Social Defense Systems

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The point of defense mechanisms – individually and in groups – is to provide us with illusions of certainty and safety that protect us from being overwhelmed by anxiety, terror and helplessness. The fundamental problem with these defense mechanisms is that they often keep us from taking constructive action that would eliminate the sources of the stress or threat.

Group analyst, Isabel Menzies, building on the work of the noted group theorist, Eliot Jaques, described the ways in which mental health systems create their own “social defense systems” [1-2]. She described how systems develop specific and static protective mechanisms to protect against the anxiety that is inevitably associated with change. The defense mechanisms she describes sound uncannily like those that we see in victims of trauma - depersonalization, denial, detachment, denial of feelings, ritualized task-performance, redistribution of responsibility and irresponsibility, idealization, avoidance of change.

Menzies used as an example of a social defense system conflict in the nursing staff of a hospital that played itself out at every level within an organization. In describing this she said the nursing staff “develop some form of relationship that locates madness in the patient and sanity in themselves, with a barrier to prevent contamination. Such an arrangement allows the nurses to stay in the situation without feeling that their minds are being damaged. It justifies the use of control by the nurses, entitles patients to care and refuge, and is a virtual guarantee that they will continue to be thought ill and therefore will not be sent outside” (p. 604) [3].

Janis looked at how groups make decisions, particularly under conditions of stress. He reviewed studies of infantry platoons, air crews, and disaster control teams and felt that this work confirmed what social psychologists had shown on experiments in normal college students, that stress produces a heightened need for affiliation, leading to increased dependency on one’s group. The increase in group cohesiveness, though good for morale and stress tolerance, could produce a phenomenon he called “groupthink”, a process he saw as a disease that could infect otherwise healthy groups rendering them inefficient, unproductive, and sometimes disastrous. He observed that certain conditions give rise to a group phenomenon in which the members try so hard to agree with each other that they commit serious errors that could easily have been avoided. An assumed consensus emerges while all members hurry to converge and ignore important divergences. As this convergence occurs, all group members share in the sense of invulnerability and strength conveyed by the group, while the decisions made are often actually disastrous. Later, the individual members of the group find it difficult to accept that their individual wills were so
affected by the group. As we know, the inability to think clearly under stress is also typical of individuals as well [4-5].

In a recent study, Smith, Kaminstein, and Maradok have looked at the possibility that the collective dynamics of an organization may lead to individual illness. Although it is well established that physically toxic environments can produce illness, these authors raised the question about the consequences of emotionally noxious environments. In their study of 13,000 employees in sixteen organizations, they found that there is a significant connection between employee health and organizational dynamics of their workplaces. The health of workers improved or worsened based on four major variables: a) the degree of difficulty in maintaining a balance between work and personal life; b) the respect afforded workers by management; c) the extent to which decision-making can lead the worker to appropriate actions; and d) the amount of racial and gender discrimination [6].

Another interesting observation comes from Poland. Group therapists working in a day hospital program in Poland noticed that there was a relationship between behavior in their therapeutic community and larger social unrest during 1980 and 1981 and again in 1992 and 1993. Bursts of anti-authoritarian behavior directed at nonauthoritarian therapists occurred regularly one or two days prior to the unheralded eruption of strikes or other anti-government demonstrations. This suggested to the authors that the responsivity of emotionally vulnerable groups of people may serve as early warning signals of forthcoming outbreaks of aggression in the larger sociopolitical milieu, a sort of “sociopolitical canaries” phenomenon [7].

Although I can provide only testimony rather than scientific “proof”, I have become convinced that there are processes at work in a group that go far behind the workings or maneuverings of any single individual or even the summed effects of an aggregation of individuals. I have been observing, studying, and immersed in the workings of small group processes for over thirty years, largely in two settings - group practice and the therapeutic community. On innumerable occasions I have seen a process occur in which the outcome cannot be sufficiently explained by the input. Quite frequently we come away with better ideas, better decisions, and better plans than can be attributable to any individual, but which is instead the shared conscious processing of a group. Likewise, the power of a group to create an environment of anger, threat, or destruction goes far beyond that of any individual, and can take on a life of its own. Groupmind? I do not really know, but these repeated observations have led me to concur completely with Trigant Burrow who said, “Whether it is a question of mollusk or man, science cannot understand the part until it has understood the whole” (Burrow, 1984).

This social defense system can be seen operating in psychiatrists who spend more time deciding on the diagnosis that most adequately fits the DSM-IV-R and then based on the diagnosis, prescribing the “proper” medication, then they spend actually talking to the patient. It is
operating when the staff fails to ask about a client’s trauma history or keep forgetting what it was. It is operating whenever the “silencing response” is occurring. It is operating when a collective disturbance arises. It is operating when we collude to create a blame culture and engage in groupthink. And whenever staff members engage in reenactment behavior, our social defense system is unconsciously operating. It is also operating in the institution as a whole, when that institution provides services that are called “treatment” but which are more accurately designed to control or “manage” the individual patient on behalf of the society. It is be operating when psychiatrists deal with the constraints on care determined by funding and demands for productivity by exclusively focusing on the use of medications and by making diagnoses that accommodate such a focus, and when the rest of the components of the human service delivery system go along with this.

The conflict between “controlling” the less fortunate among us for the sake of society and helping actually helping people by empathizing with and empowering them to make positive change is a source of chronic conflict. And this conflict is a source of chronic, unspoken, unrealized stress for everyone working within virtually any social service institution. As an example, as long as the mental health system is responsible for the legal and social containment of mental illness, it will be exceedingly difficult and perpetually stressful for the staff of institutions to offer the kind of care sought by many advocates of the recovery movement. This then presents a major barrier to the goals of the consumer-recovery movement [8].

Over time and as a result of collusive interaction and unconscious agreement between members of an organization, this social defense system becomes a systematized part of reality which new members must deal with as they come into the system. These defensive maneuvers become group norms, similar to the way the same defensive maneuvers become norms in the lives of our individual patients and then are passed on from one generation of group participants to the next. Upon entering the system each new member must become acculturated to the established norms if he or she is to succeed. In such a way, an original group creates a group reality which then becomes institutionalized for every subsequent group, firmly lodged in the institutional memory [2]. This aspect of the “groupmind” becomes quite resistant to change, rooted in a past that is forgotten, now simply the “way things are” [9].

When trauma is experienced, the social defense system goes on “high alert”. Intense and primitive emotions are precipitated by exposure to trauma and are experienced empathically by all the members of a group. The occurrence of trauma is a reminder to peers that they too are vulnerable and one way to defend against this sense of vulnerability is by projecting anxiety outward and that can be accomplished by finding something peculiar to the therapist or the worker involved in the event rather than perceiving the risks involved in the work itself. When peers experience this they are likely to distance themselves from the traumatized peer and in that way one person may carry the vulnerable feelings for the entire group [10].

“Institutions that deal with trauma or with trauma survivors will inevitably encounter secondary traumatic stress... In the case of institutions that deal with physical dangers, their members can be traumatized both directly and indirectly; that is, they can be exposed to both primary stressors
and secondary stressors...If any personnel are exposed to primary stressors, then all other personnel are in danger of secondary stress” (p. 232-233) [11].

Institutional Uncertainty

In every organization there is the level of “what we say we do” and the levels of “what we really believe we are doing” and also “what is going on” – and the members of an organization may be completely unaware of this third level [12]. Depending on what institution we are addressing, the more unconscious motivations vary. In the health care system, the third level can be addressed as “keeping-death-at-bay” and in a variety of ways denying that death will inevitably occur. In the mental health system, this third level shows itself attempts to reject the enormous complexity of emotional problems and our relative helplessness in affecting cure and “keeping-insanity-at-bay”.

The collective result of this natural inclination to contain anxiety becomes a special problem when institutional events occur that produce great uncertainty, particularly those events that are associated with insanity, death or the fear of death. Under these conditions, containing anxiety may become more important than rationally responding to the situation. But this motivation is likely to be denied and rationalized. As a result, organizations may engage in behavior that may serve to contain anxiety but that is ultimately destructive to organizational purpose [13-15]. One of the ways in which this happens is when a group feels threatens and projects the reason for their fear onto an external enemy who then becomes dehumanized. This is typically what happens in situations that are confusing and complex. This is most likely to happen when our “social defense systems” begin to fail.


References


