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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.

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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

be prepared to accept the temporary lowering of their operational level because they were in training. This was no real solution. It contributed to the 30–50 percent wastage of student nurses during training: students who were too “high-level” for the job they were doing, felt degraded and diminished by it and could not tolerate the situation until they were qualified. It also contributed to great suffering among students and staff.

AVOIDANCE OF CHANGE

Change is 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 relationships and in social structure, which implies in turn a change in the operation of the social system as a defense system. While this change is proceeding, anxiety is likely to be more open and intense. This is a familiar experience while the individual’s defenses are being restructured in the course of psychoanalytic therapy. 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 defenses against deep and intense anxieties.

It is understandable that the nursing service, whose tasks stimulated such primitive and intense anxieties, should anticipate change with unusually severe anxiety. In order to avoid this anxiety, the service tried to avoid change wherever possible and to cling to the familiar, even when the familiar had obviously ceased to be appropriate or relevant. Changes tended to be initiated only at the point of crisis. The presenting problem was a good example of the 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 problem was approaching the point of breakdown and the limits of the capacities of the people concerned when we were called in. Other examples of this clinging to the inappropriate familiar could be observed. Changes in medical practice and the initiation of the National Health Service had 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 work-load of a ward from day to day. These changes pointed to the need for increasing flexibility in the work organization in wards. In fact, no such increase had taken place. Indeed, the difficulty inherent in trying to deal with a fluctuating work-load by the rather rigid system described above tended to be handled by increased prescription and rigidity and by reiteration of the familiar. The

greater the anxiety the greater the need for reassurance in rather compulsive repetition.

Commentary on the Social Defense System

The characteristic feature of the social defense system was its orientation to helping the individual to avoid the conscious experience of anxiety, guilt, doubt and uncertainty. This was done by eliminating situations, events, tasks, activities and relationships that caused anxiety or, more correctly, evoked anxieties connected with primitive psychological remnants in the personality. Little attempt was 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 them. Basically, the potential anxieties in the nursing situation were felt to be too deep and dangerous for full confrontation. They threatened personal disruption and social chaos. In fact, of course, the attempt to avoid such confrontation could never be completely successful. A compromise was inevitable between the implicit aims of the social defense system and the demands of reality as expressed in the need to pursue the primary task.

It followed that the psychic defense mechanisms that had, over time, been built into the socially structured defense system of the nursing service were, in the main, those which by evasion give protection from the full experience of anxiety. These were derived from the most primitive psychic defense mechanisms typical of the young infant's attempts to deal, mainly by evasion, with the severe anxieties aroused by the interplay of instincts. Individuals vary in the extent to which they are able, as they grow older, to modify or abandon their early defense 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. 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 more primitive methods of defense. The intense anxiety evoked by the nursing task had precipitated just such individual regression to primitive types of defense. These had been projected and given objective existence in the social structure and culture of the nursing service, with the result that anxiety was to some extent contained, but that true mastery of anxiety by deep working-through and modification was seriously inhibited. Thus, it was to be expected that nurses would persistently experience a higher degree of anxiety than was justified by the objective situation.

Consideration in more detail of how the socially structured defense system failed to support the individual in the struggle towards more effective mastery of anxiety may be approached from two different but related points of view. First, I will consider how far the current functioning of the nursing service gave rise to experiences that reassured nurses or aroused anxiety. As a direct consequence of the social organization, many situations and incidents arose that aroused anxiety. On the other hand, the social system frequently deprived nurses of necessary reassurance and satisfaction. In other words, the social defense system itself aroused a good deal of secondary anxiety as well as failing to alleviate primary anxiety.

THREAT OF CRISIS AND OPERATIONAL BREAKDOWN

From the operational point of view, the nursing service was cumbersome and inflexible. It could not easily adapt to short- or long-term changes in conditions. The task-list system and minutely prescribed task-performance made it difficult to adjust work-loads when necessary by postponing or omitting less urgent or important tasks. The total demands on a ward varied considerably and at short notice according to factors such as types and numbers of patients and days on which operations took place. The numbers and categories of student nurses also varied considerably and at short notice. Recurrent shortages of second-year or third-year nurses occurred while they spent six weeks in school; sickness or leave frequently reduced numbers. The work/staff ratio, therefore, varied considerably and often suddenly. Since work could not easily be reduced, this generated considerable pressure, tension and uncertainty among staff and students. Even when the work/staff ratio was satisfactory, the threat of a sudden increase was always present. The nurses seemed to have a constant sense of impending crisis. They were haunted by fear of failing to carry out their duties adequately as pressure of work increased. Conversely, they rarely experienced the satisfaction and lessening of anxiety that came from knowing they had the ability to carry out their work realistically and efficiently.

The nursing service was organized in a way that made it difficult for one person, or even a close group of people, to make a rapid and effective decision. Diffusion of responsibility prevented adequate and specific concentration of authority for making and implementing decisions. The organization of working groups made it difficult to achieve adequate concentration of knowledge. In a ward, only the sister and the staff nurse were in a position to collect and co-ordinate knowledge. However, they had to do this for a unit of such size and complexity that it was impossible to do it effectively. They were, inevitably, badly briefed. 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 tended to be made, therefore, by people who felt that they lacked adequate knowledge of relevant and ascertainable facts. This led to both anxiety and anger. To this anxiety was added the anxiety that decisions would not be taken in time, since decision-making was made so slow and cumbersome by the system of checking and counter-checking and by the obscurity surrounding the location of responsibility.

EXCESSIVE MOVEMENT OF STUDENT NURSES

The fact that a rise in work/staff ratios could be met only within very narrow limits by a reduction in the work-load meant that it was often necessary to have staff reinforcements, usually, to move student nurses. The defense of rigid work organization thus appeared as a factor contributory to the presenting problem of student-allocation, and the consequent distress and anxiety. Denial of the importance of relationships and feelings did not adequately protect the nurses, especially since the moves most directly affected student nurses, who had not yet fully developed these defenses. Nurses grieved and mourned over broken relationships with patients and other nurses; they felt they were failing their patients. They felt strange in new surroundings. They had to learn new duties and make relationships with new patients and staff, and probably had to nurse types of illness they had never nursed before. Until they got to know more about the new situation they suffered anxiety, uncertainties and doubts. Senior staff estimated that it took a student two weeks to settle down in a new ward. We regarded this as an underestimate. The suddenness of many moves increased the difficulty. It did not allow adequate time for preparing for parting and made the parting more traumatic. Patients could not be handed over properly to other nurses. Sudden transfers to a different ward allowed little opportunity for psychological preparation for what was to come. Nurses tended to feel acutely deprived by this lack of preparation. As one young woman 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—an opportunity denied to the nurses.

This situation did indeed help to produce a defensive psychological detachment. Students protected 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 reduced their interest and sense of responsibility and fostered a "don't care" attitude of which nurses and patients

complained bitterly. Nurses felt anxious and guilty when they detected such feelings in themselves, and angry, hurt and disappointed when they found them in others. The resulting detachment also reduced the possibility of satisfaction from work well done in a job one deeply cared about.

UNDER-EMPLOYMENT OF STUDENT NURSES

Understandably, since work-loads were so variable and it was difficult to adjust tasks, the nursing service tried to plan its establishment to meet peak rather than average loads. As a result, student nurses quite often had too little work. They hardly ever complained of overwork but rather a number complained of not having enough work, although they still complained of stress. We observed obvious under-employment in spite of the fact that student nurses were apt to make themselves look busy doing something and talked 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 were also under-employed in terms of level of work. A number of elements in the defense system contributed to this. Consider, for example, the assignment of duties to whole categories of student nurses. Since nurses found it so difficult to tolerate inefficiency and mistakes, the level of duties for each category was pitched low, near to the expected level of the least competent nurse in the category. In addition, the policy that made student nurses the effective nursing staff of the hospital condemned 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 was at a low level. The level depends also on how much opportunity was given for the use of discretion and judgment in the organization of the tasks—which, when and how. In fact, the social defense system specifically minimized the exercise of discretion and judgment in the student nurse's organization of tasks, for example, through the task-list system. This ultimately determined the under-employment of many student nurses who were capable of exercising a good deal of judgment and could quickly have been trained to use it effectively. Similar under-employment was obvious in senior staff connected, for example, with the practice of delegating upwards.

Under-employment of this kind stimulates anxiety and guilt, which are particularly acute when under-employment implies failing to use one's capacities fully in the service of other people in need. Nurses found the limitations on their performance very frustrating. They often experienced a painful sense of failure when they had faithfully performed their prescribed tasks, and expressed guilt and concern about incidents in which they had carried out

instructions to the letter, but, in so doing, had practiced what they considered 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 judgment told her to leave him asleep and she felt very guilty that she had disturbed him. The nurses felt they were being forced to abandon common-sense principles of good nursing, and they resented it.

Jaques (1956) discussed the use of discretion and came to the conclusion that the level of responsibility experienced in a job was related solely to the exercise of discretion and not to carrying out the prescribed elements. We may say that the level of responsibility in the nurse's job is minimized by the attempt to eliminate the use of discretion. Nurses felt insulted, indeed almost assaulted, by being deprived of the opportunity to be more responsible. They felt, and were, devalued by the social system. They were intuitively aware that the further development of their capacity for responsibility was being inhibited by the work and training situation and they greatly resented this. The bitterness of the experience was intensified because they were constantly being exhorted to behave responsibly, which, in the ordinary usage of the word in a work-situation, they were prevented from doing. We came to the conclusion that senior staff tended to use the word "responsible" differently from ordinary usage. For them, a responsible nurse was one who carried out prescriptions to the letter. There was an essential conflict between staff and students that greatly added to stress and bitterness on both sides. Jaques (1956) 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 were, in effect, workers in the hospital for most of their time, were certainly not content.

DEPRIVATION OF PERSONAL SATISFACTIONS

The nursing service seemed to provide unusually little in the way of direct satisfaction for staff and students. Although the dictum "nursing should be a vocation" implied that nurses should not expect ordinary job satisfaction, its absence added to stress. Mention has already been made of a number of ways in which nurses were deprived of positive satisfactions potentially existent in the profession. Satisfaction was 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* had considerable success in nursing patients, the individual nurse had little direct experience of success. Success and satisfaction were dissipated in much the

same way as anxiety. Nurses missed the reassurance of seeing patients get better in a way they could easily connect with their own efforts. The nurses' longing for this kind of experience was shown in the excitement and pleasure felt by a nurse who was chosen to "special" a patient, that is give special, individual care to a very ill patient in a crisis. The gratitude of patients, an important reward for nurses, was also dissipated. Patients were grateful to the hospital or to the nurses for their treatment and recovery, but they could not easily express gratitude in any direct way to individual nurses. There were too many and they were too mobile. Ward sisters, too, were deprived of potential satisfaction in their roles. Many of them would have liked closer contact with patients, and more opportunity to use their nursing skills directly. Much of their time was spent in initiating and training student nurses who came to their wards. The excessive movement of students meant that sisters were 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, was dissipated and impersonal.

The nursing service inhibited in a number of ways the realization of satisfactions in relationships with colleagues. The traditional relationship between staff and students was such that students were singled out by staff almost solely for reprimand or criticism. Good work was taken for granted and little praise given. Students complained that no one noticed when they worked well, when they stayed late on duty, or when they did some extra task for a patient's comfort. Work-teams were notably impermanent. Even three-monthly moves of student nurses made it difficult to weld together a strong, cohesive work-team. The more frequent moves, and the threat of moves, made it almost impossible. In such circumstances, it was difficult to build a team that functioned effectively on the basis of real knowledge of the strengths and weaknesses of each member, her needs as well as her contribution, and adapted to the way of working and type of relationship each person preferred. Nurses felt hurt and resentful about the lack of importance attached to their personal contribution to the work, and the work itself was less satisfying when it had to be done not only in accordance with the task-list system, but also within an informal, but rigid, organization. Nurses missed the satisfaction of investing their own personality thoroughly in their work and making a highly personal contribution.

Support for the individual was notably lacking throughout the whole nursing service within working relationships. Compensation was sought in intense relationships with other nurses off duty. Working-groups were characterized by isolation of their members. Nurses frequently did not know what other members of their team were doing or even what their formal duties were; indeed, they often did not know whether other members of their team were on duty or not. They pursued their own tasks with minimal regard to those of their

colleagues. This practice led to frequent difficulties between nurses. One nurse, carrying out her own tasks correctly by the prescription, might undo work done by another nurse also carrying out her tasks correctly by the prescription, because they did not plan their work together and co-ordinate it. Bad feeling usually followed. One nurse might be extremely busy while another had not enough to do. Sharing work was rare. Nurses complained bitterly about this. They said "there is no team spirit, no one helps you, no one cares." They felt guilty about not helping and angry about not being helped. They felt deprived by the lack of close, responsible, friendly relations with colleagues.

The lack of personal support and help was particularly painful for the student nurses as they watched the care and attention given to patients. It was our impression that a significant number of nurses entered the profession under some confusion about their future roles and functions. They perceived the hospital as a kind and supportive organization particularly well-equipped to deal with dependency needs, and they expected to have the privilege of being dependent themselves. However, because of the categorization they were denied the privilege except on very rare occasions, notably when they became sick themselves and were nursed in the hospital.

I go on now to consider the second general approach to the failure of the social defense to alleviate anxiety. This arose from the direct impact of the social defense system on the individual, regardless of specific experiences, that is, from the more directly psychological interaction between the social defense system and the individual nurse.

Although I have used the term "socially structured defense 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 defenses. Defenses are, and can be, operated only by individuals. Their behavior is the link between their psychic defenses and the institution. Membership necessitates an adequate degree of matching between individual and social defense systems. I will not attempt to define the degree of matching, but state simply that if the discrepancy between social and individual defense systems is too great, some breakdown in the individual's relation with the institution is inevitable. The form of breakdown varies, but it commonly takes the form of a temporary or permanent break in the individual's membership. For example continuing to use one's own defenses and to follow one's own idiosyncratic behavior patterns may make an individual intolerable to other members of the institution who are more adapted to the social defense system. They may then respond with rejection. Trying to behave in a way consistent with the social defense system rather than individual defenses, will increase anxieties and make it impossible for the individual to continue membership. Theoretically, matching between social and individ-

ual defenses can be achieved by a re-structuring of the social defense system to match the individual, by a re-structuring of the individual defense 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 defense system into the social defense system and repeated introjection of the social defense system into the psychic defense system. This allows continuous testing of match and fit as the individual experiences his or her own and other people's reactions (Heimann, 1952).

The social defense system of the nursing service has been described as an historical development through collusive interaction between individuals to project and reify relevant elements of their psychic defense systems. However, from the point of view of new entrants to the nursing service, the social defense system at the time of entry is a datum, an aspect of external reality to which they must react and adapt. Fenichel (1946) makes a similar point. 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 nurses were faced with a particularly difficult task in adapting to the nursing service and developing an adequate match between the social defense system and their psychic defense systems. It will be clear that the nursing service was very resistant to change, especially change in the functioning of its defense system. For the student nurses, this meant that the social defense system was to an unusual extent immutable. In the process of matching between the psychic and social defense systems, the emphasis was heavily on the modification of the individual's psychic defenses. This meant in practice that the social defense system had to be incorporated and used more or less as it was found, and psychic defenses re-structured as necessary to match it.

An earlier section of this paper described how the social defense system of the hospital was built on primitive psychic defenses, those characteristic of the earliest phases of infancy. The fact that the student nurses had to incorporate and use this defense system has certain intrapsychic consequences. These defenses are oriented 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 defense system, therefore, perpetuates in the individual a considerable degree of pathological anxiety.

The enforced use of this defense system inhibited maturation in many ways and even led to regression. It interfered with the capacity for symbol formation; it inhibited the capacity for abstract thought and conceptualization; it prevented full development of the individual's knowledge, understanding and skills. The social defense system inhibited the psychic integration on which the development of such capacities depends. Individuals were prevented from realizing to the full their capacity for concern, compassion and sympathy, and for action based on these feelings which would strengthen their belief in their own good aspects and capacity to use them. The defense system struck directly, therefore, at the roots of sublimatory activities in which infantile anxieties could be re-worked in symbolic form and modified.

In general, one may say that forced introjection of the defense system prevented the personal defensive maturation that alone would allow for the modification of the remnants of infantile anxiety and diminish the extent to which early anxieties may be re-evoked and projected into current real situations. Indeed, in many cases, it forced the individual to regress to a maturational level below that achieved before entering the hospital. In this, the nursing service failed its individual members desperately. It seemed clear that a major motivational factor in the choice of nursing as a career was 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.



Conclusion

Attention has been concentrated mainly on the way in which the social defense system in the nursing service was ineffective in containing anxiety in its members. It did not help them work it through. Incidentally, however, mention was made from time to time of the effect of the social defense system on diminishing the efficiency of task-performance. The inefficiencies were not so great as to prevent task-performance from continuing, although at a less than optimum level and accompanied by fears that it might be in jeopardy.

Inefficiencies noted include high staff/patient ratios, bad nursing practice, excessive staff turnover, failure to train students effectively for their future roles. Further, the high level of anxiety in nurses added to the stress of illness and hospitalization for patients and had adverse effects on such factors as recovery rates. A later investigation (Revans, 1959) connected recovery rates of patients quite directly with the morale of the 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 of the situation cannot be regarded as separate. The inefficiency is an inevitable consequence of the chosen defense system.

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 (1948) put forward such ideas as his work developed. The work of Melanie Klein and her colleagues has given a central position to anxiety and the defenses in personality development and ego-functioning (Klein, 1948). Similarly, 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 defenses are re-structured. The many failures experienced by social scientists and others in attempts to change social institutions would seem to be connected with their not taking sufficient account of the need to analyze anxieties and defenses.

The nursing service illustrated the problem of achieving social change to a marked degree. Efforts to initiate serious change were often met with acute anxiety and hostility. The people concerned felt very threatened, the threat being of nothing less than social chaos and individual breakdown. To give up known ways of behavior 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 defense systems are dominated by primitive psychic defense mechanisms, those which have been collectively described by Melanie Klein as the paranoid-schizoid defenses (Klein, 1952a; 1959). One may compare this socio-therapeutic experience with the common experience in psychoanalytical therapy, that the most difficult work is with patients whose defenses are mainly of this kind, or in phases of the analysis when such defenses predominate.

Some therapeutic results were achieved in the hospital, notably in relation to the presenting symptom. For example, a planned set of courses was prepared for student nurses, which jointly ensured that the student nurse had adequate training and that the hospital was adequately staffed, and took more realistic account of the real discrepancies between training and staffing needs. To prevent emergencies from interfering with the implementation of the planned courses, a reserve pool of mobile nurses was created. The common feature of the changes, however, was that they involved minimal disturbance of the existing defense system. Indeed, it might be more correct to say that they involved reinforcing and strengthening the existing type of defense. Proposals were made for more far-reaching change, involving a re-structuring of the social defense 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 in spite of our clearly expressed view 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 defense system. These would have made the therapeutic task of accomplishing change very difficult for both the nursing service and the therapist.

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