

# Who is the Saboteur?

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*"Every time a friend succeeds, a little part of me dies".*

Gore Vidal

## Abstract

This article explores how envy may exist between staff and patients within any areas of General and Psychiatric Health Care, the more so as there is little or no hope of this being thought about and owned by the participants.

This dynamic, again the more so as it is unconscious, may massively interfere with 'the work', with many destructive ramifications.

Although the particular area of Health Care delivery reported on here happens to be Nephrology, it is suggested that the issues raised are relevant to all services in which ill patients are looked after by staff who are dedicated to their care.

**Key Words:** Envy, spoiling, denial and haemodialysis

## England: Summer 2005

In the summer of 2005 I was doing a small piece of rather atypical work for a Primary Care Trust (PCT) located in the North East of England. This region has one of the highest rates for the prescription and therefore use of sleeping tablets (hypnotics) in the UK and, in accordance with Department of Health guidelines, a response to this was initiated with the relevant PCTs.

Selected patients were written to and told about this planned reduction following which they then had, in effect, one of several options:

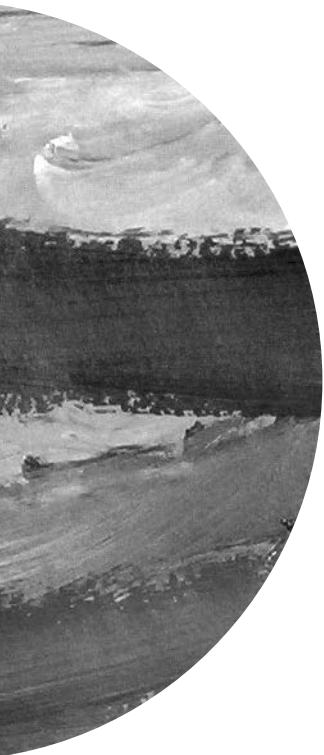
- Ignore the letter and hope that they would be forgotten.
- See the GP, talk it through and perhaps reduce the dose.
- See a pharmacist for a more supported programme of reduction.
- See a therapist (me) for an even more supportive and therapeutic programme to assist reduction.

As part of this programme a female patient, Maureen, in her late 40's was referred to me by her GP as she had been taking Zopiclone to help her to sleep for the last few years.

When I first saw her she appeared to be cross about all this and obviously had not come to cooperate.

I discovered from her that she lived at home and had a nine year old daughter, Rebecca, who usually slept with her. Her daughter had been bullied at school because she was beautiful and she was a good dancer. Eventually she was bullied, "by 33 children" and this only stopped when Maureen involved the local MP and the ring leader was expelled.

It slowly emerged that Maureen had had a successful renal transplant ten years earlier and she said that when she started on the hypnotics it was because, at that time, "I felt like I did when I was on dialysis.....tired...." However, no 'cause' had been found for her insomnia although she did get off to sleep eventually when she took the sleeping tablet.



I tried to explore the feelings that she might have living with a kidney that could fail (her 'old' kidneys, now defunct were still sited within her) but she snorted at the idea of fear. She was not afraid in the least of dying and couldn't care less about that. I suggested that for her daughter's sake at least, she must have some such worries. She still scorned such a notion, she could die tomorrow for all she cared, but she then talked more about the circumstances of her transplant.

She could no longer visit the hospital within which she had had all her treatment. Of the twenty-nine patients who had been in her cohort of patients awaiting transplants, she was the one left alive. She talked of how they would be summoned at the drop of hat to attend the clinic as a kidney had 'been found' and they must attend to see if they would be the recipient. She described it as a callously humiliating process in which the 'winner' was announced to them all and the 'losers' would have to trek back home again, disappointed.

Unbidden by me, she suddenly said how they all envied each other. On one occasion a kidney that she might have had was given to a rival – she had never spoken to this woman again.

She then added that this kidney then rejected and the triumph was, shockingly, tangible. Shortly, she added that in fact, though she otherwise would have been an ideal match for this kidney, as she had just received a blood transfusion she could not be preferred and it was this that meant the other patient received the kidney.

She herself made no links between any of these facts and clearly did not want to think at all and left saying that she was going to see her Consultant Nephrologist who would refer her to a Consultant Psychiatrist. I had little doubt that she was invoking their status to remain on the medication that she wanted and that, as with her MP, she would put paid to my 'bullying' and get me, as it were, expelled.

Sure enough, I never saw her again.

## Australia: 1985-86

Between 1984 and 1987 the author lived and worked as a Psychiatric and then General Nurse in Sydney Australia.

It was while working at the Royal North Shore Hospital, which is a large, long-established teaching hospital in Sydney, that I undertook a Nursing course in 'Nephrology, Renal Transplant and Dialysis'.

## 'Nephrology World'

As I worked through this course and the various departments I grew to see how patients and nurses got to know each other very well and, much, much later I could see that they (we) became, in fact, mutually dependant upon one another. This process developed over time, as patients were initially seen in 'out-patients' and thence, if things deteriorated towards End Stage Renal Failure (ESRF), into the world of the in-patient Nephrology Department.

So, at the onset of emerging renal failure, patients would attend the ward for various investigations, often sitting around watching the then new day-time TV and generally whiling away the hours.

Later they might be admitted for surgery, e.g. for the creation or repair of the fistulas needed for the dialysis process, or for further tests and investigations of developing symptoms.

Further down the line they might have a Renal Transplant, which would require Intensive Care, and which would, too, involve close monitoring for weeks and months afterwards.

Sadly, the kidney might reject and further procedures would be necessary, along with the inevitable return to some form of dialysis.

Thus, over time patients would become ever more involved with each other, with the nursing and other staff and with the whole 'world', within which we all were embroiled. This was all the more so as nurses, having completed a very difficult and complicated training and having learned skills through years of experience, tended to stay within this speciality for long periods so that, in the main, they also knew each other well.

## The Haemodialysis Unit

As part of my training I spent about four months working within the haemodialysis unit where I quickly came to terms with this process, which is pretty much the same I imagine in any such unit around the world.

Patients were divided fairly randomly into two separate groups. One group would attend for their four-hour dialysis on Mondays, Wednesdays and Fridays while the other group would attend on Tuesdays, Thursdays and Saturdays. Each session lasted for about four hours.

When patients started arriving for their session, there was a huge bustle as they were each weighed, observations taken etc following which they were attached to their haemodialysis machine. Following this there was a lull while the machines whirred quietly away, patients dozed, read or chatted and the staff got on with some routine tasks and then took their break.

Occasionally a patient would 'buzz' if they, say, had cramp or were worried about the functioning of the equipment and staff members were on hand to attend to this. Sometimes, rarely, there would indeed be a crisis if, say, the blood in the lines began to clot and in the worst case, a patient might have a heart attack.

Routinely though, when all was quite settled and staff would take a collective meal break which for convenience was usually taken on the Unit rather than in the canteen. One or two staff members went to the canteen and came back to the unit with trays laden with the various orders and staff sat in the staff area (which was an annexe within the unit, only feet away from the patient area) to enjoy their meal together, chatting perhaps about their social lives, plans for the weekend and so on.

Now, with one of the two groups of patients, say the Monday, Wednesday, Friday group, this meal-time passed uneventfully and it was only rarely disturbed. However, with the other group things were very different.....

Shortly after the staff sat down, a buzzer would sound and a staff member would have to attend to this. This would be followed by more buzzers until the staff members were constantly up and down while hot food went cold and the whole meal-break was disrupted such that it was hardly a break at all.

It was increasingly evident that the calls for help were often spurious in nature. Machines were not, 'malfunctioning' and requests to be made, 'more comfortable' or to, 'deal with my cramp' were greeted with a growing scepticism by the staff.

In fact, staff became openly angry about this process as their meal-breaks were repeatedly spoiled by this one group and eventually the almost unprecedented step was taken of, 'calling in a psychologist' to tackle this issue.

Unfortunately, I moved onto another department before this happened (if in fact it did so) and I therefore have no idea as to how this particular episode was eventually thought about or managed.

## Discussion

Patients who are in renal failure and receiving haemodialysis are on an extremely limited dietary intake of both food and fluids. Fluids of any type are limited while food containing potassium, calcium and other minerals are also strictly limited.

Thus, wine for instance which is both fluid and filled with potassium would be strictly limited and patients would be regularly monitored so that any slackness or 'cheating' with their diet would be quickly exposed, noted and commented upon by the nurses.

Though only too aware of this, nurses (including me) would happily chat about meals, hangovers and the like without any thought for the patients and equally certainly, without any conscious malice at all.

The trays of food too groaning, as it were, with fluid, potassium and other forbidden delights were not consciously flaunted in front of the patients and, indeed, the crassness of this was not evident to me at the time.

Would not patients who were exposed day after day to such a demonstration be resentful and would not the fact of their dependence upon (in fact mutual interdependence with) the staff members, stir up their envy at the staff's continuing health and their body's immunity to excess intake?

But how do you get in touch with or express envy towards those who look after you, who keep you alive and with whom, at the same time, you have built up a genuine liking, affection, and trust?

Importantly, I have little doubt too that staff envied the patients to whose every need they had to attend. For instance, I well recall my sense of resentment as patients sat 'idly' around the ward while I, having caught the bus at 6.00am for an eight hour shift, would be 'slaving away' all day, often with little thanks. Of course, this is the norm within hospitals; patients are encouraged to regress to a more dependant, childlike state, whilst nurses are expected to nurture them in a basically adult and ultimately maternal way.

While it is difficult to accept the concept of staff envy of patients, especially perhaps in the field of general medicine, I have heard of other cases where nursing staff working in Psychiatric Forensic settings have openly complained to each other about the easy life of the patients who do not have to work and who get everything for free!

However, when emotions cannot be expressed in words they are more likely to be 'acted out', by being expressed in actions or other, indirect words. The staff, in flaunting their ability to eat and drink as they pleased, were actually being attacking towards the patients whilst being, at a conscious level quite unaware of this. It is my belief that this attack was motivated by the unconscious envy of the staff towards their patients and an unconscious wish to spoil their peace of mind, while the patients, in turn, retaliated by spoiling the nurses' break.

## Envy

Envy and jealousy are often spoken of as if they were inter-changeable terms but when I discuss it here I differentiate these words thus: jealousy is triadic or oedipal in nature whilst envy is dyadic.

So, person 'A' is jealous of person 'B' because person 'B' has someone or something that person "A" wants. If they get it then person 'A' is glad but they may care little about person 'B's loss, or they may feel variously guilty.

However with envy, person 'A' cannot bear the thought or fact that person 'B' possesses someone or something and this gnawing envy manifests as the wish for person 'B' not to have the envied object but with no particular wish for person 'A' to have it for themselves. The object of envy might be a person or tangible possession but it might also be a skill, a talent or simply 'peace of mind'.

Schoeck (1966 pp.77-79) lists the following as the essential criteria for envy:

1. Despair at others' advantages.
2. Spiteful rage and...
3. ...destructive attack without procuring any advantage or material; gain (food, sexual favours etc).

Berke (1985) points out that "*perhaps the most dangerous aspect of envy is not the envy itself, but the denial of it. Then the envious impulse cannot be modified by loving, grateful and reparative wishes, and the envier is likely to use the very mechanism of envy, powerful projective processes in order to dissociate himself (sic) from a major part of himself, his own destructiveness.*"

So in our example, because the nurses 'denied' their envy of the patients it could be said that they projected this envy onto the patients who duly 'acted it out'.

Berke, along with Melanie Klein (Klein 1957) links the word and the concept of envy with another word – that of *spoiling*. However one frames it, no matter who the personnel are or what are the objects of the envy, the envier will always be aiming to spoil something. Thus, the other's new car, his good job, her academic or intellectual abilities, their pleasure together as a couple, his peace of mind or the satisfaction of the other *has to be spoiled* - for this perceived gap between what one has and what the other has (whether real or not) has to be eliminated.

What is unbearable is what Berke indeed calls the (sensed) "gap" between what oneself has and what the other possesses and the envy is directed at eliminating "the gap" and thus restoring one's own peace of mind.

Envy, one of the original seven deadly sins, is a particularly hated emotion and one which few are confident enough to own in themselves and it is often therefore disavowed, denied and pushed out of mind or, we might say, pushed into the unconscious. There are varied ways of doing this. One way of 'getting-rid-of' one's envy is to stir it up in others and to then locate it there. So, having duly flaunted one's possession(s) we might then say to the other, "Oh, you *do* have a problem with envy don't you"!

In other cases however, we are *fearful* of arousing envy in others as we may fear then being attacked by them and this can in fact inhibit people from achieving success (Elizabeth Bott Spillius. 1993. Pp.1203). Berke, quoting Martin Amis in his novel 'London Fields', describes a character who averts others' envy by sticking on fake 'rust patches' and mud onto his new car.

Who could blame him when the deliberate scratching of another's new or posh looking car is so ubiquitous!

As with previous examples, two other common ways of eliminating, 'the gap' (and thus the awful, envious feeling) are also the 'opposites' of each other: That is by either *denigrating*, 'the other' so one might be able to say, "Envy them? You must be joking!" or, to otherwise *idealise* them so that one might say instead, "Well, I could never even be in that league, so it doesn't affect me at all!"

So, one way of understanding the dynamics in the case of the Dialysis Unit is that the nurses could be seen to be envious of the patients who received total care from them and who were relatively passive recipients of this care. The nurses would then stir up the patient's envy as, one might say, their envy was projected into the patients. And all the envy could now be safely located within the patient group, who then acted it out.

## 'Splitting and Projection' as a Defence against Anxiety

Projecting parts of ourselves with which we are uncomfortable and locating them in others is usually described as 'Splitting and Projecting' (Klein 1952).

Klein described this as a normal part of the development of the infant in which the baby fantasises that there is one, *good* mother who feeds, nurtures him/her and another, *bad* mother who 'neglects' him/her by leaving them hungry, wet etc.

Klein called this the 'paranoid-schizoid position' and suggested that, later, the infant, 'realises' that the two mothers are one and the same – a more ambivalent and thus mature position – and she called this the 'depressive position'.

In adulthood, especially at times of anxiety and/or regression, we are likely to return to this defence and split off parts of ourselves that lead to internal conflict (anxiety) and project them onto others.

Of course we might ask, "What of the patient's own 'original' envy of the nurses – of their health, their skills, of their 'independence' and indeed of their future"? Well, this is a fair question but, in such a matrix of projection and introjection one has to start somewhere and it is salutatory to note that, in the case illustrated, what actually happened was that *it was in the patients that all this was located*.

However, if we were to realistically tackle this it would surely be fairer and more practical, in terms of real change, to start with the nurses, not least because; they are the professionals, they have more resources and the infrastructure within which to address this and because too, they are arguably more likely to be in a state of denial

## How might this be done?

### 'Social systems as a defence against work-based anxiety' - Isabel Menzies (1959)

It is 50 years since Isabel Menzies (1959) wrote her ground-breaking report, which followed her investigation into the staffing difficulties in a General Hospital in London. It is beyond the scope of this paper to discuss this report in detail but some of the points relevant to this paper are worth re-examining.

She and her team studied the Nursing Service for some time and slowly realised the enormous stress and anxiety engendered by the work. She did not discuss the manifest causes of stress caused by the long hours and different shifts although this must have been part of the picture.

What she noted however, was the anxiety which must be stirred up in the nurses by the many and unsettling emotions generated by the patients, the patients' relatives and the staff members' colleagues.

Examples of these were:

- Pity.
- Compassion.
- Love.
- Guilt & Anxiety.
- Hatred & Resentment - of the patients who arouse these feelings.
- Envy - of the care given to the patient.

As Menzies put it, "by the nature of her profession the nurse is at considerable risk of being flooded by intense and unmanageable anxiety" (ibid. p.110).

After some time she came to ask herself the question, 'How do the nurses fulfil their wish to care empathically for these patients and also manage to face all the stress and all the anxiety which this work inherently stirs up?' Her answer was, in effect, *'Their response to this conflict is to try to not face it!'*

In essence she thought that the Hospital, and in particular (as this was her brief) the Nursing Service defended against the inherent anxieties of the work by limiting intimate contact between nurses and patients by developing the system of task-orientated nursing. A nurse would, say, have all the temperatures and pulses to do for all of the patients, whilst others might for instance do all the bed-making or bathing.

Thus individual patients were turned more into 'parts-of-patients' and, in fact, into a series of tasks. One pictures too, an old-fashioned type of Hospital with 'Nightingale Wards' where the arrangement of serried rows of patients would lend itself to this task orientated approach such that it would be easily thought to the most economical and sensible approach to the work.

Presumably this defence against the anxiety of having to 'face' the feelings of despair, anger, guilt, disgust, attraction etc that were inherent in the task of nursing was partially successful. However, a key discovery by Isabel Menzies was that, in time, *this defence had become a source of anxiety in itself.*

In part it was her insights that led to the now more familiar 'care planning approach' in which nurses care 'holistically' for a small group of patients from admission and throughout their stay. However one might think about the reasons for this it is true too, that around this time there was a movement away from Nightingale Wards to wards with small bays of four to six patients.

Thus the system used to deploy and roster staff was changed, as was the physical layout of the building that had also served its part in maintaining the defence.

## Potential changes within the Dialysis Unit?

Following the ideas developed by Isabel Menzies and which are still followed broadly by Organisational Consultants using the 'Tavistock Model' the possible changes would have to have several component parts:

1. A recognition of the unconscious processes active in this particular setting. I.e. the unconscious anxieties inherent in the work and the institution's unconscious defences against them.
2. A willingness to look at different ways of working, such that more mature defences could be utilised.
3. The possibility of changing the physical arrangements of the Unit such that the new arrangement might be less likely to reinforce the more unhelpful and unconscious defences.

What might this mean in practice? Well, lets look at all three component parts in turn:

1. *Staff would need to find a forum in which they could slowly find the confidence to talk about the more ambivalent aspects of their work as is described in Tom Main's paper, 'The Ailment (1957). This describes just such a staff group at the Cassel Hospital in London where (mainly) nursing staff explored their attitudes to particular patients who had been identified as being difficult because they had also, in ways that had not been acknowledged at the time, been seen by staff as being 'special'. This staff group took time to mature to such a level where frank*



exposure of complicated feelings and thoughts could be tolerated. When that stage had been reached a general shared understanding, of what might have been some common interpersonal (and thus group) dynamics could be explored.

- A facilitated staff group could be held weekly. The aim of this would be to provide a setting in which staff could talk about, 'the nature of the work'.
  - Equally, patients too could have a forum in which they could meet, possibly facilitated by a neutral outsider, and with the possibility too of liaison between the two sets of group members.
2. It might be thought helpful to mix-and-match the patient groups more, or at any event to think about the implication of such a fixed division between them, as this is likely to promote the, 'good' Vs 'bad' splitting process. Splitting one's feelings off from oneself and locating them elsewhere is a common defence against anxiety in all settings.
  3. Clearly it was not a good idea to eat meals more-or-less in front of the patients, although it could be argued that 'hiding this process away' might only represent a type of denial of the 'brutal truth' of the difference between staff and patients. However, sometimes it is sensible to acknowledge that the harm of the 'brutal' exceeds the value of the 'truth' and for simple common sense to drive one's actions: 'How would you like it?' sort of thing.

## Conclusions

This paper has tried to understand how difficult feelings, that are inevitably stirred up within Health Care Institutions by the nature of the work may be defended against by the staff within an institution by means of unconscious defences that are then, in effect, institutional defences.

One of the primary defences against anxiety is that of 'Splitting and Projecting' and is associated with the more 'primitive' (from early life) '*Paranoid-Schizoid position*'. A healthily functioning organisation needs to operate more within the '*Depressive Position*' where ambivalence can be borne, ones own anxieties and shortcomings can be thought about and the reality of the situation can be faced.

Institutional defences against anxiety are analogous to individual defences against anxiety in that they have served people well in the past or, in the institutions case in the short-term, but in the longer-term they are no longer effective but have, rather, become a *further cause of anxiety*.

When Tom Main (1967) revisited the Cassell Hospital many years after the 'liberalising' reforms had been instituted he was shocked to see how, after all these years the new processes that had been established through thoughtful discussion, had by now become ossified into hard and fast rules.

Thus, before the patients had never been allowed weekend leave but were later allowed to do so if all agreed that it was appropriate. Ten years later, he was shocked to hear a nurse tell a reluctant patient, "No, you must go home this weekend – it's our policy here"!

The inference is obvious: the pull back to the defensive structure, though now cloaked in contemporary language (Today perhaps, Health and Safety, Equal Opportunities etc), is a constant dynamic that can only be guarded against by continuing to *think and by continuing to talk*.

Unless institutions (and that means those within them who are most senior and have most responsibility) take this process seriously, health care settings will suffer the

consequences of providing an unnecessarily inferior quality of service as energy is absorbed by the 'acting out' instead of on delivering the Primary Task of the work setting.

The acting out may take the form as described in this paper but anyway will, in more general terms, lead away from a 'culture of enquiry' and a realistic approach to the work and instead into a 'culture of complaint' characterised by:

- Sickness and absenteeism.
- Disciplinary procedures.
- Grievance procedures.
- Staff shortages.
- Scapegoating
- Low morale etc.

The example given here was taken from the author's experiences in an Haemodialysis Unit but is applicable to any work setting and particularly perhaps settings within Mental Health Teams, where these dynamics are likely to be obscured by the very nature of the difficult work.

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