented a collapse of culture.

Extrapolating from groups of primates, Chance (1988) hypothesised that human groups may become stuck in the agonic or hedonic mode or unconsciously move back and forth between them. Each mode predisposes individuals and groups to deploy their attention in distinct ways so that they are either prevented from, or enabled to, employ their intelligence.

As some of you might be aware there have been notorious examples of chimps fighting and murdering each other, the culture shifting rapidly from the hedonic to the agonistic. The interesting question is what brings this about? What changes? Chance (1988) was fascinated by this question and was particularly interested in the famous example at Jane Goodall's research centre in Tanzania where something tipped a happily hedonic society of chimps into the murderous, agonistic mode. He observed that human researchers had introduced bananas to engage the chimps and hypothesised that it was competition for bananas that had provoked this change: it had distracted their attention, squeezing out the expression of reciprocity and mutual reward so essential to keeping tension down and sustaining benign relationships. Members of the community had moved from awareness to reactivity in the context of the competitive situation.

Sadly, it appears that hedonic cultures are the most vulnerable to collapse. Agonic cultures – all hierarchy, subservience, and knowing your place – are more protected against such dangers by their rigidity, hyper-vigilance to threat, and their being accustomed to managing high levels of tension. But they are not gentle, attentive or creative. The problem is that the gentle chimps that habitually focused their energy on nurturing relationships were easily tipped into

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becoming envious, hateful, and violently murderous under pressures of competition that subtly changed their relationships with each other. These concepts can be helpful in understanding the increasing number of incidents of systemic neglect and cruelty in the NHS as the competitive market and austerity colour the environment.

REFLECTIVE PRACTICE AND CULTURE: LEARNING FROM THERAPEUTIC COMMUNITIES

A group of organisations that consciously attempt to prioritise the understanding of relationships are aptly called therapeutic communities (TCs). While always falling short of the ideal, reflective practice is fundamental to these organisations in a way I think is unique. At Francis Dixon Lodge, the TC where I used to work, the day would start with a reflective handover with the night staff. This was not only important in terms of sharing necessary information, but also that these staff felt held in mind, valued, and not split off from the rest of the work. Throughout the day, after all the various groups, there would be after-groups where staff could let off steam, laugh, cry, give and take support, follow up themes that had been touched on, fill in gaps, make links, and generally make sense out of chaos. On top of this, an externally facilitated weekly staff support group and three-monthly staff "awaydays" were attended by everyone including non-clinical staff. It was not just the volume of reflective thinking that was important but the overall philosophy: maintaining a psychologically healthy community using Rapoport's (1960) idea of the "community as doctor". In other words, the healing process was not seen as dependent on heroic individual doctors, nurses, and social-workers, but on the healthy functioning of the system as a whole, with everyone involved taking some responsibility. In addition, a culture of enquiry which included constant questioning, reflecting, and trying to make sense of things was seen as fundamental to this objective.

Since the events in Mid Stafford Hospital documented in graphic detail in the Francis Reports (Francis, 2010), healthcare culture is much talked about but in a way that tends to miss the point. One can understand the sense that new initiatives must be thrown at the problem, that "something must be done", but so often the new initiatives take time away from patients and end up creating more bureaucracy: more form-filling, exam questions on compassion, more mandatory training, a worthy document called the 6Cs, etc. There is such a tendency in the NHS to fragment and compartmentalise that new discoveries like "compassion" and "mindfulness" (yes, I'm being ironic but some people do behave as if compassion was discovered in 2012 and mindfulness has just been invented) are boxed off, "commodified", and seen as add-ons, that is, discreet activities that happen at a specified time each week. But the point of mindfulness is not that you protect time each week to concentrate on breathing in and out and thinking lovely things, it is about being more fully present, more connected, more aware at all times. The same could be said for reflective practice.

Cultural change cannot be prescribed or taught or ordered from above. It has to emerge and grow. Horticultural metaphors are probably the most helpful. Just as in therapeutic communities, we believe that focusing on sustaining a healthy psychosocial therapeutic environment creates the conditions for individuals to heal and grow, we have to start thinking about the conditions that will nurture a healthier healthcare culture. First, we need to be clear about what we want to grow and to be realistic about the climate. One way we can do this in reflective practice settings is to encourage people to talk about values, guiding principles rather than guidelines. What does it mean to be a

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professional clinician or social worker? What do we value in ourselves and not want to lose touch with? What is important about the work?

THE IMPORTANCE OF HISTORY: REFLECTIONS ON A VISIT TO BERLIN

I recently spent a week in Berlin with my youngest daughter who is passionate about 20th century history. There can be no better place to reflect on 20th century European history and to think about one's values. It is a city that has faced its history and allows you to explore it. The German History Museum, the Jewish Museum, the Berlin Experience (along with Cold War bunker), the GDR Museum, Checkpoint Charlie, The Stasi Headquarters, etc. give one a unique opportunity. One finds oneself imagining living through different regimes. What would I have done if I had been a citizen of Berlin during the Nazi period? How would I have behaved as an East German citizen? Would I have had the courage to refuse to spy on my neighbours for the Stasi and put my career and my children's opportunities for further education at risk?

This encouragement and expectation to honestly explore our history is not so prevalent in the UK despite our national taste for television programmes that commemorate the First World War. I find a younger generation of psychiatrists, for example, are largely unaware of the history of psychiatry, its Victorian containment system, and its tragic list of perceived advances that in retrospect seem cruel and, in many cases, frankly unscientific. Having a sense of this gives an important perspective on our present so-called "advances" and, for me, acted as something of a safeguard against professional arrogance. Not only that, but taking a history from patients – once the bedrock of good clinical practice – no longer seems so important and often gets neglected in all areas of medicine, not just psychiatry. More generally, the phrases "get over it" or "move on", often delivered in a patronising tone, are over-used and institutionalised, and now usually mean "stop asking difficult questions".

In addition, the fact that the new is idealised inhibits us from turning an honest eye to the future. Denial is rampant. In the NHS, new initiatives tend to get implemented without due exploration of the unintended consequences or the impact on the system as a whole. At a national level, we seem unable to look ahead and plan appropriately, for example, to plan for the massive demographic shift towards the elderly or to tackle the increasing domination of London at the expense of the rest of the country. At a global level, there seems to be very little hope that we can make progress as fast as we need to on global warming, and the escalation of conflict in the Middle East has led some journalists to talk in terms of a Third World War. News programmers are worried about the drop in viewing figures and have a strategy to increasingly interweave grim reality with light and fluffy items on fashion and celebrities in the hope that we can be encouraged to keep watching. So much for an honest eye.

While I was in Berlin I read *Alone in Berlin*, a novel by Hans Fallada (1947/2010), written at the end of the Second World War. It is a fictionalised account of a true story of a middle-aged, working class, uneducated couple who, on receiving the news that their only son has been killed on the Western Front, decide they need to do something against the Nazi regime. So every Sunday they painstakingly write two postcards with anti-Nazi, anti-Hitler messages and drop them anonymously in buildings round the city (painstaking because they are not used to writing and it takes them hours). They are eventually arrested by the Gestapo and sentenced to death. It is made clear in the book and from the historical records that their postcards made very little difference as they

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tended to be handed straight to the police by the first terrified person who happened to pick them up and, on occasions, these innocent people would themselves be implicated and duly punished. Most of us are familiar these days with Hannah Arendt's term "the banality of evil". One of the reviewer's comments on *Alone in Berlin* is that it documents the banality of good. These were two people with good hearts, imperfect and without many resources to call on, who had reached a point in their lives when the most important thing seemed to be to find a way to be true to themselves whatever the cost.

The other book I read while there was *Red Love*: *The Story of an East Berlin Family* written by journalist Maxim Leo (2013), which has just come out in translation. It is about his own childhood in East Berlin and the story of his parents and grandparents. For anyone interested in how ordinary people survive repressive political situations, I thoroughly recommend it.

While on one level, it may seem outrageous to make comparisons between staff trying to keep the NHS alive and healthy in 21st century Britain and the totalitarian regimes of the 20th century, there do seem to be some common themes that throw light on our present situation. One of the things it brought home to me was the impossibility of having a perspective on the living history that we are immersed in. There's a telling passage in *Red Love* (Leo, 2013) where Wolf Leo, the author's father, is watching the Berlin Wall being built in August 1961. Although it goes up almost overnight, he is there at a point where it was still possible to climb over the wall. It crosses his mind briefly but he has no sense of what the wall really means, imagining that it will be temporary. In the following passage Leo (2013) reflects on this and compares it with his own behaviour when the wall came down in 1989.

> When the wall went up, Wolf was nineteen years old, the same age as I was when the wall came down. It's possible that he had just as little understanding of the historical significance of the moment as I did when I stood by Checkpoint Charlie in Berlin on 9th November 1989. The first thing I thought of when I stepped onto the soil of West Berlin was that I'd left my cigarettes at home. I was really annoyed about that, because I always smoke when I'm excited. I had no Western money to buy cigarettes, and I didn't dare ask anyone for one. I thought about what the Westerners would think of me if I started begging as soon as I'd taken three steps into freedom. I wondered if I should quickly go back to the East, fetch my cigarettes and come back later. But I wasn't sure they'd let me out a second time. And it struck me that I didn't really know if they'd even let me back in again. If a Western reporter had asked me at that moment what I felt at the time, I'd have probably said that this Wall coming down was really stressful. (Leo, p. 53)

In my role as clinical director, I used to do a lot of consultant appraisals and was often struck by people's lack of perspective and awareness of the bigger movements, living history if you like; the paradigm shifts and forces at work in society that so directly affect our working lives. One of the exercises I get people doing at reflective practice workshops is called "the winds of change". I ask them to work in pairs with a poster-size piece of paper with a heading in each corner capturing the forces at work in the wider world that impact on their work, for example, the digital revolution, the promotion of competition and the market, industrialisation, consumerism, and, of course, austerity. They are then encouraged to imagine themselves in the middle of the paper and draw the pressures blowing in from the winds in the four corners. Sometimes exercises of some sort can be a useful aid to reflection. It does not need to be all about sitting down and talking. I use the idea of "wind" to give some sense of choice – you can be buffeted around by a strong wind or, with a bit of thought and determination, stand square and hold your ground. Participants hopefully leave with a more realistic sense of what they are up against but also, perhaps paradoxically, a renewed sense of their own agency.

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One of the pleas from Steve Illiff's (2008) excellent book on the industrialisation of primary care is that GPs should wise up to the bigger picture – the inevitability of economies of scale and some degree of industrialisation – so that they can think clearly about how to mitigate some of the worst consequences and adapt creatively, taking a lead rather than drifting passively into a world where they feel alienated. If we are to help health and social care staff recover a sense of agency, they will need to know their history and think intelligently about the socioeconomic forces at work. So many of these processes have taken hold without proper debate and understanding of the unintended consequences for the system as a whole.

THE PROBLEM OF MISTRUST

Another theme that emerged from my visit to Berlin and from reading about the regime in the GDR (Leo, 2013) was the deep mistrust those in power felt towards their citizens. Ulbricht and his colleagues, the leaders of the GDR, were German communists (some of them Jewish) who had escaped the Nazis by moving to Moscow or other parts of Europe. Some of them, for example, had fought for the French Resistance. They settled back in East Germany for ideological reasons but were in effect governing those they had been at war with, those they had been persecuted by, those who had driven them out, those they saw as the enemy. This context of mistrust seems to me fundamental to understanding what went so badly wrong – the anxious watchfulness created by the Stasi (think of those highly tense baboons). Two percent of the population were spying for the Stasi with cameras hidden in everyday objects such as hymn books and watering cans. Towards the end, when it was clear there were going to be riots, the Stasi had a plan worked out to arrest half a million ordinary people – mostly students – with buildings already identified as makeshift prisons. The order never came and when they realised the old regime was finished they ordered all the files to be shredded. The suspicion continues to this day as workers are still being paid to painstakingly paste the shredded files back together and people discover their best friend or even their spouse had been spying on them for years. An agonic culture, if ever there was one.

Mistrust also seems to me to be one of the defining characteristics of 21st century Britain. We are governed by people who profoundly mistrust the public sector and seem to have a need to denigrate the poor and the vulnerable (Jones, 2011). Onora O'Neil spoke about this issue of trust in the Reith lectures back in 2002 but it seems that things have continued to get worse. O'Neil argued that we have got the problem wrong; we behave as if there is a crisis in trustworthiness when there is in fact no evidence that people are less trustworthy than they were in the past. The real crisis is not about the lack of trustworthiness but about the lack of trust, the growing culture of suspicion linked to excessive accountability regimes (O'Neill, 2002). It is difficult for micro-managed clinicians, constantly watching their back, to develop into discerning clinicians who can rely on the wisdom they have gained through experience. And it is difficult for distrusted managers in a distrusted sector to create a permissive culture in which we are – in Onora O'Neil's words – "free to serve our patients" and not tied up in swathes of bureaucracy. And it is even more difficult in this climate to create a culture where it feels safe enough to risk being more fully ourselves, and for some of us, a culture where it is possible to heal.

What goes on in reflective practice groups of course reflects these dynamics. Complicated issues around trust and trustworthiness are talked about over and over. And acted out. It is not easy

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to create a culture in the group where participants feel safe enough to risk being open and more fully themselves.

A NEW INITIATIVE: SCHWARZ CENTRE ROUNDS

Schwarz Centre Rounds started in America in 1997. The focus of the Rounds is on the whole organisation so all who work there, including at least one executive director, are invited to each Round and given lunch. Rounds are held in a large group setting for one hour each month – hardly a huge investment. Typically, a team will prepare and present a clinical scenario but the focus is explicitly on the experience of staff, so it is different from a case discussion group. Sometimes there is a theme with different people talking around it. For example, I attended a pre-Christmas Round at the Royal Free Hospital in London where four people had been asked to talk about a "colleague who went the extra mile". We sat through four incredibly moving accounts by staff from different backgrounds. The Rounds are designed to enhance relationships and communication among members of multidisciplinary teams and to create supportive environments in which all can learn from each other. The initiative has been well researched and evaluations are positive (Lown & Manning, 2010). The Kings Fund started a Rounds pilot in Britain in 2010 which is now managed by the Point of Care Foundation and includes more than a 120 hospitals. In retrospective surveys most attendees report an increased likelihood of attending to psychosocial and emotional aspects of care and an enhanced belief in the importance of empathy. There also seems to be a significant decrease in perceived stress and improvements in people's ability to cope with the psychosocial demands of care. Better teamwork was reported, including heightened appreciation of the roles and contribution of colleagues and a sense of being less alone and better supported. The majority of staff found the Rounds provided a touchstone, reminding them why they entered their profession, strengthening relationships with colleagues and patients, and counteracting the pressure to approach patient care as a business. This feedback is very important given evidence that the altruism which doctors and nurses experience at the start of their training has a tendency to wane (Maben, Latter, & Macleod Clark, 2007). In summary, Schwarz Rounds are a time-efficient way of making an impact on an organisation by bridging the personal, individual encounter between the patient and the clinician and the system as a whole. Perhaps most important is the inclusive setting of the large group that allows everyone to observe and feel part of the wider system.

THE TASK AHEAD: THE IMPORTANCE OF NAMING AND CONTAINING ANXIETY

As a readership interested in psychoanalytic ideas and group dynamics, we have important things to say about reflective practice and need to continue to search for creative ways of developing our ideas and making them accessible. A bifocal approach is useful as shifting perspective between the individual and the wider system can throw light on intriguing parallel processes and suggest creative interventions. We also have a lot to say about the need for reflective practice in the wider system.

Perhaps most importantly, I like to think of us as experts in anxiety. We know the lengths to which individuals, groups, and organisations will go in order to defend against anxiety, to project it, to displace it, to deny it, and in so doing distort and turn a blind eye to reality. At the present time, our hospitals, our health and social care systems, in fact, our whole public sector is driven by

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anxiety in a way that I think that few people can understand, let alone articulate. At every level, there is repression of history and a manic reactive response to problems - quick-fix solutions that tend to overload and fragment the system, making things worse.

One person that understood and documented the effects of anxiety on organisations was Isabel Menzies Lyth (1959/1988). Her famous study of nurses in the 1950s sought to understand why nurses resigned from their profession in such high numbers. It showed that the stresses of nursing and the intimate relationship it demanded with patients made an impact on the organisation of care, leaving those closest to patients exposed to emotional pressures that most senior staff and managers defended against. Menzies Lyth felt that the work of nursing, because it involves physical and emotional contact with illness, pain, suffering, and death, arouses feelings and thoughts associated with the deepest and most primitive levels of the mind. She proceeded to show how the organisation of the hospital can be seen as consciously and unconsciously structured around the evasion of this anxiety. For example, she identified the process of splitting the relationship of nurse and patient by breaking the workload into a list of tasks and dividing each nurse's time between 30 patients. She observed depersonalisation and categorisation, for example by referring to a particular patient as "the liver in bed 10" rather than by name, and the accompanying detachment and denial of feelings. She noted the attempt to eliminate decisions by ritual task performance and to reduce the weight of responsibility in decision-making by checks and counter-checks. She found purposeful obscurity in the formal redistribution of responsibility and both idealisation and under-estimation of personal development possibilities. This is all very familiar but, sadly, a lot of these issues have become worse.

Menzies Lyth (1959/1988) proposed that the success and viability of a social institution was intimately connected with the techniques it uses to contain anxiety. In the intervening years, these ideas have been developed, looking at the goodness of fit between organisational structures on the one hand, and the emotional demands of healthcare work on the other. But they have made little impact on the system as a whole and there is little understanding or attempt to contain the primitive anxieties that pervade the system and affect all involved, including decision-makers at government level. If anything there is more disconnection between the policy level of the organisation and the emotional reality of clinical encounters. We desperately need leaders who can contain their own anxiety and understand the importance of emotional work at every level of the organisation; leaders who understand that the emotional task is fundamental to the job.

To finish, despite my warnings and perhaps cynical comments, I feel strongly that some of us should be working with front-line staff where we can. They deserve it and the work, whilst frustrating, is endlessly touching. I am often being told "it made all the difference"' and feel humbled that such a little of what often feels like common-sense can go such a long way. But there is a sense of helping people fire-fight, of working with staff beaten down by a toxic system. As psychotherapists, we have things to say about toxic systems, about primitive anxieties and the perverse effects they can have on individuals and organisations, about the importance as a society of facing our worst fears about decay, pain, and madness, and, perhaps most importantly, our fears about death and dying.

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