"MANAGING BOUNDARIES IN ORGANISATIONS"

by

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CHAPTER 7

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Introduction

The notion of boundaries is a key concept in the psychology of individuals, families and groups. In the organizational literature, boundaries are discussed more implicitly. For example, boundary spanners and boundary spanning activities are discussed and the importance of effectively managing boundaries is mentioned (Aldrich & Herker, 1977; Adams, 1976). How boundaries are managed and how that relates to the levels of differentiation and integration necessary for effective functioning within organizations, however, have not been addressed sufficiently.

Boundaries separate a system from its environment and delineate the parts and processes within that system. Boundaries also determine relatedness and relationships within and between systems. Thus boundaries need to be defined yet flexible. As systems develop, they become increasingly differentiated, requiring greater integration for internal coherence and coordination and external responsivenss (Lawrence & Lorsch, 1967; Katz & Kahn, 1978; Galbraith, 1974). This paper explores how boundaries are managed, i.e. established and negotiated, at multiple levels of analysis. Several common themes emerge. The case of a partial hospital program will then be discussed to illustrate the application of these themes. Finally, implications will be drawn regarding organizational analysis and intervention.

Levels of Analysis

Individual Level

Establishing and negotiating boundaries occurs both at the intrapersonal (intrapsychic) and interpersonal levels. At the intrapsychic level, boundary management reflects the process whereby the psyche becomes better differentiated and integrated. In Freud's (1932) tripartite system of id, ego, and superego, boundaries evolve to a point at which ego functioning achieves autonomy from id and superego demands. "Where id was ego shall be" means that the ego shall control rather than be controlled by the id. This strengthens the boundary between fantasy and reality such that perceptions are less distorted by desires or wishful thinking (id derived) (Hartmann, 1950). The differentiation of ego and superego reduces the inhibition and restriction of ego functioning (Freud, 1932). The increased ego autonomy, in turn, strengthens the boundary between the individual and the external world (Shapiro & Zinner, 1979). Yet, in mediating between the id, the superego and the environment as well, the ego negotiates these boundaries to achieve integration.

The process of establishing and negotiating interpersonal boundaries has also been described (Mahler, Pine & Bergmann, 1975). Infants initially are unable to differentiate self from other. In this stage of autism, there is no awareness of other or self. A gradual awareness of self emerges but not as separate from other (symbiosis). At eighteen months the process of separating and individuating begins, which establishes a sense of self as separate from mother. This stage, rapprochment (often referred to as the "terrible two's"), is marked by the child's incredible bossiness and willfulness. The ability to say "no", and efforts to control self and exert control over others, are crucial for developing a separate and autonomous self, i.e. establishing boundaries. Yet these boundaries must be negotiated to meet the child's need for relatedness.

Subsequent stages of development - mastery of the environment, establishing identity, and developing intimacy - are dependent on the successful resolution of these early stages (Mahler et al., 1975; Erikson, 1950; Freud, 1932). For example, identity requires establishing boundaries that delineate self from external other as well as differentiating internalized objects and self representations (Klein, 1932). Yet integration is necessary to create a coherent identity. Intimacy is possible only when the boundaries are secure enough to allow closeness. Otherwise intimacy raises fears of loss of self and engulfment by the other. Psychological health requires establishing boundaries, while maintaining the necessary relatedness. These boundary issues are revived and become increasingly salient when individuals negotiate their roles in families, groups and organizations.

Family Level

In family systems, managing the boundaries between members is an important process. Role and generational boundaries need to be established. Family dysfunction often reflects difficulties in establishing boundaries as they are either overly diffuse at one extreme or overly rigid at the other. Problems negotiating boundaries result in a failure of mutuality (relatedness) (Minuchin, 1974; Bowen, 1976). Pseudomutuality refers to a condition in which families appear to be well-integrated or well-related but, in fact, lack sufficient differentiation as the boundaries within the family are blurred (Wynne, Ryckof, Day & Hirsch, 1958). In these families, individual and generational boundaries are poorly defined and the roles and functions are confused (who's mothering or parenting whom?).

For example, the identified patient, who through symptom formation requires being taken care of, is actually taking care of the system by preserving its interdependence (Bateson, 1972; Haley, 1977). The family is brought together to address what to do about the patient, thereby forcing relatedness. An under-functioning family member establishes a role boundary to complement the role boundary established by an over-functioning member thereby negotiating the type of

relatedness needed to keep the family together. Furthermore, family fighting is often seen as a symptom which redefines the boundary when individual autonomy is threatened. However, fighting may also be seen as a substitute for intimacy since it maintains relatedness. The task of treatment is viewed as redrawing the generational and role boundaries; for example, father and mother are united in parenting the child. Family therapy assists in negotiating boundaries and allowing for individual identity and autonomy while preserving the family system's relatedness.

Hirschhorn & Gilmore (1980) suggest that family therapy models may be useful in intervention in organizations, particularly as they stress the need to clarify boundaries (differentiate) and to increase relevant communication (improve integration). They warn, however, that boundaries in organizations are far more complex than in families. There is greater differentiation, for example, greater role complexity in organizations and integration is not as easily threatened by the loss of one individual. However, dynamics at the family level are often played out at the work group level as family roles are replayed and conflicts (e.g. with authority) are reexperienced (Levinson, 1976).

Thus, at the family level, boundaries are managed so that both individual identity and family relatedness are maintained while the boundary around the family is reinforced. The way in which these boundaries are managed influences the roles that family members establish in the outside world.

Group Level

Boundaries in groups need to be managed for the individual vis a vis the group and for the group vis a vis other groups. The development and ongoing dynamics of groups reveal how boundaries are established and negotiated (Tuckman, 1965; Bion, 1961; Miller & Rice, 1967; Slater, 1966). In the early stages of group development, individual boundary and control issues become most salient. Dependency needs are revived as the group serves some function (their reason for joining) for the individual. Group membership requires negotiating

individual boundaries, seeing oneself as part of a group and accepting being controlled by the group norms. At this point, members often reassert individual boundaries and reassert autonomy by testing the group's rules or norms. Leadership is often challenged and power struggles are frequent until a new balance of power is established. As group cohesiveness evolves, the boundaries between members are lessened and the boundary between group and other groups gets better defined.

Group boundaries are established and continuously negotiated when new members join and when old members leave. These events are often marked by induction ceremonies (such as hazing) and retirement rituals (Trice & Beyer, 1984). Boundaries are also strengthened and internal integration facilitated by identifying internal scapegoats or external enemies (Janis, 1972). Conflicts between groups often reflect efforts to reassert group boundaries while enhancing internal integration. Renegotiating roles within or between groups is required, however, to clarify the necessary differentiation while strengthening integration.

At the group level, another boundary exists between fantasy and reality. Groups often operate according to basic assumptions (fantasies) regarding the purpose of the group that may not pertain to task performance (Bion, 1961). These shared fantasies of being taken care of (dependency), of persecution (fight/flight), or of salvation (pairing) reduce the boundary between the individual and the group. Group boundaries are strengthened by creating an all-powerful leader who everyone will follow, an enemy who everyone will fight or a messiah for whom everyone will wait. To the extent to which these fantasies interfere with task performance, the boundary between reality and fantasy needs to be strengthened. Sometimes these fantasies facilitate task performance, for example, when unquestioning loyalty to the leader is required.

The basic assumption operating may also relate to the stage of group development and reflect the boundary and control issues relevant to that stage. Early in development, as dependency needs are revived, the fantasy of being taken care of may be more salient. This allows the group to coalesce around a strong leader

blurring individual boundaries. Later on, between-group boundaries may be reinforced by persecution fantasies which coalesce the group by identifying an enemy. Concerns with task performance may elicit "pairing" fantasies in that the coming together of group members will magically (without effort) produce what is hoped for.

Organization Level

The boundary issues present at the group level exist between groups within organizations and between the organization and its environment (Miller & Rice, 1976). Organizations can establish their boundaries by buffering or isolating their operations (Thompson, 1967); by creating "niches" in developing distinctive competence (Kotter, 1977); and by controlling the flow of inputs and outputs (Katz & Kahn, 1978). How the boundary between organizations and their environments is negotiated relates to the extent to which organizations are controlled by or control their environments (Aldrich & Pfeffer, 1976; Pfeffer & Salancik, 1978; Child, 1972). This determines the degree to which organizations respond proactively or reactively to environmental change (Miles & Snow, 1978), or in fact choose the aspects of that environment to which to respond (Weick, 1979). Public sector organizations and professional bureaucracies, such as hospitals and universities, are often unable to define and negotiate external boundaries as environmental stakeholders (e.g.regulatory agencies) may dictate goals, methods, or strategies.

Strategies for managing the boundaries within the organization and between the organization and its environment may differ in terms of increasing differentiation or enhancing integration. Often innovations or new ventures within the organization need to be isolated, allowed to develop apart, better differentiated, before integration (Zaltman, Duncan & Holbek, 1973). The IBM personal computer had to be developed in this manner, "protected" from the bureaucratic system that would strangle it. Other strategies reflect efforts at increasing integration such as coopting, building coalitions, developing networks, and take-over (Kotter, 1977).

These strategies emphasize relatedness by demonstrating the need for interdependence.

Problems within the organization may reflect excessive or insufficient boundaries. Insufficient boundaries create symptoms of overlap and redundancy. Tasks, roles or functions are duplicated creating wasted resources. On the other hand, boundaries may be overly defined or rigid so that tasks are not performed, e.g. "it's not my job" syndrome. Excessive differentiation or boundary formation can result in fragmentation. Attempts to create interdisciplinary study groups, task forces, or projects are often thwarted as maintaining the professional group boundary is seen as more important than the task.

During reorganizations, boundaries are redrawn and redefined. The individual and group dynamics previously described combine with the organizational context to determine how boundaries are established. The individual's personal boundaries are negotiated with others, within groups and through the organizational structure in terms of roles and hierarchical position. The renegotiation of boundaries is often marked by a scramble for power and by pervasive anxiety among the individuals and throughout the groups affected. The resolution of boundaries rests on the required interdependence or the amount of interaction. But the resolution is dynamic in that it is continuously changing. The role of leadership is to manage the boundary between what is inside and what is outside in order to preserve the integrity and the internal coherence of the system (Shapiro & Zinner, 1979).

From the discussion above, we can see the process of managing (establishing and negotiating) boundaries across levels of analysis. Several common themes emerge: first, boundary management at each level is apparent and important; secondly, boundary management determines the levels of differentiation and integration within and between systems; third, boundary management is a dynamic process which changes over the stages of development; and, finally, boundary management is closely related to issues of autonomy and control. In what follows, the case of the design and implementation of a partial hospital program is described

and discussed to demonstrate how boundaries were managed and the implications for the program's effectiveness.

The Partial Hospital Program: A Case Example

In 1980 I was hired to design and implement a partial hospital program (PHP). The purpose of this program was to provide mental health care to patients at risk of hospitalization and to patients reentering the community following hospitalization. Programs of this nature were developed as part of the deinstitutionalization effort to decentralize the delivery of mental health care services from the state to the community level. The PHP was a service required by federal mandate as part of a community mental health center (CMHC). The CMHC in turn reported to the department of psychiatry of the municipal hospital wherein it was housed. As shown in figure 1, the reporting lines were further complicated given the multiple stakeholders - federal, state, municipal and private agencies - upon which the CMHC was dependent for resources. My task was to create a program that would address the needs of the patient group targetted (primarily chronic psychiatric patients) and to manage the relationships with the numerous stakeholders.

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Chronic psychiatric patients suffer primarily from schizophrenic or affective disorders as well as the effects of long-term institutionalization, e.g. learning to be patients (Goffman, 1961). The deinstitutionalization effort meant not only moving the locus of care to the community level but also unlearning the role of patient and learning the role of community member (Schneider, 1984). Therefore, one of the goals of the program was to teach the skills, roles, and behaviors necessary to stay out of the hospital. Group and family therapy were the predominant treatment

modes as the primary task of treatment was to develop and strengthen both intrapsychic and interpersonal boundaries while managing dependency needs, exacerbated for some by the "custodial care" approach of the state hospitals. Activity therapy was critical to developing both social and daily living skills. Patients were assigned "primary therapists" who would coordinate treatment plans with the other staff. Patients were actively involved in developing their treatment plans as every effort was made to unlearn the role of patient as incompetent, helpless and passive.

The program staff consisted of a program coordinator (myself a clinical psychologist), a part time psychiatrist, a nurse, two social workers, occupational and recreational therapists, and therapy aides. With the exception of the psychiatrist, all performed as primary therapists (generalists) responsible for coordinating treatment plans of their assigned patients as well as providing specialized services to the unit (e.g. nursing, social work, etc.). Each staff member reported to their functional department. The staff were hired from within (the municipal hospital) as well as from the outside and selected based on their interest in a more generalist approach and a willingness to take on more program and patient responsibility. They were expected to participate in the program design, development of policies and procedures, in administrative functions and to pursue individual interests and ideas that related to group goals. It was felt that if the staff were involved in developing the program and themselves within the context of that program, then they would provide the model for the participation of the patients in program and personal development.

This participative approach was in keeping with the "grass roots" ideology of the CMHC but ran counter to the prevailing "medical" ideology of the municipal hospital (Schneider, 1987). As many had been recruited from the latter, this created an internal role conflict, e.g. how they were supposed to behave as social workers. Role generalization also meant that some less than appealing tasks were shared rather than dumped on the aides. Furthermore, the participative approch while

appealing in principle is difficult in practice as it means assuming responsibilities for which one may feel ill-prepared or ill-paid. Over time, as the program demands on staff's energy, creativity and resourcefulness were high, the dependency assumption became apparent. The greater autonomy and broader roles, created stress. increasing the desire to be taken care of by a strong leader, i.e. for the M.D. to make all the decisions and to take care of the staff. Thus passivity on the part of the staff also had to be counteracted as well as the tug of the departmental reporting lines. Staff meetings often involved reiterating roles and relationships in keeping with the overall purpose of the program in order to help the team differentiate as well as integrate.

Boundary problems between professional roles and tasks within the larger system created potential problems within the program. For example, an investigation was conducted regarding tensions between psychiatrists and psychologists which concluded that the psychologists were "overstepping their boundaries" and needed "to be brought in line". This rigidified the boundary between professional groups, impairing the needed integration, which posed a potential problem in the PHP. For example, in our first meeting, the psychiatrist assigned part-time to the unit demanded to know who was responsible for the program. Boundaries were drawn by stating that the program responsibility was mine (a pyschologist) while the patient responsibility belonged to him. The negotiation of this boundary was begun by stating that interdependence was desired. This boundary flexibility evolved over time as a function of the quality of interpersonal relatedness, i.e. with the experience of mutual respect for the other's expertise and autonomy. The psychiatrist, who had long tenure in the municipal hospital, did not react strongly to the pull of departmental reporting lines and in fact reacted strongly against them, perhaps part of his own personal boundaries issue. He was, however, consistently late in arriving for staff rounds wherein patients' treatment plans were discussed.

With other disciplines (nursing and social work), boundaries were not as well-negotiated. Here the pull of reporting lines to disciplines was stronger, particularly true for those assigned from within. For example, when I wanted to conduct a seminar for the staff (all disciplines) on family therapy, the social work staff protested that family therapy was their domain, not that of the other disciplines, and furthermore, the social work department ruled that they did not have to attend a seminar given by a non-social worker. The interpersonal boundaries here were more problematic, perhaps out of personal rivalries and jealousies. We were more similar in terms of being young and female, than was the case of the psychiatrist, an older male. The clearer age and gender boundaries may have facilitated role boundary differentiation.

Despite these struggles, a united front was presented outwardly. The innovativeness of the program fostered a "utopian" assumption - that the group together would create "an ideal" program (Miller, 1979). The "newness" furthered the sense of a "special" identity and group cohesiveness. These shared fantasies helped to establish the group's boundary in the initial phase of development. Furthermore, the program was housed in a building on the other side of campus from the CMHC and the department of psychiatry. What also helped was It took several weeks for the telephones to function. Few guidelines existed as to how the program should be developed. This provided autonomy and encouraged the development of a separate identity and group cohesiveness creating, however, a "we/they" attitude vis a vis the CMHC and the department of psychiatry. The fight/flight assumption served to resist appeals for better integration and reinforced the group's boundary.

However, this period of splendid isolation did not last forever. Eventually our presence began to be known. The inpatient programs moved in across the hall. At administrative meetings of the department of psychiatry which I was required to attend, I was repeatedly asked, "What's the difference between the partial hospital and the day hospital programs?" The day hospital was part of the municipal hospital

and was predominantly staffed by psychiatrists and psychologists. Psychiatric residents and medical students rotated through this service as well. This unit operated within a "medical model" ideology in that roles and tasks were specialized and decision making rather centralized, i.e. the doctors made the decisions. According to the PHP staff that had previously worked there, "They did therapy with a capital "T". Given the difference in staffing patterns - the day hospital being heavily M.D. and Ph.D. dominated - the boundaries were drawn according to the psychosocial and rehabilitative purpose of the partial hospital. Care was taken to emphasize the complementary nature of the program and thereby address concerns that there would be competition for patients. Thus the boundaries were drawn and the relationship negotiated so that the day hospital became a source of patient referrals to the PHP. The boundary flexibility was enhanced by the physical proximity of the day hospital and in-patient services which moved to the same building as the PHP. In many ways, the PHP was better linked to the Department of Psychiatry than to the CMHC. As the former had more power, establishing good relations and providing a necessary function could aid in long term viability.

The CMHC administration was also calling for more accountability and better linkages with their services. Linkages between the other CMHC services were weak and there were strong pressures for better integration. However, other CMHC services were under threat of merger or absorption by the municipal hospital as the continued existence of the CMHC was in question (due to funding uncertainties). Therefore, the preservation of a strong boundary between the PHP and CMHC may have been important to ensure its survival.

The department of psychiatry was hostile to (or at least not enthusiastic about) the existence of the CMHC, due in part to the excessive overlap of services which created competition. The emergency room, which was a shared service (blurred boundaries), however, required much negotiation regarding staffing, responsibility, and accountability. Part of the hostility was also created by ideological boundaries of a community oriented vs. medical model approach which was also in line with

that of the private/voluntary teaching hospital which was a major source of resources (money and residents). These ideological differences were, in part, the cause of the role boundary conflict mentioned earlier. These conflicts demonstrate that excessive differentiation and/or boundary rigidity can interfere with task performance such as patient care. Trying to establish a program based on a generalist model in a specialist context becomes difficult. Trying to create multidisciplinary teams, particularly when professional discipline boundaries have been long-standing and previously rigidified, is also problematic.

Finally, boundaries had to be established and negotiated with various stakeholders in the community, such as agencies that were responsible for funding and had to be satisfied with regard to their specific criteria. For example, for insurance companies, reimbursement for clinical visits meant medical (M.D.) consultation. Discussions with several local agencies that had similar, potentially competing programs helped to define the program boundaries in such a way as to complement other existing services and to fill identified gaps in the broader community network of mental health care service.

In summary, the program's boundaries were established by virtue of its mandate, its uniqueness in its therapeutic approach and non-professional staffing pattern, by its separate (at first) physical location, and its initial autonomy. Roles and tasks were negotiated and decision-making was participative. The group cohesiveness that developed within the PHP reinforced its boundaries. This helped the program to subsequently negotiate its boundaries within the organization and with the environment. By stressing how it differed from other services, this boundary was reinforced; by providing a needed function, integration was enhanced. The boundary between the PHP and the external environment was established by defining a "niche", by providing a necessary service, and by controlling the flow of customers (patients). Boundary negotiations involved developing a network of services which emphasized interdependence. In this way, boundary flexibility evolved instead of rigidity which would have been established

by "competing camps". This was done to encourage longer term viability derived from being a necessary piece of this network. In this manner external differentiation and integration were established. The program began six weeks after my arrival on a trial, part-time basis and was then fully implemented six weeks later. I left 15 months later to do postdoctoral work in organizational analysis. Five years later, the program was still running.

Discussion

Working with chronic psychiatric patients and within systems created for these patients highlights individual boundary issues. First of all, the treatment approach must explicitly address the patients' boundaries through individual, group, family and activity therapies. Chronic patients are primarily psychotic if not organically (sometimes due to the iatrogenic effects of long term psychotropic medication) and developmentally impaired as well. Often they have been cared for at home or in institutions where their dependency and helplessness are reinforced. Within their families, their illness may become an integrating force as it unites the family in "deciding (or arguing) what to do about him/her." Their illness also serves as a differentiating force in that roles are often defined by "who's crazy and who isn't". However, the role of "being crazy" often serves as a repository of the other family members' fears and anxieties. Family therapy with schizophrenics involves redefining the boundaries and finding other mechanisms for relating, for being interdependent, as discussed above. Group or "milieu" therapy approaches provide a more neutral, supportive environment in which the patients can develop ego functions, e.g. reality testing. Activity therapy further assists in the development of skills and therefore the "autonomous ego". Individual treatment most often involves supportive psychotherapy to help strengthen boundaries between fantasy and reality as well as to help reinforce the boundaries between self and other. Thus individual, group, family and activity therapy were all considered to be important and interlinked treatment modalities which became the rationale for services provided by the partial hospital.

Working with psychotic patients, however, creates strains on the individual boundaries of the staff members. Providing individual therapy normally requires establishing empathy, a regression in the service of the ego. The psychotic material brought to the sessions can stimulate associations on the part of the staff member and thereby threaten their own (more or less well-established) boundary between fantasy and reality. Furthermore, the intense dependency needs of these patients threatens the interpersonal boundaries of the staff member. Often "helping" professionals have chosen these careers in reaction to personal and family issues. For example, interests in psychotic processes may reflect concerns for their own "normalcy". In locked units, the symbolic value of the "key" should not be underestimated and is often jokingly referred to as that which distinguishes staff from patients. Addressing the extreme dependency needs of the chronic patients may represent a way of working through their own needs. Care-taking and being taken care of can be opposite sides of the same coin. Many have also served in the care-taking role or as the "overfunctioning member" in their families and seek careers that will continue this role.

Working within systems created to treat chronic psychotic patients can also threaten individual boundaries. Public hospitals are often bureaucratic, clearly differentiated and hierarchically organized along professional lines. "Doctors" are medically trained and responsible for patient care. Other disciplines, including "doctors" qua psychologists, generally have little decision making responsibility with regard to patients or programs and perform specialized tasks in keeping with their training. Professional boundaries are jealously guarded as the hierarchy determines who has status, if not power, over whom. The patient, of course, is at the bottom of the hierarchy and often has the least to say about the course of treatment. These systems create an overly centralized and specialized approach to providing health care services which can encourage a passive dependent reaction on the part of the staff, i.e. "It's not my job" or "Sorry I can't do anything about it, the Doctor says...". Bureaucracies can thus encourage and reinforce dependency

needs. Personal and professional conflicts often erupt due to the regressive tendencies stimulated by these systems and out of frustration with the limits imposed therein.

Conclusions and Implications

This paper has discussed issues of managing boundaries at several levels of analysis. The way in which boundaries are established and negotiated determines the appropriate levels of differentiation and integration assumed necessary for effective functioning. Common themes emerge regarding how differentiation and integration are achieved through boundary management and how establishing and negotiating boundaries evolves throughout development. The innovation of a partial hospital program was discussed to demonstrate how the manner in which the program's boundaries were established and negotiated affected its long term viability. What can be learned by drawing the parallels across levels of analysis? What are the implications for organization analysis and intervention? Several issues and some paradoxes emerge and need to be addressed.

1. Boundaries are necessary and need to be established and negotiated in order to assure appropriate levels of differentiation and integration. This is a critical task of development across levels. In organizations, the process of managing boundaries is most readily apparent and necessary during birth, innovation, creation of new departments and internally developed new businesses, mergers and acquistions, internal reorganization and under threat of forces in the external environment (e.g. government regulation, competition). More explicit attention needs to be paid to how this is done.

2. Boundaries cannot be managed without autonomy. A certain amount of autonomy is necessary to be able to separate and develop. This is the underlying rationale for "skunkworks" i.e. letting projects develop outside established organizational structures and policies. This has also been the criticism in the

management of mergers and acquisitions wherein organizations too quickly impose their policies on the newly acquired businesses. Therefore, how is the autonomy necessary for boundary setting achieved and preserved by these units?

To establish and negotiate boundaries requires and provides autonomy and control. The less autonomy, the more difficult it is to manage boundaries. Establishing boundaries results in greater control which in turn, reinforces boundaries. Therefore, what are the dynamics of boundaries and autonomy and control over time within an organization?

3. Stronger boundaries incur the risk of reduced integration, while strong pressures for integration threaten boundaries. When autonomy and control are threatened, boundaries are reinforced and rigidifed resulting in the loss of necessary interdependence. During periods of external threat, change or reorganizations, turf battles and fragmentation of effort may be evident. How can flexibility be maintained to assure the required integration particularly in situations of crisis and change?

4. A crucial dilemma faced by organizations is how to maximize a sense of identity and autonomy in individuals and groups, yet maintain the necessary interdependence and integration as well as efficiency. Participative management and power sharing ("empowerment") are well-preached but how possible? How is it possible to maximize autonomy and coordination simultaneously?

5. Interventions at other levels (such as individual, family and group therapy) suggest that the primary task of intervention at the organizational level should be to:

a) help differentiate: clarify boundaries through identifying and defining roles, structures, functions and units; determine "niche" or distinctive competence in relation with the larger system; develop understanding of where, when and how to separate or reduce interdependence and how to gain and preserve autonomy.

b) help integrate: clarify key linkages; determine necessary interdependencies; develop the understanding of the distribution of power within an organization;

promote the ability to negotiate boundaries in order to achieve required level of integration without loss of capability.

c) help design structures and processes that facilitate rather than interfere with the pursuit of organizational goals; enable interdisciplinary teams to perform required tasks without unnecessary adherence to ideology, or professional/functional loyalties.

To function effectively, organizations need appropriate levels of differentiation and integration. This requires establishing boundaries that are firm yet flexible and managing the above-mentioned paradoxes and dilemmas. Firm but flexible boundaries enable interpersonal intimacy, group cooperation, and organizational interdependence without fear of loss of identity and autonomy. An effective leader must define and redefine boundaries particularly in the face of undue external or internal pressures that can interfere with performing tasks and maintaining distinctive competence. This requires the autonomy necessary to preserve the systems integrity and internal coherence while achieving the integration necessary for the effective functioning of the larger system.

Boundary and control issues are becoming increasingly salient given the recent upsurge of activity involving hostile takeovers, acquisitions, mergers and joint ventures. Organizational integrity, identity and autonomy are being threatened. The notion of organizations as hierarchies is being challenged as the emphasis is being placed more and more on horizontal vs. vertical differentiation. Organizations are now viewed as networks, as linkages of points of distinctive competences or areas of specialized expertise on a global scale, which require greater and greater efforts at integration without losing differentiation (Ghoshal & Bartlett, 1990). Differences between internal and external stakeholders are becoming less clear, for example when customers become organizational members and vice versa.

Boundaries within and between organizations must be considered as subjective and not as objective (Fiol, 1990). As boundaries are perceived; they can not be taken as given. Therefore, in order to study boundaries within and between

organizations, an interpretive approach is required. Fiol (1989) using semiotic analysis of letters to shareholders has demonstrated that the strength of boundaries within the organization vs. between the organization and its environment as expressed in these letters related to the propensity to engage in joint venture activity. Fiol (1990) has also demonstrated that internal vs external boundaries are stressed at different stages of development in the case of TWA. According to her analysis of management newsletters, boundaries at the business unit level were first stressed, followed by external and then internal boundaries.

Walsh's (1990) discussion of cycles of internal vs. external control in the case of the hostile takeover of TWA airlines by Carl Icahn raises the question of how the boundaries between what is internal vs. what is external are established. This also raises an interesting question for research: In what ways do the cycles of internal and external control mechanisms relate to the focus on internal vs. external boundaries? To what extent is the vulnerability to external control a function of the nature of organizational boundaries? Investigating the relationship between organizational boundaries and control is an exciting area of future research at a time when the very nature of organization is being challenged.

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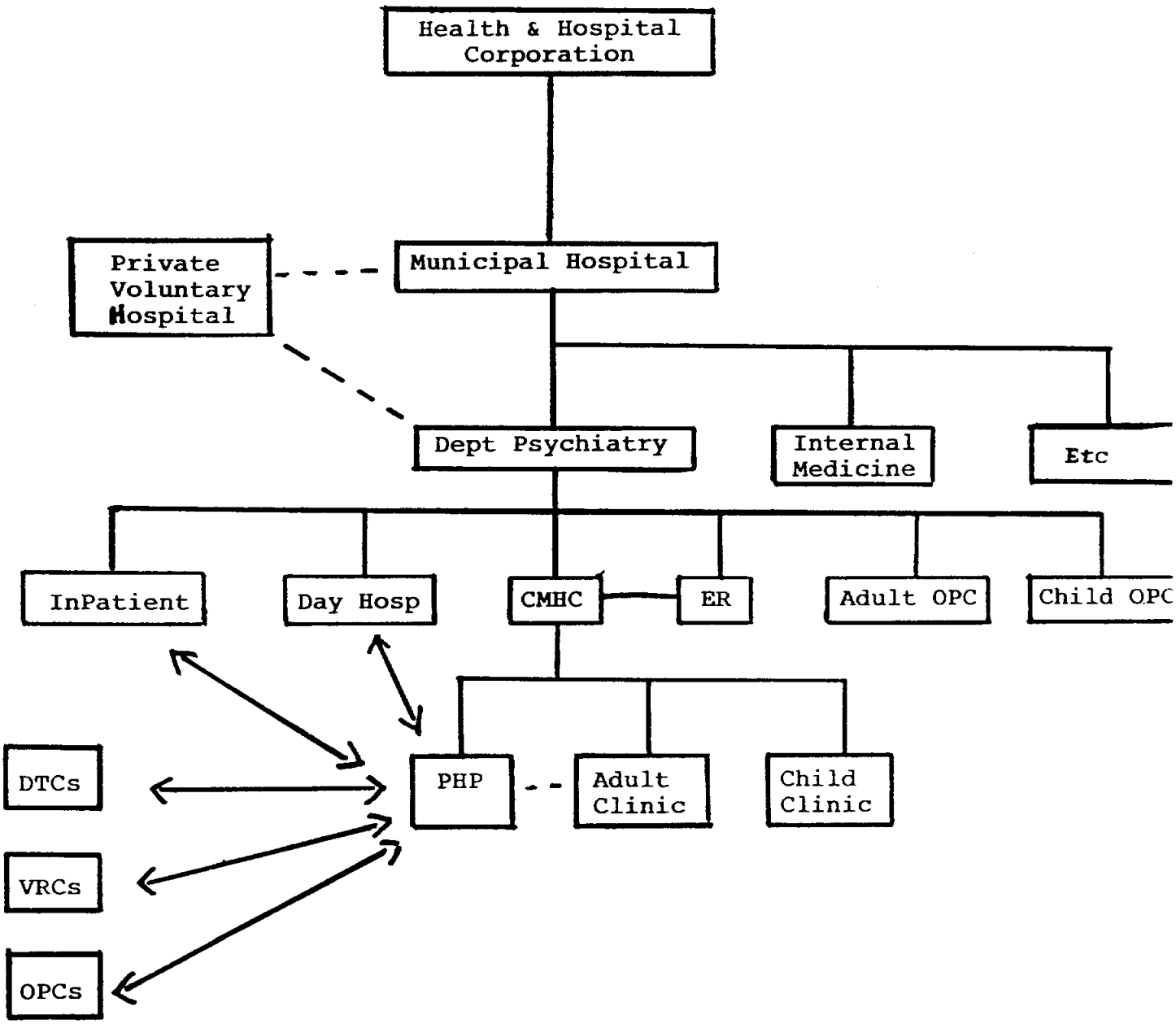

Figure 1

Partial Hospital Program Boundaries

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