第九章 形成使命：一个案例

本章从我到目前为止发展成形的思想的一个扩展应用案例的（第九到十一章）开始。这是一个小的心理治疗组织在美国精神卫生环境变动背景下的巨变和组织学习。（E.R. Shapriro, 2001b）。在我作为奥斯腾里格斯中心首席执行官的二十年里，形成了一系列的原则，加强了一个自我反思性组织的发展，同时也增强了其成员在社会中发现自身的立足点的可能性。这些核心原则列示如下以便于参考，同时也会在本章中随着我讲述20年CEO的经历而得到阐述。

1. 发现、发展并形成使命需要对组织独特性（它的历史、传统、资源和技能）的原初关注和机构能够满足的社会需求的清晰表达。

2. 从内部和外部的不同的利益相关者听取关于机构使命的不同意见，并认可他们的观点可以发展出一个与机构相连的共同联结。

3. 系统如何完成使命会通过其集体行为对外沟通，其中有些会由领导者指导，最初会激发防卫反应。从这样的信息可能包含关键信息这一假设（“他们如何是正确的”）出发可以允许领导者抑制他的最初的反应、提供充足的空间从系统中学习并更彻底地参与其中。

4. 一旦使命已经形成，与使命有着清晰关联的权力的下放和管理结构的创设，可以帮助发展分布式领导力和对于工作的整体观（集体所有权）。

5. 如果CEO能够站在一个解释性立场工作，承认他的盲点，公开尝试解释他的角色经验的合理性并且听取其他人如何可能是对的，机构职员就可以冒险承担一个解释性立场并开始认识到领导力并不全部在于领导者而也在那些可以最清楚地定义任务的人身上。

6. 任何机构的使命都应与外部社会和社会价值及信念有着清晰的联结。这些价值应与这家特别的机构有着清晰的联系从而其职员能够很容易地将他们自身的价值与其工作联系起来。（见第6章）

7. 当外部世界的压力威胁到使命，思考这些压力如何抑制重要信息可能会使机构允许让其使命焦点更尖锐。

8. 如果使命能够压缩为简单的使命宣言，每位雇员能够容易地说出它并将它变成他或她自己的，将十分有用。

自从当上奥斯腾里格斯中心的CEO，我首先聚焦于明确中心的任务以作为其与大社会的一个共同的现实的联结，并授权给员工承担起解释使命的立场，明确一系列内部管理架构来支持这一使命。我发现对员工强调权力与权威的区别很重要。权力，我觉得与资源的使用相关，是以一种强迫方式让他人去工作，它可能是与任务相关的或不相关的。相反地，权威是定义一个任务从而人们愿意拿起他们自己的权威去参与，参与（和代表）的自由是作为公民权中的一个重要方面。

这些想法最初来源于系统心理动力学和团体关系工作的语言。当我加入里格斯，我发现自己在一个不熟悉的文化中寻找这些熟悉的标记。之后我将这一组织的语言嫁接在这一框架之上，通过与员工、董事会广泛的、非定向地、常常也是痛苦的协商发展出一种新的语言。尽管有一些困难，机构使命替代了主要任务；个人边界（心理分析“熟悉“的语言””）扩展到角色、子系统和机构边界； 对大团体和小团体过程的研究伴随着对机构使用团体的公开评估； 对机构动力的共同认识也逐渐从协商式的使命解释文化的发展过程中浮现。当我开始明白我的角色，我尽一切努力公开我的经验并公开分享我通过协商的方法对使命释义的方法，邀请他人加入我的这一努力，从而试图以此作为一种了解系统动力的途径。机构的中心两难是当它加入变化的世界时如何维持与里格斯有价值的传统的联系。为帮助员工达成此目标，我不得不在拥有过去的概念同时引入不熟悉的概念。这些相联系的概念提供了必要的框架。

当我刚来到中心时，美国精神卫生的世界由于管理的改革――保险业的转型聚焦于限制卫生机构的可用的融资而处于混乱中，作为一个长期的治疗机构，奥斯腾里格斯中心受到了很大的影响。同时精神卫生领域也处于大社会的主要压力中。有关剽窃、裙带关系、资金滥用以及不轨性行为的指控也迫使精神科主任不得不辞职。精神治疗医师卷入与病人间丧失职业角色丑闻，植入错误的滥用职权的印象一些法庭案件也开始出现，中心的长期治疗处于密切关注之下。财务压力改变了工作环境，精神病学治疗受到生物学和行为科学的围攻。里格斯的使命和大社会的需要间的联结变得越来越难以说清楚。

It had represented the best in psychoanalytic theory and practice. Giants in the field, such as David Rapaport, Erik Erikson, Robert Knight, Margaret Brenman, and Roy Schafer had made significant contributions while at the Austen Riggs Center. Riggs was a reservoir of psychoanalytic thinking and one of the last psychiatric centers that provided intensive psychoanalytic psychotherapy for disturbed patients in a long-term hospital setting. Prior to my arrival, Riggs had more than a million dollars in accounts receivable in the context of a six-million-dollar budget with a small endowment.  There was no human resource function,and consequently no established institution-wide personnel policies or procedures. The administration of benefits often fell to the department manager’s interpretation for specific individuals. Job descriptions listed a smattering of tasks but no measurements or expectations. Performance evaluations were missing. There was no differentiated compensation system, and everyone expected a salary adjustment every year no matter their performance. The place ran on oral tradition. When I asked why something was done, the usual answer was, “Because that’s the way we’ve always done it.” Managers were not trained in management. In response to newly developing external accrediting pressures, brilliant clinicians had taken up quasi-administrative roles which they experienced as “tacked-on responsibilities.”The institution was entirely focused on the needs of the patients; it did not have theinfrastructure necessary for a changing environment. Administrators handled employee issues without grasping the impact on the wider system or considering the systemsimplications of staff dynamics on patient care. The staff barely discussed or attempted to understand what was going on in the larger system. Individual psychotherapy was the dominant discipline; there was one full-time social worker. Nursing staff felt devalued and therapists used them as supports for the psychotherapy. The dynamics of the institution indicated a systematic confusion between power and authority. Authority derives from a shared task, and members of different subgroups in the institution were not in agreement about what that task was. My concern was that in a system that used power without a clear connection to a task, individuals can feel abused. This experience is often accompanied by splitting and projection, which I saw between the board and the staff. I had learned that a shared and agreed-upon task can serve as an abstract “third party” that allows members to bridge their polarized connections and grasp a shared reality. The question was how to define it. In the year prior to my taking up my new position, the board of trustees and the medical director invited me to take up the role of consultant to the board.

里格斯是一家杰出的非营利精神病机构，其员工超多年来对精神分析和自我心理学做出了重大贡献。它曾经代表了精神分析理论和实践中最好的。赛场上的巨人，比如大卫·拉帕波特、埃里克·埃里克森、罗伯特·奈特、玛格丽特·布伦曼和罗伊·谢弗在奥斯汀·里格斯中心期间做出了重大贡献。里格斯是精神分析思维和最后一个提供强化治疗的精神卫生中心之一，在长期医院环境中对精神失常患者进行心理治疗。在我到达之前，里格斯有600万美元预算和少量捐赠的背景。和许多人一样在那个时期的精神病院里，里格斯被组织成一个等级制度做出所有重大决定的医务主任。没有人力资源职能，因此没有既定的机构范围的人事政策或程序。这个福利管理往往由部门经理来解释特定的个人。列出了一些工作描述任务环，但没有测量或期望。缺少绩效评估。没有区分薪酬制度，每个人都希望每年都能调整工资他们的表现。这个地方沿袭了口头传统。当我问为什么完成后，通常的回答是，“因为我们一直都是这样做的。”经理们没有接受过管理培训。针对新发展的外部认证在压力下，杰出的临床医生承担起了准行政角色，他们经验丰富的“附加责任”该机构完全专注于患者的需求；它没有不断变化的环境所必需的基础设施。管理员处理的员工没有把握对更广泛系统的影响或考虑系统的问题员工动态对患者护理的影响。工作人员几乎没有讨论或试图了解更大的系统中发生了什么。个体心理治疗是优势学科；有一名全职社会工作者；护理人员感觉被贬低了治疗师将其作为心理治疗的支持。该机构的动态表明权力之间存在系统性的混乱和权威。权力来源于共同的任务，不同的成员该机构的小组对这项任务的内容并不一致。我的令人担忧的是，在使用电力而没有与任务的明确连接的系统中，个人可能会感到被虐待。这种经历往往伴随着分裂和我在董事会和员工之间看到的投影。我了解到和商定的任务可以作为一个抽象的“第三方”，允许成员弥合他们两极分化的联系，把握共同的现实。问题是如何定义它。在我担任新职位的前一年，董事会和医务主任邀请我担任董事会的顾问。

I realized that not only did I not know what institution I was joining, the staff and the board did not know what medical director they were getting. With the authorization of the board, I set up a structure from Boston to renegotiate a mission. I invited patients, staff, and the board to organize subgroups within each role for the purpose of articulating their distinctive views of the center’s mission. I asked each subgroup to authorize representatives to negotiate the differences. Finally, I asked the entire system to authorize representatives to negotiate a final version of the mission with me. The process revitalized us all. Each subgroup engaged in lively discussions that helped them to clarify their values and beliefs and their ownership of the institution and its traditions. Each group articulated distinctive but overlapping areas. The final negotiation allowed me more fully to grasp the institution and discover the connections I was bringing in from the outside. Much of what I added linked the institution’s values to the realities of the outer world. The final statement was complex, but clearly articulated both the center’s traditions and some hopes I had about its links to the outside. The process also authorized me to take up the role of medical director/CEO. The negotiated mission became the context for our work over the first three years.

我意识到，我不仅不知道自己要加入什么机构，员工和董事会不知道他们得到了什么样的医疗主管。经授权董事会，我在波士顿建立了一个结构来重新谈判一项任务。我邀请了病人，员工和董事会在每个角色内组织小组，目的是阐明他们对中心使命的独特看法。我要求每个小组授权代表就分歧进行谈判。最后，我问了整个系统授权代表与我谈判任务的最终版本这一进程使我们大家都恢复了活力。每个小组都进行了生动的讨论，这对他们有帮助阐明他们的价值观和信念，以及他们对机构及其传统。每组都有各自独特但重叠的区域。决赛谈判让我更充分地掌握了这个制度，并发现了其中的联系我是从外面带来的。我补充的许多内容将该机构的价值观与外部现实联系起来世界最后的陈述很复杂，但清楚地表达了中心的我对它与外界的联系抱有一些希望。这个过程也是授权我担任医疗总监/首席执行官。谈判达成的任务成为我们头三年工作的背景。

Senior medical staff sat together at lunch. Shortly after I arrived, I joined them, taking the seat at the head of the table. As I sat, there was a sharp intake of breath and several said to me at once: “You can’t sit there!” I got up. Staff members informed me that the seat was reserved for the most senior clinician in the institution (a former director of psychotherapy); it was his seat.  I took this very seriously. This clinician was one of three partially retired senior staff. They did not talk with each other and were never in the same room together. Staff members assumed a deep disconnection between them and found it painful. Not attending to institutional meaning, staff gossip attributed the disconnection to conflicting personalities. All three were held in awe by the clinical staff.  As we socialized over dinner, their institutional roles emerged. The second was the former director of psychotherapy, representing the therapeutic community and the open hospital.  As I formulated this question, they began to tell stories about these roles, leading to a warm and engaged evening. I articulated the aspects of the institution I heard from them and invited them to represent these within the institution. They seemed delighted. Their agreement to work with me meant symbolically that the new administration had respectfully engaged the center’s tradition. Over the first six years of my tenure each of these seniors became gradually more involved. The first began attending case conferences on a regular basis. The second became director of alumni projects, organizing former patients and staff in a developing association. The third became a research affiliate and joined the staff as Erikson Scholar. Four years after my arrival, Riggs hosted a gala celebration of the senior clinician’s seventy-fifth birthday. I presented him with an engraved Riggs chair to place at the head of the senior staff lunch table, where he continued to sit until his death a decade later.

高级医务人员共进午餐。在我到达后不久后，我坐在他们桌子头的座位。当我坐着的时候，有人急促地吸了一口气我立刻对我说：“你不能坐在那里！”我站了起来。工作人员告诉我座位是为该机构最资深的临床医生保留的（精神疗法的前董事）；那是他的座位。倾听他们让我正确看到了这一点这次对峙是一次哨兵事件，象征性地提醒我，为了采取行动作为我的角色，我必须关注已经存在的传统的力量。我非常喜欢这个认真地这位临床医生是三名部分退休的高级职员之一。他们没有说话彼此在一起，从来没有一起呆在同一个房间里。工作人员假设他们之间的深深脱节让人感到痛苦。不参加机构也就是说，员工八卦将这种脱节归因于性格冲突。三者皆有受到了临床工作人员的敬畏。作为图标，它们代表了该中心伟大的过去。所以，我邀请了三个人共进晚餐。工作人员对我的鲁莽感到震惊，但事实上，三位学长对邀请表示感谢。当我们在晚餐时社交时，他们的制度角色出现了。其中一个代表里格斯和Chestnut Lodge（另一家著名的精神分析机构）之间的联系，以及强化个体心理治疗的中心地位。第二个是前者心理治疗主任，代表治疗团体和公众医院；第三个代表了与埃里克·埃里克森和里格斯研究的联系。我开始怀疑他们脱节的制度原因。作为我提出这个问题后，他们开始讲述这些角色的故事，引发了一场热烈的讨论晚上订婚了。我阐述了我从他们那里听到的机构的各个方面邀请他们在机构内代表这些人。他们似乎很高兴。他们的与我合作的协议象征着新政府尊重中心的传统。在我任职的前六年这些老年人越来越多地参与进来。第一个开始处理案件定期举行会议。第二位成为校友项目总监，在发展中的协会中组织以前的病人和工作人员。第三个变成了研究附属机构，并以埃里克森学者的身份加入工作人员。在我到达四年后，里格斯为这位资深临床医生的七十五岁生日举办了一场盛大的庆祝活动。我送给他一把刻有里格斯图案的椅子，放在高级职员的头上午餐桌，他一直坐在那里，直到十年后去世。

Shaping management structures (Principle 4)

塑造管理结构（原则4）

   Riggs had many brilliant clinicians and a creative clinical structure. It housed fifty patients in long-term hospital care, with a “step-down” program to less intensive care located in a separate building on campus. The hospital was completely open with no privilege system, no seclusion rooms, and no restrictions. Patients were free to come and go though many were significantly troubled. The center had a therapeutic community in which patients were invited to take charge of their lives and contribute to the functioning of the hospital. There was a unique activities program started by Erik Erikson’s wife, Joan, where patients temporarily left the patient role and worked as students with craftspeople and artists. The intensive psychotherapy was well-organized and supervised, with a clear psychoanalytic focus and traditional boundaries.

   里格斯有许多杰出的临床医生和富有创造性的临床结构。它有50名长期住院患者，在校园的一独栋大楼里有一个“降压”的重症监护计划。医院完全开放，没有特权制度，没有隔离室，也没有任何限制。尽管许多患者都有严重的问题，他们依旧可以自由出入。该中心有一个治疗社区，邀请患者负责自己的生活，为医院的运作做出贡献。埃里克·埃里克森的妻子琼发起了一个独特的活动项目，患者暂时离开了患者的角色，作为学生与手工艺者和艺术家一起工作。强化心理治疗是有组织和监督的，有明确的精神分析重点和传统的边界。

   The major problem was in the organizational structure, which was inflexible and outdated. Without a shared picture of the institution and its task, each department constituted its own world; the organizational atmosphere was filled with competition and rivalry. Information was a means of gaining power and control.

   主要问题在于组织结构，这种结构既不灵活又过时。如果没有对机构及其任务的共同了解，每个部门都构成了自己的世界；组织气氛充满了竞争。信息是获得权力和控制的一种手段。

   One staff member said, “It felt like we were in the same boat, but each rowing in different directions.”

   一名工作人员说：“感觉我们在同一条船上，但每个人都朝着不同的方向划船。”

   As I came on board, staff immediately turned to me for decisions for which I had little or no information. They asked me to approve funding for various projects, but they had no data about comparative budgetary needs, priorities, or benefits to the institution. Delegation of authority and flattening out the hierarchy seemed essential if anything was to get done. I invited staff members to learn about the rest of the institution and take authority for decisions in their areas from housekeeping to clinical care. We began the process of negotiating what I needed from them and learning what they needed from me. This proved to be a slow process. Staff did not know me and weren’t sure they wanted to take up any authority. Meanwhile, though staff took authority as individuals for the clinical work, their links to a shared authority and distributed leadership were difficult for me to discern. I had to be consulted on everything.

   当我上船时，工作人员立即向我寻求我几乎没有或根本没有信息的决定。他们要求我批准为各种项目提供资金，但他们没有关于比较预算需求、优先事项或对该机构的好处的数据。如果要做任何事情，授权和扁平化等级制度似乎是必不可少的。我邀请工作人员了解该机构的其他部门，并授予他们进行从家政到临床护理的决策权。我们开始谈判我需要从他们那里得到什么，并从我那里了解他们需要什么。事实证明，这是一个缓慢的过程。工作人员不认识我，也不确定他们是否想获得任何权力。与此同时，尽管工作人员在临床工作中作为个人行使权力，但我很难辨别他们与共同权力和分散领导的联系。每件事都得征求我的意见。

  I broadened the executive committee and encouraged its members to notice my ignorance and interpret blind spots both in my understanding of the institution and in my style of working. I told the executive staff that I would speak to them about areas they might not notice and hoped they would work with me in a similar way. My invitation seemed unsettling. When several dared to confront me and l was able to learn publicly from their observations, staff members began to take up their own authority. They began to see that I believed that leadership belonged to the system (Principle 5). I articulated my view that the person who most clearly could discover and articulate the task in any particular situation became the leader. This was an unusual authorization and was felt deeply by staff members.

   我扩大了执行委员会的范围，并鼓励其成员注意到我的无知，解释我对该机构的理解和工作中的盲点。我告诉行政人员，我将与他们谈论他们可能没有注意到的领域，并希望他们能以类似的方式与我一起工作。我的邀请似乎让人不安。当有几个人敢于与我对质，而我能够从他们的观察中公开学习时，员工们开始掌握自己的权威。他们开始意识到，我认为领导权属于这个系统（原则5）。我阐述了我的观点，即在任何特定情况下，最清楚地发现并阐明任务的人成为领导者。这是一项不同寻常的授权，工作人员对此深有同感。

   One noted, “Few executive gestures cost so little and have such immense impact as recognizing task leadership in employees.”

   其中一位指出，“很少有行政人员的姿态能像认可员工的任务领导力那样，成本如此之低，却有如此巨大的影响。”

   It was difficult to grasp the way the clinical operation worked. The only role that seemed valued was that of individual psychotherapy. One full-time and one part-time social worker responded to social work needs for all the patients, and nurses ran a separate culture in the patient building. Aside from the administrator, a few business office personnel, and various credentialing committees, there was little formal administration. Dependency filtered down to the staff level with members complaining to me about issues but assuming no responsibility for addressing them directly. Staff would complain about a co-worker, but when I took disciplinary action, they would rally to the staff member’s side in sympathy.

   很难理解临床工作的运作方式。唯一被重视的作用似乎是个体心理治疗。唯一似乎受到重视的角色是个人心理治疗。一名全职和一名兼职的社会工作者对所有病人的社会工作需求作出回应，护士在患者楼里经营一种独立的文化。除了行政人员、一些业务办公室人员和各种资格认证委员会，几乎没有正式的管理。依赖关系渗透到员工层面，员工向我抱怨问题，但不承担直接解决这些问题的责任。工作人员会抱怨某个同事，但当我采取纪律处分时，他们会站在工作人员一边表示同情。

   The result was a diffuse blurring of roles between nursing and therapists, and within each discipline. Homogenization of staff avoided feelings of competition and inequality and resulted in dilution of role authority. Staff could not be assigned responsibilities based on differentiated abilities and training, so delegation was limited. Staff in leadership roles tended to “do it all” themselves, both because delegation was not accepted practice, and because doing it all gave the illusion of being indispensable. This process contributed to stagnation in professional growth, fragmentation in operations, and a crippling of role authority. For example, department managers were not authorized to develop their own budgets. Instead the administrator would present each budget based on historical data, “with a little added for inflation.” Consequently, managers felt neither in charge nor invested in finding ways of saving money. The problem was in managing a shift from dependency in a hierarchical power structure to interdependency and team functioning in a system with a shared mission.

   结果是护理和治疗师之间以及每个学科中的角色都变得模糊不清。工作人员的同质化避免了竞争和不平等的感觉，并导致角色权威的淡化。不能根据不同的能力和培训来分配工作人员的责任，因此授权是有限的。担任领导职务的工作人员往往自己“一手包办”，这既是因为授权不被接受，也是因为一手包揽给人一种不可或缺的错觉。这一过程导致了专业发展的停滞、业务的分散以及角色权威的削弱。例如，部门经理无权制定自己的预算。相反，管理者会根据历史数据提交每一份预算，“再加上一点通货膨胀”。因此，管理者既不负责，也没有投入精力去寻找省钱的方法。问题在于管理从等级权力结构中的依赖性向具有共同使命的系统中的相互依赖性和团队运作的转变。

   To this end, I delegated to senior staff members unfamiliar directorial responsibilities: clinical care, education, the community program. I authorized the director of admissions to manage the external boundary around managed care and the changing healthcare world and asked him to take charge of program development. I hired human resources and marketing directors. I sent administrative staff to group relations conferences. As staff members took up these new roles, they began to negotiate with each other, feel the shape of the institution, and see the needs of the staff below them. Grasping a changing administrative structure was a developmental move for many. They gradually recognized that good administration was a way to provide for the next generation. They discovered the generativity in creating the conditions for good clinical work and managing an open boundary to society, all while becoming excited about the larger mission.

   为此，我将临床护理、教育、社区项目等不熟悉的指导责任委托给了高级工作人员。我授权招生主任管理围绕管理性护理和不断变化的医疗保健世界的外部边界，并请他负责项目开发。我聘请了人力资源和营销总监。我派行政人员参加团体关系会议。当工作人员担任这些新角色时，他们开始相互协商，感受机构的形态，并看到下面工作人员的需求。掌握不断变化的行政结构对许多人来说是一项发展的过程。他们逐渐认识到，良好的管理是为下一代提供服务的一种方式。他们发现，在为良好的临床工作创造条件和管理对社会开放边界的同时，对更大的使命感到兴奋，这就是生成性。

   From my perspective, I needed colleagues to help manage a complex system. Once they joined, we could begin to discern the ways the institution was working together and examine the place that Riggs occupied in the larger society. Riggs’ historical focus on individual psychotherapy and the professional power of medicine in a hierarchical organization had contributed to subduing the voices of other disciplines. Recognizing the importance of expanding an interpretive culture, we began an effort to strengthen these voices. Riggs had run on a model of large-group process for years. It had a morning conference, where all the clinicians and nurses came to review all the patients every day. People would say, “Morning conference decided this,” and I would never know what they were talking about. The group seemed to organize itself through projections into the large group, where the voices of senior psychotherapists held all the power. Given that most patients had stayed at the center for two to five years, there was a shared sense of the collective, but I was stunned by the degree of irrationality that was contained (and promulgated) by the large-group process.

   从我的角度来看，我需要同事来帮助管理一个复杂的系统。一旦他们加入，我们就可以开始了解该机构的合作方式，并检查里格斯在更大的社会中所占据的地位。里格斯对个体心理治疗的历史关注，以及医学在等级组织中的专业权力，促成了对其他学科声音的压制。认识到扩大解释文化的重要性，我们开始努力加强这些声音。里格斯多年来一直采用大群体进程的模式。它有一个晨会，所有的临床医生和护士每天都来检查所有的病人。人们会说，“上午的会议决定了这个”，而我却不知道他们在说什么。这个小组似乎是通过投射到大组中来组织自己，在那里，高级心理治疗师的声音占据了所有的权力。考虑到大多数患者已经在中心呆了两到五年，人们对集体有着共同的感觉，但我对大团体过程所包含（和公布）的不合理程度感到震惊。

   The large group seemed to me to interfere with the delegation of authority and responsibility, so I attempted to shift the work into smaller groups. Against much resistance, we gradually developed small interdisciplinary teams to oversee the treatments of assigned patients. This marked a significant change in the direction of interdependency. Staff worried that this new structure would eliminate the “sense of the whole” and interrupt the dependent connections held by the large group. To their surprise, however, staff found the change exciting. It was new to hear the voices of other disciplines discuss details of their work with patients. Patients began to be invited to team discussions so that they could join in thinking about their own treatment. Team leaders developed new administrative and leadership skills. The dynamics of the organization shifted from large-to small-group process: more coherent, differentiated, and graspable from the perspective of different roles.

   在我看来，大团体似乎干涉了权力和责任的分配，所以我试图将工作转移到小团体中。克服重重阻力，我们逐渐发展了小型跨学科团队来监督指定患者的治疗。这标志着相互依赖的方向发生了重大变化。工作人员担心，这种新结构会消除“整体感”，并中断大团队所拥有的相互依赖的联系。然而，令他们惊讶的是，工作人员发现这种变化令人兴奋。听到其他学科的声音与患者讨论他们的工作细节，这是一件新鲜事。患者开始被邀请参加团队讨论，这样他们就可以加入到对自己治疗的思考中。团队领导者培养了新的管理和领导技能。组织的动态从大团体过程转变为小团体过程：从不同角色的角度来看，更具连贯性、差异性和可把握性。

Defining unique institutional values (Principle 6)

确定独特的制度价值观（原则6）

   In 1993, in response to a shift in the accreditation agency, we re-articulated an aspect of the mission, focusing on the set of values that defined the institution (E. R. Shapiro, 2001c). This was an example of an external pressure that improved organizational functioning. Values are nodal points for staff and patient commitment and passion; articulating them allowed people more clearly to discover their connections to the mission. We underlined the importance of human relationships, the dignity and responsibility of the individual, and respect for individual differences. Our therapeutic community involves what Riggs calls “examined living,” pointing to the inevitable tension between individual choice and community need. Patients at Riggs take up differentiated roles as patient, student, and citizen and we underlined the importance of preserving those role distinctions in our effort to support the patient’s authority for the treatment. The community agreed that without any of these values the Austen Riggs Center would not be recognizable. Defining our mission and articulating these values helped to clarify our connection to society, making more evident the possibility for both staff and patients to have a public voice.

   1993年，为了应对认证机构的转变，我们重新阐述了使命的一个方面，重点关注定义该机构的一系列价值观（E.R.Shapiro，2001c）。这是外部压力改善组织运作的一个例子。价值观是员工和患者承诺和激情的节点；阐明它们可以让人们更清楚地发现他们与使命的联系。我们强调了人际关系、个人尊严和责任，以及尊重个体差异的重要性。我们的治疗社区涉及里格斯所说的“审视生活”，指出个人选择和社区需求之间不可避免的紧张关系。里格斯的病人扮演者不同的角色，分别是患者、学生和公民，我们强调了在努力支持患者的治疗权威时保留这些角色差异的重要性。社区一致认为，如果没有这些价值观，奥斯汀·里格斯中心将无法被认可。明确我们的使命并阐明这些价值观有助于澄清我们与社会的联系，使工作人员和患者都有机会在公众面前发声。

   At the beginning of 1993, President Clinton gave a speech to Congress about his plans to transform the healthcare system by providing care for all citizens. Within thirty days the number of admissions in East Coast psychiatric hospitals dropped dramatically. Private practitioners, fearful of government intrusion, held onto their patients because they were afraid referrals would stop. With a dropping census, Riggs began to lose $100,000 a month. It became clear that attention to the internal world of the institution was not enough; we had to face our surrounding context.

   1993年初，克林顿总统在国会发表演讲，讲述他为所有公民提供医疗保健的改革计划。在30天内，东海岸精神病医院的入院人数急剧下降。私人医生害怕政府的干预，因为担心转诊会停止，所以留住了他们的病人。随着人口普查的减少，里格斯开始每月损失10万美元。很明显，对该机构内部世界的关注是不够的；我们必须面对周围的环境。

   We developed a small staff group that reassessed every job in the institution. We looked at what we absolutely needed to preserve the mission. The results led to a dramatic and painful downsizing, losing almost a third of the staff. This event was staggering for an institution where long-term staff had committed their lives and careers to a previously reliable culture. Though most of the departing staff members were able to find other positions, many remained in the small town of Stockbridge, where they passed their former colleagues daily on the street. The pain of this decision affected us all.

   我们成立了一个小型员工小组，重新评估机构的每一项工作。我们研究了维护使命所绝对需要的东西。结果导致了一场戏剧性而痛苦的裁员，几乎失去了三分之一的员工。对于一个长期工作人员将自己的生命和事业奉献给以前可靠的文化的机构来说，这一事件令人震惊。尽管大多数离职的员工都能找到其他工作，但许多人仍留在斯托克布里奇小镇，他们每天在街上与前同事擦肩而过。这个决定带来的痛苦影响了我们所有人。

   The process deepened our interdependency with each other and the patients. We placed more weight on the therapeutic community and on the patients’ capacities to manage themselves. Expanding patient independence allowed us to learn more about the ways our patients resisted self-authorization because of unconscious delegations from their families and society that were meant to be held, locked away, and not interpreted. Patients taught us how they had become “good citizens” of their families and social groups, by identifying with unspoken directives about the roles they were to assume. Unconscious compliance with these delegations interfered with their capacity to discover their own authority. Our invitation for patients to become citizens in the Riggs community of examined living allowed many of these formerly unconscious family delegations to become visible (sometimes through their enactments with others). Beginning to recognize these irrational roles provided patients with perspective and theopportunity to feel more in charge of their participation (see Chapter Ten).

   这个过程加深了我们彼此和患者之间的相互依赖。我们更加重视治疗团体和患者的自我管理能力。扩大患者的独立性使我们能够更多地了解我们的患者是如何抵制自我授权的，因为他们的家人和社会无意识地委托他们，而这些委托本应被扣留、锁起来，不被解释。患者告诉我们，他们是如何通过认同关于他们应该承担的角色的潜指令，成为家庭和社会群体的“好公民”的。无意识的服从这些委托，妨碍了他们发现自己权威的能力。我们邀请患者成为里格斯检查生活社区的公民，使许多以前无意识的家庭代表团变得可见（有时是通过他们与他人的行为）。开始认识到这些不合理的角色为患者提供了视角和机会，让他们觉得自己对自己的参与更加负责（见第十章）。

   We believed that the managed-care perspective was shortsighted; mental illness is not a short-term problem and we felt that the pressure for short-term solutions would not last. We recommitted ourselves to our mission and to intensive, four-times-a-week, psychodynamic psychotherapy in a treatment community that offered the longest opportunity to learn from this work, but we decided that the survival of our mission required taking seriously what the world was saying to us (Principle 7). We began to include families in patient care and expanded the social work department. And since we were listening to how the healthcare world was right about there being limited resources for treatment, I organized a Resource Management Committee to bring together business people and clinicians to examine the management of limited

resources and their clinical meaning.

   我们认为管理式医疗的观点是短视的；精神疾病不是一个短期问题，我们觉得短期解决方案的压力不会持续下去。我们重新致力于我们的使命，并在一个治疗社区中进行强化的、每周四次的精神动力心理治疗，这为我们提供从这项工作中学习的最长机会，但我们认为，我们的使命的生存需要认真对待世界对我们说的话（原则7）。我们开始将家庭纳入患者护理，并扩大了社会工作部门。由于我们听到了医疗界对治疗资源有限的看法，我就组织了一个资源管理委员会，将商界人士和临床医生聚集在一起，研究如何管理有限的资源及其临床意义。

   This in turn prompted us to learn more about our own institution. As the Resource

Management Committee began addressing the limited resources, they ran into irrational responses from patients, families, and staff. Denial of limitations, rage about deprivation, and projection of responsibility were common on all sides. The presence of clinical people in these discussions required negotiating a shared language. We discovered that “limited resources” was both a reality and a metaphor. The reality required management. The metaphor, applied to financial, emotional, and family resources, required discovery and interpretation for each case.

   这反过来促使我们更多地了解我们自己的机构。当资源管理委员会开始处理资源有限的问题时，他们遇到了患者、家属和工作人员的不合理反应。否认资源的有限性、对剥夺的愤怒和对责任的投射在各方都很普遍。要让临床医生参与这些讨论，就需要协商出一种共同的语言。我们发现“有限的资源”既是一种现实，也是一种隐喻。现实需要管理。这个比喻适用于经济、情感和家庭资源，需要对每个案例进行发现和解释。

   Staff and patients felt enraged about limitations but focused their rage on managed- care companies rather than integrating that feeling into the treatment. The Resource Management Committee pulled together these pieces and began to work with patients and families both to manage resources and to discover the appropriate metaphor within each treatment. These metaphors were much like a shared context. Connections initially denied through the operation of polarities could—through a linking metaphor —be named and owned. For example, an adopted male patient’s struggle with limited financial resources could be linked to his unconscious sense that his father had died too soon, depriving him of the necessary resources to become a man. Interpreting this connection helped transform paranoid and unworkable anger into more manageable grief. This was an example of our interpretive stance, interpreting experience in role (both staff and patient roles) and relating it to a shared task (treatment).

   工作人员和患者对这些限制感到愤怒，但他们将愤怒集中在管理护理的公司身上，而不是将这种情绪融入到治疗中。资源管理委员会将这些部分整合在一起，开始与患者和家属合作，管理资源，并在每种治疗中发现适当的隐喻。这些隐喻很像是一个共享的环境。最初通过极性操作而被否认的联系可以通过一个链接隐喻来命名和拥有。例如，一名被收养的男性患者与有限的经济资源作斗争，可能与他无意识地认为父亲去世得太早，剥夺了他成为一个男人所必需的资源有关。解释这种联系有助于将偏执和不可行的愤怒转化为更易控制的悲伤。这是我们解释立场的一个例子，解释角色（工作人员和患者角色）中的经验，并将其与共同的任务（治疗）联系起来。

  This new language both energized the institution and transformed it. Staff began to help patients take charge of their limits and to understand the meaning of their reactions within their psychotherapy. The negotiation between business and clinical staff sensitized both groups to each other’s world. With the patients’ consultation, we developed a range of treatment settings at reduced cost which looked to managed care like six different programs: inpatient, residential, day treatment, aftercare, a halfway house, a residential apartment. Since Riggs was small enough for the same therapist and interdisciplinary team to follow the patient all the way through the spectrum, to those of us inside Riggs it felt like one program. Given this development, we renegotiated our external boundary so that we could both maintain our mission and allow patients, families, and managed-care companies to save money. The concept made patients’ living situations more flexible and reduced ancillary staff. The new program definitions and boundaries were largely in the minds of patients and staff since two of these programs and the Community Center were in the same building. The collective work was to define a set of boundaries that would allow patients and families to assess—with our help—what length of treatment they needed, what behaviors they could manage, and what additional staff resources cost. With this information, they could select services so as to extend the length of their psychotherapy and manage the total cost of their treatment.

   这种新的语言既激励了这个机构，也改变了它。工作人员开始帮助患者掌握自己的极限，并在心理治疗中理解自己反应的意义。业务和临床工作人员之间的谈判使两组人都对彼此的世界敏感起来。通过患者的咨询，我们以较低的成本开发了一系列治疗方案，这些方案看起来像六个不同的管理式医疗方案：入院、住院、日间治疗、康复、中途之家、住宅公寓。由于里格斯足够小，同一位治疗师和跨学科团队可以全程跟踪患者，对我们里格斯内部的人来说，这就像是一个项目。考虑到这一发展，我们重新协商了我们的外部边界，以便我们既能维持我们的使命，又能让患者、家属和管理式医疗公司节省资金。这一概念使患者的生活环境更加灵活，并减少了辅助人员。由于其中两个项目和社区中心在同一栋大楼里，新的项目定义和边界在很大程度上影响了患者和工作人员。集体的工作是定义一组界限，让患者和家属在我们的帮助下评估他们需要多长时间的治疗，他们可以管理什么行为，以及额外的人力资源成本。有了这些信息，他们就可以选择服务，从而延长心理治疗的时间，并管理治疗的总成本。