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Scapegoating

LINDA LOUISE STAFFORD

Scapegoating, an ancient practice, began as a magical deliverance from evil. In a group whose members felt threatened by a dire or "evil" phenomenon, such as the plague, mortal sin, or madness, the group colluded to fix the blame on a specific person or animal, frequently a goat. By the projections of the group, the scapegoat represented the evil or malignant force, thus it had to be destroyed so the group could be rid of its pernicious influences(1).

Scapegoating continues in contemporary society, although in a less drastic, less open form. In our culture, certain groups appear to be selected for scapegoating while others remain relatively free of persecution.

Jacques postulates that one factor influential in the selection of a group to scapegoat is the consent of that group, at an unconscious or fantasy level, to be scapegoated. Supposedly, the persecuted minority, intensely hating its oppressors, seeks punishment in order to alleviate unconscious guilt. Another effect is that the persecuting majority can see itself as vastly superior by comparison(2).

Scapegoating, therefore, represents a dysfunction in group process. It probably occurs when a group feels threatened, vulnerable, or inadequate in coping with a problem, thus it projects its difficulties on one or a few of its members. To illustrate this point, I will describe three situations of scapegoating.

Example: A Psychotherapy Group

Tom, a 24-year-old member of a psychiatric inpatient therapy group, had been exhibiting "inappropriate sexual behavior" on the unit. Diagnosed as schizophrenic, he was typically shy and withdrawn. However, he had recently begun accosting female staff members and patients, saying that he wanted "sex." He would grab

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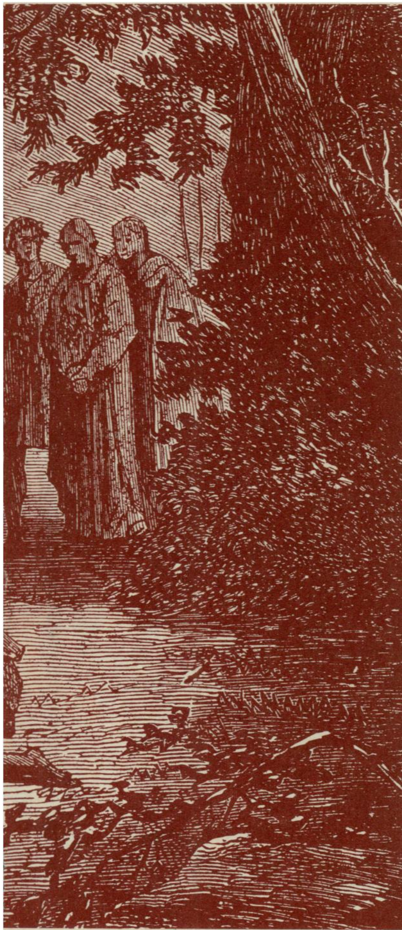

the arm of a woman and cling to her side in a curiously childlike manner.

During the last two group sessions, the leaders noted that other men in the group seemed unusually angry with Tom. While the women in the group expressed mild annoyance at his "advances," the men referred to him as a "sex maniac," "pervert," and "psycho." Toward the end of one session, the men demanded that Tom be removed from the group. During the discussion, Tom sat meekly in the circle without responding.

After the session, the leaders discussed what dynamics might be operating in the group, whose membership consisted of four men and four women between the ages of 23 and 42. Two of the men had had serious problems with impulse control in the past—primarily impulses relating to sexual feelings. The leaders surmised that Tom's behavior was quite threatening, especially to these two men who feared a breakdown of their own controls.

In the next session, the leaders asked the group to talk about what feelings they experienced when in the presence of a person who had poor control over his impulses. This session proved to be a very meaningful one, for nearly all of the members related fears of losing control in a number of areas—including that of sexual behavior. Thus the group, in a supportive manner, began suggesting to Tom more appropriate ways of approaching women.

Within the context of a psychotherapy group, scapegoating can be seen as a defense mechanism in which there is projection of anxiety and/or pathology(3). In the example described, Tom's behavior activated conflicts in several group members which they probably preferred to suppress. When unable to suppress these conflicts, it was fairly easy to project all the "pathology" onto Tom. Only after the leaders helped the group members to focus on their own feelings did the scapegoating diminish. As various individuals became comfortable enough to discuss their fears within the group, there was no longer a need to project exaggerated, undesirable characteristics onto Tom.

Example: A T-Group of Students in a Psychiatric Nursing Program

This group, a required part of the curriculum, consisted of nine female students working toward master's degrees in psychiatric nursing. The women ranged in age from 25 to 41. The leader of the group was a faculty member.

A central objective for the group was to explore patterns of interaction between group members. Only two of the students, Diane and Mary, had previous experience working in psychiatric settings before entering the master's program. Both had acquired some psychotherapeutic skills and sophistication in relation to psychiatric theories before beginning graduate school. Diane tended to be rather quiet unless the discussion centered around theoretical material. Then she would participate actively—usually in an "information-giving" role. Mary was much more aggressive in the group—talking about her past experiences as a psychiatric nurse. Over a period of several weekly sessions, the rest of the group became increasingly hostile toward both women, calling Diane "aloof," and Mary "a know-it-all."

After observing the group interaction for several sessions, the leader intervened. The group members were asked to analyze what was occurring in the group without focusing on individual behavior. In this context, the students began discussing anxieties surrounding a specific requirement of the program—that of functioning as a therapist with a psychiatric patient.

Several members revealed that Diane and Mary, who appeared extremely self-confident, intensified the feelings of insecurity the rest of the group were already experiencing. The leader suggested that much of the anger felt in the group was in reality toward her for not providing more structure and/or support in the clinical assignments.

The group agreed with the leader's interpretation, admitting that it was much less threatening to "scapegoat" two other students than to chance a confrontation with a faculty member.

In this case, scapegoating resembles an individual's ego defense mechanism of displacement by "displacing" aggression from the original object to a less formidable one.

This example illustrates several steps that may occur in the scapegoating process. First, the group members felt inadequate in meeting an objective designated by the faculty. An initial response was probably anxiety

and anger, possibly not conscious, toward the faculty.

Next, the group needed an outlet for its anger to alleviate the anxiety. The attacks on the two scapegoats most likely represented an attempt to control or eliminate certain painful fantasies. The content of the fantasies probably related to the other students' perceived discrepancies between their present abilities and their goals and/or the expectations of the faculty. The presence of Diane and Mary was a constant reminder that some graduate students already possessed many of the abilities in which they themselves felt inadequate.

Interestingly, as the graduate program progressed and the majority of the group members did increase their psychotherapeutic skills, hostility decreased, and the scapegoating process ceased, enabling the students to function as a cohesive, working group.

Example: A Faculty Work Group

This group consisted of six instructors in a baccalaureate nursing program. All were women between ages 26 and 48. They met on a weekly basis to plan curriculum changes for the following semester. Each instructor was responsible for preparing a study unit each week and for submitting portions of it to the group.

All the women had worked together on a number of occasions with the exception of Jill, who was new to the group. The other five instructors tended to work together on their units; Jill typically worked alone. During the meetings Jill appeared enthusiastic about the tasks at hand, asked many questions, and sometimes attempted to interject new ideas into the group. When she did this, a frequent response from the rest of the group was "We really need to be moving on," or "It doesn't sound very practical for us."

As the weeks passed, the atmosphere in the meetings became quite tense. On one occasion Jill was chided for being late and taking up too much of the group's time with irrelevant discussion. During the next meeting, each instructor presented a rough draft of her completed unit. The group members warmly supported the efforts of everyone until it came time for Jill's presentation, which was followed by such comments as, "This isn't the format we agreed upon," "You've included far too much content," and

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SCAPEGOATING AMONG PROFESSIONALS

HOW TO AVOID SCAPEGOATING BY USING A TRANSACTIONAL APPROACH

NANCY WACHTER-SHIKORA

Recently, a group of us were talking about the extraordinary amount of criticism and fault-finding we were seeing in our clinical areas. We noted that more and more people seemed to be scapegoating others for clinical errors or mishaps on their units. I began wondering why there should be such an increase: the work situation and most of the staff were the same. What was prompting this behavior?

It seems to me that pressures on professionals today are immense; responsibility, accountability, and consumer demands stand out among these. Physicians are under pressure from the mandated PSRO and the increase in malpractice conflicts and threats. Nurses are becoming independent and accountable for their professional acts. Nurses are also feeling the push for quality assurance in patient care and the need for advanced education as part of their professional growth. With the exception of malpractice suit excesses, I believe that these pressures are positive and necessary for improving the health care system, but they *do* cause anxiety.

Since anxiety is uncomfortable, we seek ways to reduce it. One of the ways is to regress—to go back to earlier, safer patterns and start behaving in childlike ways. One of the things children do is deny responsibility by blaming others, or scapegoating.

In our developing years our parents tried to build moral standards within us. They tried to teach us accountability and responsibility for our acts. Sometimes it worked, sometimes not.

MOM: "Who took the money from the cookie jar?"

CHILD: "Johnny did it," or "Not me!"

Sometimes this "stayed the execution" a little longer, but one thing was certain. It kept Mom going around the ring—for a while. As we grew older and more mature, we realized that blaming others was not effective and our responses became more adult.

CHILD: "I'm sorry. I did it. I'll take a cut in my allowance."

In adult life, we communicate at our Parent, Adult, and Child transactional levels which reflect the ego states we are in at that moment. While most of the time we use our computer-like, problem-solving Adult level to communicate, regression under pressure to the Child level is not uncommon.[1]

I contend that this is what happens internally to us as professionals in our fervor to be responsible without fear of punishment. Frequently, the criticism comes from within ourselves. For instance, our internal Parent says "Did you really do the best you could?" and

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[1]Harris, T.A. *I'm OK—You're OK.* New York, Harper and Row, 1969.

other such rather negative criticisms.

At this point one instructor, who had been sitting quietly, interrupted, saying, "Wait a minute–what are we doing? We've been giving Jill a hard time for weeks. Maybe we ought to look at what's really happening in this group." Immediately the discussion shifted and various individuals admitted having felt "uneasy" and "pressured" about the tasks needing completion by the end of the semester. Another instructor analyzed:

"I think the five of us have been acting like a clique, since we've known each other for a while. Actually we've been huddling together for security. We've treated Jill like an outsider and blamed her for our anxieties about the curriculum changes."

In this situation, one individual had been able to separate herself from the group long enough to identify a problem unseen by the others. When the other instructors began to look at their own feelings, the scapegoating came to an end. As group members became more comfortable in expressing feelings of insecurity about curriculum changes, there was less need to form a clique to protect themselves and to find an object upon which to project "bad" feelings.

Scapegoating is possibly the most dramatic manifestation of a group's tendency to exploit an individual. To some extent, all group membership is dependent upon a contract, whether conscious or unconscious, in which the individual is obliged to suppress certain unique aspects of his personality in order to develop others(4). However, if carried to an extreme, the individual may find himself feeling constricted and dominated by the group. Since scapegoating behavior is symptomatic of dysfunction in a group, when it occurs productive activity in a group is likely to halt. Professional nurses in all kinds of work settings should develop an increased awareness of this behavior in order to intervene effectively when scapegoating does occur.

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we respond with a childlike, "Yes, but someone else spoiled my efforts." At other times, our colleagues provide the parental transaction which evokes a Child response.

I remember, in particular, a client in an ICU who had a tracheostomy performed. The procedure was very difficult because of a deviated trachea. Neither the nurses nor physicians, however, noted this on the chart. The next evening, as the nurses changed the tracheostomy tapes, the client coughed out the tube. The physicians who replaced the tube were angry, although no harm was done to the client. The next day a note appeared on the chart: "DO NOT CHANGE THE TRACH TAPES." The nurses were furious. An irate physician and nurse exchanged the following transaction:

NURSE: You are not going to order us around! Changing trach tapes is a nursing procedure, and you are simply not going to order us around! (Child)

PHYSICIAN: We have a responsibility to the patients. We *have to* give orders if we can't trust the nurses to handle the simplest responsibilities! (Child)

NURSE: Don't blame us! The resident was an idiot for not writing down the problem! (Child)

PHYSICIAN: It's not our fault! Why didn't that dumb nurse hold down that tube more firmly? (Child)

If both of them used the Adult communication level, they would have avoided this scapegoating. For example:

NURSE: We feel uncomfortable about your writing an order not to change the trach tapes. Since these tapes become soiled and need changing, we feel we ought to talk about this order.

PHYSICIAN: Well, we're afraid that the tube might slip out again.

NURSE: We just found out that the trachea is deviated, and the tracheostomy incision is larger than usual. Was this known at the time the procedure was done?

PHYSICIAN: Yes. Perhaps we should have made a better effort to communicate that information.

NURSE: Okay. Well, let's figure out a way to approach this "change of tape" problem then.

In the first transaction, the physician and the nurse scored insult points. Such communication would undoubtedly affect client care if they continued to blame each other. What was the problem here?

I believe it's a gap in communication because we are being defensive. Are we afraid to admit our mistakes? Is the pressure of accountability too great? Sometimes it is, but it doesn't need to be.

When accountability becomes liability, honest communication is impaired. Some errors that reflect on our skills and esteem need not be hidden by scapegoating if we can have open and honest communications.

We must realize that we are accountable for the best of our abilities, but that we have human limitations. We must not make the halls echo with "Dumb nurse—Dumb doctor," but begin to say "How can we cooperate?" We must feel that we can safely let our weaknesses show as well as our strengths. That way we spend less time on fault-finding and scapegoating, and more on improving ourselves and our conditions.

Determining the transactional level (Parent, Adult, Child) underlying scapegoating behavior is one way to break out of the scapegoating pattern, and it is an approach that I have used very successfully in many situations. Initially, people tested me to see if they could trust me. But once they found that I sincerely wanted to communicate openly, they no longer feared reprimand and we were freed to exchange Adult dialogue.