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Unconscious Processes of Organizing: Intergroup Conflict in Mental Health Care

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ABSTRACT A critical but overlooked issue in Weick's seminal work, *The Social Psychology of Organizing* (1969/1979), concerns 'the heat' of organizing processes, namely, the underground emotional processes underpinning the organizing of conflictual work relationships. We present a qualitative case study of psychiatric agencies mandated by public policy to collaborate but instead engaged in persistent conflict despite its deleterious effects on their working relationship and on the wellbeing of the clients they intended to serve. To explain these conflictual features of organizing, we integrate Weick's organizing theory with systems psychodynamics to deepen the understanding of emotions in organizing, specifically the motivational forces underpinning sensemaking and actions between interacting psychiatric agencies. This integration of theories reveals a critical feature of the relationship between the conscious and unconscious organizing processes: When a threat is involved, sensemaking and action are overtaken by social defences, resulting in dysfunctional organizing of the primary task. Drawing on these findings, we enrich Weick's seminal work by developing a model that portrays organizing as the ritualized interaction of emotions, sensemaking and behavioural responses.

Keywords: conflict, mental health care, systems psychodynamics, Weick's organizing model

INTRODUCTION

In *The Social Psychology of Organizing* (1969/1979), Weick presents a comprehensive theory of the social processes through which organizations emerge. In this classic work, Weick conceives of organization as the collective outcome of organizing processes by envisioning organizational members playing an active role in creating the environment which later imposes on them. Weick's work propelled a conceptual shift from viewing organizations as objective systems to envisioning them as ongoing intersubjective accomplishments

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(Gioia, 2006), best studied by using a processual lens (Langley and Tsoukas, 2017). Eschewing the idea that organizations work rationally toward a specified shared goal, *The Social Psychology of Organizing* (1979) emphasizes that through shared sensemaking, organizational actors collectively construct the meaning of an issue. Organizing then emerges as they collectively enact the cognitive content of their sensemaking.

This assumption of a negotiated order perspective on organizing is also visible in much of the scholarly literature on sensemaking that has followed Weick's original theorizing. Here, research has been concerned with the development of shared meaning and how coordinated action may be restored in situations of ambiguity (e.g., Balogun and Johnson, 2005; Gephart, 1993; Maitlis and Sonenshein, 2010), oftentimes portraying sensemaking as an ordering force (Maitlis and Christianson, 2014). This focus on ordering has come at the expense of acknowledging the sometimes-conflictual nature of meaning in organizing processes (Brown et al., 2008; Gray et al., 1985 for exceptions). Nonetheless, in his original theorizing, Weick did allow that dysfunctional phenomena may in fact be very functional because they comprise people acting in response to what he calls an organized *underground* of acceptable behaviour (1979, p. 53), which points to the emotional underpinning of organizing.

Although Weick himself never specified the qualities of this organized underground, its specification could enhance our understanding of how emotional processes impact sensemaking and potentially contribute to dysfunctional organizing. To explain how Weick's (1979) organizing model connects with underground emotional behaviour, we integrate it with a systems psychodynamic lens (Gould et al., 2001; Menzies, 1960). Systems psychodynamics is particularly useful for investigating organizational processes that appear irrational because they do not advance the overt organizational task but instead serve a parallel covert function, which is often to reduce workers' painful emotions (Gabriel, 1995; Petriglieri et al., 2018). Thus, the value of systems psychodynamics is that it can shed light on the unconscious processes of organizing, defined as underground emotional and relational processes (Arnaud, 2012; Pratt and Crosina, 2016; Vince, 2019), and explain especially irrational behaviour, which have often been neglected in the literature (see Stein, 2004 for an exception). In particular, instances of intergroup collaboration may heighten unwanted emotions among group members, leading to the enactment of unconscious processes of organizing, which can result in dysfunctional conflict between the groups (Fiol et al., 2009; Gould et al., 1999; Tajfel and Turner, 1979). We therefore address the following research question: How do unconscious emotional processes influence sensemaking and organizing in situations of conflict between organizations required to collaborate?

To address this question, we conducted a qualitative case study of interorganizational conflict among Danish mental health care agencies. Because users of mental health services need support from both hospital and community organizations at different times during their course of treatment, service delivery frequently depends on different mental health professionals working collaboratively across traditional organizational boundaries. While, at least on paper, such collaborative arrangements appear sensible and complementary, our case clearly shows a gap between policymakers' intentions for mental health care collaborations and their actual outcomes, because they leave the overt task of the agencies' – to cure and care for patients – unfulfilled (see Petriglieri and Petriglieri, 2015).

Instead, collaboration proved to be an extreme case of conflictual organizing between agencies, at the cost of taking care of individuals with mental illness. By scrutinizing the underground of the mental health professionals' seemingly irrational behaviour, we come to understand their reactions as normal responses to the way systemic influences at the societal level impact interorganizational relationships and the work itself. Conceptually, we capture the dynamics observed by developing a model of the ritualized cyclic pattern of emotions, sensemaking and reciprocal responses in which staff groups stereotype each other to preserve a positive sense of their professional selves, resulting in the ritualized maintenance of destructive conflict between their agencies.

Our contribution is intended to accommodate Weick's own criticism of his organizing model for being too cool (1979, p. 240), that is, it fails to acknowledge emotions in processes of organizing. We demonstrate the potential for integrating Weick's organizing theory with systems psychodynamics by revealing how underground emotions shape conflictual processes of organizing between organizations. To develop our argument, we provide brief overviews of the literatures on organizing and systems psychodynamics and then, describe our methods. We proceed by presenting key findings and finalize by discussing our contribution to both Weick's foundational theorizing and systems psychodynamics.

THEORY

The Process of Organizing

Rooted in symbolic interactionism, Weick's classic *The Social Psychology of Organizing* (1979) argues that people in organizations play active roles as creators of their environment. He refers to this process as enactment in which organizational members initiate events and activities that later constrain them (Weick, 1988). Integral to enactment is the conception of organizational sensemaking, which focuses on how people give meaning to experience and take action on the basis of that meaning in recursive processes by which organizing occurs (Weick, 1993, 1995). Thus, rather than conceptualizing organizations as objective systems, Weick views them as dynamic intersubjective accomplishments. Accompanying this shift in focus toward processes of organizing is the adoption of a process-oriented language emphasizing verbs and gerunds to characterize organizations (Bakken and Hernes, 2006; Langley and Tsoukas, 2017).

Understanding organizations as richly dynamic accomplishments means focusing on three interrelated processes of organizing – *enactment*, *selection*, and *retention* –which occur in ongoing cycles (Weick, 1979). During enactment, individuals undertake action by noticing and bracketing the flow of equivocal experience into portions for closer attention, which are then faced as the environment. Then, in the selection process, they retrospectively make sense of these raw materials by chopping the extracted experiences into meaningful pieces and labelling and connecting them so that they form a fuller, more nuanced, coherent understanding of what has occurred. Meanings and interpretations that proved useful in the past are selected and imposed on these lived experiences to remove equivocalities. While sensemaking occurs during both enactment and selection,

the interpretations imposed during selection more firmly remove equivocality (1979, p. 186). Finally, during retention, successful interpretations imposed during selection are stored as a reservoir of accounts that constrain subsequent enactment in future cycles. Over time, patterns of sustained interaction form interlocked cycles of behaviour that constitute collective actions to cope with equivocality.

For Weick (1979), then, organizing occurs when the cognitive content of actors' sensemaking converges, and they act collectively upon it. He conveys this notion frequently by using expressions such as, 'Organizing involves shared recipes' (1979, p. 47), 'means convergence in the formation of collective structure' (1979, p. 91), and 'collective structures… are the elements of organizing' (1979, p. 118). As Taylor and Van Every (2000, p. 275) note, '[S]ensemaking is a way station on the road to a consensually constructed, coordinated system of action'. Building on this notion of consensus, sensemaking enables the accomplishment of important organizational processes such as learning and creativity (e.g., Christianson et al., 2009; Dougherty et al., 2000) and coordinated action in situations of ambiguity (e.g., Balogun and Johnson, 2005; Gioia et al., 1994).

Despite the prevalence of this negotiated order perspective on organizing in the sensemaking literature, some more recent contributions acknowledge the contested nature of meaning in organizing processes (Gray et al., 2015; Mikkelsen and Wåhlin, 2020; Patriotta, 2003). For example, major organizational changes frequently lead to cognitive disorder, creating anxiety and tension among organizational members (Balogun and Johnson, 2004; Luscher and Lewis, 2008), and often posing threats to their professional identities (Reay and Hinings, 2009). In interorganizational settings, when identity threats by one organization challenge the extant status of others (Bryan, 2004), strong identity-based responses to protect group and organizational identity can result in particularly intractable interorganizational conflict (Brummans et al., 2008; Fiol et al., 2009).

An understudied theme in Weick's original theorizing intimated that seemingly dysfunctional phenomena, such as conflict-ridden organizational arrangements, may in fact be very organized because they comprise people acting responsively to what Weick calls 'an organized *underground* with specific limits on acceptable behaviour' (1979, p. 53; italics ours). In fact, his theorizing acknowledges that even something assumed to be dysfunctional, although unstable, may function persistently and effectively (1979, p. 55). Although Weick himself never specified the nature of this organized underground, he left the door open for its exploration, and some scholars have begun to pick up this gauntlet by linking identity threats with strong emotions (Maitlis, 2009; Maitlis et al., 2013; Neimeyer et al., 2002), such as anxiety, that trigger elaborate defence mechanisms to protect individuals from these painful feelings (Brown and Starkey, 2000; Petriglieri, 2011). How emotional responses impact sensemaking and potentially contribute to dysfunctional organizing, however, has not yet been well-explicated. To elucidate how emotions influence organizing processes in situations of conflict, we turn to the systems psychodynamic perspective on organizations originally developed by the Tavistock Institute of Human Relations (Miller and Rice, 1967). This framework allows us to investigate actors' unconscious social defence mechanisms deployed to minimize anxiety associated with identity threats and explain how these mechanisms are linked to organizing of conflictual interactions between organizations.

Systems Psychodynamic: Unconscious Processes of Organizing

At the root of systems psychodynamics is the psychoanalytic idea that unconscious emotions and desires are the product of psychological defences that work to alleviate painful emotions arising from threats, particularly anxiety (Freud, 1936/1946). At the individual level, these defence mechanisms distort reality but also safeguard the mind against thoughts and feelings too painful to cope with. At the organizational level, social defences are created and embedded in organizational structures and processes to stave off collective unconscious anxieties (Gould et al., 2001). Bion (1961) theorized that individuals' unconscious anxieties and the covert, unconscious defence mechanisms they exhibit in groups become collective, unconscious assumptions that then constitute their social environment. Individuals' emotional experiences become part of a social system, where unconscious forces connect people through shared anxieties, fantasies, and memories into emotional and political collectives of which they are largely unaware (French and Vince, 1999). Additionally, to escape from confronting these anxieties, organizations either 'eliminate situations that expose people to anxiety-provoking activity altogether or they insulate people from the consequences of their actions' (Krantz, 2010, p. 194).

Understanding the role of system psychodynamics has three important implications for our theorizing here. First, it suggests that within organizations, individual sensemaking is tied to interpersonal relations and broader collective experiences. Second, it implies that sensemaking is also profoundly emotional, albeit at an unconscious level, because groups and organizations mobilize social defence systems to defend against unconscious emotions evoked by the task itself and its organization (Jacques, 1955). Third, mechanisms to insulate members from facing these unconscious emotions are built into the system's structure, design, and relational processes. The social system in turn then comes to influence how members think, feel, and behave. Thus, unconscious dynamics must be understood at a systemic level. For example, in her pioneering study of hospital nurses, Menzies (1960) found that socially structured defence mechanisms were embedded in how the organization worked and helped nurses to systematically avoid proximity to patients, deny feelings, and depersonalize care to evade painful feelings of fear, sadness, inadequacy, shame, and anxiety arising from their work with serious illness, suffering patients, and death. Since these early developments of systems psychodynamics, a considerable body of knowledge has developed (e.g., Fotaki and Hyde, 2015; Gould et al., 2001; Krantz and Gilmore, 1990; Petriglieri and Petriglieri, 2015; Vince, 2019) to show how collective defence mechanisms become customary ways of thinking about and engaging in work, allowing individuals to cope with the painful emotions associated with their tasks while simultaneously side-stepping them.

Interestingly, Stein (2004) observed differences in whether organizations embrace anxiety or develop social defences against it. Combining the sensemaking perspective with systems psychodynamics, he found that some organizations could tolerate anxiety and take steps to avert threats, whereas others could not; in the latter, social defences, such as projections, attributions, and stereotyping, to avoid anxiety were built into the organizational systems and procedures, leading to distorted sensemaking. Recently, Vince (2019) coined the term *institutional illogics* to explain how such sensemaking can be illusory despite also seeming totally natural.

In the case of intergroup interactions, the use of unconscious defences helps explain the seemingly dysfunctional conflict that arises between organizations (Gould et al., 1999). The interdependencies associated with working together often require drawing new boundaries, which, if they prove durable, heighten anxiety over the prospect of losing one's power and identity (Miller and Rice, 1967). To curb such anxiety, members of interdependent organizations may enact organizing processes rooted in the defence mechanisms of rationalization, projective identification, and fantasy.

Rationalization is the unconscious attempt to explain controversial behaviour or feelings in a manner that makes them appear less threatening, more logical, and consciously tolerable (Brown, 1997). Projective identification refers to the unconscious attribution of unwanted aspects of ourselves to others to uphold a desired self-definition (Klein, 1946/1975). This unconsciously driven sensemaking enables those engaging in projection to disown their unwanted or difficult feelings by assigning them to others (Bion, 1961). Fantasies refer to vivid daydreams and unconsciously held desires that are difficult or impossible to fulfil (Brown, 1997; Freud, 1953). Fantasies often arise in response to issues that are avoided but simultaneously appear to be dealt with (Baum, 2011). Bion (1961) convincingly showed that groups may collectively retreat into shared fantasies for substitutive gratification but that doing this obscures what is actually occurring. Although fantasies may have such negative influences, Gabriel (1995) also suggested their potential benefits, viz. they may provide workers with consolation for the harshness of organizational life. Fantasies are also theorized to have structuring effects because they unconsciously shape people's desires and guide their behaviour (Vince, 2019). Shared fantasies may be expressed in public policies that reflect shared aspirations and protection from painful realizations (Fotaki, 2010).

While systems psychodynamics has mostly studied defences and irrationalities within organizations, we investigate how these processes affect organizational members' sensemaking across organizations required to collaborate. We therefore extend Weick's foundational framework by showing how unconscious emotions play important roles in the organizing of conflict and generate dysfunctional consequences for the organizations involved and the users they serve.

METHODS

Data Context and Collection

In Denmark, in the 1980s, the psychiatric system was split into two divisions, which reduced hospital care to providing acute care only and introduced community-based long-term care (Kelstrup, 1983). Hospital care comprises inpatient and outpatient care units, and community care covers residential facilities and community outreach teams. At different times during their course of treatment, many users of psychiatric services need support from both hospital and community care, for example, diagnosis and treatment at psychiatric hospitals and follow-up care in community settings. Therefore, mental health service delivery often depends on coordination between multiple mental health professionals across traditional organizational boundaries. National inquiries have shown,

however, that rivalry over the best ways to treat mental illness imposes severe obstacles to coordinating services between psychiatric systems (Holm-Petersen and Buch, 2014; Johansen et al., 2012; Mikkelsen et al., 2013). Although we chose the Danish setting because of the high degree of manifest conflict, such rivalry is not unique to Danish mental health services. Conflicts stemming from professionals' effort to promote expansion of authority and jurisdiction (e.g., Colombo et al., 2003) have also been documented elsewhere. Nevertheless, our case can be considered an extreme case of protracted, structural conflict in an interorganizational setting.

Intrigued by the dynamics and complexities of the deadlocked relationships between psychiatric agencies, we designed this study to gain insights into the organizing processes of interorganizational conflict. For this purpose, we apply what Langley (1999) calls 'process research', which is concerned with understanding how things evolve and why they evolve the way they do. Langley advocates that process research be used for explaining sequences of events leading to outcomes. Our 'process data' is collected in the real context of conflict between hospital and community organizations and consist of accounts of what occurred and who did what and when, told by both community and hospital staff who are part of an interface for coordinating treatment and care for the same users across psychiatric organizations. The first and third authors interviewed staff from hospital and community organizations within the same geographical area. They conducted 20 individual qualitative interviews and four same-group interviews with 21 hospital staff who were all professional nurses, nursing assistants, and psychiatrists working in psychiatric hospital wards and an ambulatory hospital clinic, and 19 community staff who were professional social workers, psychologists, and domiciliary support workers working at community-based residential facilities and in community outreach health teams. Table I provides details of the 40 interviewees. All interviews lasted from 45 to 120 minutes and were audiotaped and transcribed verbatim.

Although from the outset our interest was in sensemaking during conflictual organizing among different psychiatric agencies, because conflict is often a sensitive topic that people might not want to discuss (Kolb and Bartunek, 1992), we did not ask direct questions about conflict but framed our interview questions to ask about tasks, collaboration, interactions, problems, disagreements, and opposition. We asked interviewees to identify concrete tasks in which they collaborated with staff across the two psychiatric systems and invited them to elaborate on situations where collaborations had gone well and poorly, to explain the problems they often experienced and to describe significant events in the interactions, focusing on disagreement or opposition. This process enabled us to capture the overt meanings that staff attached to events. In the same-group interviews, we used similar questions but also focused on how they talked about the perceived interorganizational conflicts when with colleagues.

Analytical Process

We used thematic analysis (Braun and Clarke, 2006) to analyse the empirical data and identify themes and patterns of behaviour. The analysis was conducted in four separate steps moving iteratively between data analysis and theoretical ideas (Charmaz, 2006). In the first step, we conducted close reading of all transcripts followed by inductive coding

Table 1. Interviews and interviewees' characteristics

Ppt.	*Occupation*	*Org status*	*Organization*	*Care system*	*Interview*
1.	Residential social worker	non-managerial	residential facility A	community care	single
2.	Residential social worker	non-managerial	residential facility A	community care	single
3.	Residential social worker	non-managerial	residential facility A	community care	single
4.	Residential social worker	non-managerial	residential facility A	community care	single
5.	Residential social worker	non-managerial	residential facility A	community care	single
6.	Residential social worker	non-managerial	residential facility A	community care	single
7.	Nurse	non-managerial	closed psychiatric ward A	hospital care	single
8.	Nurse	non-managerial	closed psychiatric ward A	hospital care	single
9.	Nurse	managerial	closed psychiatric ward A	hospital care	single
10.	Nursing assistant	non-managerial	closed psychiatric ward A	hospital care	single
11.	Psychiatrist	managerial	closed psychiatric ward A	hospital care	single
12.	Nursing assistant	non-managerial	closed psychiatric ward A	hospital care	single
13.	Nursing assistant	non-managerial	closed psychiatric ward A	hospital care	single
14.	Psychiatrist	managerial	psychiatric ER	hospital care	single
15.	Nurse	non-managerial	psychiatric ER	hospital care	single
16.	Nursing assistant	non-managerial	psychiatric ER	hospital care	single
17.	Nurse	non-managerial	psychiatric ER	hospital care	single
18.	Residential manager	managerial	residential facility A	community care	single
19.	Nurse	non-managerial	closed psychiatric ward A	hospital care	single
20.	Residential social worker	non-managerial	residential facility B	community care	single
21.	Psychologist	non-managerial	residential facility A	community care	group 1
22.	Psychologist	non-managerial	residential facility A	community care	group 1

(Continues)

Table 1. (Continued)

Ppt.	*Occupation*	*Org status*	*Organization*	*Care system*	*Interview*
23.	Residential social worker	non-managerial	residential facility B	community care	group 1
24.	Domiciliary support worker	non-managerial	mental health team C	community care	group 1
25.	Domiciliary support worker	managerial	mental health team A	community care	group 1
26.	Residential social worker	non-managerial	residential facility B	community care	group 2
27.	Residential social worker	non-managerial	residential facility B	community care	group 2
28.	Residential social worker	managerial	residential facility B	community care	group 2
29.	Domiciliary support worker	non-managerial	mental health team A	community care	group 2
30	Domiciliary support worker	non-managerial	mental health team B	community care	group 2
31.	Domiciliary support worker	non-managerial	mental health team C	community care	group 2
32.	Nurse	non-managerial	closed psychiatric ward B	hospital care	group 3
33.	Nurse	non-managerial	closed psychiatric ward B	hospital care	group 3
34.	Nurse	non-managerial	closed psychiatric ward B	hospital care	group 3
35.	Nurse	non-managerial	ambulatory clinic	hospital care	group 3
36.	Nurse	non-managerial	ambulatory clinic	hospital care	group 3
37.	Nurse	non-managerial	ambulatory clinic	hospital care	group 3
38.	Nurse	non-managerial	closed psychiatric ward C	hospital care	group 4
39.	Nurse	non-managerial	closed psychiatric ward C	hospital care	group 4
40.	Nurse	non-managerial	closed psychiatric ward C	hospital care	group 4

to investigate key themes in how hospital and community staff in supposedly collaborating psychiatric agencies understand the conflictual events between them. Given that sensemaking is a social process, it should be studied in talk and discourse because that is how people do or do not construct a sense of shared meaning (Gephart, 1993). Consequently, we focused on text passages that conveyed different accounts of problems in their collaboration. The coding overwhelmingly revealed themes of failed communication, reciprocal negative stereotyping, distrust, and neglect in taking care of individuals with mental illness (termed the revolving-door problem).

In the second step, following Weick's (1979) notions on sequences of interaction and response patterns as the unit of analysis in organizing, we examined how actions taken by one group evoked a specific response in the other group, which was then reciprocated by the first group. We wanted to focus on the interlocked behaviours between groups rather than only their cognitive processes because enactment is core in sensemaking and organizing (Maitlis and Sonenshein, 2010). To explore the response patterns in conflictual organizing, we applied Weick's ESR framework (1979) to ask three fundamental questions of the data: According to the groups, what is the problem (enactment)? How do the groups explain those actions that cause the problem (selection)? What enactments of the problem have the groups retained (retention)?

Although these questions helped us understand the organizing processes in our case, we also noticed subsurface dimensions in the data that the ESR framework did not capture. Why was neither group accepting any responsibility for their dysfunctional interactions, and why were both groups uncompromisingly blaming each other for their failure to collaborate? Moreover, given the harmful consequences of their actions for the users, why did neither group show any signs of anxiety, anger, or shame about these failures? Additionally, both groups used extreme images and accusations to denigrate each other's work, for example, 'concentration camps' and 'doctor-controlled drug abuse'.

To better understand the motivational forces behind both the lack of responsibility-taking and use of extreme characterizations of each other, in the third step, we conducted a systems psychodynamics reading of the data to uncover evidence of collective unconscious dynamics in the case. This perspective acknowledges that people, especially those involved in conflicting events, can react in seemingly irrational ways as a result of transferring intrapsychic anxiety to interpersonal, organizational, and interorganizational interactions (Petriglieri and Petriglieri, 2020). These unconscious processes can be captured using storytelling methods (Gabriel, 2015), such as those we used to elicit problem situations from our interviewees. Following Gabriel (1995) and Vince (2019), we examined our data for strange and extreme associations, irrational practices, contradictions, rationalizations, projections, shared fantasies, and social defences against emotions as important markers that alluded to unconscious subtexts in seemingly coherent accounts. For example, irrational practices are critical markers that allude to an unconscious subtext associated with identity threats and attendant anxiety. We considered all those instances to be illustrations of the transfer of intrapsychic ambivalence to interorganizational interactions. One specific contradiction we observed between the two groups of staff concerned how they referred to the people under their care. Hospital staff labelled them as 'patients' and community staff referred to them as 'residents' or 'citizens', suggesting that the two groups perceived different levels of dependence between

themselves and those in their care.[[1]] During this step of our analysis, we identified both groups' habitual use of three social defences – rationalization, projective identification and fantasizing – which yielded new insights.

In the final step, we linked the three theoretically informed, but empirically derived, organizing processes in Weick's ESR framework to these three unconscious social defences. This process allowed us to make inferences about how organizing processes of conflict unfold dynamically through ritualized response patterns and when and why unconscious dynamics may inform and even overtake staffs' sensemaking and enactment. Next, we present our findings, which we organize around the ESR model.

FINDINGS

Enacting the Revolving-Door Problem in Mental Health Care

Both hospital and community staff acknowledged that their agencies' failure to coordinate treatment and care worsened what they called 'the revolving-door problem' of mental health care. That is, many users never recovered from mental illness but remained in the psychiatric system for decades with frequent readmissions to psychiatric hospitals. Although both groups of staff acknowledged this as a major problem, they enacted this environment by bracketing different parts of users' experiences that left them uncertain about how to act.

Community staff identified a practice regularly employed by hospital staff: They discharged users even though they were still seriously ill and then, expected that they would receive the appropriate follow-up care at a community residential facility. A residential manager explained, however, that community care was not geared toward medical treatment: 'Often our residents are discharged much too early from the psychiatric hospital, but the problem is that we don't have the resources or knowledge to handle them when they are very sick' (#18). Another consistently problematic practice flagged by community staff was that users were regularly discharged and appeared out of the blue at residential facilities without any notification or follow-up treatment documentation: 'When citizens are discharged from the hospital, we have no idea whether there is a change in the medication, what has happened during hospitalization or what will happen now' (residential social worker/25). Both practices created uncertainty for community staff about how to help users who were seriously ill. They observed that users who experienced these very chaotic hospital discharges frequently required re-hospitalization only weeks after discharge.

Hospital staff also observed and criticized certain practices that the community staff engaged in toward users: They regularly avoided visiting users during hospitalization, preventing the transfer of important treatment information for community care after discharge. A hospital nurse explained: 'When we discharge patients from the psychiatric ward nobody takes over. It often feels like discharging them to nothing until the next time they are admitted' (#38). For hospital staff, this practice created uncertainty about how to help the users once they left the hospital; they often observed that treatment was interrupted once users left the hospital: 'As soon as they are back at the residential facility

they stop taking their medication and then it's only a matter of weeks until they're readmitted and we've got to stabilize them again' (hospital nurse/32). Consequently, many discharged users quickly relapsed because their treatment was discontinued and had to be re-hospitalized, exacerbating the revolving-door problem.

Both sets of practices appear irrational to outside observers: They did not serve the overt task of caring for individuals with mental illness. Curiously, though, neither group overtly expressed feelings of anxiety or shame about their own work. All references to anxiety in the data were attributed to either the users or their counterparts. Comments such as 'it's such a pity for the patients' (nursing assistant/10), 'our residents get so confused' (residential social worker/2), 'the residents get caught in between' (residential social worker/27), and 'the community professionals get frustrated when we discharge too quickly' (hospital nurse/9) suggest that anxiety-related emotions indeed are present. However, despite the negative outcomes of their practices for users, neither group of staff publicly owned any anxiety or shame associated with these failures during the interviews.

Instead of admitting their own inability to help certain users and/or their collective concerns about users not improving, community staff blamed hospital staff by assuming that they deliberately chose to discharge seriously ill users that they had deemed too difficult to deal with:

> One of our residents is in a really bad state, he gets very violent and sets fire to things. So, we regularly get him hospitalized because we can't help him, but they discharge him after only two days, saying that there's nothing more they can do for him. And we are shocked. But then another resident who is the sweetest thing, not making any fuss at all, him they'll keep for a month or more. But they can't be bothered with the difficult one (residential social worker/23).

Community staff also accused hospital staff of picking and choosing who they would admit, only admitting users that they could handle:

> When we escort a very sick resident to psychiatric hospital to get admitted, we sense that they [hospital staff] let us sit and wait for hours, hoping that we'll leave gain. It's random whom they do decide to admit, and those who get admitted have to behave in a manner so that the staff over there feel that they can be handled (residential social worker/26).

These strange attributions by community staff linking the admittance and discharge of very sick users to the hospital staffs' personal preferences imply the indifference of hospital staff toward the users and suggest that they could not be bothered with these difficult users, and therefore, discharged or avoided admitting them despite their continuing illness.

The hospital staff made similarly strange attributions to explain why community staff avoided visiting users during hospitalization. They either asserted that it was too painful for community staff to see the users at their worst, 'It's very frightening for them to see the patients when they're hospitalized at the closed psychiatric ward' (hospital nurse/19),

or blamed the community staff for being oversensitive and having insufficient emotional resilience, 'We called them, but they simply refused to come and said that the patient had to learn to eat properly before he was allowed to come home' (hospital nurse/9). Both groups accounted for their ineffective services by offering seemingly logical explanations for their counterparts' irrational preferences and behaviour.

Constructing Attributions and Assigning Blame for Collective Failure

We were struck by the degree to which both groups of staff imposed negative stereotypes of the other's professional competence and work effort based on their extracted lived experiences when selecting explanations of their collective failure to coordinate treatment and care between them. We found that each group developed coherent explanations for the revolving-door problem that implicated the others but not themselves while suppressing their own anxiety and shame. In addition to stereotyping the community staff as incompetent for their failure to visit the users, the hospital staff also labelled them as incompetent for failing to get users to continue their medication after discharge: 'We often discharge stabilized, well-medicated patients but their medication is taken from them as soon as they are back at the residential facility. And of course, one week later they are back with us and we have to start all over' (nursing assistant/12).

The hospital staff also accused the community staff of not understanding that medication is crucially important to manage psychiatric illness. This attribution stemmed from their belief that the community staffs' training in social work was extremely inadequate to handle individuals with mental illness. Expressing her incredulity on this topic, a hospital nurse commented: 'I simply can't understand why they hire social workers to look after some of the worst mentally ill patients. I mean everyone knows that social workers believe psychosis to be a learning process' (#7). Consequently, the hospital staff concluded that inadequate training and incompetence of the community staff were polluting the psychiatric system because it caused many readmissions: 'Patients who are hospitalized for long periods of time are discharged directly to the residential facility. But often we see them involuntarily readmitted back to the ward only a day after discharge' (nursing assistant/13).

Finally, the community staff was accused of failing to provide a firm structure of support for users, which was believed to create chaos and neglect at the residential facilities. They assumed users were left to themselves to spend their days drinking alcohol and doing illegal drugs in their rooms or picking fights with each other that the community staff supposedly did not handle: 'The stories we hear about that place, robberies, physical fights, someone was killed in there and several have died from drug overdoses' (hospital nurse/9). Similarly, a psychiatrist (#11) offered this extreme attribution, 'Some of the patients we receive from that place [the residential facility] look like they came from a concentration camp'.

Alternately, the community staff offered the extreme attributions about hospital staff as uncaring and controlling for several reasons. As aforementioned, the community staff blamed the hospital staff for discharging seriously ill users prematurely. They therefore stereotyped the hospital staff as showing no concern for how strong doses of medication affected the users. Instead, they were seen as merely wanting to control users' lives by

keeping them on high doses of long-term medication that was highly addictive, had many adverse side effects, and from which it was almost impossible to withdraw: 'Many residents remain stuck in doctor-prescribed drug abuse. They are simply addicted to the medication and nobody cares if it does them any good' (residential social worker/3). The community staff also pointed to the frequent use of coercion by the hospital staff in their treatment of users: 'Our residents never say, 'Wow, I had such a good stay at the psychiatric hospital. Their medicine dose is heavily increased', and coercion is something that many hospital professionals resort to very easily' (residential psychologist/22). These extreme associations stemmed from community staff members' belief that the hospital staffs' work practices were inhumane. According to one residential social worker: 'They do nothing in there [the psychiatric ward] but give them food and medicine three times a day. They really should try to get to know our residents and see them as the human beings they are' (#1). Another (#6) summed up the community staffs' attributions of the hospital staff as unfit caregivers for people with mental illness, saying: 'It's basically insensitive people who work over there'.

Ritualizing Enactments of the Revolving-Door Problem

Thus far, we have shown the reciprocity of intense stereotyping by each group of staff of their 'collaborative' partners that served to explain the revolving-door problem. Next, we consider how it illustrates retention, namely, how it has become the collective, habitual modus operandi of this failing collaborative arrangement because each group has imposed their own enacted environment on future actions and sensemaking.

When the two groups described themselves and their own contributions to the users, a more asymmetrical ritual emerged. A ritual is a 'mechanism that reproduce as well as reinforce a given institutional order' (Dacin et al., 2010, p. 1393), which in our case further solidified the revolving-door problem. Comparing themselves to the community staff, the hospital staff envisioned themselves as professional 'relief providers' because they effectively relieved users of their painful symptoms as soon as they were hospitalized. The hospital staff enacted this self-conception in their interactions with the community staff by imagining that they were taking over for or *relieving* the community staff who were incompetent. One nursing assistant explained how patients' condition improved quickly when hospitalized:

> Often the mere change to our environment will calm the patient down, change his behavior completely and get him back on his medication. But when we want to discharge the patient, the residential facility won't have any of that. So often we end up keeping them longer than necessary just to help the staff over there because they really lack qualifications (#10).

Another characterized this behaviour as providing relief: 'I often call them and say "Now the patient is well-medicated, he takes the medicine and he is calm now. But do you want us to keep him in for two more days, so you'll be relieved?" That's the impression we get, that we are relieving them of their distress with the patients' (nurse/34). These enactments reinforced the hospital staffs' preferred self-definition as omnipotent relative

to the more incompetent community staff, whom the former believed were unfit to care for individuals with mental illness.

The community staff experienced these enactments with mixed emotions. Some resisted and resented the characterization of their work effort as inferior compared to the hospital staffs' focus on diagnoses and medication: 'They act as if they are the big brother in the relationship, as if they are the only ones who possess the necessary knowledge, training, and professionalism' (domiciliary support worker/26). Others accepted the inferiority attributed to the community staff: 'Our staff's low professional self-esteem strongly influences our interacting with them in a very negative way. Our most noble task is to see the medical professionals as our partners, who know more than we do' (residential manager/18).

Interestingly, rooted in a belief in their own superior competence, the hospital staff elevated their importance by imagining themselves as being in charge of the entire psychiatric system. As one psychiatrist noted, 'I would love to see a psychiatry that wasn't split into two, and where I, as the leading psychiatrist, knew about everything that goes on. I'm not the only one who wants this' (#14). This wish was rooted in a belief in their superior competence vis-à-vis the incompetent community staff whom they saw themselves as helping by taking over the patients. Other hospital staff reinforced this notion by emphasizing that the users simply preferred to be in their care: 'We get many aggressive patients, but when they are in here, they are gentle as doves. When they get readmitted to hospital, they say to us "can I please stay here because in here I know what I can and can't do." They feel safe in here' (hospital nurse/8). The hospital staffs' desire to be in charge was enacted in takeover behaviour such as arranging for hospital nurses to provide social support to newly discharged users, involving the community staff as little as possible in decision-making about the treatment of users, and giving them specific tasks or timetables to adhere to for individual users, all under the guise of combating the revolving-door problem. As a domiciliary support worker noted, 'They never ask how we work with the citizens but often they tell us what we must do and make demands' (#27).

This domineering behaviour enacted by the hospital staff had repercussions on their relationship with the community staff who then reinforced the enactment by withdrawing. Examples of the community staffs' withdrawal behaviour included neglecting to seek out hospital staffs' opinions on users' treatment and failing to visit users who were hospitalized despite the requirement to do so: 'We used to always visit the residents when they're hospitalized at least once, but we never really do that anymore. It's probably because we are too busy anyway' (residential social worker/1). Their withdrawal can be interpreted as a sign that they also believed their work was inferior compared with that of the hospital staff, and therefore, it was better to leave it to the hospital staff to cure and care for sick users. This low professional self-esteem was evident in the contradictions in the community staffs' interviews, in which they would simultaneously acknowledge and deny feeling inferior to the hospital staff: 'It is not because I think they look down on our professionalism, but we are at the bottom of the hierarchy' (residential social worker/20).

Simultaneously, the community staff acknowledged the benefits of the hospital staff taking over: 'A dream scenario would be if they would just keep all the sick residents at the psychiatric hospital and give them medication and a firm structure until they recover' (residential social worker/2). Another similarly said in Danish: 'Hvem skal have aben',

which directly translates as 'who should have the monkey', where the *monkey* refers to a burdensome problem. The speaker explained, 'It's always been a battle between us who should have the monkey. But they should really take it' (residential social worker/5), suggesting another meaning of the Danish phrase which means 'passing the buck'. Over time, this dynamic led the hospital staff to identify with and repeatedly enact their wish of being in charge, because they believed they were the only ones who knew how to do this type of work. The result was that each group spent a lot of energy either taking over or withdrawing in relation to the other and thereby avoiding the overt task of taking care of the mentally ill.

DISCUSSION

This study focused on how unconscious emotions influence sensemaking and organizing in situations of conflict between organizations. Our findings revealed how psychiatric agencies who were mandated by public policy to collaborate instead engaged in persistent conflict despite its deleterious effects on their working relationship and on the clients they intended to serve. Our findings suggest three theoretical contributions. First, we integrate Weick's organizing theory with systems psychodynamics to reveal how underground emotions shape conflictual processes of organizing between organizations. Second, and relatedly, we develop a model that portrays organizing as the ritualized interaction of emotions, sensemaking and behavioural responses. Third, we extend the systems psychodynamics literature by explaining how unconscious dynamics operate across levels (from individuals, to groups, to interorganizational relationships and society, and back again). Our systems psychodynamics perspective illuminates what Weick calls the heat of organizing processes (1979, p. 240), that is, the *underground* emotional processes underpinning the organizing of conflict.

Integrating Enactment, Selection, and Retention with Unconscious Dynamics

Systems psychodynamics acknowledges that individuals and groups, when confronted with threats to their identity, unconsciously react to ameliorate anxiety (Bion, 1961; Gould et al., 2001) and preserve their desired identities (Collinson, 2003). Our data suggest that unconscious dynamics unwittingly infused the sensemaking and actions of the hospital and community staff. Both groups of staff specifically engaged in three unconscious processes – rationalization, projective identification, and fantasy – to cope with the anxieties they experienced at work.

Enactment and rationalization. Our data demonstrate that both groups of staff identified practices that appear irrational because they do not serve the overt task of caring for individuals with mental illness, but instead left them uncertain about how to act. We propose that these irrational practices are indicators of the failure of the system to effectively treat and care for the users, suggesting an unconscious subtext associated with identity threats and attendant anxiety (see Vince, 2019). Given the nature of these irrational practices, it appears that a major source of anxiety relates to boundary

management (see Miller and Rice, 1967) between the agencies, which feels impossible, making interorganizational collaboration anxiety provoking. Neither the hospital nor community staff feel in control of the transactions across the boundary between their agencies, that is, admissions, discharges, and transfers, which creates a sense of powerlessness that is exacerbated when they realize that their efforts at care are futile in many cases. While this would challenge anyone's sense of competence as a professional, staff neither surfaced nor acknowledged their collective concerns about feeling unable to help the users recover. Following Stein (2004), we interpret the absence of visible anxiety expression as stemming from their own low tolerance for anxiety. Acknowledging their own anxiety would have forced them to directly confront the threats to their professional competence. Instead, they repressed their anxieties and projected them onto the users and/or each other.

To shore-up their identities and further quell the attendant anxiety threats, both groups engaged with the unconscious defence mechanism of *rationalization* (Brown, 1997). Rationalization is the attempt to make controversial behaviours or feelings less threatening by explaining them in a seemingly logical manner. Our data revealed that rationalization played a critical role during enactment in that both groups felt uncertain of how they should act in the face of blurred boundaries between agencies and their own ineffectiveness. Rather than owning the anxiety the uncertainty provoked, they offered the seemingly logical explanations that they were not culpable because the ineffective services were caused by their counterparts' irrational behaviour. The community staff rationalized that the hospital staff was deliberately admitting and discharging users according to their personal preferences; hospital staff claimed that community staff were oversensitive and had insufficient emotional resilience toward the users.

Although rationalization often reduces the burden of unwanted emotions, it appeared in our case that rationalization did not fully alleviate the groups' feelings of anxiety. Similar to Vince's (2006) managers at Hyder, the hospital and community staffs' attempts to rationalize the irrational and harmful practices appeared to generate additional unwanted emotions. Most likely, this occurred because their seemingly logical explanations, while effectively positioning their counterparts as totally irrational and unreliable, still left them unable to help the users. To protect themselves from inescapable anxiety threats associated with their continued ineffectiveness, both groups bolstered their rationalizations by resorting to the forceful unconscious mechanism of projective identification to explain the revolving-door problem.

Selection and protective identification. During the selection process of the ESR model, both groups made extreme characterizations of each other's work, accusing them of misconduct and blaming them for causing the revolving-door problem. The hospital staffs' comparison of the residential facilities to 'concentration camps' and attributions of the community staff's incompetence and ignorance of psychiatric illness were reciprocated by the community staff's accusations that hospital staff were inhumane, used force easily, and engaged in 'doctor-prescribed drug abuse'. From a systems psychodynamic perspective, these extreme associations are a sign of some very intense unconscious emotional activity.

To protect themselves from consciously experiencing these intense emotions and uphold a desired self-definition, staff on each side unconsciously resorted to the defence mechanism of *projective identification* (Bion, 1961; Klein, 1946/1975). By employing projective identification, both groups could unconsciously split off the unwanted aspects of their professional selves and project them onto their counterparts so that it appeared that those receiving the projections possessed these unwanted characteristics: it is the community staff who cannot cure; it is the hospital staff who do not care. The hospital staffs' intense denigration of the community staffs' work and training as incompetent and inadequate therefore really serves to safeguard the hospital staff from their own feelings of incompetence in caring for the users whose chronic condition most likely is a source of professional shame. They may fear that *they* do not understand psychiatric disorders because apparently, they cannot cure them. Similarly, the community staffs' intense denigration of hospital staff as uncaring and controlling may serve to safeguard them from their own feelings of shame for not caring properly for the users. They may fear that *they* are unfit as caregivers for sick users because apparently, they cannot help them.

It is important to stress, however, that projective identification is an unconscious process. What is especially curious about the projections is that each group portrayed the other as the antithesis of themselves (Ashforth and Reingen, 2014). Through stereotyping and denigrating each other, they compared themselves favourably with the recipient of the projections. Thus, the hospital staff highlighted their sense of superior professional competence toward users and perceived the community staff as incompetent, and the community staff emphasized their own consistent attempts to interact with the users as human beings and considered the hospital staff to be uncaring and controlling. This allowed the groups to internalize and sustain a sense of self-definition that matched their specific role requirements of caring for and hopefully curing individuals with mental illness.

It is also important in our case to understand the reciprocal patterns that served to ritualize the two groups' interactions. Projective identification is a forceful mechanism for unburdening painful inner emotions because it works as the unconscious manipulation of others to introject (adopt) and then, enact the unwanted projected characteristics. This introjection, however, triggered additional anxieties about the recipient group's own self-definition and capabilities. To rid themselves of the projected elements, the recipients unconsciously returned the unwanted projections back onto the sending group, thereby fuelling a destructive cycle (Petriglieri and Stein, 2012). The reciprocity of this dynamic became ritualized, transforming each group's internal professional identity threat into conflict at the interorganizational level. Although our data showed that projective identification had become both groups' prevalent means of sensemaking of self and other, creating these dysfunctional processes of organizing, we observed that the defensive pattern played out asymmetrically in the fantasy lives of the two groups during the retention process of the ESR model.

Retention and fantasy. Our data provided evidence that during retention, hospital and community agencies employed the unconscious dynamic of *fantasizing* (Brown, 1997) to fulfil difficult or impossible aspirations. Fantasies have structuring effects in that they limit the intensity of emotions within a system and work as a mechanism to control what

the task means and define the expectations that surround it (Vince, 2019). Both agencies revealed converging fantasies about the hospital staff's omnipotence. For example, the hospital staff advanced a narrative of themselves as professional 'relief providers' and fantasized completely taking over community care and assuming responsibility for a single collective psychiatric system. To enact this fantasy of 'us in charge', hospital staff attempted to control the collaborative arrangement, and the community staff, although ostensibly protesting this fantasied arrangement, effectively condoned it by withdrawing from their responsibilities. This was evident in contradictions expressed by the community staff in which they would simultaneously acknowledge and deny feeling inferior to the hospital staff.

From a systems psychodynamic perspective, contradictions are a sign of unconscious emotions (Gabriel, 1995; Vince, 2019), which reflect the shame in feeling inferior to the hospital staff. Thus, the dynamics of rationalization and projective identification are never fully reciprocated by the community staff, who – to temper their emotional response – participate in the shared fantasy that the hospital staff can save them by assuming responsibility for 'the monkey', that is, all the sick users, and keep them hospitalized. This fantasy of 'them in charge' also has structuring effects: The hospital staff enact the community staffs' fantasy by taking over community care tasks. Their converging fantasies of hospital care's omnipotence support the interpretation of asymmetry in the two groups' defensive behaviour (see Padavic et al., 2019). The hospital staff receive some relief from anxiety by projecting their sense of incompetence and inability to cure onto the community staff, who – in contrast – seem to introject the projected inferiority, which only increases their anxiety. The collective consequence was a further deterioration of an already conflictual working relationship among the groups. Table II provides an analytical overview of the organizing processes in this case and their associated unconscious dynamics.

Reciprocal Cycle of Unconscious Dynamics Underpinning Conflictual Organizing

Extending Weick's theory of organizing with systems psychodynamics to understand the role of emotions in organizing processes, we reveal a critical feature of the relationship among the unconscious, sensemaking and action in processes of organizing: Unconscious emotions may flow inconspicuously alongside cognitive sensemaking and action when anxiety is low, but when anxiety increases, conscious theories of organizing are insufficient to explain the dysfunctional processes that occur. Instead, sensemaking and action are overtaken by social defenses, which conflict with the primary task (Bion, 1961). Combining theories of organizing with psychodynamic insights offers powerful explanations for such otherwise inexplicable organizational dynamics.

In Figure 1, we depict a reciprocal cycle of emotions, sensemaking and responses that generated and eventually ritualized the organizing of conflict between the mental health agencies. The first section of the model depicts the *unconscious feelings* generated by the failure to deliver successful care. Facing inordinate anxiety and shame, mental health staff under pressure to perform quickly rationalize that their counterparts are the source of their problems; however, rationalization only seems to exacerbate their unwanted

Table 2. Integrating the processes of organizing and unconscious dynamics

Organizing processes	*Enactment: Enacting the revolving-door problem in mental health care*		*Selection: Constructing attributions, and assigning blame for collective failure*	*Retention: Ritualizing enactments of the revolving-door problem*
Hospital staff:	Identify irrational practices of the other group: community staff do not take over the treatment and care of users after discharge		Community staff is incompetent because they are inadequately trained for the job: • they take medication from the users • residential facilities are like concentration camps	Self-definition as professional relief providers: • want to control users' treatment • act by taking over community care tasks
Community staff:	Identify irrational practices of the other group: hospital staff discharge sick users prematurely and do not inform community staff about discharge or follow-up treatment		Hospital staff is controlling and uncaring toward the users: • they keep users in doctor-prescribed drug abuse • they frequently coerce the users	Self-definition as inferior: • both acknowledge and deny feeling inferior • act by withdrawing from users' treatment
Associated unconscious processes	**Low anxiety toleration**	**Rationalization**	**Projective identification and anxiety repression**	**Structuring fantasies**
Hospital staff:	Anxiety is attributed either to the users or the community staff	Community staff lack emotional resilience when interacting with the users	Projections of incompetence onto community staff; these safeguard hospital staff from their unbearable feelings of anxiety and shame arising from being unable to cure the users	Their omnipotence: • completely taking over community care so that there is only one mental system Community staff incompetence: • 'us in charge' of all

(Continues)

Table 2. (Continued)

Organizing processes	*Enactment: Enacting the revolving-door problem in mental health care*		*Selection: Constructing attributions, and assigning blame for collective failure*	*Retention: Ritualizing enactments of the revolving-door problem*
Community staff:	Anxiety is attributed to the users	Hospital staff discharge and admit users based on their personal preferences	Projections of controlling and uncaring behaviour onto hospital staff; these safeguard community staff from their own unbearable feelings of anxiety and shame arising from being unable to care for and help the users	Hospital staff omnipotence: • the hospital should keep the very sick users (the monkey) Their own incompetence: • the hospital staff is superior

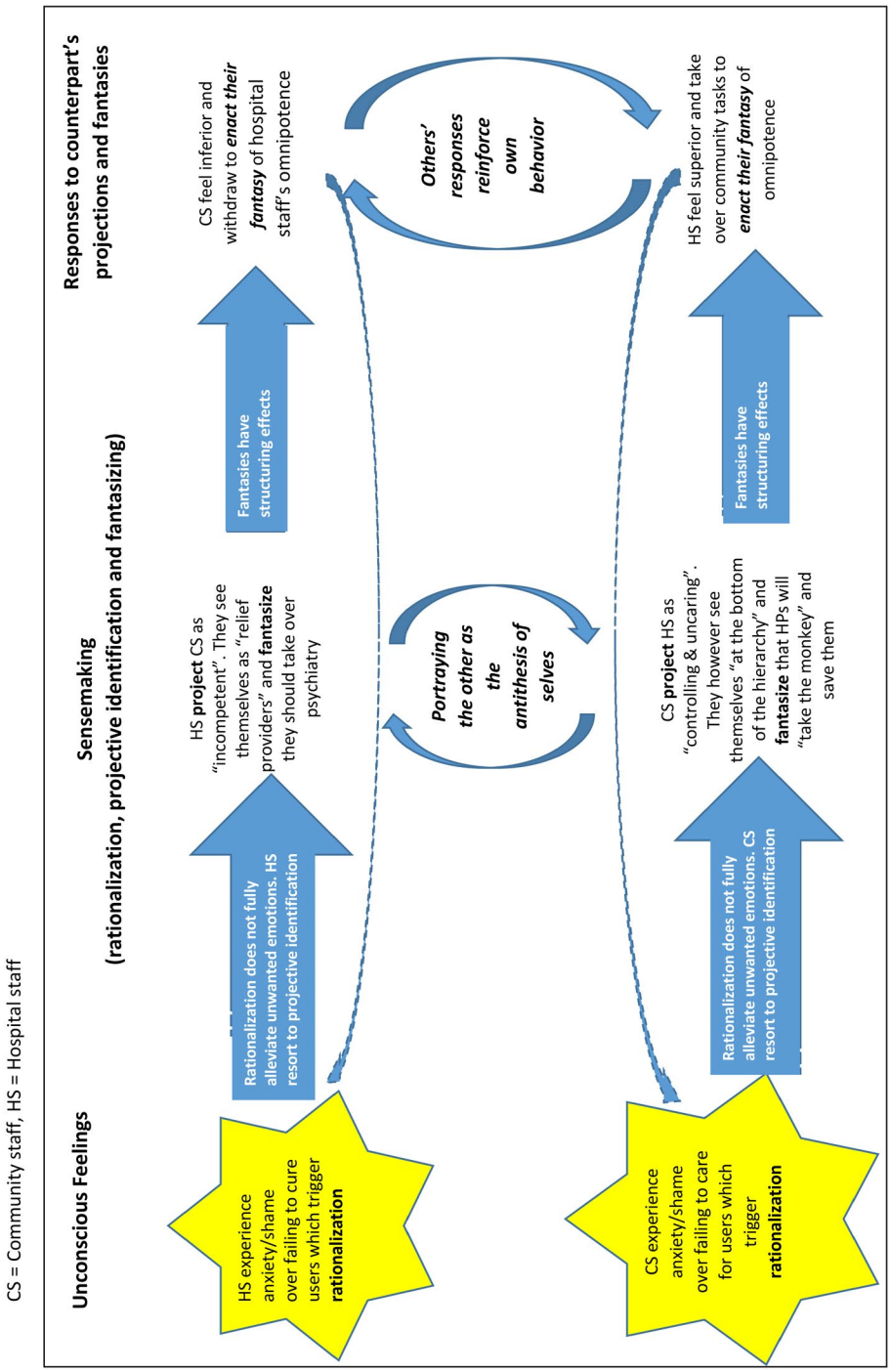

Figure 1. Ritualized Cycle of Emotions, Sensemaking and Reciprocal Responses. CS = Community staff, HS = Hospital staff. [Colour figure can be viewed at wileyonlinelibrary.com]

emotions. Consequently, in the second part of the model about *sensemaking*, they effectively project these unwanted aspects of themselves onto their counterparts, imposing negative stereotypes on them and blaming them for their collective failures. While both rationalization and projective identification are means of sensemaking, the projection of stereotypes becomes both groups' most prevalent means of sensemaking as they portray the other as the antithesis of themselves. A further aspect of sensemaking, which also serves to limit the intensity of their unwanted emotions, is both groups' fantasizing about the hospital staff's omnipotence.

The third part of the model depicts each staff's *responses to their counterpart's projections and fantasies*. To defend against the negative feelings provoked by initial projections, both groups of staff respond in kind with projections of their own. The model also shows that both staffs act out their fantasies to create an asymmetric response pattern of behaviour between them. That is, community staff, feeling inferior, enact their fantasy of the hospital staff's omnipotence by withdrawing, and hospital staff, feeling superior, enact their fantasy of omnipotence by taking over. The defence system thereby has an inherent functional logic because it insulates both staffs' identities from the narcissistic trauma and the attendant painful anxiety and shame triggered by their failure to cure and care for users. Instead, anxiety and shame go underground in the system – only to resurface and retrigger the reciprocal process again and again with long-term system-wide effects. Figure 1 shows that unconscious emotions, sensemaking, and reactive behaviour occur in a persistent self-sustained pattern that distorts sensemaking, prevents effective contact and the exchange of information, and serves to constitute, drive, and effectively ritualize the protracted conflict between groups.

This reciprocal cycle sustains a climate of conflict in which conflicting parties deny their interdependence, distrust each other, and are less likely to acknowledge and seek out each other's professional skills and knowledge, thwarting effective collaboration and service to the users of the system. As staff groups in our case transferred their shame and anxieties onto the collaboration, they become trapped in this vicious circle of dysfunctional organizing, neglecting their main task of caring for the mentally ill. Vince (2019, p. 953) refers to unconscious dynamics that become institutionalized as 'institutional illogics' because these unconscious processes exert powerful 'structuring and unsettling effects' on organizations, institutions, and as in our case, interorganizational relationships. Extension of Weickian theory to account for the unconscious processes of sensemaking and action is especially useful for exposing the competing effects of pretending to take deliberate actions to solve rational problems within and between organizations while actually inducing unconscious emotions and behaviours, which work against achieving the hoped-for consequences (Baum, 2011; see also Padavic et al., 2019; Weick, 1993).

Organizing Dysfunctional Conflict among Organizations

Our paper also contributes to systems psychodynamics by demonstrating the bidirectionality and reciprocity of unconscious dynamics and how they operate across levels (from individuals, to groups, to interorganizational relationships and society, and back again). As we have demonstrated in this paper, conflict in one part of the system can be exported to another part (Alderfer, 1987), which – in our case – occurs through the transforming

of internal professional identity threat into interorganizational conflict, and by transferring society's struggle with mental illness onto the relationship between psychiatric agencies. Systems psychodynamics has primarily studied defences and irrationalities within organizations, showing how anxiety and unconscious defences permeate organizational life and become ritualized (Jacques, 1955; Menzies, 1960). Our study goes further by demonstrating and accounting for unconscious structuring effects on human interactions across organizations attempting to collaborate, thereby responding to a recent call by Petriglieri and Petriglieri (2020) to build cross-level understanding of workers' experience in new organizational forms. We reveal how professionals' individual anxieties concerning their feelings of ineptitude transcend organizational boundaries, spilling over into and poisoning these professionals' collaborative relationships with professionals from other agencies. Essentially, the reciprocal cycle of rationalization, projective identification, and fantasizing suggests the formation of a 'compulsive tie' (Klein, 1946/1975) between these organizations.

Systems psychodynamic analysis offers a plausible, compelling explanation for how and why such a persistent tie could develop. Over time, as the tie becomes ritualized, it enables both sets of professionals to continuously extrude the unwanted parts of their professional selves onto others (Petriglieri and Stein, 2012) and perpetuate fantasies that allow them to elude taking responsibility for organizational outcomes. However, a compulsive tie can leave conflicting groups bitter and collectively unable to recognize and address the unconscious processes that impede their collaboration. Instead, each group clings to the tie to sustain their preferred narratives of professional accomplishment and competence.

Lest we leave the impression in our case that the initiation and escalation of these dynamics solely originates from the staff of the agencies involved, systems psychodynamics also enables us to more deeply examine how societal mental health policy impinges on interorganizational conflict. Historically, systems psychodynamics has elucidated how structural arrangements of (mental) health care may evoke vulnerability and anxiety in the people who work in this field because these arrangements expose them to their own mortality (Menzies, 1960; Obholzer and Roberts, 1994) and their own susceptibility to madness (Hyde and Thomas, 2002; Willshire, 1999). Following this stream of scholarly work, the 'madness' observed in the interrelations of hospital and community staff in our study can also be understood as stemming from the burden imposed on them of working and managing mental illness on behalf of society. That is, by splitting off and locating madness in the mentally ill, mental health workers and society at large can keep their own madness at bay. Willshire (1999) argues that working with mental illness is by its very nature impossible because of its incorrigibility and that organizing it across settings is designed primarily so that society can keep alive its illusion that mental illness is curable. The social defence system enacted by mental health staff, although protecting them to some degree, diverts attention away from the real problem: how society organizes its mental health care services and how this organizing fails to help either the mentally ill or their caregivers.

Splitting the delivery of mental health care between hospital- and community-based services, forces them into a symbiotic relationship, with the users oscillating back and forth between them, but does not give either group the tools to address these larger

societal issues associated with mental health care; instead, both are forced to shoulder this enormous and impossible burden, but now, conveniently, each has a scapegoat (in the other) to blame when they find the task impossible (Fotaki and Hyde, 2015). Exacerbating this broader systemic problem of working with and managing mental illness are decades of New Public Management in Denmark and similar countries introduced to publicly funded health and social care systems, keeping mental health care chronically under-resourced in the name of efficiency and quality. Acknowledging the bidirectionality of unconscious dynamics, specifically how macro-level systems psychodynamics operates across levels, we consider the particularities of the conflictual organizing we observed between agencies as a normal and even appropriate response to the impossible task that they have been mandated to do in society's search for the most effective and cost-efficient treatment of mental illness.

Practical Implications

Our Danish case is not unique and has broader implications for other interorganizational systems that experience conflictual organizing. For example, other health care delivery systems in which coordinated care is a necessity are plagued by ongoing battles for professional jurisdiction that may thwart their collaboration (Louis et al., 2019; Reay and Hinings, 2009). We suggest several steps to break the reciprocal cycle of rationalization, projective identification, and fantasizing in contexts of conflictual organizing between organizations. A critical first step is developing processes that encourage staff and managers to become aware of the unconscious influences on their own and other's behaviour. Research into systems psychodynamics particularly emphasizes the damage from individuals and groups when they are unconsciously transferring their inner conflicts to interpersonal interactions (Gray and Schruijer, 2010; Petriglieri and Stein, 2012; Vince and Mazen, 2014). Our case equally showed the damage that the transfer of internal professional identity threat to interorganizational conflict has on the users of mental health care services. Although this type of awareness is critical, so is the realization that triggers of collective unconscious dynamics are usually organizational (Pratt and Crosina, 2016), or as in our case, interorganizational in nature rather than individually motivated. This admission may relieve some of the shame associated with self-attributions of incompetence.

A second step is to ascertain whether dysfunctional routines and practices serve a hidden functional purpose of assuaging threats to professional identity; once this is understood, a critical component of this step would be acknowledging that elements of mental health work are impossible because of the incurability of the disease (cf. Willshire, 1999) – a realization that might even evoke the need for some collective mourning (Neimeyer et al., 2002). With this realistic appraisal of their collective efficacy in treating mental health illness, organizations might undertake a third step: initiating a process of relationship repair (Petriglieri, 2015) and co-creation of facilitating structures (Schruijer and Vancina, 2008) that might ameliorate the dysfunctional dynamics between them.

To enable a move from awareness of the unconscious organizing of conflict to its management at a system level, a fourth step is critical: Policymakers and health managers at mental health agencies must acknowledge rather than deny the limits of their collective

ability to cure mental illness (see Fotaki and Hyde, 2015). Acknowledging this proposition would free up mental resources currently devoted to dysfunctional stereotyping to redesign psychiatric care so that staff feel supported in their work with mental illness. This acknowledgment could promote new service forms in which staff focused on making mental illness bearable rather curable. Finally, we suggest that additional research on societal-level systems psychodynamics is warranted in mental health and in other areas of intractable societal conflict.

CONCLUSION

The split of Danish psychiatry into two systems propelled a failure in the care of individuals with mental illness. We have offered an account of this failure by drawing on and enriching Weick's foundational theory of organizing with insights from systems psychodynamics theory. Our account explicates how and why the unconscious dynamics of rationalization, projective identification, and fantasizing exerted structuring effects that generated dysfunctional outcomes for both users and staff while simultaneously serving staff's emotional needs for anxiety reduction and ego gratification. Despite their deteriorated relationship and the high number of revolving-door patients, relying on their defence mechanisms became a functional means for both hospital and community staff to feel competent and in control of the problem. On an emotional level of organizing, such reliance is in fact very functional and organized because it allows mental health care staff to sidestep painful emotions of professional failure and insulate themselves from feelings of identity loss. Thus, this dysfunctional collaborative arrangement is simultaneously psychologically advantageous and organizationally damaging and highlights the need for research that goes beyond variance explanations for why so many well-intended attempts at organizing go awry. Our research is among the few studies that examine such issues and their cross-level implications (Hirschorn & Gilmore, 1989). It leads us to encourage additional macro, cross-level inquiries to address, for example: What covert individual or interpersonal dynamics thwart successful organizational or interorganizational conflict resolution? And what projected identities, rosy or even messianic fantasies, or hidden authority structures may be sabotaging organizational or interorganizational efforts to collaborate? Coupling the systems psychodynamic perspective with Weick's cognitive and interactional views of organizing can uncover insights into the otherwise hidden, emotionally charged organizing within, what Gabriel (1995) terms, the unmanaged spaces of organizations. Finally, by illuminating our unconscious complicity as 'internal saboteurs' (Fairbairn, 1951, p. 173) in creating such spaces, their productive transformation can begin.

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NOTE

[1] Because hospital and community staff use different language for the recipients of their care, we consistently use the word 'users' when referring to patients, residents, or citizens to avoid confusion. In direct quotes, we retain their exact wording to display and honor the contestation in language between the two groups of staff.

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