THE PROCESS OF SCAPEGOATING IN A NEONATAL NURSES' GROUP

Jerri M. Oehler, Ph.D., R.N., C.S.
Peter Z. Perault, M.D.

This paper reviews the literature on scapegoating, elaborating on the underlying mechanisms before describing the process of scapegoating as it occurred in a neonatal nurse support group. Illustrative vignettes are used to discuss how scapegoating was used by group members to avoid painful feelings arising from their care of extremely ill infants. Group process is related to the stages of the group's development as feelings were addressed more directly and the need to use scapegoating as a defense decreased.

High-risk infants evoke intense and painful feelings in their caretakers. Support groups for nurses offer a therapeutic environment in which to work through these painful feelings. This paper discusses the phenomenon of scapegoating as a defense against dealing with these feelings. Scapegoating is discussed from a theoretical point of view before presentation and discussion of the clinical material. The vignettes illustrate the ambiguity surrounding the actual and seeming use of scapegoating as well as how confrontation and interpretation of the defense led to revelation of deeper feelings of anger, sadness, and guilt.

HISTORY OF SCAPEGOATING

Since ancient times scapegoating has been known as a means of magical deliverance from evil, referred to in Greek mythology and in the Old Testament as a magical cure for evil (Johnson-Soderberg, 1977; Kahn, 1980; Scheidlinger, 1982). The term "scapegoat" originated in the Hebrew account of Yom Kippur, the Day of Atonement. The 16th chapter of Leviticus, verses 10–21, describes the process of symbolically labeling a goat with the iniquities of the group and sending it away to placate Azazel, a demonic being. In this process, a second goat was reserved for the Lord and sacrificed as a burnt-offering in the Temple. Others have described scapegoating as a means of relieving accumulated suffering by transferring it to objects, animals, or other persons who would bear the suffering in place of another (Johnson-Soderberg, 1977; Kahn, 1980).

Dr. Oehler is a clinical associate in nursing and psychiatry at Duke University Medical Center. Dr. Perault is a clinical associate in the Department of Psychiatry, Duke University Medical Center and is in private practice. Correspondence should be addressed to Dr. Oehler, School of Nursing, Duke University Medical Center, Durham, NC 27710.

Scapegoating also has been seen as displaced aggression, not directed at the true source of difficulty but transferred onto some particular group or class (Allport, 1954; Kahn, 1980; Scheidlinger, 1982).

Within the group psychotherapy literature, scapegoating is described in various ways. Toker (1972) describes scapegoating as an essential phenomenon providing "an arena into which aggression can be channelled and focused without presenting a threat to the psychic integrity of the individual or a threat to the stability and unity of the group itself" (p. 320). Some clinicians suggest that scapegoating occurs when the group ignores, criticizes, or drives away the member who represents or expresses unacceptable aspects of the group's internal struggle (Foulkes & Anthony, 1964; Kahn, 1980). Beck and Peters (1981) describe a scapegoat group role in which the scapegoat becomes the recipient of direct attack or of nonverbal hostility from the other group members, usually in response to the expression of conflicted ideas or thoughts.

Scapegoating has been seen as a reflection of group dysfunction secondary to the group's feeling threatened, vulnerable, or inadequate in coping, resulting in the group's tendency to exploit an individual (Stafford, 1977). In this instance, "the scapegoat functions as the repository of unacceptable impulses and is then attacked as a way of attacking or destroying the impulse that he now personifies" (Whitaker & Lieberman, 1964, p. 288).

Scheidlinger (1982), however describes scapegoating somewhat differently. Viewing the phenomenon of scapegoating as a complex, interactive group-level process, he proposes that scapegoating involves the simultaneous behavioral components from the individual intrapsychic, the interpersonal, and the group-as-a-whole frames of reference. Even though the scapegoaters may be acting on their own behalf, more often they are, through conscious and unconscious collusion, the carriers of the desires of other group members as well, if not the whole group. For example, a group may harbor aggressive feelings which cannot be discharged directly for some reason (e.g., members may not be able to identify exactly who or what they are angry at, or the object of their anger may seem very powerful and capable of harsh retaliation, or very vulnerable and helpless, like a small infant, who might easily be annihilated, evoking intense guilt). Further, they may be angry at existential dilemmas, or intangible targets such as the "system" or the "corporation." In any case, the pent-up, punitive feelings may be displaced onto a safer, or more easily identified target.

Scheidlinger (1982) proposes a narrower definition of scapegoating. He suggests that displacement of hostility to group leaders or other people is not scapegoating. Further, he suggests limiting the term "scapegoating" to a group defensive maneuver in which the mechanisms of projection or projective identification are used. Therefore, he suggests that "the phenomenon of scapegoating be viewed as occurring in two different, yet related ways: 1) a group defensive process where shared, unacceptable impulses or ideas are projected onto a victim with the intent of thus getting rid of them; and 2) a more primitive process similar to projective identification, in which there is a longer and ongoing unconscious interaction between scapegoater and the scapegoat" (p. 114). This definition is more consonant with the biblical interpretation presented at the beginning of the paper. During the formative phases of all unstructured small groups, according to Scheidlinger, scapegoating via projection may occur fairly frequently. These primitive defensive manifestations, including "splitting" and introjection, are characteristic of the anxiety-laden group transactions. However, the second type of scapegoating, resulting in projective identification, is more expressive of individual member pathology and more prevalent

in groups including members with borderline personality organization. It is this narrower definition, proposed by Scheidlinger, that will be utilized in this paper.

The characteristics of the scapegoat have also been described. For example, the scapegoat stands apart from others, perhaps as an authority figure, or as an inferior, or as a deviant from the group norms. The scapegoat may display histrionic, inappropriate or provocative behavior, or may act passively or ambivalently in a way that raises anxiety and invites attack. It has been suggested by some that the scapegoat plays a collaborative role in the process, inviting the attack in some way. Low self-esteem, guilt, or unconscious masochistic needs may drive one to perpetuate the scapegoating process. Slavson and Shiffer (1975) suggest that victims of scapegoating may invite the process because of their own unconscious masochistic needs that arouse sadistic feelings in others. It may not be an either/or phenomenon, and Scheidlinger (1982) argues that the scapegoat in a group ranges from a wholly innocent person to a more-or-less willing recipient of the direct or indirect emotionality from the scapegoaters.

Management of scapegoating is regarded as complex (Scheidlinger, 1982). The leaders must be concerned with group maintenance of at least tolerable individual and group anxiety levels. Direct measures of control and support of the scapegoat and the scapegoater may be needed to restore equilibrium and for the working through process to be facilitated by interpretive intervention. Johnson-Soderberg (1977) suggests that the therapist needs to help the group deal directly with the scapegoating phenomenon; however, she suggests that the therapist not immediately focus on the scapegoat because such an intervention might reinforce the group's perception of the scapegoat as the primary source of the problem at hand. Instead, refocusing on the group, exploring the process (i.e., why the scapegoat allowed scapegoating to occur and how and why group aided and abetted the scapegoating) is indicated. Toker (1972) suggests that the therapist "walks a tightrope in that the scapegoat has to be protected and supported and not sacrificed on the altar of displaced aggressions, while at the same time hostility must be permitted to find some expression so that it can be understood" (p. 331).

In summary, the person or group who scapegoats harbors an excessive store of unacceptable feelings and thoughts, and displaces and projects these feelings onto the scapegoat. However, the tendency to displace or project feelings onto persons outside the group does not necessarily constitute scapegoating. This mechanism might be more properly labeled "externalization" of the group conflict. Scapegoating is more than displacement or projection because of the wish to drive the person away, thus symbolically ridding themselves of the unacceptable feelings. Additionally, the scapegoater reaps some secondary benefits, such as narcissistic gratification of feeling morally superior to the discredited scapegoat. Also, the scapegoater may derive voyeuristic pleasure in all the gossip, scandalmongering or ritual that may be involved (Taylor & Rey, 1953). Using this definition, it can readily be seen that the tendency to displace or project feelings onto persons outside the group would not necessarily constitute scapegoating.

In terms of group dynamics, scapegoating may help to foster cohesion among members and promote group homeostasis by providing a "common enemy" around which to unify in the face of threatening internal conflict. This is how Minuchin (1974) sees the symptom-bearing child in a family, the "identified patient," who helps the family system avoid conflicts which threaten to destroy it. The paradox in this is that conflict usually cannot be resolved when hostility is directed away from the true target (Yalom, 1975).

ICN NURSES GROUP

Inherent Stresses

Scapegoating has been identified as a problem on nursing units, particularly where stress is high and conditions that foster scapegoating are inherent in the work. A growing literature attests to anxiety and vulnerability to feelings of personal failure which stem from the continuous responsibility for critically ill and dying infants in an atmosphere geared to highly perfectionistic standards of performance (Marshall & Kasman, 1980; Scully, 1981; Sherman, 1980; Shubin, 1979; Skinner, 1980). One survey of neonatal nurses revealed that the most stressful situations or feelings were guilt engendered by not being able to do enough for the babies, by discomfort with perceived inconsistencies in staff approach to treatment, by interpersonal staff problems, and by fear of attachment to an infant with an uncertain outcome (Sherman, 1980). Nurses working in an intensive care setting have also been found to be more depressed, more hostile, more anxious, and more vocal in expressing dislike of work conditions than nurses in noncritical care areas, as measured by the MMPI and other objective personality tests (Gentry et al., 1972).

In the intensive care nursery, the dependent and defenseless infant powerfully evokes staff members' instincts to form "family" bonds and fill parental roles, particularly when parental figures are absent or visit infrequently. The staff is repeatedly exposed to loss through impairment or death of the babies, and this may lead to feelings of professional helplessness and failure, as well as frustrate unconscious longings for attachment and maternal gratification. Even when the outcome is favorable, the nurses also face loss as the infant returns to the family. Further, many sick infants do not reward their nurses with medical improvement and actually increase anxiety through extubation, aspiration, or development of complications of a possibly iatrogenic nature. In addition, social responses of the full-term, normal baby are not always apparent in these tiny, immature babies. This lack of reward, compounded with anxiety over outcome, may arouse further frustration, anger, and guilt. Nurses may be discouraged from expressing the feelings that arise in these situations because such feelings may be seen as a hindrance to cool, competent performance. Finally, personal conflicts with persons in authority, ambivalent maternal transference to nursing supervisors, and frequent turnover of housestaff and other personnel also contribute to strained relations within the staff.

Development of the Support Group

Due to recurrent morale problems, the administrative staff requested help with starting a "support group." Attempts to meet with the staff were met with massive resistance in the form of no attendance at scheduled meetings. Therefore, individual interviews with each staff member were arranged. These pregroup interviews revealed that nurses on this unit identified interpersonal relationships as the major source of stress, with many emphasizing friction between the staff and head nurses. Few acknowledged feelings toward the sick infants as significantly stressful. Depressed affect appeared widespread. In response to a pregroup questionnaire, more than half responded that they were frequently upset, worried, or uncomfortable during work; three-quarters were often dissatisfied with their job performance. About two-thirds believed others talked about them behind their backs "much of the time" and felt that gossip on the unit was frequently hurtful and destructive. The ward atmosphere at that time

indeed appeared very negative and many of the staff seemed to have a "paranoid-like" attitude.

The group was formed after a second series of individual interviews, in which the purpose of the group was explained briefly and the importance of regular attendance was discussed. The group was billed as a support group which would be confined to issues relating to work. However, the format was relatively unstructured and to some extent fostered the kind of process associated with a more traditional psychotherapy group. The process of the group was considered confidential, and the only communication to unit leadership was that the group was meeting weekly. The final group was composed of eight female nurses, all in their 20s. It met for one 75-minute session each week.

A model of coleadership was adopted for several reasons. It was felt that it would be helpful if one of the leaders had experience in critical care, utilizing the idea that it is helpful to have one leader who is inside the unit and one who is outside (Hay & Oken, 1972; Oehler, 1983; Scully, 1981). The leader from the unit has the advantage of first-hand knowledge of the stress of intensive care. The outside person, while less knowledgeable about intensive care, may be more objective about the situations arising out of intensive care, and can prevent the group from getting caught up in old but nonproductive patterns (Scully, 1981).

The following vignettes from various stages of group development illustrate the group's tendency to use defensive maneuvers to avoid conflict and painful feelings. Before the group was even formed there had been a long-standing tendency to scapegoat nursing leadership. In the beginning phase of the group this scapegoating continued, and the wish to drive away the nursing leaders was apparent.

Orientation Phase

In the opening phase, amidst the usual introductory concerns over boundaries, norms, confidentiality and trust, group members repeatedly complained about nursing administration. There was considerable discontent about how various aspects of unit function were managed. The group members repeatedly complained about the head nurse and other nursing supervisors, all of whom were outside the group and in various ways seemed to invite hostility. These supervisors were seen as callous to the emotions that the staff nurses were feeling and seemingly were intolerant of any displays of emotion that might threaten the unit's efficient, technical care. There was considerable discussion around the thoughts that these persons were no longer competent clinicians, if they ever had been, and seemed lazy and out of touch with the problems nurses faced on a day-to-day basis. Of further concern was the perception that these leaders were ineffective in fighting for the nurses' welfare with the higher administration. A coffee klatsch atmosphere often prevailed for these discussions, and a gossipy excitement attended speculation about behind-closed-doors intrigues. The leaders initially elected to listen empathically to these complaints, which had existed for a lengthy period of time, since group member's distrust of authority figures was great; it was felt that confrontation at this early stage might result in premature termination. This early tendency toward scapegoating of leaders outside the group may have been a means of externalizing the conflict within the group. Whitaker and Lieberman (1964) suggest that "early wishes and fears may be displaced onto outside figures, offering a means of coping with the conflict by avoiding recognition of the fact that the feelings belong to oneself or that conflict pertains to the present situation" (p. 289). However, there was more than a wish to externalize the conflict; there was also

a wish to be rid of the leaders in hopes of obtaining new ones, suggesting scapegoating.

After four or five sessions, members seemed to be generally anxious about having expressed negative feelings, and there were innuendos about transfers to other units to avoid conflict. Feelings of discouragement about people leaving the unit and feelings of powerlessness were prominent. There was a sense that problems in the unit could be resolved only if the head nurse changed her ways. While there was no direct mention of a replacement, there was a hint that things would be better if a more compassionate, effective head nurse existed. During these sessions, any brief focus on caring for babies was quickly shifted to the administration. When the therapists asked if issues with the babies were similar to administrative concerns, the reply was that the administration could change but "we can't change the babies, they either live or die." Focus remained on communication problems within the unit and angry feelings. While the group seemed to use scapegoating as a means of developing cohesion, focus on persons outside the group also served the purpose of avoiding dealing with painful feelings. A tendency to deal with angry feelings by staying away from group was pointed out and at least half-heartedly accepted by the group.

The tenth session, which revolved around the death of a baby on the unit, illustrated the group's difficulty dealing with painful feelings.

> As members were assembling for this meeting, a few of the nurses talked about an infant named Tony, who had died the day before, and wondered how it affected a particular group member who was not yet present. When she arrived the subject was dropped. It was not until close to the end of group that Carol brought up the subject saying, "Yesterday was awful." But she chose to focus mainly on anger toward the head nurse who, seemingly, had discouraged her from crying and incensed her by saying, "You'll get over it." Other group members agreed and sympathized, reassuring Carol that, in contrast to the head nurse, she had truly cared about the infant and the family, and had handled herself well in a difficult situation. The nurses seemed to feel a common bond of anger toward the allegedly unfeeling head nurse. Carol went on to describe a poignant scene where Tony was disconnected from the ventilator and held and rocked by her, prompting a physician to remark that he hoped someone would care for him in death in that manner. While there were tears in the eyes of several members, there was still no overt crying. Carol seemed unable to explore her feelings about the baby's death any further, and she could not ask for or receive more specific forms of support from the group even though the therapists attempted to facilitate this. Several others, however, did recall their own experiences with special infants, but discussion soon shifted to problems in the unit. The session concluded with the leaders pointing out that it seemed easier to focus on problems in the unit than on feelings about the babies.

Again it seemed easier for the group to externalize and focus on problems outside the group. At the same time, it seemed clear that the head nurse was again being scapegoated for preventing expression of feeling even though little affect was expressed by the group, even in a permissive atmosphere. During this phase, the defensive maneuvers included displacement and a tendency to externalize conflict. However, the behavior also fit the classic description of scapegoating, with the consistent wish to be rid of the offending object.

The continuous outpouring of criticism became increasingly discouraging and

anxiety provoking to group members; they felt helpless and impotent to change anything for the better. What could change as long as the head nurse retained her position? Several nurses talked of quitting their jobs on the unit to avoid further frustration and conflict. Even though the leaders recognized that much of the criticism was scapegoating, they also recognized the existence of realistic problems. Attempts by the leaders to confront the nurses' helpless and hopeless stance and question what prevented them from approaching their leaders to try and work out their problems failed. They stated firmly that negotiation with leadership would be worthless.

Conflict Phase

By the end of the third month, conflict within the group became apparent as attendance dropped noticeably. Some complained that the mutual support and comradery exchanged in the group seemed phoney because of the backbiting, criticism and unresolved hostility between nurses that continued on the unit as before. Vague or indirect references were made to simmering conflicts between group members. For example, S would complain that someone not present today had offended her by questioning some aspect of her nursing care. Because the offending member was not present, the issue could not be pursued. It was suggested that she discuss the conflict the next session when the nurse would be present. However, the next session, S failed to attend.

As these conflicts between members were being vaguely hinted at, group members attacked a new series of scapegoats. "Other shifts" of nurses could not be trusted because they made sloppy errors and sometimes mismanaged babies. Attending physicians were in conflict with each other about treatment plans and were critical of the nurses. Housestaff were either obnoxious know-it-alls or bumbling incompetents, and in any case, they would leave the unit for another rotation before they knew them. Then there was scornful discussion of "supernurses" who repeatedly performed their work perfectly and criticized any inferior who occasionally made mistakes. It was not clear just who was in this category – certainly never anyone present in the group. In these instances the group continued to talk about conflict outside the group. These accusations seemed to suggest displacement rather than scapegoating.

Attendance continued to be sporadic and often as few as three members showed up and usually not the same three. Each week it was interpreted rather vigorously to whomever might be present that people were staying away from the group to avoid conflict between members. It was suggested that perhaps they were afraid that if they expressed their angry feelings they would alienate one another, or somehow damage their ability to work together effectively on the unit. It was suggested that it was necessary to learn how to express conflict openly and resolve it if any real sense of cohesion and support was ever to develop. Two members transferred to other units during this period. One group member offered that the group had not been what she had wanted and suggested that what was missing was conflict and talking about interpersonal feelings with group members. Several weeks later, all group members were present.

> Amidst disparaging remarks regarding the elusive "supernurses," S rather tentatively approached L about her questioning the amount of suction of a chest tube set up for a particular infant. L replied that it was a high setting and she had wanted to check it. S explained that it was purposely set high because of the baby's special problems. Now S's judgment was un-

> derstood and L's question vindicated and readily resolved. It was clearer to the group that conflicts could be aired, tolerated and resolved, and thus more acceptable and less frightening. One group member volunteered that this was more like group should be. It appeared that the group seemed to have a renewed sense of purpose.

A series of other confrontations between group members followed this one, and each one turned out to be easily resolvable. For example there were situations in which some comment had been misinterpreted; when this was clarified, the conflict evaporated.

Shortly afterward the group made plans to confront the head nurse with a number of grievances in an assertive but diplomatic way. They were surprised by her cooperativeness. A series of staff meetings were held in which a member of the group, J, assumed a leadership position in articulating the nurses' concerns and negotiating for some changes they desired with the nursing administration. These changes included increased frequency of staff meetings, input in the agenda for meetings, increased participation in patient care by administrative staff, changes in the evaluation process, and integration of sick and well babies into one room so that staff dissatisfaction with "sick" and "well" rooms was alleviated. J gained substantial support and encouragement from the group members for taking this role, which she saw as a significant personal step for her in being effective.

During this period of increasing ability to face conflict and increasing positive feeling about the group, an attack on the leaders arose in connection with some technical errors made. Six weeks earlier M had transferred out of the nursery to another unit in the hospital, but did not terminate cleanly from the group. She expressed a desire to remain in the group, although she now worked elsewhere, and said she would come to meetings whenever she could. The leaders did not confront this avoidance of termination issues, and did not contact M during the following 5 weeks, when she was absent from all of the group's meetings. Suddenly one day she appeared in the group, eager to catch up on the gossip which had dominated our discussions in the earlier stages of the group when she had been an active member. Both the members and leaders were caught off-guard. The members tried to explain to her that the group had changed in her absence and now had less interest in complaining and gossiping. The leaders, feeling irritated and defensive of the new, hard-won group norms, now tried belatedly to force this intruder's unequivocal termination from the group. It was decided that M should attend one more meeting to say goodbye more satisfactorily, but during this and the following session group members expressed anger at the leaders for mishandling the incident. The leaders essentially heard out their anger and accepted it, acknowledged the errors, and with some transparency discussed the confusion and mixed feelings about M's surprise return. One nurse commented after this that the leaders now seemed "more human and more a part of the group."

Working Phase

After nearly 6 months of weekly sessions, the stress of working with the sick babies finally became a major theme in group discussions. Resistance to discussing these feelings would arise in the form of renewed criticism of nursing administration and doctors, but when confronted, deeper material about feelings toward the babies quickly emerged. In one such session members were expressing anger at fellow staff:

> When one of the leaders asked if it was easier to get angry at the babies or the staff, a member sheepishly replied "the staff" and related a "breakfast" conversation between several staff where they had concluded that their frustration with the babies led to backbiting in the unit. With prompting from the therapists, one group member recalled differences in her feelings about a primary baby when he was on the ventilator "kicking and fussing" and causing her anxiety about extubation. In contrast, when he was off the ventilator, he was more like a baby and more lovable. Occasional death wishes were recalled with guilt. The therapists acknowledged the frustration of caring for babies who offered little feedback and actually caused anxiety, which tended to stir up angry feelings. They suggested that the situation was similar to that of a mother who was unsuccessful in attempts to quiet a crying infant.

Subsequent meetings followed similar themes. The nurses, in addition to developing more understanding of their own feelings about the babies, developed insight into their feelings for the administration.

> S suggested that someone needed to "get the blame" for mistakes. C offered that the anger and frustration associated with caring for the infants seemed to be associated with fault-finding with each other and the administration. This discussion prompted J to conclude that caring for the babies was frustrating and made the nurses angry, but "you can't get angry at the baby, so we get angry at those around us, particularly those in administration who have the power." She concluded, "We're scapegoating the administration. Even though they have definite faults, nurses tend to take their anger out on them." She also added that even though the babies were dependent and helpless, they had a lot of power over the nurses.

Subsequent sessions dealt with the painful feelings of loss, whether through death or return to the family. The pros and cons of feeling attached to a given infant were discussed at length. Issues with nursing administration and fellow staff were rarely mentioned, and then with greater objectivity. Members appeared to have had a very positive feeling about the group and its effect on the climate of the unit. In response to a follow-up questionnaire, the members commented: "The group helped me deal with feelings that kept me from getting involved with the patients." "Seeing an improvement on the part of the entire staff has been encouraging to me." "I feel as if the unit has grown closer." "The group has kept me in the ICN – I'm positive I would have left otherwise." "Because I feel I may be starting to see myself better, I really hesitate to leave the unit."

DISCUSSION

The reaction of the group to the nursing administration illustrates the dynamics of scapegoating outlined in the initial part of the paper. There was a tendency to scapegoat leadership both as a means of coping with unacceptable feelings of anger, guilt, and self-dissatisfaction that came up in the nurse's work and that carried over into the group, and as a means of achieving cohesion. There were realistic problems with the "scapegoats," which needed to be addressed. However, focus on the "scapegoats" delayed dealing with conflict within the group. What was different about this group was the utilization of scapegoats outside the group. This not only projected away unacceptable feelings and

wishes, it also kept conflict out of the group, initially allowing a false sense of cohesion. It was not until conflict within the group was addressed that true cohesion developed.

The tendency to scapegoat authority figures as well as the function of displacement have to be understood in terms of how the group process develops. Yalom (1975) describes three stages of group development. The first is a stage of "orientation" where there may be a kind of cocktail party atmosphere in which members size each other up in the course of relatively superficial chatter. There is a preoccupation with acceptance, approval, and commitment to the group. One feature of the stage is a search for similarities between members, which helps define the group's boundaries, relieves anxiety about inclusion in the group, and lays the foundation for a more profound sharing of feelings later on as more genuine cohesiveness develops. But at this stage the sense of "groupness" is somewhat fragile, and internal conflict is avoided. For this group, scapegoating someone outside the group served an important function during this stage in providing a vehicle for sharing common grievances and establishing some identity as a group. This behavior contrasts with the usual tendency to scapegoat someone within the group and reflects the group's difficulty in dealing with conflict. During this stage efforts to suggest that feelings arising from the work with the babies might have resulted in scapegoating nursing supervisors were ignored at best, and at worst jeopardized the leaders' alliance with the group members. Although this process continued over a fairly lengthy period of time in the group, it is important to recognize that this pattern of scapegoating had been in place for many years in the unit. Because the need to avoid conflict was high, confrontation of scapegoating was resisted.

The second stage is characterized by "conflict, dominance, and rebellion" (Yalom, 1975). It is here that conflict between members, or between members and the leader, is explored, and ways of resolving conflict are developed. Given the natural ambivalence toward leaders and the inevitable disappointment of unrealistic expectations of them, hostility toward leaders is an invariable feature of groups and, if not vented directly, may result in scapegoating of other members or outsiders. As the nurses were openly told, the ability to deal directly with conflict is necessary for the development of the true cohesiveness of a working group. In fact, some therapists actively provoke attacks upon themselves in an effort to hasten therapeutic group development.

The second stage, in which methods of handling conflict were developed, was the key to the resolution of the tendency to displace aggression to those outside the group. In this stage the members learned to address conflict more directly, and found that this enhanced their ability to work together rather than destroying it. Consequently, the need for rigid defenses against conflict diminished. At this point, active acknowledgement of their tendency to scapegoat and to displace angry feelings could be accepted, and led rapidly to a deeper and supportive discussion of the painful emotions that had been displaced and projected. Because the group was more cohesive, there was less need to continue to scapegoat, and the nursing leaders could be seen in a more objective way.

In the third working stage, the group feels an excitement in being able to explore issues in a useful way, and chief concerns involve intimacy. It was at this point in the group, for instance, that the nurses began to consider their feelings of attachment to the infants in the face of the possibility that they might die.

The vignettes illustrated the phenomenon of scapegoating. Although at times there appeared to be only displacement of unacceptable feelings, scapegoating

was a major defense for this group. It offered a way to project painful feeling in hopes of ridding themselves of these conflicted feelings; additionally, the conflicts within the group were externalized.

In the future it would seem helpful to provide a support group for nursing administrators, since their jobs as middle management are difficult, and they often lack the communication and negotiating skills necessary to function optimally in an intensive care environment. Their stress may inadvertently cause them to use scapegoating themselves, thus perpetuating and colluding with the staff in this process.

REFERENCES

Allport, G. W. (1954). *The nature of prejudice.* Reading, MA: Addison-Wesley.

Beck, A. P., & Peters, L. (1981). The research evidence for distributed leadership in therapy groups. *International Journal of Group Psychotherapy, 31,* 43-71.

Foulkes, S. H., & Anthony, E. J. (1964). *Group psychotherapy: The psychoanalytic approach* (2nd ed.). London: Penguin.

Gentry, W., Foster S., & Froehling, S. (1972). Psychologic response to situational stress in intensive and nonintensive nursing. *Heart and Lung, 1,* 793-796.

Hay, D., & Oken, D. (1972). The psychological stresses of intensive care unit nursing. *Psychosomatic Medicine, 34,* 109-118.

Johnson-Soderberg, S. (1977). Theory and practice of scapegoating. *Perspectives in Psychiatric Care, 15,* 153-159.

Kahn, L. S. (1980). The dynamics of scapegoating: The expulsion of evil. *Psychotherapy: Theory, Research, and Practice, 17,* 79-84.

Marshall, R. C., & Kasman, C. (1980). Burnout in the neonatal intensive care unit. *Pediatrics, 65,* 1161-1165.

Minuchin, S. (1974). *Families and family therapy.* Cambridge: Harvard University Press.

Oehler, J. (1983). Organizing a support group. *Dimensions of Critical Care, 2,* 304-309.

Scheidlinger, S. (1982). *Focus on Group Psychotherapy.* New York: International Universities Press, Inc.

Scully, R. (1981). Staff support groups: Helping nurses to help themselves. *Journal of Nursing Administration, 11,* 48-51.

Sherman, M. (1980). Psychiatry in the neonatal intensive care unit. *Clinics in Perinatology, 7,* 38-39.

Shubin, S. (1979). Rx for stress: your stress. *Nursing 79, 9,* 53-55.

Skinner, K. (1980). Support group for ICU nurses. *Nursing Outlook, 28,* 296.

Slavson, S. R., & Schiffer, J. (1975). *Group psychotherapy for children.* New York: International Universities Press.

Stafford, L. L. (1977). Scapegoating: How and why scapegoating occurs. *American Journal of Nursing, 77,* 406-409.

Taylor, F., & Rey, J. (1953). The scapegoat motif in society and its manifestations in a therapeutic group. *International Journal of Psychoanalysis, 34,* 253-264.

Toker, E. (1972). The scapegoat as an essential group phenomenon. *International Journal of Group Psychotherapy, 22,* 320-332.

Whitaker, D. S., & Lieberman, M. A. (1964). *Psychotherapy through the group process.* New York: Atherton.

Yalom, I. (1975). *The theory and practice of group psychotherapy.* New York: Basic Books.