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Social Systems as a Defense Against Anxiety

An Empirical Study of the Nursing Service of a
General Hospital*

Introduction

This study was initiated by the nursing service of a general teaching hospital in London which sought help in planning the training of student nurses of whom there were 500 in the hospital. Trained nursing staff numbered 150. The student nurses spent all but six months of their three years of undergraduate training working full-time in wards and departments as "staff" while learning and practicing nursing skills. They carried out most of the actual nursing. The task with which the nursing service was struggling was effectively to reconcile two needs: for wards and departments to have adequate numbers of appropriate student nurses as staff; for student nurses, as students, to have the practical experience required for their training. Senior nurses feared the system was at the point of breakdown with serious consequences for student nurse training since patient care naturally tended to take priority whenever there was conflict. The study was carried out within a sociotherapeutic relationship the outcome of which, it was hoped, would be institutional change. The early part was devoted to an exploration of the nature of the problem and its impact on the people involved. While doing this "diagnostic" exploration we became aware of the high level of tension, distress and anxiety in the nursing service. How could nurses tolerate so much anxiety? We found much evidence that they could not. Withdrawal from duty was common. One-third did not complete their training; the majority of these left at their own request. Senior staff changed their jobs appreciably more frequently than workers at similar levels in other professions. Sickness rates were high, especially for minor illnesses requiring only a few days' absence from duty.

*A shortened version of the original—*Human Relations*, 13:95–121, 1960.

The relief of this anxiety seemed to us an important therapeutic task in itself and, moreover, proved to have a close connection with the development of more effective techniques of student-nurse allocation. In this paper I attempt to elucidate the nature and effect of the anxiety level in the hospital.

Nature of the Anxiety

The primary task of a hospital is to care for ill people who cannot be cared for in their own homes. The major responsibility for this task lies with the nursing service, which provides continuous care, day and night, all year around. The nursing service bears the full, immediate and concentrated impact of stress arising from patient-care.

The situations likely to evoke stress in nurses are familiar. Nurses are in constant contact with people who are physically ill or injured, often seriously. The recovery of patients is not certain and may not be complete. Nursing patients with incurable diseases is one of the nurse's most distressing tasks. Nurses face the reality of suffering and death as few lay people do. Their work involves carrying out tasks which, by ordinary standards, are distasteful, disgusting and frightening. Intimate physical contact with patients arouses libidinal and erotic wishes that may be difficult to control. The work arouses strong and conflicting feelings: pity, compassion and love; guilt and anxiety; hatred and resentment of the patients who arouse these feelings; envy of the care they receive.

The objective situation confronting the nurse bears a striking resemblance to the phantasy* situations that exist in every individual in the deepest and most primitive levels of the mind. The intensity and complexity of the nurse's anxieties are to be attributed primarily to the peculiar capacity of the objective features of the work to stimulate afresh these early situations and their accompanying emotions.

The elements of these phantasies may be traced back to earliest infancy.† The infant experiences two opposing sets of feelings and impulses, libidinal and aggressive. These stem from instinctual sources and are described by the constructs of the life-instinct and the death-instinct. Feeling omnipotent and attributing dynamic reality to these feelings and impulses, the infant believes that the libidinal impulses are literally life-giving and the aggressive impulses death-dealing; similar feelings, impulses and powers are attributed to other people and to important parts of people. The objects and the instruments of the

*Throughout this paper I follow the convention of using fantasy to mean conscious fantasy and phantasy to mean unconscious phantasy.

†In my description of infantile psychic life I follow the work of Freud, particularly as developed and elaborated by Melanie Klein (1952b; 1959).

libidinal and aggressive impulses are phantasized as the infant's own and other people's bodies and bodily products. Physical and psychic experiences are intimately interwoven. The infant's psychic experience of objective reality is greatly influenced by its own feelings and phantasies, moods and wishes.

Through their psychic experience infants build up an inner world peopled by themselves and the objects of their feelings and impulses. In the inner world, these exist in a form and condition largely determined by phantasies. Because of the operation of aggressive forces, the inner world contains many damaged, injured or dead objects. The atmosphere is charged with death and destruction. This gives rise to great anxiety. Infants thus fear for the effect of aggressive forces on the people they love and on themselves, grieving and mourning over others' suffering and experiencing depression and despair about their own inadequate ability to right their wrongs. They fear the demands that will be made on them for reparation and the punishment and the revenge that may result, and that libidinal impulses (their own and those of other people) cannot control the aggressive impulses sufficiently to prevent chaos and destruction. The poignancy of the situation is increased because love and longing themselves are felt to be so close to aggression. Greed, frustration and envy so easily replace a loving relationship. This phantasy world is characterized by a violence and intensity of feeling quite foreign to the emotional life of the normal adult.

In the hospital situation the direct impact on the nurse of physical illness was intensified by having to meet and deal with psychological stress in other people, including colleagues. Quite short conversations with patients or relatives showed that their conscious concept of illness and treatment was a rich intermixture of objective knowledge, logical deduction and fantasy. The degree of stress was heavily conditioned by the fantasy, which was in turn, conditioned, as in nurses, by the early phantasy-situations. Unconsciously, the nurse associated the patients' and relatives' distress with that experienced by the people in the nurse's own phantasy-world, which increased personal anxiety and difficulty in handling it.

Patients and relatives had complicated feelings towards the hospital, which were expressed particularly and most directly to nurses, and often puzzled and distressed them. Patients and relatives showed appreciation, gratitude, affection, respect; a touching relief that the hospital coped; helpfulness and concern for the nurses. But patients often resented their dependence; accepted grudgingly the discipline imposed by treatment and hospital routine; envied nurses their health and skills; were demanding, possessive and jealous. Patients, like nurses, found strong libidinal and erotic feelings stimulated by nursing care, and sometimes behaved in ways that increased the nurses' difficulties, for example by unnecessary physical exposure. Relatives could also be demanding and critical, the more so because they resented the feeling that hospitalization

implied inadequacies in themselves. They envied nurses their skill and jealously resented the nurse's intimate contact with "their" patient.

In a more subtle way, both patients and relatives made psychological demands on nurses that increased their experience of stress. The hospital was expected to do more than accept the ill patients, care for their physical needs, and help realistically with their psychological stress. Implicitly it was expected to accept and, by so doing, free patients and relatives from, certain aspects of the emotional problems aroused by the patient and the illness. The hospital, particularly the nurses, had projected into them feelings such as depression and anxiety, fear of the patient and the illness, disgust at the illness and necessary nursing tasks. Patients and relatives treated the staff in such a way as to ensure that the nurses experienced these feelings instead of, or partly instead of, themselves, for example by refusing or trying to refuse to participate in important decisions about the patient and so forcing responsibility and anxiety back on the hospital. Thus, to the nurses' own deep and intense anxieties were psychically added those of other people. We were struck by the number of patients whose physical condition alone did not warrant hospitalization. In some cases, it seemed clear that they had been hospitalized because they and their relatives could not tolerate the stress of their being ill at home.

The nurses projected infantile phantasy-situations into current work-situations and experienced the objective situations as a mixture of objective reality and phantasy. They then re-experienced painfully and vividly in relation to current objective reality many of the feelings appropriate to the phantasies. In thus projecting phantasy-situations into objective reality, the nurses were using an important and universal technique for mastering anxiety and modifying the phantasy-situations. The objective situations symbolize the phantasy-situations and successful mastery of the objective situations gives reassurance about the mastery of the phantasy-situations. To be effective, such symbolization requires that the symbol *represents* the phantasy object, but *is not equated* with it. The symbol's own distinctive, objective characteristics must also be recognized and used. If, for any reason, the symbol and the phantasy object become almost or completely equated, the anxieties aroused by the phantasy object are aroused in full intensity by the symbolic object. The symbol then ceases to perform its function in containing and modifying anxiety (Segal, 1957). The close resemblance of the phantasy and objective situations in nursing constitutes a threat that symbolic representation will degenerate into symbolic equation and that nurses will consequently experience the full force of their primitive infantile anxieties in consciousness. Modified instances of this phenomenon were not uncommon in this hospital. For example, a nurse whose mother had had several gynecological operations broke down and had to give up nursing shortly after beginning her tour of duty on the gynecological ward.

To understand the sources of the anxiety was one thing; to understand why

overt anxiety remained chronically at so high a level was another. Therefore our attention was directed to the adaptive and defensive techniques within the nursing service.

Defensive Techniques in the Nursing Service

In developing a structure, culture and mode of functioning, a social organization is influenced by a number of interacting factors, crucial among which is its primary task, i.e., the task it was created to perform (Rice, 1958) and the technology that this requires. The influences of the primary task and technology can easily be exaggerated. Indeed, I would prefer to regard them as limiting factors. The need to ensure viability through efficient enough performance of the primary task and the types of technology available to do this set limits to possible organization. Within these limits, the culture, structure and mode of functioning are determined by the psychological needs of the members (Trist and Bamforth, 1951).

The need of the members of the organization to use it in the struggle against anxiety leads to the development of socially structured defense mechanisms, which appear as elements in the structure, culture and mode of functioning of the organization (Jaques, 1955). An important aspect of such socially structured defense mechanisms is an attempt by individuals to externalize and give substance in objective reality to their characteristic psychic defense mechanisms. A social defense system develops over time through collusive interaction and agreement, often unconscious, between members of the organization as to what form it shall take. The socially structured defense mechanisms then tend to become an aspect of external reality with which old and new members of the institution must come to terms.

It is impossible here to describe the social defense system fully, so I shall illustrate only a few of its striking and typical features. I shall confine myself mainly to defense used within the nursing service and refer minimally to ways in which the nursing service made use of and was used by other people, notably patients and doctors. For convenience of exposition, I shall list the defense as if they were separate, although, in operation, they functioned simultaneously and interacted with each other.

SPLITTING UP THE NURSE/PATIENT RELATIONSHIP

The focus of anxiety for the nurse lay in the relation with the patient. The closer and more concentrated this relationship, the more the nurse was likely to experience the impact of anxiety. The nursing service attempted to protect the

individual nurse from anxiety by splitting up contact with patients. It is hardly too much to say that the nurse did not nurse patients. The total work-load of a ward or department was broken down into lists of tasks, each of which was allocated to a particular student nurse, who performed patient-centered tasks for a large number of patients, perhaps as many as all the patients in a ward. As a corollary, the student performed only a few tasks for, and had restricted contact with, any one patient, and was thus prevented from contact with the totality of any one patient and his or her illness.

DEPERSONALIZATION, CATEGORIZATION AND DENIAL OF THE SIGNIFICANCE OF THE INDIVIDUAL

The protection afforded by the task-list system was reinforced by a number of other devices that inhibited the development of a full person-to-person relationship between nurse and patient. The implicit aim of such devices, which operated both structurally and culturally, may be described as depersonalization or elimination of individual distinctiveness in both nurse and patient. For example, nurses often talked about patients not by name but by bed number or by disease or diseased organ: "the liver in bed 10" or "the pneumonia in bed 15." Nurses themselves deprecated this practice, but it persisted. There was an almost explicit "ethic" that any patient must be the same as any other patient. It must not matter to the nurses whom they nursed or what illness. Nurses found it difficult to express preferences even for types of patients or for men or women patients. Conversely, it should not matter to the patient which nurse attended or, indeed, how many different nurses did. By implication it was the duty, as well as the need and privilege, of the patient to be nursed and of the nurse to nurse, regardless of the fact that a patient might need to "nurse" a distressed nurse and nurses might sometimes need to be "nursed." Outside the specific requirements of physical illness and treatment, the way patients were nursed was determined largely by their membership in the category patient and minimally by idiosyncratic wants and needs. For example, there was only one way of bed-making except when the physical illness required another, only one time to wash all patients—in the morning.

The nurses' uniforms were a symbol of an expected inner and behavioral uniformity; a nurse became a kind of agglomeration of nursing skills, without individuality; each was thus interchangeable with another of the same seniority. Socially permitted differences between nurses tended to be restricted to a few major categories, outwardly differentiated by minor differences in insignia on the same basic uniform. This attempted to create an operational identity between all nurses in the same category. To an extent indicating clearly the need for "blanket" decisions, duties and privileges were allotted to categories

of people and not to individuals according to their personal capacities and needs. Something of the same reduction of individual distinctiveness existed between operational sub-units. Attempts were made to standardize all equipment and layout to the limits allowed by the different nursing tasks, but disregarding the idiosyncratic social and psychological resources and needs of each unit.

DETACHMENT AND DENIAL OF FEELINGS

The entrant into any profession that works with people needs to develop adequate professional detachment. He or she must learn to control feelings, refrain from excessive involvement, avoid disturbing identifications and maintain professional independence against manipulation and demands for unprofessional behavior. The reduction of individual distinctiveness aided detachment by minimizing the mutual interaction of personalities, which might lead to "attachment." It was reinforced by an implicit operational policy of "detachment." "A good nurse doesn't mind moving." A good nurse is willing and able without disturbance to move from ward to ward or hospital to hospital at a moment's notice. The implicit rationale appeared to be that a student nurse would learn to be detached psychologically if given sufficient experience of being detached literally and physically. This approach comes dangerously close to concrete thinking. Most senior nurses did not subscribe personally to this implicit rationale. They were aware of the personal distress as well as the operational disturbance caused by over-frequent moves. However, in their formal roles they continued to initiate frequent moves and made little other training provision for developing genuine professional detachment. The pain and distress of breaking relationships and the importance of stable and continuing relationships were implicitly denied by the system, although they were often stressed personally by people in the system.

This denial was reinforced by denial of the disturbing feelings that arose within relationships. Interpersonal repressive techniques were culturally required and typically used to deal with emotional stress. Both student nurses and staff showed panic about emotional outbursts. Brisk, reassuring behavior and advice of the "stiff upper lip," "pull yourself together" variety were characteristic. Student nurses suffered severely from emotional strain and habitually complained that the senior staff did not understand and made no effort to help them. Indeed, when the emotional stress arose from nurses' having made a mistake, they were usually reprimanded instead of being helped. A student nurse told me that she had made a mistake that hastened the death of a dying patient. She was reprimanded separately by four senior nurses, and not comforted. However, student nurses were wrong when they said that senior nurses

did not understand or feel for their distress. In personal conversation with us, seniors showed considerable understanding and sympathy and often remembered surprisingly vividly some of the agonies of their own training. But they lacked confidence in their ability to handle emotional stress in any way other than by repressive techniques, and often said, "In any case, the students won't come and talk to us."

THE ATTEMPT TO ELIMINATE DECISIONS BY RITUAL TASK-PERFORMANCE

Making a decision implies making a choice between different possible courses of action and committing oneself to one of them, the choice being made in the absence of full factual information about the effects of the choice. All decisions are thus attended by uncertainty about their outcome and consequently by some conflict and anxiety. The anxiety consequent on decision-making is likely to be acute if a decision affects the treatment and welfare of patients. To spare staff this anxiety, the nursing service attempted to minimize the number and variety of decisions. For example, the student nurse was instructed to perform the task-list in a way reminiscent of performing a ritual. Precise instructions were given about the way each task must be performed, the order of the tasks and the time for their performance, although such precise instructions were not objectively necessary, or even wholly desirable.

Much time and effort were expended in standardizing nursing procedures in cases where there were a number of effective alternatives. Both teachers and practical-work supervisors impressed on the student nurse the importance of carrying out the ritual, reinforcing this by fostering an attitude to work that regarded every task as almost a matter of life and death, to be treated with appropriate seriousness. This attitude applied even to those tasks that could be effectively performed by an unskilled lay person. As a corollary, student nurses were actively discouraged from using their own discretion and initiative to plan their work realistically in relation to the objective situation, for example, at times of crisis to discriminate between tasks on the grounds of urgency or relative importance and act accordingly. Student nurses are the staff most affected by "rituals," since ritualization is easy to apply to their roles and tasks, but attempts were also made to ritualize the task-structure of the more complex senior staff roles and to standardize task-performance.

REDUCING THE WEIGHT OF RESPONSIBILITY IN DECISION-MAKING BY CHECKS AND COUNTERCHECKS

The psychological burden of anxiety arising from a final, committing decision by a single person was dissipated in a number of ways, so that its impact was

reduced. The final act of commitment was postponed by checking and re-checking decisions for validity and postponing action as long as possible. Executive action following decisions was also checked and re-checked at intervening stages. Individuals spent much time in private rumination over decisions and actions. Whenever possible, they involved other nurses in decision-making and in reviewing actions. Nursing procedures prescribed considerable checking between individuals, but it was also a strongly developed habit among nurses outside areas of prescribed behavior. The practice of checking and counter-checking was applied not only to situations where mistakes might have serious consequences, such as in giving dangerous drugs, but also to many situations where the implications of a decision were of only the slightest consequence. Nurses consulted not only their immediate seniors but also their juniors and nurses or other staff with whom they had no functional relationship but who happened to be available.

COLLUSIVE SOCIAL REDISTRIBUTION OF RESPONSIBILITY AND IRRESPONSIBILITY

Each nurse had to face and, in some way, resolve a painful conflict over accepting the responsibility of the role. Nursing tends to evoke a strong sense of responsibility, and nurses often discharged their duties at considerable personal cost. On the other hand, the heavy burden of responsibility was difficult to bear consistently, and nurses were tempted to abandon it. Each nurse had wishes and impulses that would lead to irresponsible action, to skipping boring, repetitive tasks or to becoming libidinally or emotionally attached to patients. The balance of opposing forces in the conflict varied between individuals; some are naturally "more responsible" than others, but the conflict was always present. To experience this conflict fully and intrapsychically would be extremely stressful. The intrapsychic conflict was alleviated by a technique that partly converted it into an interpersonal conflict. People in certain roles tended to be described by themselves and others as responsible, while people in other roles were described as irresponsible. Nurses habitually complained that other nurses were irresponsible, behaved carelessly and impulsively, and in consequence needed to be ceaselessly supervised and disciplined. The complaints commonly referred not to individuals or to specific incidents but to whole categories of nurses, usually a category junior to the speaker. The implication was that the juniors were not only less responsible now than the speaker, but also less responsible than she was when she was in the same junior position. Few nurses recognized or admitted such tendencies in themselves. Many people complained that their seniors, as a category, imposed unnecessarily strict and repressive discipline, and treated them as though they

had no sense of responsibility. Few senior staff seemed able to recognize such features in their own behavior to subordinates. These juniors and seniors were, with few exceptions, the same people viewed from above or below, as the case might be.

We came to realize that the complaints stemmed from a collusive system of denial, splitting and projection that was culturally acceptable to, indeed culturally required of, nurses. Each nurse tended to split off aspects of herself from her conscious personality and to project them into other nurses. Her irresponsible impulses, which she feared she could not control, were attributed to her juniors. Her painfully severe attitude to these impulses and burdensome sense of responsibility were attributed to her seniors. Consequently, she identified juniors with her irresponsible self and treated them with the severity that self was felt to deserve. Similarly, she identified seniors with her own harsh disciplinary attitude to her irresponsible self and expected harsh discipline. There was psychic truth in the assertion that juniors were irresponsible and seniors harsh disciplinarians. These were the roles assigned to them. There was also objective truth, since people acted objectively on the psychic roles assigned to them. Discipline was often harsh and sometimes unfair, since the multiple projection also led the senior to identify all juniors with her irresponsible self and so with each other. Thus, she failed to discriminate between them sufficiently. Nurses complained about being reprimanded for other people's mistakes while no serious effort was made to find the real culprit. A staff nurse* said, "If a mistake has been made, you must reprimand someone, even if you don't know who really did it." Irresponsible behavior was also quite common, mainly in tasks remote from direct patient-care. The interpersonal conflict was painful but was less so than experiencing the conflict fully intrapsychically, and it could more easily be evaded. The disciplining eye of seniors could not follow juniors all the time, nor did the junior confront her senior with irresponsibility all the time.

PURPOSEFUL OBSCURITY IN THE FORMAL DISTRIBUTION OF RESPONSIBILITY

Additional protection from the impact of responsibility for specific tasks was given by the fact that the formal structure and role system failed to define fully enough who was responsible for what and to whom. This matched and objectified the obscurity about the location of psychic responsibility that inevitably arose from the massive system of projection described above. The content and boundaries of roles were obscure, especially at senior levels. The respon-

*In the nursing service, a sister is the head nurse in a ward and a staff nurse is a fully qualified nurse who is her deputy.

sibilities were more onerous at this level so that protection was felt as very necessary. Also the more complex roles and role-relationships made it easier to evade definition. The content of the role of the student nurse was rigidly prescribed by her task-list. However, in practice, she was unlikely to have the same task-list for any length of time. She might, and frequently did, have two completely different task-lists in a single day. There was therefore a lack of stable person/role constellations, and it became very difficult to assign responsibility finally to a person, a role or a person/role constellation.

Responsibility and authority on wards were generalized in a way that made them non-specific and prevented them from falling firmly on one person, even the sister. Each nurse was held to be responsible for the work of every nurse junior to her. Junior, in this context, implied no hierarchical relationship, and was determined only by the length of time a student nurse had been in training, and all students were "junior" to trained staff. Every nurse was expected to initiate disciplinary action in relation to any failure by any junior nurse. Such diffused responsibility meant, of course, that responsibility was not generally experienced specifically or seriously. This was a policy for inactivity.

THE REDUCTION OF THE IMPACT OF RESPONSIBILITY BY DELEGATION TO SUPERIORS

Delegation in the hospital seemed to move in a direction opposite to the usual one. Tasks were frequently forced upwards in the hierarchy so that all responsibility for their performance could be disclaimed. Insofar as this happened, the heavy burden of responsibility on the individual was reduced.

The results of years of this practice were visible in the nursing service at the time of the study. We were struck by the low level of tasks carried out by nursing staff and students in relation to their personal ability, skill and position in the hierarchy. Formally and informally, tasks were assigned to staff at a level well above that at which one found comparable tasks in other institutions. The task of allocating student nurses to practical duties was a case in point. This work was carried out by the first and second assistant matrons* and took up a considerable proportion of their working-time. The task was such that, if policy were clearly defined and the task appropriately organized, it could be efficiently performed by a competent clerk part-time under the supervision of a senior nurse. We saw this delegation upward in operation a number of times as new tasks developed for nurses out of changes resulting from our study. The senior staff decided to change the practical training for post-graduate students so that they might have better training in administration and supervision. The

*The nurses third and fourth in seniority in administration.

students were now to spend six months continuously in one operational unit during which time they would act as understudy-cum-shadow to the sister or staff nurse. Personal compatibility was felt to be important, and it was suggested that, with training, the sisters should take part in the selection of the fourth-year students for their own wards, a task within their competence. At first there was enthusiasm for the proposal, but as definite plans were made and the ward sisters began to feel that they had no developed skill for selection, they requested that, after all, senior staff should continue to select for them as they had always done. The senior staff, although already overburdened, accepted the task.

The repeated occurrence of such incidents by mutual collusive agreement between superiors and subordinates is hardly surprising considering the mutual projection system described above. Nurses as subordinates tended to feel very dependent on their superiors in whom they had psychically vested, by projection, some of the best and most competent parts of themselves. They felt that their projections gave them the right to expect their superiors to undertake their tasks and make decisions for them. On the other hand, nurses as superiors did not feel they could fully trust their subordinates in whom they had psychically vested the irresponsible and incompetent parts of themselves. Their acceptance of their subordinates' projections also conveyed a sense of duty to accept their subordinates' responsibilities.

IDEALIZATION AND UNDERESTIMATION OF PERSONAL DEVELOPMENTAL POSSIBILITIES

In order to reduce anxiety about the continuous efficient performance of nursing tasks, nurses sought assurance that the nursing service was staffed with responsible, competent people. To a considerable extent, the hospital dealt with this problem by attempting to recruit and select staff, that is student nurses, who were already mature and responsible people. This was reflected in phrases like "nurses are born not made" or "nursing is a vocation." This was a kind of idealization of the potential nursing recruit, and implied a belief that responsibility and personal maturity cannot be taught or developed. As a corollary, the training system was mainly oriented to the communication of essential facts and techniques, and paid minimal attention to teaching events oriented to personal maturation within the professional setting. The nursing service faced the dilemma that, while a strong sense of responsibility and discipline were necessary for the welfare of patients, a considerable proportion of actual nursing tasks were extremely simple. This hospital, in common with most similar British hospitals, attempted to solve this dilemma by the recruitment of large numbers of high-level student nurses who, it was hoped, would