

Affective Overflows in Clinical Riskwork¹

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Abstract

Emotional-affective aspects of risk work are integral to risk management in many fields, particularly in human service organizations; yet rational notions of risk management often obscure these emotional-affective aspects. In this chapter, we discuss the case of high risk mental healthcare (for people with personality disorders), characterised by both formal and informal risk management systems. Drawing on sociomaterial perspectives, we explore empirically how affective dimensions of routine clinical risk work flow between these formal and informal risk management systems, *affecting* intersubjective relations and experiences. We show how affect can ‘inflammate’ incidents, producing heated interactions that escalate and ‘overflow’ through the risk management technologies, devices and systems intended to contain and manage them. The chapter draws conclusions on dynamics of affective flows and overflows that are present – if less visible – in other areas of risk work.

Keywords:

affect; emotion; healthcare; mental health care; overflow; personality disorder; risk management; risk work; sociomateriality

The terms ‘clinical’ and ‘risk management’ are commonly associated with rational detachment and cold, objective calculation, emotionally removed from the subjective experience of dealing with sickness, injury and death. In contrast, we suggest that emotion and affect are integral to the work of managing clinical risk, often involving the intimate handling of human subjects and their embodied subjectivities. Dominant ideals of clinical risk management obscure these emotional-affective dimensions and what we describe below as ‘affective overflows’ in the ‘heat’ of day-to-day risk management (Dolan & Doyle, 2000; Godin, 2004; Hirschhorn, 1999). In day-to-day clinical practices emotions are materially entangled with the micro-technologies and devices of risk management, in its routine practices, habits and scripts (Fischer & Ferlie, 2013; Power, 2011). Indeed, these practices reveal an informal and more ‘indigenous’ practice of clinical ‘risk work’, in which risk technologies and devices are tactically deployed, refashioned or undermined (Fischer, 2012; McGivern & Ferlie, 2007; McGivern & Fischer, 2010; 2012; Nicolini et al., 2011; Waring, 2005).

The interaction between people and material objects – sociomateriality - is of growing scholarly interest (Cetina & Bruegger, 2000; Orlikowski & Scott, 2008; Star & Griesemer, 1989;) and regarded as an intrinsic feature of everyday working practices. Less attention though, has been paid to the way emotions, passions, fantasies and desires shape and ‘animate’ this world of material objects. For example, in his manifesto for relational sociology, Emirbayer (1997; 311) advocates exploring ‘culture and collective emotions’ and notes that “the study of transpersonal emotional flows has remained seriously underdeveloped.”

Studies of emotion within organizations generally consider intra- and inter-subjective emotion operating within and between individuals and groups (Fineman, 2008; Gabriel, 1995, 1999), often elusively (Courpasson & Thoenig, 2010; Morrill, 1995; Roberts et al., 2006). However, emotions are inherently connected with desires, values and fantasies – and readily caught up with material objects. These ‘affective intensities’ (Massumi, 2002; Thrift, 2008) confer emotional meaning and attachment to objects, which are ‘reworked’ as they come into and out of mental focus, continuously shaped and remade through changes in everyday practice.

This affective dimension of risk management work has previously been suggested across diverse fields, including in studies of financial traders, accountants and auditors (Fenton-O’Creivy et al., 2007, 2011, 2012). For example, Guenin-Paracini et al.’s (2014) ethnographic study of a large audit firm found that risk was associated with the emotion of fear, which shaped accountants’ thoughts and use of techniques during audit processes. Similarly, Boedker and Chua’s (2013) study of a major corporation found that both affect and rational calculation generated energy and collective action as an ‘affective technology’ tied to circulating accounting practices and devices:

“A flow of emotional energy that travels in networks of technology, people, images... technologies are important because they distribute and circulate affect in action nets ... Affect flows from non-human devices to people and back again ... its circulation via technology ... act(ing) as a node in a network of affect production” (Boedker & Chua, 2013, pp. 262-263).

From this perspective, the affective dimension of organizational life involves shared ‘intensities’, which circulate between subjective and material ‘realities’, *affecting* subjective experience and emotions, rather than emanating from them (Navaro-Yashin, 2012; Wetherell, 2012). In contrast, previous empirical research (Fischer, 2008), has found that ‘indigenous’ risk systems are more strongly imbued with intersubjective dynamics and meanings. However, these (and all risk systems) have a dynamic tendency to acquire a public trajectory: what begins as a latent risk representation may become an object of formal risk management (Castel, 1991; O’Malley, 2004; Power, 2007).

In this chapter, we focus on clinical risk management in mental health care as an exemplary case of the submerged dynamics of indigenous risk systems. Understanding the (necessarily) more intersubjective and embodied aspects of extreme cases can reveal dynamics that are present, if less visible, in other contexts (Eisenhardt, 1989). To bring our material to the fore, we draw from an ethnography (Fischer, 2008) of a specialist health service for the treatment of a high risk patient group (people with personality disorders).

We suggest, firstly, that practising health care elicits a mix of positive and negative emotional feelings connected with handling and being accountable for the care of other people – their bodily experiences, transformations, illnesses and sometimes death. In classic studies, such as Menzies-Lyth’s (1960) psychoanalytic study of nurses’ defensive mechanisms, anxiety appears as a diffuse and generalised explanation of these experiences. However, this overlooks a more complex picture in which diverse subjective experiences are bound up with one another.

Such ‘inter-subjectivity’ involves connections folded into human experience (Mitchell, 2000; Mitchell & Aron, 1999). Crapanzano’s (1992, 2006) describes the experience of intersubjectivity as an ‘interlocutory drama’ that connects us with others – mediating our own experiences of ourselves and others. There is “nothing irrational, nothing even fictive about the scene... in its experience, in its description... Both the scene and ... objective reality are subjectively experienced.” (Crapanzano, 2006, p. 398). As this suggests, intersubjective experiences tend to be emotional ‘dramas’ filled with expectations, meanings and desires, which are continuously improvised and which unfold in often surprising and unpredictable ways. Such dramatisation arises in many contexts

involving emotional investments in the work of managing risk, but especially so in 'human service organizations' where there are expectations of balancing the desire for healing and care, with the wish to be protected from harm.

Secondly, these dramas become entangled with material possessions, tools and artefacts. Indeed, we argue that intersubjective experiences involve a material focus, involving people as well as other material objects. Influenced by anthropology, human geography and cultural theory, the scholarship on affect tends to focus on the so-called 'affective intensities' of physical objects, institutions and buildings, as though such objects themselves produce 'affects' on humans (see Massumi, 2002; Thrift, 2008). However, this chapter suggests a different starting point for these intersubjective aspects in the context of clinical risk work. (For other intersubjective accounts of affect, see Navaro-Yashin, 2012; Wetherell, 2012). We argue that material objects do not have the 'solidity' they may appear to have, but are being continuously brought into being and shaped as part of the 'making' of risk. As we describe below, devices and technologies that appear as background context in one moment can become dramatically 'real' in the heat of a crisis or near-miss. Risks and their material representations thus reflect and 'embody' subjective experiences and projections that produce *affects* during incidents and crises.

Finally, we argue that during dramas and crises, affective flows between indigenous and formal systems may become affectively 'heated' (Fischer & Ferlie, 2013). As Callon (1998) argues, in such conditions 'everything becomes controversial', creating 'overflows' which can escalate, producing new risk objects and eroding arrangements for containment through expert framing. Indigenous clinical risk work reveals processes of 'organizational becoming' (Tsoukas & Chia, 2002) that are inherently caught up in 'affective interactions' between human subjects and the material objects, devices and technologies with which they work. We empirically explore how complaints and whistleblowing affectively 'inflammate' incidents, producing heated interactions that 'overflow' (Callon, 1998) beyond the technologies and devices intended to contain and manage them.

Overall, the chapter suggests that affective investments in the work of clinical risk management produce an 'affective economy' in which risk objects, technologies and devices circulate. Whereas in 'cool' conditions risk management may proceed along

intended decision pathways (Callon, 1998), when affect is added, interactions between relational and formal risk management systems create turbulent flows (Fischer, 2008, 2012), with repercussions for those invested and involved in the field. As the case of mental health personality disorder services discussed below shows, affective flows and the tendency for overflows are an intrinsic aspect of clinical risk and its management.

Personality disorder as a risk object

The healthcare context is of general interest because technical, rational-analytic prescribed guidelines and standardised practices are blended with traditional clinical judgements, a ‘felt’ sense, and an idealised empathic engagement with patients. For example, the ideal of ‘a good bedside manner’ has become increasingly a focus of medical training and professional standards. Thus there is a potentially paradoxical dual trajectory towards technocratic healthcare on the one hand and informed patient choice involving equal and empathic engagement with patients on the other.

The sub-field of psychiatry is an ideal case for exploring this dual trajectory and the ‘felt’ emotional aspects of healthcare. In part, this is because psychiatry pays more attention to patients’ cognitions, emotions and subjective experiences than other medical sub-fields, but also because technical treatment emphasises relations and ‘therapeutic alliances’ between patients and clinicians over pharmacological or physical interventions. Formal organizations also play a significant and visible role in psychiatric health care in the sense that organizational responses to clinical crises and risk management become the ‘front stage’ for risks which emerge from professional and patient communities that may be more or less attuned to the lives and experiences of their participants. ‘Difficult to manage’ personality disorders provide an opportunity to study clinical risk management as it unfolds in the space between front and back stage, where emotional-affective indigenous clinical work interacts with risk systems but also, ultimately, with public policy issues.

A number of high-profile homicides in the late 1990s, committed by people with mental illness, heightened public concern about the perceived risks presented by people with severe mental disorders. Determined to tackle the dangers presented by people with such disorders, the UK government put public protection at the centre of its mental

health policy (Department of Health & Home Office, 1999, 2000). It proposed legislation to allow the indefinite detention of people with severe mental disorders, based on presumed risk to the public. What particularly exercised UK government attention, were the risks presented by people with severe personality disorders. While medical psychiatry often considers severe personality disorders as untreatable, the realization that some people with these conditions were dangerous brought this issue into the political spotlight.

Shortly after the UK 1997 general election, Michael Stone – a convicted psychopath – was arrested for the double homicide of Lin Russell and her six-year old daughter, Megan, the previous year. Her other daughter, nine-year old Josie, had been left for dead with severe head injuries producing public shock and outrage. A public enquiry attributed blame to severely flawed systems of risk management by mental health services (which had released him into the community after assessing his condition as untreatable) (Francis et al. 2006).

While managing risk of violence or self-harm in personality disorder patients has been a longstanding focus in mental health and prisons, such rare but high profile cases of homicide in the 1990s, committed by people with either severe personality disorders or schizophrenia, drove the UK Government to introduce a National Service Framework for Mental Health. Public protection from ‘dangerous people’ became a policy priority and the new Labour government (Department of Health, 1998) produced a comprehensive mental health strategy covering topics ranging from promoting ‘healthy communities’ to ensuring the secure incarceration of people with severe mental illnesses, considered to be of greatest risk to others. A National Service Framework (Department of Health, 1999b) set out new statutory responsibilities for assessing and handling patients, differentiating and managing patients deemed to be at high risk of violence or self-harm (Home Office & Department of Health, 1999; National Institute for Mental Health in England, 2003).

A Care Programme Approach (CPA) was developed as an interagency administrative framework for assessing, planning, coordinating and reviewing care plans (Department of Health, 1999a). The CPA specifies arrangements for multidisciplinary, multiagency meetings requiring crisis and contingency plans, handover arrangements between

agencies, recording and sharing records, and formally reviewing plans. These requirements are managed by named key workers – usually nurses or social workers – who are responsible for coordinating and administering the framework. The new arrangements were overseen by statutory ‘clinical governance’ arrangements assigned to hospital boards as an accountability framework for assuring systematic standards of care, transparency, reporting and care improvements. The boards were formally responsible for auditing their CPA framework on an annual basis.

However, unlike patients with physical disorders, the engagement of people with personality disorders with a system like CPA can be difficult, even when they actively seek help. People with personality disorders tend to engage erratically with care programmes, often dropping out of treatment. High levels of emotional vulnerability prompt some to seek help only when they are in a state of crisis, often threatening suicide, or following self-harm. Although relatively few treatments for personality disorders have been found to be effective, an influential report (Reed, 1994) argued that the Democratic Therapeutic Community (DTC) model had been shown to be more promising than other existing models of treatment. The DTC model involves full-time immersion in an intensive, demanding and psychologically challenging programme for up to a year. The Department of Health commissioned a national DTC service consisting of three communities, along with well-resourced outreach teams operating across district mental health services.

Methods and data

Our empirical focus in what follows is based on a four year ethnographic study (Fischer, 2008) of interorganizational relations between one of the DTCs and external agencies in health services, social care, high security hospitals and prisons. One author (Fischer) had professional links to the DTCs and studied its clinical work and wider engagement across three UK inner-city conurbations and a rural area. During an initial 2 year phase, he explored care coordination and the transition of patients between services. In a second phase, the empirical material concentrated on the DTC itself and its relations with a broader set of agencies, including national commissioners and the Department of Health. Participant observations (195 hours), 76 in-depth formal interviews (1½-2 hours in duration), and informal interviews (over a period of seven years) were triangulated against clinical, management and policy texts collated during the study.

Managing risk in local mental health services

In our first example, drawn from an inner-city hospital, we see various ways in which psychiatrists and clinical psychologists attempt to prevent risk escalation by handling cases of personality disorder behind the scenes, drawing on emotional-relational techniques rather than formal organizational processes. Practitioners' sensitivity to patients' emotions is generally regarded as a valuable tool, providing insights into possible reactions or escalation of problems. Handling their patients, their own reactions, and colleagues' emotions is an everyday aspect of psychiatrists' and clinical psychologists' work.

"I don't like working with angry, antisocial men, they freak me out. I am irrationally uncomfortable with them and probably just not empathic. And I worry about bumping into them in the street, that they will come and track me down ... you hear of therapists being stalked by patients. And the other thing which freaks me out is that they are often very charming and you just feel: Jesus, I am getting sucked in here! They have done horrendous things to people and yet they are actually being quite nice, saying you are really helping me." Clinical psychologist.

"Doctors were thrashing around trying to find out what was the matter with me. And I was telling them but they didn't hear... All my suicide attempts were because nobody was listening to me, everyone got caught up in all of this self-harm stuff and seemed to think that was more serious than the real problem, which they just ignored completely, even though I was desperate. It was making me feel even more suicidal." Patient.

As one psychiatrist describes, emotional relations can spread and quickly escalate, especially where there is risk of harm.

"They create massive anxiety - my colleagues come running, terrified because the patient's talking about self harm. These patients know our anxieties; they know how to engage the doctor, because that doctor is scared for his professional life, frightened about presiding over a patient who kills themselves. They test you, they will say, 'oh doctor I feel suicidal'; and they look you in the eye to see how you react. I feel dead anxious too. But it means we always act defensively, we end up admitting them (to hospital) because we have to be seen to be doing

something, when sometimes doing nothing or putting responsibility back to the patient might be the best course of action.” Consultant psychiatrist 1.

As we find in this example, emotions tend to readily flow between human subjects and systems of risk management, which can become articulated in various and contradictory ways within organizational settings. These include administrative and technological responses that tend towards diffusing risks (such as continuous observation and forcible detention of patients under mental health legislation) as well as clinical responses that may seek to elicit greater patient responsibility.

Interactions between professionals and patients thus tend to be mediated by responses to actual clinical risks (first order, acting in the patient’s best interests to prevent harm) and systems of formal risk management (second order risks, arising from challenges to the risk management system).

“Professionals get their fingers burnt because these patients challenge the system and get detained for their own safety. And the whole thing becomes increasingly confused, because the patient fights to come out and you end up restricting them even more, trying to stop them from hurting themselves, rather than addressing any underlying psychopathology. You feel, well, I have taken over a very difficult patient and have ended up being backed into a corner, with the patient detained. And the nursing staff all divided and are up in arms screaming at you, and the patient seems to be deteriorating, and I am trapped. What do I do next? It is very, very difficult.” Consultant psychiatrist 2.

Far from these formal risk management systems (including responses, such as physical detention or pharmacological sedation) being experienced as ‘cold’, clinical or organizational technologies that are external to emotional exchange, we see that emotion becomes embroiled within this risk system itself, attaching itself to the technologies and materials of risk management. This intersubjective entanglement with technologies can further intensify emotional reactions and clinical risk. For this reason, experienced practitioners often seek to manage personality disorder patients invisibly, outside of formal risk management systems. Although not formally visible, handling intersubjectivity and emotional reactions through private engagement increases the scope for clinically embedded risk management.

So we find professionals working in a semi-autonomous capacity, managing clinical relations unencumbered by formal risk management arrangements. We see such clinical risk work as mediating between formal and informal risk management systems. Indeed, especially for many experienced clinicians, working with difficult patients takes place through an informal and indigenous risk system, out of sight of the formal risk systems, and often the wider clinical care system. As one community psychiatrist described it, his personal style was like a ‘warm bath’ which his patients tended to want to stay in for long periods. He kept in touch with one long-term patient who visited him (‘like an old friend’), several years after he had moved to a different country. More commonly, however, clinicians described striving to provide psychological ‘containment’ for personality disorder patients, relying more on a therapeutic alliance rather than interventions, and attempting to insulate them from the wider clinical and risk systems.

“The service is not set up to cope with personality disorders, they end up being disliked and labelled as time wasters, it makes them worse and more entrenched. I would never refer anyone with a personality disorder to the rest of the team. Anyone who I would see as personality disorder will inevitably stay (just) with me.” Consultant psychiatrist 3.

This illustrates the dynamic tension between indigenous and formal risk systems. In the case of personality disorders, such tensions are not exceptional incidents requiring an emergency response, but are part of the everyday tensions and signs of trouble that practitioners are vigilant about – steering between relational and formal risk management as part of everyday work.

These tensions become particularly salient when localised trouble escalates to formal complaints or whistleblowing involving external parties. One medical director described how his staff attempted to manage a patient through a more informal out-patient care – rather than run the risk of her repeating a pattern of escalating self-harm by admitting her to hospital. But this backfired as this patient attracted the attention of authorities:

“(She) presented very dramatically, standing on the edge of a motorway bridge, blocking traffic... police helicopters out and everything... she actually fell from the bridge and was badly injured. The police were traumatised by it and released a lot of damaging information to the press... big newspaper headlines – a hatchet job. No mention of the fact that she had had months as an inpatient, she was being managed through a seven days a week care plan, involved

in all sorts of therapies. There were (Members of Parliament) involved, the authorities demanding weekly statements on what was happening.” Medical Director.

As Callon (1998) suggests, the local handling of risk in complex and relationally ‘volatile’ cases such as this may produce ‘overflows’, shifting the focus from first order risks to the risk management systems. Whereas such escalation can increase tensions within formal (and reputational) risk management arrangements, this may be in direct conflict with the handling of clinical risks. As our medical director describes it:

“(Our hospital) lawyers said if we had been in the coroner’s court, it would have been very difficult to convince a jury of peers that (treating such a high risk patient as an outpatient) was a sensible plan. You have to understand the risks of doing things that seem crazy but are in the patient’s long term interests.” Medical director.

In other words risk work can *produce* risk as emotions run high, producing affective flows and overflows beyond formal risk management systems. In this sense, in the case of complaints and whistleblowing, the risk management system may become ‘heated’ through this emotional economy of risk. This can create pressure to develop more elaborate informal and relational risk work practices to containing this ‘heating’ process.

For instance, a multidisciplinary care team became divided over whether they should work with a patient who some believed posed a risk to children. Unable to resolve the conflict internally, their manager referred the issue to the hospital CEO:

“It was really destructive and created a big split in the team. The service wasn’t geared up for dealing with this level of risk. We were never going to meet his needs but just compound his frustration and further increase his risky behaviour. There was a real deadlock. Eventually it was resolved because this man was excellent at complaining, flagging up deficits in our service to the highest echelons, it made everybody really anxious. In the end, our CEO and the director of social services ended up having weekly (counselling) sessions with him. It was incredibly bizarre!” Head of Psychology.

While such indigenous clinical risk management work is often invisible to formal risk systems, it is an important aspect of clinical work. The dynamics of emotional entanglement between people and the risk systems and technologies produce unexpected flows and overflows to other parties, altering usual decision path dependencies. In the

next section, we explore how ‘materiality’ operates as part of this emotional economy of risk.

The DTC: Shifts between informal and formal riskwork systems

The Democratic Therapeutic Community (DTC) system had been identified as one of the few successful clinical treatments for personality disorders (Reed, 1994), requiring an intensive re-socialisation programme involving full time residential treatment over a period of 12 months. The DTC was run using a complex set of rules and a structured programme of groupwork designed to ‘slow incidents down’ so that they could be discussed and ‘worked through’ over time (often several days), before making decisions and taking action.

Risk assessment and management were seen as the principle therapeutic task, requiring all current and prospective DTC members to learn to recognise and understand their own emotions and those of others, as a means of handling the potential for risk escalation. Indeed, patients were seen as more effective and accurate assessors of clinical risk than clinical staff, and they generally had a strong personal investment in keeping the DTC ‘a safe space’. Accordingly they played a significant role in running the DTC (the elected ‘Top Three’ patients jointly led the day-to-day running of the community, together with a senior team of doctors, psychologists and nurses), as well as clinical decision-making, voting on who should be admitted to, or discharged from, the unit.

The DTC’s rules were democratically determined, interpreted and occasionally amended, based on long-established principles of democratisation (the full community of patients and staff make clinical and management decisions throughout the day through democratic voting); communalism (all members are required to participate in the life of running the community, such as cleaning and preparing meals); permissiveness (members are expected to interact authentically and to ‘surface’ problem issues and behaviours); and reality confrontation (members are expected to learn and take responsibility for the impact of their behaviour on others) (Rapoport, 1960). Meetings of the full community could be called at any time of the day or night to manage emerging incidents or crises until the following scheduled community meeting.

Emphasis was placed on patients identifying and managing risks within the community. The DTC ran a daily timetable of small and large group activities from morning until late evening, which all patients and staff were expected to fully participate fully in as the DTC's model of therapeutic treatment, and its core technology for identifying, assessing and managing clinical risk. Outside of formal group activities, members were expected to take any concern or issues to Top Three who, together with staff, would decide whether to call an emergency meeting of the full community, or to provide informal support until the next scheduled meeting. As one therapist described it:

“If the culture of enquiry is not carried by residents, it becomes something that the staff are left to do. And when questions come from staff rather than residents, we are accused of being too psychotherapeutic (and) making residents feel vulnerable and abused. The longer (this) goes on, the less communication takes place, and momentum builds for things to take place behind the scenes.”

A major aspect of this collective risk work was the process of selecting and ‘constructing’ risks, which often develop through a rather fragmented and accidental clustering of events. For instance, a heated altercation developed during a daily community meeting between Simon (patient) and John (a senior therapist), triggered by a comment that Simon interpreted as a ‘put-down’.

Simon explodes in anger, protesting that John’s got it in for him – he’s always on his case... another exchange promptly follows. Simon mutters (ambiguously) ‘if you think you can do that, think again.’ John, visibly flushed and agitated, protests that Simon’s ‘threat’ is completely unacceptable: ‘we don’t do that kind of thing in here, it’s not on.’ Frustrated, Simon storms out of the unit... feeling provoked by John and ‘sick of being controlled.’ Extract from fieldnotes.

As members tried to work out how to make sense of what John perceived as Simon’s ‘threat’, there was uncertainty and effort in constructing this as a risk. Few had noticed much of the interaction between the two. Overall, the community was sympathetic to Simon feeling ‘picked on’ by staff. Some clinicians seemed uncertain as to whether Simon’s comment was intended as a threat. John looked awkwardly for reassurance from colleagues, and seemed even less certain about his interpretation after the meeting. Perhaps he had just overreacted? Yet in a subsequent staff debriefing, John’s continuing

emotional reaction to the exchange persuaded the staff team that Simon should face the consequences of his aggressive outburst.

After speaking with staff, Top Three called an emergency meeting of the community which (after much debate) voted to technically 'discharge' Simon from the community. However, under the community's structured system of rules, they allowed him to request a temporary 24-hour 'sleeping-in extension' to renegotiate his membership of the community. While formally suspended from the community and no longer permitted to vote in community meetings, a condition for renewing his temporary extension was his willingness to review his perceptions, behaviour and attitude, in the daily community meetings. Members were, in turn, required to assess his commitment to the community and the risks he presented to himself and others, and to review and vote on his extension every 24 hours. They finally elected to re-instate him as a community member after the maximum permitted extension of 72 hours.

Such risk reviews were conducted as part of the daily community meetings, which were ritualistic and formalised in tone. Led by the 'Top Three' patients, the proceedings followed a structured agenda, recording 'missed groups' (patients were considered to have 'suspended themselves' if they missed three groups), reviewing 'referred meetings' (emergency meetings with patients 'at risk'), noting rule-breaking, feeding back unstructured leisure time, and planning meals and cleaning rotas. An elected secretary minuted the meetings in detail and then read the minutes (at length) in a morning community meeting the next day. Meetings involved frequent votes for decision-making based upon a set protocol: a five minute open discussion, followed by a proposal from the chair, a call for objections, and then a vote based on a show of hands (both staff and patients are required to vote). Two 'tellers' finally counted and recorded votes for, against, and abstentions.

The meeting is very formal (ritualised), starting with a name-round 'for the visitor'. There was a reading of the previous day's very detailed minutes and notes of discussion, which seemed verbatim ... This was listened to in silence, with an almost religious respect ... It felt the reading was being received like a sacred text in a monastery. Extract from fieldnotes.

Although a central part of the DTC's functioning, the content of these meetings and their minutes were treated as confidential and formally invisible to the wider CPA and

clinical governance requirements. As a record of community events, rather than individual patient case notes, they were not shared with outside agencies. In line with the DTC treatment model (as a group-based model in which there is no individual therapy) staff did not record separate case notes of clinical care.

Importantly, however, this approach to assessing, planning and reviewing care was translated into how the DTC contributed to its formal CPA requirements. When producing written reports for outside agencies, patients were involved in assessing each other's risk, determining their future care needs, and (usually, but not always with a clinical staff member) providing written accounts of their treatment. The DTC insisted upon patients attending their interagency CPA meetings to contribute to the assessment, planning and review process. Often to the surprise of other agencies (who tend to treat the CPA as an administrative exercise), DTC patients also brought along one or more other patients with the intention of supporting them.

“The client wrote her own assessment report, saying she was just about to leave and how well she'd done. We don't know what goes on because the DTC gives you very little information. And so the client comes to the CPA meeting with this report and her agenda. I am like, WHAT? Clients don't have agendas - we tell them! So that's all been quite threatening for some staff, especially the psychiatrists. And we've had to walk a real tightrope with this client, trying to explain you can't just walk in and demand all these things from services, because when you do, they just cut you off.” Social work manager.

The DTC's collective methods for identifying and creating risk objects can be seen as an elaborate and embedded 'indigenous system' of clinical risk work that is strongly based on relational forms of risk management. Whereas not all risks were necessarily brought into the DTC's community meetings (incidents take place in private, in the evenings and sometimes outside of the community) this system was designed to be responsive and “concertina-like” in bringing clinical riskwork closer to the underlying uncertainty and flux of possible and actual incidents in patients' everyday lives. For example, a request to Top Three for 'floors and doors' would result in a rota of patients sleeping on the floor or remaining awake outside the bedroom of a patient feeling vulnerable, to provide active support through the night. In keeping with this indigenous system, the textual representations of these risks was recorded and recited as confidential community minutes that remained invisible to, and unaudited by, formal risk management procedures.

Affective overflows into the policy domain

A critical incident produced a significant change in the way the DTC and its hospital board handled clinical risks. A former DTC patient murdered his partner, several weeks after being discharged from the community. Health authorities reacted by instigating a ‘root and branch’ comprehensive risk assessment of the entire service to bring the DTC ‘in line’ with the working of other psychiatric units. The hospital board commissioned specialists in forensic psychiatry to conduct an inquiry, emphasising actuarial (statistics-based) models of risk prediction, rather than the DTC’s model of clinical judgement. New formal risk management arrangements required regular staff audits and upward reporting of risks, such as ‘ligature points’ (physical features that could provide a noose for strangulation). Arrangements included formally recording and reporting discussions with patients, including ‘advice on clinical risks’ and discharge planning. Hospital managers challenged the idea of patients’ equal participation in the CPA process, insisting that clinical authority should override patient opinion.

The introduction of these new formal risk arrangements heightened DTC members’ emotional reactions (of bereavement, guilt and self-blame) to the homicide, and added to anxiety about what some staff perceived to be a ‘witch hunt’ as they “(waited) for the finger of blame to be pointed.” However, they also disrupted the DTC’s indigenous risk management system, as staff adopted a more procedural mindset. Patients perceived this as a betrayal of the DTC’s democratic methods.

A key change was the manner in which risks were identified and materially represented within the DTC, shifting from open and exploratory practices of ‘slowing things down’ to a more ‘heated’ process of rapidly identifying and formally reporting risks. For example, widespread drug and alcohol use within the DTC was discovered one night after a violent disturbance (a patient “lost it” and started throwing furniture), to which police were called. Anxious to reassert clinical authority, the DTC clinical team immediately discharged several patients who they believed to be directly responsible, and insisted that remaining patients formally consent to random drug and alcohol testing by local police. During the morning’s community meeting, DTC leaders introduced hospital consent forms that they handed to patients, passing them between each other in silence.

A few patients ran from the room in tears. Most of those remaining signed the forms, reluctantly consenting to the police taking random samples of their saliva, urine, blood and hair at any time of day or night.

I'm struck by the seemingly draconian and legalistic consent form ... The clinical director is taking advice from the drugs liaison police. Afterwards, junior staff disagree about the new arrangements: 'we are far too reactive, we really undermine the residents... constantly checking up on them and it's really not helping' ... But DTC leaders insist their decision is not going to be reversed. Extract from fieldnotes

Staff feelings of anger, resentment and betrayal by increasingly 'untrustworthy' patients were integral to the way that these risks were perceived and constructed. Amongst patients, these new arrangements were experienced not as neutral 'technologies' (Miller & Rose, 2008) but as emotionally and morally laden, and with a perceived wish to blame and punish.

Instead of community meetings operating as a 'safe space' for surfacing and exploring emerging risks, they became points of tension between formal and informal risk systems.

"It's like a prison stand-off... trying to psyche each other out. Who's going to break first? Who's going to be able to stay silent the longest? The most powerful people are the ones who say nothing." Patient.

During a routine community meeting 'visited' by senior managers, for instance, they suspected that two patients were in a sexual relationship, which was discouraged, rather than prohibited according to DTC rules. Afterwards the senior managers insisted that the clinical director should stop their relationship, if necessary by threatening the pair with immediate discharge.

"We said to the clinical director: look, you need to do something to stop it. These people should be concentrating on their therapy... A lot of work had to go on from here to say have you counselled those individuals, have you recorded that you have counselled (them), and have you advised the different agencies." Hospital manager.

With escalating disturbance developing 'behind the scenes' amongst patients and in confrontations with staff, clinical identification and upwards reporting of risk (through

daily risk reports) produced an increasingly ‘heated’ sense of conflict – with the unintended perverse consequence of increasing substantive (first order) and constructed (second order) risks.

“There is not one community here - there are two. I really don’t trust staff. You can’t call it a community when you can’t talk with them about anything...you can’t call it democratic.”
Patient.

“The past months have been hell ...a complete lack of trust ... There was no protected time, no retreat ... it’s like a year in Beirut.” Patient.

An important dimension of risk escalation within and beyond the DTC is its repercussions within the clinical setting. The dynamics of overflow were significant beyond the setting, in terms of reshaping wider perceptions of risk and especially notions of what constitutes the relevant risk object to be managed. However, these perceptions and reactions also shaped how clinical risk was managed internally and, as we have seen, how clinicians and managers orientated themselves to handling an increasing range of circulating risk objects. As one senior manager commented, this sense of progressively tense risk negotiations between patients, clinicians and managers tended to reinforce the confusion and ‘heat’ in the risk management system.

“I deliberately don’t get close to operational delivery. You can see other... directors getting pulled in and you can see how all-consuming it is. So I have tried to keep a bit of a distance so I can try to help them think logically. There’s been an awful lot of emotion for them. It is really like being in a total institution - you give your whole life to that service.” Hospital manager.

Indeed, such tensions were further fueled by the DTC senior managers’ sensitivity to wider reactions as uncertainty about the risk management arrangements caught the attention of the national commissioners who “didn’t understand the model, acted highly emotionally (and) upped the ante even more... It makes the Board anxious, it really does” (senior executive). As one official commented, the DTC was perceived as “poisonous . . . the atmosphere is so intense that people just get fried up. I have never...faced that degree of hostility. It is the only organization that (the national commissioners) agreed never to meet single-handed” (senior official).

Although such wider reactions are important and interesting in illustrating the dynamics

of overflow in risk management systems, the most salient aspect for our analysis were their local effects upon the DTC, in particular the amplification of perceived threats arising from second order risk management. Officials lost confidence in the service, and ultimately closed all three units (even though they had received a positive, independent evaluation, (Fiander et al., 2004)). Significant factors in this closure process were the affective tensions that were mobilised within and beyond the DTC and expressed in its system of clinical risk management.

“I’m astounded at the failure...to support the place. We end up with the service collapsing because it did what it was asked to do...politically, there were some ‘shenanigans’ went on and the thing collapsed. There is a serious underestimation of the dynamics of these (interorganizational) relationships and how they work.” Senior official.

Discussion and conclusions

The cases of the hospital setting and the DTC environment analysed in this chapter point to how affective components of clinical risk work may be influenced by intersubjective relations within ‘ordinary’ clinical practice. We suggest that this is an under-explored area that may rebalance previous studies of emotional reactions evoked through formal risk management systems (Fischer & Ferlie, 2013; McGivern & Fischer, 2012). Furthermore, future studies should take a ‘sociomaterial turn’ in order to understand these ‘back stage’ dynamics of clinical risk management, as an important yet under-explored aspect of risk management technologies. In conclusion, we suggest three implications for the future analysis of the routines and ‘facticity’ (Power et al., 2009) of everyday risk management and its inherently emotion-laden character.

The intersubjective dynamics of affective flow in everyday clinical work.

Firstly, the cases in this chapter show how the intersubjective dynamics and tensions of staff-patient relations necessarily bring affect and risk together. Patients and staff attempt to engage but often end up talking past each other: staff “got caught up in all of this self harm stuff and seemed to think that was more serious than the real (clinical) problem”. Indeed, staff tend to be strongly affected by this interrelationship, producing a sense of affective contagion. Their perceptions of possible or actual danger connect

interpersonal tensions and reactions within the clinical interaction, with implied or actual threat of risk technologies being (potentially) invoked. In this sense, staff experience being ‘made to feel’ tensions that are both intersubjective in relation to particular patients yet simultaneously relate to the risk management systems. This suggests that formal risk technologies are not somehow separate from, but intrinsically bound up with these staff-patient interactions, and embedded in routine clinical assessment, treatment, and rehabilitation. Clinical risk is thus constructed and experienced as threatening and potentially overwhelming.

Invoking and using risk technologies is affectively & morally laden, entailing local material effects.

Secondly, the DTC case reveals how texts, devices and material technologies are an essential part of the community interaction. These are powerfully brought into play as part of the risk management process, increasing forms of relational control (sometimes referred to in clinical settings as ‘relational security’), and shifting power dynamics in ways that may exacerbate tensions. They may function as part of a self-regulating system creating potential ‘cooling’ and regulating effects, or possibly produce ‘heating’ dynamics that exacerbate tensions (Fischer, 2012). Our point is that these risk technologies are brought into play as already affectively laden with institutional and clinical meanings, and which acquire further meanings and influence as particular relationships develop.

For example, our analysis of Simon’s ‘threatening behaviour’ in the DTC, reveals an emergent process of risk identification within micro-level interactions. Whereas the DTC’s perception of actual risk was initially hesitant and uncertain, it was shaped and transformed through a sequence of staff and community meetings and voting rules - a core DTC method for assessing and discussing risk management. As risk identification technologies, these initial meetings and procedures strengthened the idea of risk within the clinical interaction, helping to fuel emotional reactions and the perception of Simon as presenting a risk of harm. Once this risk object was collectively formed, the DTC then proceeded to treat it according to the well-established rules of the formal risk management system.

This collective production of risk objects involves individual patients being actively constructed as risky or at risk. In the case of Simon, the patient reaction and

resistance/defiance added further weight to the collective emerging sense of threat, which was seen as justifying the risk management response, even when some staff doubted the accuracy of the original assessment. So we suggest that, whereas risk management may be designed to cool problems, its effects in practice may be to increase a sense of threat, fear and blame, potentially increasing tensions within the specific setting.

These insights from the DTC setting are consistent with Douglas's (1992) broader thesis that risk is tied to emotions, affect and moral values, with associated dimensions of fault and blame acting as rhetorical resources. She shows how risks are selected by groups and evaluated in terms of their potential consequences as political, aesthetic and moral matters. Indeed, we have empirically shown how, in a range of different clinical contexts, how participants fear the operations and effects of risk technologies often more than actual risks (McGivern & Ferlie, 2007; McGivern & Fischer, 2010; 2012). These risk technologies may thus produce the unintended consequence of motivating clinicians to cover up issues connected to actual clinical risk because they are anxious about being blamed and scapegoated.

How affect overflows through risk management systems - the container becomes the uncontained

Finally, in this chapter we have shown that, when 'heated', intersubjective emotions affect and can overwhelm risk management systems designed to contain them, producing escalation and overflows. Following Callon (1998) we suggested that such systems can become the conduit for escalation as risk moves beyond the original settings, increasing the difficulties of containment. We also found that heated interpersonal conflicts arising between medical professionals (McGivern & Ferlie, 2007) or between patients and clinicians (Fischer & Ferlie, 2013a; McGivern & Fischer, 2012) may lead them to construct cases of clinical risk which then escalate to become a source of further risk. In this sense, risk objects shift beyond patients as staff, managers, and risk technologies themselves become the objects of risk; this process has a dynamic fluidity that influences and shapes the 'solidity' of risk devices and technologies. Mundane processes, devices and inscriptions shift meanings and uses, reshaping experiences and perceptions of organizational dynamics beyond the original sites of risk. As we have described in the case of the DTC, affective overflows in riskwork may at times overwhelm managerial

and policy arrangements for risk management, resulting in the decline and even collapse of clinical services.

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