histories are Fosdick, 1952, and Dicks, 1970 (especially chapter 9 by S. G Gray on the Tavistock Institute of Human Relations). [Note by RY]

24. A two-week group-relations training, in existence since 1957, which now meets in Leicester. There are offshoots, called 'Mini-Leicester'.

25. Consultant, TIHR.

26. A psychiatric hospital in north London.

27. James Robertson, Member (retired from practice) of the British Psycho-Analytical Society. With his wife, Joyce Robertson, he is a specialist in child development, especially the effects of institutionalization and mother–child separation on development. The Robertsons have used film, especially *A Two-Year-Old Goes to Hospital* (1953), to communicate their findings.

28. Dame Cicely Saunders, Medical Director of St Christopher's Hospice, Sydenham, London.

29. Late Member of the British Psycho-Analytical Society, especially well known for his work on psychosis.

30. Consultant psychiatrist at The London Hospital, especially well known for his work on bereavement, which he started at the Tavistock Clinic.

31. Richard Balbernie was a specialist in the running of institutions for disturbed children and Principal of the Cotswold Community, an approved school and later a community children's home in Wiltshire.

The functioning of social systems as a defence against anxiety (1959, 1961 [1961b], 1970)

A report on a study of the nursing service of a general hospital[1]

INTRODUCTION

THE STUDY was initiated by the hospital, which sought help in developing new methods of carrying out a task in nursing organization. The research data were, therefore, collected within a sociotherapeutic relationship in which the aim was to facilitate desired social change.[2]

The hospital is a general teaching hospital in London. This implies that, in addition to the normal task of patient care, the hospital teaches undergraduate medical students. Like all British hospitals of its type, it is also a nurse-training school. The hospital has about 700 beds for inpatients and provides a number of outpatient services. Although referred to as 'the hospital' it is, in fact, a group of hospitals which, at the time of the study, included a general hospital of 500 beds, three small specialist hospitals, and a convalescent home. The group of hospitals has an integrated nursing service run by a matron located in the main hospital. Nursing staff and students are interchangeable between hospitals.

The nursing personnel of the hospital number about 700. Of these, about 150 are fully trained staff and the remainder are students. The nurse-training course lasts four years. For the first three years, the student nurse is an 'undergraduate'. At the end of the third year she takes the examination which leads to 'state-registration', effectively her nursing qualification and

licence to practise. In the fourth year, she is a postgraduate student.

The trained nursing staff are entirely deployed in administrative, teaching and supervisory roles, although those who are deployed in operational units working with patients also carry out a certain amount of direct patient care. Student nurses are, in effect, the nursing staff of the hospital at the operational level with patients, and carry out most of the relevant tasks. From this point of view, it is necessary that student nurses be deployed so as to meet the nurse-staffing requirements of the hospital. The student nurse spends comparatively little time undergoing formal instruction. She spends three months in the Preliminary Training School before she starts nursing practice, and six weeks in the nursing school in each of the second and third years of training. For the rest of the time she is in 'practical training': acquiring and practising nursing skills by carrying out full-time nursing duties within the limits of her competence. This practical training must be so arranged that the student has the minimal experience of different types of nursing prescribed by the General Nursing Council.[3] The hospital offers – and likes nurses to have – certain additional experience available in specialist units in the hospital. The hospital's training policy is that the student nurse has approximately three months' continuous duty in each of the different types of nursing. Each student nurse must be deployed in a way that fulfils these training requirements. There are many possibilities of conflict in this situation. The nursing establishment of the hospital is not primarily determined by training needs, which take second place to patient-centred needs and the needs of the medical school. For some considerable time before the start of the study, the senior nursing staff had been finding it increasingly difficult to reconcile effectively staffing needs and training needs. Pressures from patient care demanded that priority be given to staffing, and constant training crises developed. The policy of three-month training tours had in effect been abandoned and many tours were very short;[4] some nurses came almost to the end of their training without having had all the necessary experience, while others had a serious imbalance owing to too much of the

same kind of practice. These crises created the more acute distress because senior staff wished to give increasing priority to training and to raise the status of the nurse as a student.

The senior staff began to feel that there was a danger of complete breakdown in the system of allocation to practical work and sought our help in revising their methods. My purpose in writing this paper is not, however, to follow the ramifications of this problem. I will make some reference to it at relevant points, and will consider later why the existing method persisted so long without effective modification in spite of its inefficiency.

The therapeutic relationship with the hospital was to some extent based on the belief that we would be wise to regard the problem of student-nurse allocation as a 'presenting symptom' and to reserve judgement on the real nature of the difficulties and the best form of treatment until we had done further diagnostic work. We began, therefore, with a fairly intensive interviewing programme. We held formal interviews with about seventy nurses, individually and in small groups, and with senior medical and lay staff; we carried out some observational studies of operational units; and we had many informal contacts with nurses and other staff. Respondents knew the problem we were formally studying, but were invited to raise in interview any other issue that they considered central to their occupational experience. Much further research material was collected in the later meetings with senior staff as we worked together on the findings from the interviewing programme.[5]

As our diagnostic work went on, our attention was repeatedly drawn to the high level of tension, distress and anxiety among the nurses. We found it hard to understand how nurses could tolerate so much anxiety and, indeed, we found much evidence that they could not. In one form or another, withdrawal from duty was common. About one-third of student nurses did not complete their training. The majority of these left at their own request, and not because of failure in examinations or practical training. Senior staff changed their jobs appreciably more frequently than workers at similar levels in other professions and were unusually prone to seek postgraduate training. Sick-

ness rates were high, especially for minor illnesses requiring only a few days' absence from duty.[6]

As the study proceeded we came to attach increasing importance to understanding the nature of the anxiety and the reasons for its intensity. The relief of the anxiety seemed to us an important therapeutic task and, moreover, proved to have a close connection with the development of more effective techniques of student-nurse allocation. The remainder of this paper considers the causes and the effects of the anxiety level in the hospital.

NATURE OF THE ANXIETY

A hospital accepts and cares for ill people who cannot be cared for in their own homes. This is the task the hospital is created to perform, its 'primary task'. The major responsibility for the performance of that primary task lies with the nursing service, which must provide continuous care for patients, day and night, all the year round.[7] The nursing service, therefore, bears the full, immediate and concentrated impact of stresses 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 will not always be complete. Nursing patients who have incurable diseases is one of the nurse's most distressing tasks. Nurses are confronted with the threat and the reality of suffering and death as few lay people are. Their work involves carrying out tasks which, by ordinary standards, are distasteful, disgusting and frightening. Intimate physical contact with patients arouses strong libidinal and erotic wishes and impulses that may be difficult to control. The work situation arouses very strong and mixed feelings in the nurse: pity, compassion and love; guilt and anxiety; hatred and resentment of the patients who arouse these strong feelings; envy of the care given to the patient.

The objective situation confronting the nurse bears a striking resemblance to the phantasy[8] 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 her work situation to stimulate afresh these early situations and their accompanying emotions. I will comment briefly on the main relevant features of these phantasy situations.[9]

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. The infant feels omnipotent and attributes dynamic reality to these feelings and impulses. He believes that the libidinal impulses are literally life-giving and the aggressive impulses death-dealing. The infant attributes similar feelings, impulses and powers to other people and to important parts of people. The objects and the instruments of the libidinal and aggressive impulses are felt to be the infant's own and other people's bodies and bodily products. Physical and psychic experiences are very intimately interwoven at this time. The infant's psychic experience of objective reality is greatly influenced by his own feelings and phantasies, moods and wishes.

Through his psychic experience the infant builds up an inner world peopled by himself and the objects of his feelings and impulses.[10] In this inner world, they exist in a form and condition largely determined by his 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. The infant fears for the effect of aggressive forces on the people he loves and on himself. He grieves and mourns over their suffering and experiences depression and despair about his inadequate ability to put right their wrongs. He fears the demands that will be made on him for reparation and the punishment and revenge that may fall on him. He fears that his libidinal impulses and those of other people cannot control the aggressive impulses sufficiently to prevent utter 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.

The direct impact on the nurse of physical illness is intensified by her task of meeting and dealing with psychological stress in other people, including her own colleagues. It is by no means easy to tolerate such stress even if one is not under similar stress oneself. Quite short conversations with patients or relatives showed that their conscious concept of illness and treatment is a rich intermixture of objective knowledge, logical deduction, and fantasy.[11] The degree of stress is heavily conditioned by the fantasy, which is in turn conditioned, as in nurses, by the early phantasy situations. Unconsciously, the nurse associates the patients' and relatives' distress with that experienced by the people in her phantasy world, which increases her own anxiety and difficulty in handling it.

Patients and relatives have very complicated feelings towards the hospital, which are expressed particularly and most directly to nurses, and often puzzle and distress them. Patients and relatives show appreciation, gratitude, affection, respect; a touching relief that the hospital copes; helpfulness and concern for nurses in their difficult task. But patients often resent their dependence; accept grudgingly the discipline imposed by treatment and hospital routine; envy nurses their health and skills; are demanding, possessive and jealous. Patients, like nurses, find strong libidinal and erotic feelings stimulated by nursing care, and sometimes behave in ways that increase the nurses' difficulties: for example by unnecessary physical exposure. Relatives may also be demanding and critical, the more so because they resent the feeling that hospitalization implies inadequacies in themselves. They envy nurses their skill and jealously resent the nurse's intimate contact with 'their' patient.

In a more subtle way, both patients and relatives make psychological demands on nurses which increase their experience of stress. The hospital is expected to do more than accept the ill patient, care for his physical needs, and help realistically with his psychological stress. The hospital is implicitly expected to

accept and, by so doing, free patients and relatives from certain aspects of the emotional problems aroused by the patient and his illness. The hospital, particularly the nurses, must allow the projection into them of such feelings as depression and anxiety, fear of the patient and his illness, disgust at the illness and necessary nursing tasks. Patients and relatives treat the staff in such a way as to ensure that the nurses experience 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 are psychically added those of the other people concerned. As we became familiar with the work of the hospital, we were struck by the number of patients whose physical condition alone did not warrant hospitalization. In some cases, it was clear that they had been hospitalized because they and their relatives could not tolerate the stress of their being ill at home.

The nurse projects infantile phantasy situations into current work situations and experiences the objective situations as a mixture of objective reality and phantasy. She then re-experiences painfully and vividly, in relation to current objective reality, many of the feelings appropriate to the phantasies. In thus projecting her phantasy situations into objective reality, the nurse is using an important and universal technique for mastering anxiety and modifying the phantasy situations. Through the projection, the individual sees elements of the phantasy situations in the objective situations that come to symbolize the phantasy situations.[12] 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. Its 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.[13] 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 examples of this phenomenon were not uncommon in this hospital. For example, a nurse whose mother had had several gynaecological operations broke down and had to give up nursing shortly after beginning her tour of duty on the gynaecological ward.

By the nature of her profession the nurse is at considerable risk of being flooded by intense and unmanageable anxiety. That factor alone, however, cannot account for the high level of anxiety so apparent in nurses. It becomes necessary to direct attention to the other facet of the problem – that is, to the techniques used in the nursing service to contain and modify anxiety.

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 are its primary task, including such environmental relationships and pressures as that involves; the technologies available for performing the task; and the needs of the members of the organization for social and psychological satisfaction and, above all, for support in the task of dealing with anxiety.[14, 15, 16] In my opinion, the influence of the primary task and technology can easily be exaggerated. Indeed, I would prefer to regard them as limiting factors – that is to say, the need to ensure viability through the efficient 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.[17]

The need of the members of the organization to use it in the struggle against anxiety leads to the development of socially structured defence mechanisms, which appear as elements in the organization's structure, culture and mode of functioning.[18]

An important aspect of such socially structured defence mechanisms is an attempt by individuals to externalize and give substance in objective reality to their characteristic psychic defence mechanisms. A social defence system develops over time as the result of collusive interaction and agreement, often unconscious, between members of the organization as to what form it shall take. The socially structured defence mechanisms then tend to become an aspect of external reality with which old and new members of the institution must come to terms.

In what follows I shall discuss some of the social defences that the nursing service has developed in the long course of the hospital's history and currently operates. It is impossible here to describe the social system fully, so I shall illustrate only a few of the more striking and typical examples of the operation of the service as a social defence. I shall confine myself mainly to techniques used within the nursing service and refer minimally to ways in which the nursing service makes use of other people, notably patients and doctors, in operating socially structured mechanisms of defence. For convenience of exposition, I shall list the defences as if they are separate, although in operation they function simultaneously and interact with and support each other.

Splitting up the nurse–patient relationship. The core of the anxiety situation for the nurse lies in her relation with the patient. The closer and more concentrated this relationship, the more the nurse is likely to experience the impact of anxiety. The nursing service attempts to protect her from the anxiety by splitting up her contact with patients. It is hardly too much to say that the nurse does not nurse patients. The total workload of a ward or department is broken down into lists of tasks, each of which is allocated to a particular nurse. She performs her patient-centred tasks for a large number of patients – perhaps as many as all the patients in the ward, often thirty or more. As a corollary, she performs only a few tasks for, and has restricted contact with, any one patient. This prevents her from coming effectively into contact with the totality of any one patient and his illness and offers some protection from the anxiety this arouses.

Depersonalization, categorization, and denial of the significance of the individual. The protection afforded by the task-list system is reinforced by a number of other devices that inhibit the development of a full person-to-person relationship between nurse and patient, with its consequent anxiety. The implicit aim of such devices, which operate both structurally and culturally, may be described as a kind of depersonalization or elimination of individual distinctiveness in both nurse and patient. For example, nurses often talk about patients not by name, but by bed numbers or by their diseases or a diseased organ: 'the liver in bed 10' or 'the pneumonia in bed 15'. Nurses themselves deprecate this practice, but it persists. Nor should one underestimate the difficulties of remembering the names of, say, thirty patients on a ward, especially the high-turnover wards. There is an almost explicit 'ethic' that any patient must be the same as any other patient. It must not matter to the nurse whom she nurses or what illness. Nurses find it extraordinarily difficult to express preferences even for types of patients or for men or women patients. If pressed to do so, they tend to add rather guiltily some remark like 'You can't help it'. Conversely, it should not matter to the patient which nurse attends him or, indeed, how many different nurses do. By implication it is 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 may greatly need to 'nurse' a distressed nurse and nurses may sometimes need to be 'nursed'. Outside the specific requirements of his physical illness and treatment, the way a patient is nursed is determined largely by his membership of the category patient and minimally by his idiosyncratic wants and needs. For example, there is one way only of bed-making, except when the physical illness requires another; only one time to wash all patients in the morning.

The nurses' uniforms are a symbol of an expected inner and behavioural uniformity; a nurse becomes a kind of agglomeration of nursing skills, without individuality; each is thus perfectly interchangeable with another of the same skill level. Socially permitted differences between nurses tend to be restricted to a few major categories, outwardly differentiated by minor

differences in insignia on the same basic uniform: an arm stripe for a second-year nurse, a slightly different cap for a third-year nurse. This attempts to create an operational identity between all nurses in the same category.[19] To an extent indicating clearly the need for 'blanket' decisions, duties and privileges are allotted to categories of people and not to individuals according to their personal capacities and needs. This also helps to eliminate painful and difficult decisions, for example about which duties and privileges should fall to each individual (see p. 54). Something of the same reduction of individual distinctiveness exists between operational sub-units. Attempts are made to standardize all equipment and layout to the limits allowed by their different nursing tasks, but disregarding the idiosyncratic social and psychological resources and needs of each unit.

Detachment and denial of feelings. A necessary psychological task for the entrant into any profession that works with people is the development of adequate professional detachment. He must learn, for example, to control his feelings, refrain from excessive involvement, avoid disturbing identifications, maintain his professional independence against manipulation and demands for unprofessional behaviour. To some extent the reduction of individual distinctiveness aids detachment by minimizing the mutual interaction of personalities, which might lead to 'attachment'. It is 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 even hospital to hospital at a moment's notice. Such moves are frequent and often sudden, particularly for student nurses. The implicit rationale appears to be that a student nurse will learn to be detached psychologically if she has sufficient experience of being detached literally and physically. Most senior nurses do not subscribe personally to this implicit rationale. They are aware of the personal distress as well as the operational disturbance caused by over-frequent moves. Indeed, this was a major factor in the decision to initiate our study. However, in their formal roles in the hierarchy they continue to initiate frequent moves and make little other training provision for developing

genuine professional detachment. The pain and distress of breaking relationships and the importance of stable and continuing relationships are implicitly denied by the system, although they are often stressed personally – that is, nonprofessionally – by people in the system.

This implicit denial is reinforced by the denial of the disturbing feelings that arise within relationships. Interpersonal repressive techniques are culturally required and typically used to deal with emotional stress. Both student nurses and staff show panic about emotional outbursts. Brisk, reassuring behaviour and advice of the 'stiff upper lip', 'pull yourself together' variety are characteristic. Student nurses suffer most severely from emotional strain and habitually complain that the senior staff do not understand and make no effort to help them. Indeed, when the emotional stress arises from the nurse's having made a mistake, she is 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. Only the headmistress of her former school tried to help her as a person who was severely distressed, guilty and frightened. However, students are wrong when they say that senior nurses do 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.' Kindly, sympathetic handling of emotional stress between staff and student nurses is, in any case, inconsistent with traditional nursing roles and relationships, which require repression, discipline and reprimand from senior to junior.[20]

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. If the facts were fully known, no decision need be made; the proper course of action would be self-evident. All decisions are thus necessarily attended by some uncertainty about their outcome and consequently by some conflict and anxiety, which will last until the outcome is known. 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 attempts to minimize the number and variety of decisions that must be made. For example, the student nurse is instructed to perform her task-list in a way reminiscent of performing a ritual. Precise instructions are given about the way each task must be performed, the order of the tasks, and the time for their performance, although such precise instructions are not objectively necessary, or even wholly desirable.[21]

If several efficient methods of performing a task exist – for example, for bed-making or lifting a patient – one is selected and exclusively used. Much time and effort are expended in standardizing nursing procedures in cases where there are a number of effective alternatives. Both teachers and practical-work supervisors impress on the student nurse from the beginning of her training the importance of carrying out the 'ritual'. They reinforce this by fostering an attitude to work that regards every task as almost a matter of life and death, to be treated with appropriate seriousness. This applies even to those tasks that could be effectively performed by an unskilled lay person. As a corollary, the student nurse is actively discouraged from using her own discretion and initiative to plan her 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 to act accordingly. Student nurses are the 'staff' most affected by 'rituals', since ritualization is easy to apply to their roles and tasks, but attempts are also made to ritualize the task-structure of the more complex senior staff roles and to standardize the 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 is dissipated

in a number of ways, so that its impact is reduced. The final act of commitment is postponed by a common practice of checking and rechecking decisions for validity and postponing action as long as possible. Executive action following decisions is also checked and rechecked habitually at intervening stages. Individuals spend much time in private rumination over decisions and actions. Whenever possible, they involve other nurses in decision-making and in reviewing actions. The nursing procedures prescribe considerable checking between individuals, but it is also a strongly developed habit among nurses outside areas of prescribed behaviour. The practice of checking and counterchecking is applied not only to situations where mistakes may have serious consequences, such as in giving dangerous drugs, but to many situations where the implications of a decision are of only the slightest consequence – for example, on one occasion a decision about which of several rooms, all equally available, should be used for a research interview. Nurses consult not only their immediate seniors but also their juniors and nurses or other staff with whom they have no functional relationship but who just happen to be available.

Collusive social redistribution of responsibility and irresponsibility. Each nurse must face and, in some way, resolve a painful conflict over accepting the responsibilities of her role. The nursing task tends to evoke a strong sense of responsibility in nurses, who often discharge their duties at considerable personal cost. On the other hand, the heavy burden of responsibility is difficult to bear consistently, and nurses are tempted to give it up. In addition, each nurse has wishes and impulses that would lead to irresponsible action – for example, to scamp boring, repetitive tasks or to become libidinally or emotionally attached to patients. The balance of opposing forces in the conflict varies between individuals – some are naturally 'more responsible' than others – but the conflict is always present. To experience this conflict fully and intrapsychically would be extremely stressful. The intrapsychic conflict is alleviated, at least as far as the conscious experiences of nurses are concerned, by a technique that partly converts it into an interpersonal conflict. People in certain roles

tend to be described as 'responsible' by themselves and to some extent by others, and in other roles people are described as 'irresponsible'. Nurses habitually complain that other nurses are irresponsible, behave carelessly and impulsively, and in consequence must be ceaselessly supervised and disciplined. The complaints commonly refer not to individuals or to specific incidents but to whole categories of nurses, usually a category junior to the speaker. The implication is that the juniors are 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 recognize or admit such tendencies. Only the most junior nurses are likely to admit these tendencies in themselves and then justify them on the grounds that everybody treats them as though they were irresponsible. On the other hand, many people complain that their seniors as a category impose unnecessarily strict and repressive discipline, and treat them as though they have no sense of responsibility.[22] Few senior staff seem able to recognize such features in their own behaviour to subordinates. Those 'juniors' and 'seniors' are, with few exceptions, the same people viewed from above or below, as the case may be.

We came to realize that the complaints stem from a collusive system of denial, splitting and projection that is culturally acceptable to – indeed, culturally required of – nurses. Each nurse tends to split off aspects of herself from her conscious personality and to project them into other nurses. Her irresponsible impulses, which she fears she cannot control, are attributed to her juniors. Her painfully severe attitude to these impulses and burdensome sense of responsibility are attributed to her seniors. Consequently, she identifies juniors with her irresponsible self and treats them with the severity that self is felt to deserve. Similarly, she identifies seniors with her own harsh disciplinary attitude to her irresponsible self and expects harsh discipline. There is psychic truth in the assertion that juniors are irresponsible and seniors harsh disciplinarians. These are the roles assigned to them. There is also objective truth, since people act objectively on the psychic roles assigned to them. Discipline is often harsh and sometimes unfair, since the

multiple projection also leads the senior to identify all juniors with her irresponsible self and so with each other. Thus, she fails to discriminate between them sufficiently. Nurses complain about being reprimanded for other people's mistakes while no serious effort is made to find the real culprit. A staff nurse[23] said: 'If a mistake has been made, you must reprimand someone, even if you don't know who really did it.' Irresponsible behaviour was also quite common, mainly in tasks remote from direct patient care. The interpersonal conflict is painful, as the complaints show, but is less so than experiencing the conflicts fully intrapsychically, and can more easily be evaded. The disciplining eye of seniors cannot follow juniors all the time, nor does the junior confront her senior with irresponsibility all the time.

Purposeful obscurity in the formal distribution of responsibility. Additional protection from the impact of specific responsibility for specific tasks is given by the fact that the formal structure and role system fail to define fully enough who is responsible for what and to whom. This matches and objectifies the obscurity about the location of psychic responsibility that inevitably arises from the massive system of projection described above. The content and boundaries of roles are very obscure, especially at senior levels. The responsibilities are more onerous at this level, so that protection is felt to be very necessary. Also the more complex roles and role-relationships make it easier to evade definition. As described above (p. 55), the content of the role of the student nurse is rigidly prescribed by her task-list. However, in practice she is unlikely to have the same task-list for any length of time. She may – and frequently does – have two completely different task-lists in a single day.[24] There is therefore a lack of stable person-role constellations, and it becomes very difficult to assign responsibility finally to a person, a role, or a person-role constellation. We experienced this obscurity frequently in our work in the hospital, finding great difficulty, for example, in learning who should make arrangements or give permission for nurses to participate in various research activities.

Responsibility and authority on wards are generalized in a way that makes them nonspecific and prevents them from falling firmly on one person, even the sister. Each nurse is held to be responsible for the work of every nurse junior to her. Junior, in this context, implies no hierarchical relationship and is determined only by the length of time a student nurse has been in training, and all students are 'junior' to trained staff. A student nurse in the fourth quarter of her fourth year is by implication responsible for all other student nurses on the ward; a student nurse in the third quarter of her fourth year for all student nurses except the previous one, and so on. Every nurse is expected to initiate disciplinary action in relation to any failure by any junior nurse. Such diffused responsibility means, of course, that responsibility is not generally experienced specifically or seriously.

The reduction of the impact of responsibility by delegation to superiors. The ordinary usage of the word 'delegation' in relation to tasks implies that a superior hands over a task and the direct responsibility for its detailed performance to subordinates, while he retains a general, supervisory responsibility. In the hospital, almost the opposite seems to happen frequently – that is to say, tasks are frequently forced upwards in the hierarchy so that all responsibility for their performance can be disclaimed. In so far as this happens, the heavy burden of responsibility on the individual is reduced.

The results of many years of this practice are visible in the nursing service. We were struck repeatedly 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 are assigned to staff at a level well above that at which one finds comparable tasks in other institutions, while these tasks are organized so as effectively to prevent their delegation to an appropriate lower level, for example, by clarifying policy. The task of allocating student nurses to practical duties was a case in point. The detailed allocation work was carried out by the first and second assistant matrons[25] and took up a considerable proportion of their working time. In our

opinion the task is, in fact, 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, who need spend little time on it.[26] We were able to watch this 'delegation upwards' in operation a number of times as new tasks developed for nurses out of changes resulting from our study. For example, the senior staff decided to change the practical training for fourth-year nurses so that they might have better training than formerly in administration and supervision. This implied, among other things, that they should spend six months continuously in one operational unit, during which time they would act as understudy-cum-shadow to the sister or the staff nurse. In the circumstances, personal compatibility was felt to be very important and it was suggested that the sisters should take part in the selection of the fourth-year students for their own wards. At first there was enthusiasm for the proposal, but as definite plans were made and the intermediate staff 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, willingly 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 (pp. 56–8). Nurses as subordinates tend to feel very dependent on their superiors, in whom they psychically vest by projection some of the best and most competent parts of themselves. They feel that their projections give them the right to expect their superiors to undertake their tasks and make decisions for them. On the other hand, nurses, as superiors, do not feel they can fully trust their subordinates in whom they psychically vest the irresponsible and incompetent parts of themselves. Their acceptance of their subordinates' projections also conveys 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 seek assurance that the nursing service is staffed with responsible, competent people. To a considerable extent, the hospital deals with this problem by an attempt to recruit and select 'staff' – that is, student nurses – who are already highly mature and responsible people. This is reflected in phrases like 'nurses are born, not made' or 'nursing is a vocation'. This amounts to a kind of idealization of the potential nursing recruit, and implies a belief that responsibility and personal maturity cannot be 'taught' or even greatly developed. As a corollary, the training system is mainly orientated to the communication of essential facts and techniques, and pays minimal attention to teaching events orientated to personal maturation within the professional setting.[27] There is no individual supervision of student nurses, and no small-group teaching event concerned specifically to help student nurses work over the impact of their first essays in nursing practice and handle more effectively their relations with patients and their own emotional reactions. The nursing service must face the dilemma that, while a strong sense of responsibility and discipline are felt to be necessary for the welfare of patients, a considerable proportion of actual nursing tasks are extremely simple. This hospital, in common with most similar British hospitals, has attempted to solve this dilemma by the recruitment of large numbers of high-level student nurses who, it is hoped, are prepared to accept the temporary lowering of their operational level because they are in training.

This throws new light on the problem of the 30 per cent to 50 per cent wastage of student nurses in this and other British hospitals. It has long been treated as a serious problem, and much effort has been expended on trying to solve it. In fact, it can be seen as an *essential* element in the social defence system. The need for responsible semi-skilled staff greatly exceeds the need for fully trained staff – by almost four to one in this hospital, for example. If large numbers of student nurses do *not* fail to finish their training, the nursing profession risks being flooded with trained staff for whom there are no jobs. The wastage is therefore an unconscious device to maintain the

balance between staff of different levels of skill while all are at a high personal level. It is understandable that apparently determined efforts to reduce wastage have so far failed, except in one or two hospitals.

Avoidance of change. Change is inevitably to some extent an excursion into the unknown. It implies a commitment to future events that are not entirely predictable and to their consequences, and inevitably provokes doubt and anxiety. Any significant change within a social system implies changes in existing social relationship and in social structure. It follows that any significant social change implies a change in the operation of the social system as a defence system. While this change is proceeding – that is, while social defences are being restructured – anxiety is likely to be more open and intense.[28] Jaques (1955) has stressed that resistance to social change can be better understood if it is seen as the resistance of groups of people unconsciously clinging to existing institutions because changes threaten existing social defences against deep and intense anxieties.

It is understandable that the nursing service, whose tasks stimulate such primitive and intense anxieties, should anticipate change with unusually severe anxiety. In order to avoid this anxiety, the service tries to avoid change wherever possible – almost, one might say, at all costs – and tends to cling to the familiar even when the familiar has obviously ceased to be appropriate or relevant. Changes tend to be initiated only at the point of crisis. The presenting problem was a good example of this difficulty in initiating and carrying through change. Staff and student nurses had long felt that the methods in operation were unsatisfactory and had wanted to change them. They had, however, been unable to do so. The anxieties and uncertainties about possible changes and their consequences inhibited constructive and realistic planning and decision. At least the present difficulties were familiar and they had some ability to handle them. The problem was approaching the point of breakdown and the limits of the capacities of the people concerned when we were called in. Many other examples of

this clinging to the inappropriate familiar could be observed. For example, changes in medical practice and the initiation of the National Health Service[29] have led to more rapid patient turnover, an increase in the proportion of acutely ill patients, a wider range of illness to be nursed in each ward, and greater variation in the workload of a ward from day to day. These changes all point to the need for increasing flexibility in the work organization of nurses in wards. In fact, no such increase in flexibility has taken place in this hospital. Indeed, the difficulty inherent in trying to deal with a fluctuating workload by the rather rigid system described above has tended to be handled by increased prescription and rigidity and by reiteration of the familiar. As far as one could gather, the greater the anxiety, the greater the need for such reassurance in rather compulsive repetition.

The changing demands on nurses described above necessitate a growing amount of increasingly technically skilled nursing care. This has not, however, led to any examination of the implicit policy that nursing can be carried out largely by semi-qualified student nurses.

COMMENTARY ON THE SOCIAL DEFENCE SYSTEM

The characteristic feature of the social defence system, as we have described it, is its orientation to helping the individual avoid the experience of anxiety, guilt, doubt and uncertainty. As far as possible, this is done by eliminating situations, events, tasks, activities and relationships that cause anxiety or, more correctly, evoke anxieties connected with primitive psychological remnants in the personality. Little attempt is made positively to help the individual confront the anxiety-evoking experiences and, by so doing, to develop her capacity to tolerate and deal more effectively with the anxiety. Basically, the potential anxieties in the nursing situation are felt to be too deep and dangerous for full confrontation, and to threaten personal disruption and social chaos. In fact, of course, the attempt to avoid such confrontation can never be completely successful. A compromise is inevitable between the implicit aims of the social

defence system and the demands of reality as expressed in the need to pursue the primary task.

It follows that the psychic defence mechanisms that have, over time, been built into the socially structured defence system of the nursing service are, in the main, those which by evasion give protection from the full experience of anxiety. These are derived from the most primitive psychic defence mechanisms. Those mechanisms are typical of the young infant's attempts to deal, mainly by evasion, with the severe anxieties aroused by the interplay of his own instincts that are intolerable at his immature age.[30]

Individuals vary in the extent to which they are able, as they grow older, to modify or abandon their early defence mechanisms and develop other methods of dealing with their anxieties. Notably, these other methods include the ability to confront the anxiety situations in their original or symbolic forms and to work them over, to approach and tolerate psychic and objective reality, to differentiate between them and to perform constructive and objectively successful activities in relation to them.[31] Every individual is at risk that objective or psychic events stimulating acute anxiety will lead to partial or complete abandonment of the more mature methods of dealing with anxiety and to regression to the more primitive methods of defence. In our opinion, the intense anxiety evoked by the nursing task has precipitated just such individual regression to primitive types of defence. These have been projected and given objective existence in the social structure and culture of the nursing service, with the result that anxiety is to some extent contained, but that true mastery of anxiety by deep working through and modification is seriously inhibited. Thus, it is to be expected that nurses will persistently experience a higher degree of anxiety than is justified by the objective situation alone. Consideration in more detail of how the socially structured defence system fails to support the individual in the struggle towards more effective mastery of anxiety may be approached from two different but related points of view.

I will first consider how far the present functioning of the nursing service gives rise to experiences that in themselves

reassure nurses or arouse anxiety. In fact, as a direct consequence of the social organization, many situations and incidents develop that clearly arouse anxiety. On the other hand, the social system frequently functions in such a way as to deprive nurses of necessary reassurance and satisfactions. In other words, the social defence system itself arouses a good deal of secondary anxiety as well as failing to alleviate primary anxiety. I shall illustrate these points with some typical examples.

Threat of crisis and operational breakdown. From the operational point of view, the nursing service is cumbersome and inflexible. It cannot easily adapt to short- or long-term changes in conditions. For example, the task-list system and minutely prescribed task-performance make it difficult to adjust workloads when necessary by postponing or omitting less urgent or important tasks. The total demands on a ward vary considerably and at short notice according to factors like types and numbers of patients and operating days. The numbers and categories of student nurses also vary considerably and at short notice. Recurrent shortages of second-year or third-year nurses occur while they spend six weeks in the school; sickness or leave frequently reduce numbers. The work/staff ratio, therefore, varies considerably and often suddenly. Since work cannot easily be reduced, this generates considerable pressure, tension and uncertainty among staff and students. Even when the work/staff ratio is satisfactory, the threat of a sudden increase is always present. The nurses seem to have a constant sense of impending crisis. They are haunted by fear of failing to carry out their duties adequately as pressure of work increases. Conversely, they rarely experience the satisfaction and lessening of anxiety that come from knowing they have the ability to carry out their work realistically and efficiently.

The nursing service is organized in a way that makes it difficult for one person, or even a close group of people, to make a rapid and effective decision. Diffusion of responsibility prevents adequate and specific concentration of authority for making and implementing decisions. The organization of working groups makes it difficult to achieve adequate concen-

tration of necessary knowledge. For example, the task-list system prevents the breakdown of a ward into units of a size that allows one person to be fully acquainted with what is going on in them and of a number that allows adequate communication between them and to the person responsible for co-ordinating them. In a ward, only the sister and the staff nurse are in a position to collect and co-ordinate knowledge. However, they must do this for a unit of such size and complexity that it is impossible to do it effectively. They are, inevitably, badly briefed. For example, we came across many cases where the sister did not remember how many nurses were on duty or what each was supposed to do, and had to have recourse to a written list. Such instances cannot be attributed primarily to individual inadequacy. Decisions tend to be made, therefore, by people who feel that they lack adequate knowledge of relevant and ascertainable facts. This leads to both anxiety and anger. To this anxiety is added the anxiety that decisions will not be taken in time, since decision-making is made so slow and cumbersome by the system of checking and counterchecking and by the obscurity surrounding the localization of responsibility.

Excessive movement of student nurses. The fact that a rise in work/staff ratios can be met only within very narrow limits by a reduction in the workload means that it is often necessary to have staff reinforcements – usually, to move student nurses. The defence of rigid work organization thus appears as a contributory factor to the presenting problem of student allocation. The unduly frequent moves cause considerable distress and anxiety. Denial of the importance of relationships and feelings does not adequately protect the nurses, especially since the moves most directly affect student nurses, who have not yet fully developed these defences. Nurses grieve and mourn over broken relationships with patients and other nurses; they feel they are failing their patients. One nurse felt compelled to return to her previous ward to visit a patient who, she felt, had depended a great deal on her. The nurse feels strange in her new surroundings. She has to learn some new duties and make relationships with new patients and staff. She probably has to nurse types of illness she has never nursed before. Until she gets to know more about the new situation she suffers anxiety, uncertainties and doubts. Senior staff estimate that it takes a student two weeks to settle down in a new ward. We regard this as an underestimate. The suddenness of many moves increases the difficulty. It does not allow adequate time for preparing for parting and makes the parting more traumatic. Patients cannot be handed over properly to other nurses. Sudden transfers to a different ward allow little opportunity for psychological preparation for what is to come. Nurses tend to feel acutely deprived by this lack of preparation. As one girl said, 'If only I had known a bit sooner that I was going to the diabetic ward, I would have read up about diabetics and that would have helped a lot.' Janis (1958) has described how the effects of anticipated traumatic events can be alleviated if an advance opportunity is provided to work over the anxieties. He has described this as the 'work of worrying', a parallel concept to Freud's concept of the 'work of mourning' (Freud, 1917). The opportunity to work over the anticipated traumata of separation is, in the present circumstances, denied to nurses. This adds greatly to stress and anxiety.

This situation does indeed help to produce a defensive psychological detachment. Students protect themselves against the pain and anxiety of transfers, or the threat of transfers, by limiting their psychological involvement in any situation, with patients or other staff. This reduces their interest and sense of responsibility and fosters a 'don't care' attitude of which nurses and patients complain bitterly. Nurses feel anxious and guilty when they detect such feelings in themselves, and angry, hurt, and disappointed when they find them in others: 'Nobody cares how we are getting on, there is no team spirit, no one helps us.' The resulting detachment also reduces the possibility of satisfaction from work well done in a job one deeply cares about.

Underemployment of student nurses. Understandably, since workloads are so variable and it is difficult to adjust tasks, the nursing service tries to plan its establishments to meet peak rather than average loads. As a result, student nurses quite often have too little work. They hardly ever complain of overwork and a

number complained of not having enough work, although they still complained of stress. We observed obvious underemployment as we moved about the wards, despite the fact that student nurses are apt to make themselves look busy doing something and talk of having to look busy to avoid censure from the sister. Senior staff often seemed to feel it necessary to explain why their students were not busier, and would say they were 'having a slack day' or they 'had an extra nurse today'.

Student nurses are also chronically underemployed in terms of work level. A number of elements in the defence system contribute to this. Consider, for example, the assignment of duties to whole categories of student nurses. Since nurses find it so difficult to tolerate inefficiency and mistakes, the level of duties for each category is pitched low – that is, near to the expected level of the least competent nurse in the category. In addition, the policy that makes student nurses the effective nursing staff of the hospital condemns them to the repetitive performance of simple tasks to an extent far beyond that necessary for their training. The performance of simple tasks need not of itself imply that the student nurse's role is at a low level. The level depends also on how much opportunity is given for the use of discretion and judgement in the organization of the tasks – which, when, and how. It is theoretically possible to have a role in which a high level of discretion is required to organize tasks that are in themselves quite simple. In fact, the social defence system specifically minimizes the exercise of discretion and judgement in the student nurse's organization of her tasks, for example through the task-list system. This ultimately determines the underemployment of many student nurses who are capable of exercising a good deal of judgement and could quickly be trained to use it effectively in their work. Similar underemployment is obvious in senior staff connected, for example, with the practice of delegating upwards.

Underemployment of this kind stimulates anxiety and guilt, which are particularly acute when underemployment implies failing to use one's capacities fully in the service of other people in need. Nurses find the limitations on their performance very frustrating. They often experience a painful sense of failure

when they have faithfully performed their prescribed tasks, and express guilt and concern about incidents in which they have carried out instructions to the letter but, in so doing, have practised what they consider to be bad nursing. For example, a nurse had been told to give a patient who had been sleeping badly a sleeping draught at a certain time. In the interval he had fallen into a deep natural sleep. Obeying her orders, she woke him up to give him the medicine. Her common sense and judgement told her to leave him asleep and she felt very guilty that she had disturbed him. One frequently hears nurses complain that they 'have' to waken patients early in the morning to have their faces washed when they feel that the patients would benefit more by being left asleep. Patients also make strong complaints, but 'all faces must be washed' before the consultant medical staff arrive in the wards in the morning. The nurses feel they are being forced to abandon common-sense principles of good nursing, and they resent it.

Jaques (1956) has discussed the use of discretion and has come to the conclusion that the level of responsibility experienced in a job is related solely to the exercise of discretion and not to carrying out the prescribed elements. Following that statement, we may say that the level of responsibility in the nurse's job is minimized by the attempt to eliminate the use of discretion. Many student nurses complain bitterly that, while ostensibly in a very responsible job, they have less responsibility than they had as senior schoolgirls. They feel insulted – indeed, almost assaulted – by being deprived of the opportunity to be more responsible. They feel, and are, devalued by the social system. They are intuitively aware that the further development of their capacity for responsibility is being inhibited by the work and training situation, and they greatly resent this. The bitterness of the experience is intensified because they are constantly being exhorted to behave responsibly, which, in the ordinary usage of the word in a work situation, they can hardly do. In fact, we came to the conclusion that senior staff tend to use the word 'responsibility' differently from ordinary usage. For them, a 'responsible' nurse is one who carries out prescriptions to the letter. There is an essential conflict between staff

and students that greatly adds to stress and bitterness on both sides. Jaques (1956) has stated that workers in industry cannot rest content until they have reached a level of work that deploys to the full their capacity for discretionary responsibility. Student nurses – who are, in effect, 'workers' in the hospital for most of their time – are certainly not content.

Deprivation of personal satisfactions. The nursing service seems to provide unusually little in the way of direct satisfaction for staff and students. Although the dictum 'nursing should be a vocation' implies that nurses should not expect ordinary job satisfaction, its absence adds to stress. Mention has already been made of a number of ways in which nurses are deprived of positive satisfactions potentially existent in the profession, for example the satisfaction and reassurance that come from confidence in nursing skill. Satisfaction is also reduced by the attempt to evade anxiety by splitting up the nurse–patient relationship and converting patients who need nursing into tasks that must be performed. Although the nursing *service* has considerable success in nursing patients, the individual nurse has little direct experience of success. Success and satisfaction are dissipated in much the same way as the anxiety. The nurse misses the reassurance of seeing a patient get better in a way she can easily connect with her own efforts. The nurse's longing for this kind of experience is shown in the excitement and pleasure felt by a nurse who is chosen to 'special' a patient, that is, to give special individual care to a very ill patient in a crisis situation. The gratitude of patients, an important reward for nurses, is also dissipated. Patients are grateful to the hospital or to 'the nurses' for their treatment and recovery, but they cannot easily express gratitude in any direct way to individual nurses. There are too many and they are too mobile. The poignancy of the situation is increased by the expressed aims of nursing at the present time – to nurse the whole patient as a person. The nurse is instructed to do that, it is usually what she wants to do, but the functioning of the nursing service makes it impossible.

Sisters, too, are deprived of potential satisfactions in their roles. Many of them would like closer contact with patients and more opportunity to use their nursing skills directly. Much of their time is spent in initiating and training student nurses who come to their wards. The excessive movement of students means that sisters are frequently deprived of the return on that training time and the reward of seeing the nurse develop under their supervision. The reward of their work, like the nurse's, is dissipated and impersonal.

The nursing service inhibits in a number of ways the realization of satisfactions in relationships with colleagues. For example, the traditional relationship between staff and students is such that students are singled out by staff almost solely for reprimand or criticism. Good work is taken for granted and little praise given. Students complain that no one notices when they work well, when they stay late on duty, or when they do some extra task for a patient's comfort. Work-teams are notably impermanent. Even three-monthly moves of student nurses would make it difficult to weld together a strong, cohesive work-team. The more frequent moves, and the threats of moves, make it almost impossible. In such circumstances it is difficult to build a team that functions effectively on the basis of real knowledge of the strengths and weaknesses of each member, her needs as well as her contribution, and adapts to the way of working and type of relationship each person prefers. Nurses feel hurt and resentful about the lack of importance attached to their personal contribution to the work, and the work itself is less satisfying when it must be done not only in accordance with the task-list system but also with an informal, but rigid, organization. A nurse misses the satisfaction of investing her own personality thoroughly in her work and making a highly personal contribution. The 'depersonalization' used as a defence makes matters worse. The implied disregard of her own needs and capacities is distressing to the nurse; she feels she does not matter and no one cares what happens to her. This is particularly distressing when she is in a situation fraught with risks and difficulty and knows that sooner or later she will have great need of help and support.

Such support for the individual is notably lacking throughout

the whole nursing service within working relationships. Compensation is sought in intense relationships with other nurses off-duty.[32] Working groups are characterized by great isolation of their members. Nurses frequently do not know what other members of their team are doing or even what their formal duties are; indeed, they often do not know whether other members of their team are on duty or not. They pursue their own tasks with minimal regard to colleagues. This leads to frequent difficulties between nurses. For example, one nurse, in carrying out her own tasks correctly by the prescription, may undo work done by another also carrying out her tasks correctly by the prescription, because they do not plan their work together and co-ordinate it. Bad feeling usually follows. One nurse may be extremely busy while another has not enough to do. Sharing out of work is rare. Nurses complain bitterly about this situation. They say 'there is no team spirit, no one helps you, no one cares'. They feel guilty about not helping and angry about not being helped. They feel deprived by the lack of close, responsible, friendly relations with colleagues. The training system, orientated as it is to information-giving, also deprives the student nurse of support and help. She feels driven to acquire knowledge and pass examinations, to become 'a good nurse', while at the same time she feels few people show real concern for her personal development and her future.

The lack of personal support and help is particularly painful for the student nurse as she watches the care and attention given to patients. It is our impression that a significant number of nurses enter the profession under a certain confusion about their future roles and functions. They perceive the hospital as an organization particularly well equipped to deal with dependency needs, kind and supportive, and they expect to have the privilege of being very dependent themselves. However, because of the categorization they find that they are denied the privilege except on very rare occasions, notably when they go sick themselves and are nursed in the hospital.

I go on now to consider the second general approach to the failure of the social defences to alleviate anxiety. This arises from the direct impact of the social defence system on the

individual, regardless of specific experiences – that is to say, from the more directly psychological interaction between the social defence system and the individual nurse.

Although, following Jaques, I have used the term 'social defence system' as a construct to describe certain features of the nursing service as a continuing social institution, I wish to make it clear that I do not imply that the nursing service *as an institution* operates the defences. Defences are, and can be, operated only by individuals. Their behaviour is the link between their psychic defences and the institution. Membership necessitates an adequate degree of matching between individual and social defence systems. I will not attempt to define the degree, but state simply that if the discrepancy between social and individual defence systems is too great, some breakdown in the individual's relation with the institution is inevitable. The form of breakdown varies, but in our society it commonly takes the form of a temporary or permanent break in the individual's membership. For example, if the individual continues to use his own defences and follows his own idiosyncratic behaviour patterns, he may become intolerable to other members of the institution who are more adapted to the social defence system. They may then reject him. If he tries to behave in a way consistent with the social defence system rather than his individual defences, his anxiety will increase and he may find it impossible to continue his membership. Theoretically, matching between social and individual defences can be achieved by a restructuring of the social defence system to match the individual, by a restructuring of the individual defence system to match the social, or by a combination of the two. The processes by which an adequate degree of matching is achieved are too complicated to describe here in detail. It must suffice to say that they depend heavily on repeated projection of the psychic defence system into the social defence system and repeated introjection of the social defence system into the psychic defence system. This allows continuous testing of match and fit as the individual experiences his own and other people's reactions.[33]

The social defence system of the nursing service has been described as a historical development through collusive interac-

tion between individuals to project and reify relevant elements of their psychic defence systems. However, from the viewpoint of the new entrant to the nursing service, the social defence system at the time of entry is a datum, an aspect of external reality to which she must react and adapt. Fenichel makes a similar point (1946). He states that social institutions arise through the efforts of human beings to satisfy their needs, but that social institutions then become external realities comparatively independent of individuals which affect the structure of the individual. The student nurse is faced with a particularly difficult task in adapting to the nursing service and developing an adequate match between the social defence system and her psychic defence system. It will be clear from what I have said above that the nursing service is very resistant to change, especially change in the functioning of its defence system. For the student nurse, this means that the social defence system is to an unusual extent immutable. In the process of matching between the psychic and social defence systems, the emphasis is heavily on the modification of the individual's psychic defences. This means in practice that she must incorporate and operate the social defence system more or less as she finds it, restructuring her psychic defences as necessary to match it.

An earlier section described how the social defence system of the hospital was built of primitive psychic defences, those characteristic of the earliest phases of infancy. It follows that student nurses, by becoming members of the nursing service, are required to incorporate and use primitive psychic defences, at least in those areas of their life-space which directly concern their work. The use of such defences has certain intrapsychic consequences. These are consistent with the social phenomena already referred to in other contexts in this paper. I will describe them briefly to complete the account. These defences are orientated to the violent, terrifying situations of infancy, and rely heavily on violent splitting which dissipates the anxiety. They avoid the experience of anxiety and effectively prevent the individual from confronting it. Thus, the individual cannot bring the content of the phantasy anxiety situations into effective contact with reality. Unrealistic or pathological anxiety cannot

be differentiated from realistic anxiety arising from real dangers. Therefore, anxiety tends to remain permanently at a level determined more by the phantasies than by the reality. The forced introjection of the hospital defence system, therefore, perpetuates in the individual a considerable degree of pathological anxiety.

The enforced introjection and use of such defences also interferes with the capacity for symbol formation (see also p. 49 above). The defences inhibit the capacity for creative, symbolic thought, for abstract thought, and for conceptualization. They inhibit the full development of the individual's understanding, knowledge and skills that enable reality to be handled effectively and pathological anxiety mastered. Thus the individual feels helpless in the face of new or strange tasks or problems. The development of such capacities presupposes considerable psychic integration, which the social defence system inhibits. It also inhibits self-knowledge and understanding, and with them realistic assessment of performance. The deficient reality sense that follows from the defence system also interferes with judgement and provokes mistakes. The individual is confronted with them when it is too late and a sense of failure, increased self-distrust and anxiety ensue. For example, mistakes, guilt and anxiety arise from following out the prescriptions rather than applying the principles of good nursing. This situation particularly affects belief and trust in positive impulses and their effectiveness to control and modify aggression. Anxiety about positive aspects of the personality is very marked in nurses: for example fear of doing the wrong thing, expectation of mistakes, fear of not being truly responsible. The social defences prevent the individual from realizing to the full her capacity for concern, compassion and sympathy, and for action based on these feelings which would strengthen her belief in the good aspects of herself and her capacity to use them. The defence system strikes directly, therefore, at the roots of sublimatory activities in which infantile anxieties are reworked in symbolic form and modified.

In general, one may say that forced introjection of the defence system prevents the personal defensive maturation that alone allows for the modification of the remnants of infantile anxiety

and diminishes the extent to which early anxieties may be re-evoked and projected into current real situations. Indeed, in many cases it forces the individual to regress to a maturational level below that which she had achieved before she entered the hospital. In this, the nursing service fails its individual members desperately. It seems clear that a major motivational factor in the choice of nursing as a career is the wish to have the opportunity to develop the capacity for sublimatory activities in the nursing of the sick, and through that to achieve better mastery of infantile anxiety situations, modification of pathological anxiety, and personal maturation.

It may be interesting, in view of this, to add one further comment on wastage. It seems more serious than number alone suggests. It appears to be the more mature students who find the conflict between their own and the hospital defence system most acute and are most likely to give up training. Although the research objectives did not permit us to collect statistics, it is our distinct impression that among the students who do not complete training are a significant number of the better students: those who are personally most mature and most capable of intellectual, professional and personal development with appropriate training. Nurses often talked of students who had left as 'very good nurses'. No one could understand why they had not wanted to finish their training. We had the opportunity to discuss the matter with some students who were seriously considering leaving. Many said they still wanted to nurse and found it difficult to formulate why they wanted to leave. They suffered from a vague sense of dissatisfaction with their training and the work they were doing and a sense of hopelessness about the future. The general content of the interviews left little doubt that they were distressed about the inhibition of their personal development. There is also a striking difference in the personalities of groups of students at different stages of training. We do not attribute all of this difference to the effects of training. Some of the differences appear to arise from self-selection of students who give up training. If we are correct in this impression, the social defence system impoverishes the nursing service for the future, since it tends to drive away those potential

senior staff whose contribution to the development of nursing theory and practice would be greatest. Thus the wheel turns full circle and the difficulty in changing the system is reinforced. It is the tragedy of the system that its inadequacies drive away the very people who might remedy them.

SUMMARY AND CONCLUDING COMMENTS

This paper has presented some data from a study of the nursing service of a general teaching hospital. Its specific purpose was to consider and, if possible, account for the high level of stress and anxiety chronic among nurses. In following through the data, it was suggested that the nature of the nurse's task, in spite of its obvious difficulties, was not enough to account for the level of anxiety and stress. Consequently, an attempt was made to understand and illustrate the nature of the methods the nursing service provided for the alleviation of anxiety – its social defence system – and to consider in what respects it failed to function adequately. The conclusion was that the social defence system represented the institutionalization of very primitive psychic defence mechanisms, a main characteristic of which is that they facilitate the evasion of anxiety but contribute little to its true modification and reduction.

In concluding, I wish to touch briefly on a few points that space does not permit me to elaborate. I have considered only incidentally the effect of the defence system on the efficiency of task-performance, apart from stating that it does permit the continuing performance of the primary task of the service. It will have been apparent, however, that the nursing service carries out its task inefficiently in many respects – for example it keeps the staff/patient ratio unduly high, leads to a significant amount of bad nursing practice and excessive staff turnover, and fails to train students adequately for their real future roles. There are many other examples. Further, the high level of anxiety in nurses adds to the stress of illness and hospitalization for patients and has adverse effects on such factors as recovery rates. Revans's investigation (Revans, 1959) connected recovery rates of patients quite directly with the morale of nursing staff. Thus the social structure of the nursing service is defective not only

as a means of handling anxiety, but also as a method of organizing its tasks. These two aspects cannot be regarded as separate. The inefficiency is an inevitable consequence of the chosen defence system.

This leads me to put forward the proposition that the success and viability of a social institution are intimately connected with the techniques it uses to contain anxiety. Analogous hypotheses about the individual have long been widely accepted. Freud put forward such ideas increasingly as his work developed (1926). The work of Melanie Klein and her colleagues has given a central position to anxiety and the defences in personality development and ego-functioning (1948b). I put forward a second proposition, which is linked with the first: namely, that an understanding of this aspect of the functioning of a social institution is an important diagnostic and therapeutic tool in facilitating social change. Bion (1955) and Jaques (1955) stress the importance of understanding these phenomena and relate difficulties in achieving social change to difficulty in tolerating the anxieties that are released as social defences are restructured. This appears to be closely connected with the experiences of people, including many social scientists, who have tried to initiate or facilitate social change. Recommendations or plans for change that seem highly appropriate from a rational point of view are ignored, or do not work in practice. One difficulty seems to be that they do not sufficiently take into account the common anxieties and the social defences in the institution concerned, nor provide for the therapeutic handling of the situation as change takes place. Jaques (1955) states that 'effective social change is likely to require analysis of the common anxieties and unconscious collusions underlying the social defences determining phantasy social relationships.'

The nursing service presents these difficulties to a high degree, since the anxieties are already very acute and the defence system both primitive and ineffectual. Efforts to initiate serious change were often met with acute anxiety and hostility, which conveyed the idea that the people concerned felt very threatened, the threat being of nothing less than social chaos and individual breakdown. To give up known ways of behaviour

and embark on the unknown were felt to be intolerable. In general, it may be postulated that resistance to social change is likely to be greatest in institutions whose social defence systems are dominated by primitive psychic defence mechanisms, those which have been collectively described by Melanie Klein as the paranoid-schizoid defences (Klein, 1952a, 1959). One may compare this sociotherapeutic experience with the common experience in psychoanalytic therapy, that the most difficult work is with patients whose defences are mainly of this kind, or in phases of the analysis when such defences predominate.

Some therapeutic results were achieved in the hospital, notably in relation to the presenting symptom. A planned set of courses has been prepared for student nurses, which jointly ensures that the student nurses have adequate training and that the hospital is adequately staffed. Interestingly, it was in preparing these courses that objective data were calculated for the first time about discrepancies between training and staffing needs. For example, to give adequate gynaecological training the gynaecological wards would have to carry four times too many staff; to keep the operating theatres staffed, the nurses would have to have one and a half times too much theatre experience for training. Before this time the existence of such discrepancies was known, but no one had collected reliable statistical data (a simple matter) and no realistic plans had been made to deal with them. To prevent emergencies from interfering with the implementation of the planned courses, a reserve pool of nurses was created whose special duty was to be mobile and deal with them. A number of other similar changes were instituted to solve other problems that emerged in the course of the investigation.[34] The common features of the changes, however, were that they involved minimal disturbance of the existing defence system. Indeed, it would be more correct to say that they involved reinforcing and strengthening the existing type of defence. Proposals were made for more far-reaching change, involving a restructuring of the social defence system. For example, one suggestion was that a limited experiment be done in ward organization, eliminating the task-list system and substituting some form of patient assignment.

However, although the senior staff discussed such proposals with courage and seriousness, they did not feel able to proceed with the plans. This happened despite our clearly expressed views that unless there were some fairly radical changes in the system, the problems of the nursing service might well become extremely serious. The decision seemed to us quite comprehensible, however, in view of the anxiety and the defence system. These would have made the therapeutic task of accomplishing change very difficult for both the nursing service and the therapist.

The full seriousness of the situation is not perhaps clear without considering this hospital in the context of the general nursing services in the country as a whole. The description of the hospital makes it seem a somewhat serious example of social pathology, but within the context of other general hospital nurse-training schools it is fairly typical. Nothing in our general experience of hospitals and nursing leads us to believe otherwise (Skellern, 1953; Sofer, 1955; Wilson, 1950). There are differences in detail, but the main features of the structure and culture are common to British hospitals of this type and are carried in the general culture and ethic of the nursing profession. The hospital studied has, in fact, high status. It is accepted as one of the better hospitals of its type.

The nursing services in general have shown a similar resistance to change in the face of great changes in the demands made on them. There can be few professions that have been more studied than nursing, or institutions more studied than hospitals. Nurses have played an active part in initiating and carrying out these studies. Many nurses have an acute and painful awareness that their profession is in a serious state. They eagerly seek solutions, and there have been many changes in the expressed aims and policy of the profession. There have also been many changes in the peripheral areas of nursing – that is to say, those which do not impinge very directly or seriously on the essential features of the social defence system. Against that background, one is astonished to find how little basic and dynamic change has taken place. Nurses have tended to receive reports and recommendations with a sense of outrage

and to react to them by intensifying current attitudes and reinforcing existing practice.

An example of a general nursing problem that threatens crisis is the recruitment of nurses. Changes in medical practice have increased the number of highly technical nursing tasks. Consequently, the level of intelligence and competence necessary for a fully trained and efficient nurse is rising. The National Health Service has improved the hospital service and made it necessary to have more nurses. On the other hand, professional opportunities for women are expanding rapidly and the other professions are generally more rewarding than nursing in terms of the opportunity to develop and exercise personal and professional capacities as well as in financial terms. The increasing demand for high-level student nurses is therefore meeting increasing competition from other sources. In fact, recruiting standards are being forced down in order to keep up numbers. This is no real solution, for too many of the recruits will have difficulty in passing the examinations and be unable to deal with the level of the work. Many of them, on the other hand, would make excellent practical nurses on simpler nursing duties. So far, no successful attempt has been made in the general hospitals to deal with this problem, for example, by splitting the role of nurse into different levels with different training and different professional destinations.

It is unfortunately true of the paranoid-schizoid defence systems that they prevent true insight into the nature of problems and realistic appreciation of their seriousness. Thus, only too often, no action can be taken until a crisis is very near or has actually occurred. This is the eventuality we fear in the British general hospital nursing services. Even if there is no acute crisis, there is undoubtedly a chronic state of reduced effectiveness, which in itself is serious enough.

NOTES

1. This study is one of a number of projects that the Tavistock Institute of Human Relations and associated workers have undertaken in recent years in general and mental hospitals, and with nurses in other settings (Menzies, 1951; Skellern, 1953; and Wilson, 1950). Miss O. V.