Institutional and Emotion Work in Forensic Psychiatry: Detachment and Desensitisation.

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Abstract

Mental health professionals are frequently tasked with balancing care, safety and security. They are obliged to meet professional, organisational and institutional standards. Yet, these roles, expectations and practices are often in contention, whilst personal feelings and values are often ignored. This raises questions as to what the processes are in attempting to reconcile personal, professional and organisation conflict, how workers manage their emotions, and ultimately, what impacts these have upon those conducting such work, as well as those receiving care.

Forensic psychiatry is a pluralistic institution where care and containment are precariously balanced. High secure hospitals offer a unique context in which to study such tensions. The social theories of institutional and emotion work provide useful frameworks from which to study the interactions between institutions, emotions and actions in psychiatry. Interviews were conducted with healthcare professionals using a constructivist grounded theory approach. Workers’ feelings and experiences were explored in relation to their professional roles, organisational expectations and wider institutional contexts. In doing so, the relationships between institutions, emotions and actions may be better understood and institutional and emotion work theories developed, thus providing important iterative connections between sociology and psychiatry.

Introduction

Hospitals occupy unusual spaces. Similarly, healthcare organisations and healthcare professionals occupy unusual roles. Hospitals are caring, safe and nurturing environments but they are also places of death, illness and disease. These undesirable aspects serve uncomfortable reminders of human fallibility and the limitations of healthcare. Publically, healthcare professionals are viewed as archetypal public servants who devote themselves to helping others. In reality they are often faced with difficult ethical and moral dilemmas. These become even more challenging amongst mental health services, where knowledge is less certain and practitioners are called upon to ameliorate a complex set of difficulties (Pilgrim & Rogers, 2003; Middleton, 2015). Although idealised mental healthcare espouses the values of person-centeredness, recovery and empowerment, practitioners are commonly called upon to contain and treat individuals against their will, often for indefinite periods of time (Alty & Mason, 1994; Kaye & Franey, 1998; Prinsen & Van Delden, 2007). These contradictions are possibly most striking within the specialist discipline of forensic psychiatry, and especially within the high secure hospital where both care and containment are clear expectations but their contradictions rarely acknowledged (Alty & Mason, 1994; Kaye & Franey, 1998; Kontio et al., 2010; Prinsen & Van Delden, 2007; Tardiff, 1984; Vassilev & Pilgrim, 2007). High secure hospitals’ clientele are referred to as ‘patients’ and they are provided for by healthcare professionals, but security arrangements are governed by the criminal justice system, the majority of patients are subject to court orders and related restrictions, and healthcare workers are expected to manage risk, safety and security (Alty & Mason, 1994). Where patients’ behaviours do not conform to expectations, restrictive measures are sanctioned in the forms of restraint, seclusion and segregation (Alty & Mason, 1994; Department of Health, 2008, 2011; NICE,2015). High secure hospitals represent the most restricting of hospital environments, where healthcare professionals are tasked with looking after ‘violent and dangerous’ patients within contained places, whilst precariously balancing care, safety and security (Department of Health, 2008).
Exploiting this context, sociological theories of institutional work (Lawrence & Suddaby, 2006; Lawrence, Suddaby & Leca, 2009) and emotion work (Hochschild, 1979) are used to draw attention to conflicts and tensions that emerge between institutional expectations, organisational governance, individual emotions and actions (Hochschild, 1979; Lawrence & Suddaby, 2006; Lawrence, Suddaby & Leca, 2009). By analysing and exploring practices of forensic psychiatry through the lenses of institutions and emotions, the formal and informal roles of healthcare professionals are examined, and the impacts and effects these have on practitioners’ abilities to care for patients are opened to critique. The challenges of forensic psychiatric work, personal and professional values and role conflicts are illuminated, and the relevance and applicability of social sciences’ approaches to mental health practice are illustrated by investigation of real practice examples.

The Institution of Forensic Psychiatry
There is no official definition of forensic psychiatry. The institution is identified with the area where law and psychiatry meet. However, as with all pluralistic institutions, this is marked with inherent tensions which reflect ‘more than one institutionally ascribed identity and more than one societally sanctioned purpose’ (Kraatz & Block, 2009: 71). Distinct institutional histories and competing priorities create tensions and conflict for those working within, and confusion for those outside.

The forensic discipline has its roots in a legal paradigm which centres on crime, responsibility and detention (Gunn & Taylor, 1993). Judgements of criminal activity, and appropriate sentences serve as punishment. Alongside these sit considerations of risk, security and recidivism. Psychiatry, in contrast, is an arm of medicine, with concerns of abnormality, health and illness. The primary aim of psychiatry is to focus upon how illnesses and diseases are assessed, cared for and treated by healthcare facilities (Gunn, 1994).

Responsibility
From a forensic perspective, those deemed responsible for their actions are considered to be punishable by law, and risk losing their liberty (Black, 2003). From a psychiatric perspective, those considered to be of ‘diminished responsibility’ are to be cared for through assessment and treatment by healthcare facilities (Gunn, 1994).

Role
Whether or not an individual is considered responsible for their actions has consequences upon their role; upon where they are incarcerated, ways in which they are perceived and how they are treated by society. Those considered responsible are identified as prisoners and deemed punishable. Those considered lacking in responsibility are identified as patients and deemed deserving of care.

Context
Prisons are generally accepted as punitive places containing prisoners deemed responsible for their actions. Prisons inherently accommodate the ‘bad’. Psychiatric hospitals are considered a caring milieu which accommodates those considered ‘mad’.

Those who are ‘doubly deviant’ because they are considered both ‘mad and bad’ do not readily fit into either of these two disciplines or settings and the institution of forensic psychiatry serves to bridge these disparate disciplines in order to accommodate needs to address those who do not readily conform to either. Accommodating individuals in a secure hospital reinforces the legitimacy of such organisations, and reaffirms the institution that reflects their structures and processes. Those determining where individuals are placed within this range of secure facilities are considered experts within a specialist discipline. The connotations of a specialist discipline include knowledge, experience
and authority. These reinforce and legitimise ways in which a person’s behaviours might be labelled and interpreted, and in doing so, further the legitimacy of secure psychiatric facilities.

The Organisation of High Secure Hospitals
In England and Wales, secure hospitals are considered in terms of perceived needs for low, medium and high levels of security. Low secure hospitals accommodate those who pose a significant danger to themselves or others, medium secure hospitals accommodate those who pose a serious danger to the public and high secure hospitals accommodate those who pose a grave and immediate danger to the public and who cannot be safely contained within places of lesser security (Rutherford & Duggan, 2007).

Ashworth, Broadmoor and Rampton hospitals are the three high secure psychiatric settings in England and Wales. They were variously commissioned in response to overcrowding in prisons and asylums, and a lack of suitable accommodation for the ‘criminally insane’. Asylums were considered to lack levels of security necessary to accommodate those with criminal propensities, and prisons too punitive for those identified as ‘patients’, creating challenges for the placement of individuals who failed to conform to conventional criminal or psychiatric systems (Bartlett, 1993; Hamilton, 1985; Parker, 1985).

Reflecting these hybrid origins, the UK high secure hospitals have a history of being owned, managed and governed by the Ministry of Justice, the Board of Control for Lunacy and Mental Deficiency and the Department of Health (Bartlett, 1993; Black, 2003; Hamilton, 1985; Parker, 1985). All three are currently accommodated by a local NHS Trust and are governed by NHS policies and practices. However all three also have mandatory security obligations and as such are not completely independent of the prison and legal systems. Although high security hospitals are commissioned to provide a ‘distinct and separate environment from prisons’, their security standards must conform to Category B prison standards drawn up by the National Offender Management Service (NOMS), and to ensure that these security arrangements are maintained appropriately, they are annually audited by the prison service. Due to the notoriety of some of their patients the high secure hospitals are also required to work closely with the HM Prison Service and Ministry of Justice in other ways (Department of Health, 2008, 2010a; 2011).

As a result, although these hospitals’ ethos should be therapeutic, emphasis continues to be placed upon risk, public protection and security (Boardman, 2005; Department of Health, 2000; 2008; 2010a; 2010b; 2011). Despite a series of reorganisations and changes of emphasis, the very nature of their clientele has ensured that the high secure hospitals remain delicately balanced between the ideologies of healthcare and of security.

An emphasis on security necessitates a highly structured environment with everyday reminders of the patients’ status as someone compulsorily detained in an institution. Unsurprisingly, not all patients accept this readily or all of the time. For those who fail to comply with institutionally prescribed rules, regimes and practices, further sanctions are created to manage such circumstances. Within a high secure hospital context, these include the use of coercive measures; specifically restraint, seclusion, segregation and forced medication. These restrictions are deployed to manage those unable to live peaceably in an environment specifically designed for those already deemed unable to live peaceably in either a prison or a conventional psychiatric establishment; individuals who might be described as ‘deviant deviants’. Such coercive measures often raise ethical and moral concerns. If and when patients become increasingly challenging imposition of such measures can become intense. There are no even more secure settings to turn to. As this happens, however, the risks and governance of such practices become ever more demanding and controversial.
Conflict between ideologies of healthcare, safety and security are present across all mental health services. Patients contained in high secure hospitals are those identified as posing greatest risks, as well as being in greatest need of treatment and care. High secure hospitals are therefore contexts in which the conflicts and contradictions between care and containment are possibly most pronounced and therefore most clearly illustrated.

Theories of institutional and emotion work provide useful ways in which to explore these conflicting values, principles and practices. Institutional theory supports the study of actions within organisations. Theories of emotion work support explorations of actions and emotions. Together, critical consideration may be made of recursive interactions between institutions, emotions and actions. That is, examining the impacts, influences and effects these have upon creating, disrupting or maintaining institutions (Lawrence, Suddaby & Leca, 2009).

Interviews were conducted with healthcare professionals to explore their experiences of working within a high secure hospital environment. The interviews were conducted and analysed using a narrative constructivist grounded theory approach. Focus was upon professionals’ roles and practices, particularly in relation to the uses of coercive methods. Narrative inquiry captured professionals’ personal experiences, whilst grounded theory allowed these experiences to be analysed and considered in relation to the cultural context of the high secure hospital. The following sections will outline the theories of institutional and emotion work used to frame these findings. These will be followed by the analytical processes of conducting, analysing and applying them in practice.

**Institutions, Organisations and Actors**

Theorising about institutional and emotion work is not new but considering them in tandem is, and doing that in the context of a highly specialised organisation such as a high secure hospital is unique. Theorists define ‘institution’ as the ‘rules, norms and cultural beliefs’ that are specific to a particular context, place and time (Scott, 2001: 48); the ideologies, philosophies and values of a specified group, subject or discipline. In this instance the institution is forensic psychiatry. ‘Organisation’ refers to the ‘social structure created by individuals to support the collaborative pursuit of specified goals’ (Scott & Davis, 2007: 11); the physical context in which institutional ideologies are practiced and manifest, and in this instance the high secure hospital. ‘Actors’ refer to the people who populate an organisation, commonly employees and in this instance healthcare professionals, but where applicable ‘actors’ might also include others who are substantial feature of the organisation. Within a high secure hospital that must include its patients. Thus, generic use of the term ‘actors’ will refer to both healthcare professionals and patients, and ‘healthcare professionals’ and ‘patients’ will be used when more specific reference is needed. Theories of institutional and emotion work will each be considered in turn, allowing this combined framework to be applied towards the analytical study of the institution, organisation and actors within a high secure hospital setting.

**Institutional Theory**

Institutional theories can be considered under two main headings; old institutionalism and new institutionalism (DiMaggio & Powell, 1991; Hirsch & Lounsbury, 1997).

Old institutionalism views organisations as ‘closed systems’ (DiMaggio & Powell, 1991; Hirsch & Lounsbury, 1997). A closed system approach views organisations as standalone entities. Influences outside the organisation are rarely considered and socio-cultural influences beyond the organisation are largely ignored (DiMaggio & Powell, 1991; Hirsch & Lounsbury, 1997). Prominence is given to ways in which an organisation places constraints upon internal actors and their actions, while actors are perceived to lack agency and the abilities to think reflexively (DiMaggio & Powell, 1991; Hirsch & Lounsbury, 1997). This determinist perspective views individuals as products of their organisational systems; internalising and being conditioned by institutional norms and values of the organisation in...
which they are situated (DiMaggio & Powell, 1991; Hirsch & Lounsbury, 1997). Old institutionalism, favouring a determinist, closed system approach, thereby focuses upon the internal dynamics of an organisation, where the relationships between organisation and actors are examined in isolation (Hirsch & Lounsbury, 1997).

New institutionalism, in contrast, views organisations as ‘open systems’ (DiMaggio & Powell, 1991; Hirsch & Lounsbury, 1997). Organisations are framed within wider socio-cultural environments and influenced by factors beyond the organisation itself (Handel, 2003). This voluntarist perspective views actors as self-directed individuals; having free-will, autonomy and the ability to change their social contexts (DiMaggio & Powell, 1991; Hirsch & Lounsbury, 1997). From this perspective organisations are viewed as formal structures with emphases placed upon studying the institutional influences, forces and pressures (DiMaggio & Powell, 1991). New institutionalism, adopting a voluntarist, open systems approach therefore focuses upon the organisation in relation to their wider institutional environments and acknowledges actors as agents capable of change.

**Institutional Work**

The theory of institutional work developed by Lawrence, Suddaby & Leca (2009), aims to unify and transcend old and new institutional schools of thought. Displacing such polarised perspectives, this approach to institutional work adopts a relational perspective towards finding a ‘middle ground’ where constrained agency manifests (Lawrence, Suddaby & Leca, 2009). Individual actors are embedded within their social context but remain able to respond to situational occurrences (Batillana & D’Aunno, 2009; Emirbayer, 1997). Thus, while individuals may be confined to their institutional contexts they are not rigidly confined. Neither do they have absolute agency or free-will.

From this perspective individuals are not only perceived to be shaped by their institutional environment, but also able to shape it. Actions in relation to this are considered institutional work (Batillana & D’Aunno, 2009; Berger & Luckmann, 1967; DiMaggio & Powell, 1991). Thus, in relation to individual action institutions are viewed as being both simultaneously constraining and enabling (Lawrence, Suddaby & Leca, 2009). Unlike either the determinist or voluntarist perspectives, rather than viewing institutions and actions as *opposing forces*, institutional work, while adopting a relational perspective, advocates that one *presupposes* the other (Batillana & D’Aunno, 2009; Lawrence, Suddaby & Leca, 2009). In doing so, the concept of institutional work highlights the recursive nature between institutions and individual action, broadening the scope of institutional studies through relocating the traditionally narrow focus on outcomes, to one inclusive of the actions, processes and sequences of events that lead to such transformations (Lawrence & Suddaby, 2006).

This framework considers organisations to be embedded within parent institutions or sets of institutionalised rules. Organisations are permeated by, as well as permeable to, institutional rules and individual actions. They provide places for study which reveal institutional values and philosophies in action. Actions occur as practice and reveal individual agency within institutionalised and organised beliefs. In doing so, they both expose and reinforce these institutionally organised ideas. Actions are embedded within organisations as organisations are embedded within institutions. Relationships between the institution, organisation and actors are therefore equally situated, interactive and mutually reinforcing. Institutional work refers to the efforts, dynamics and relationships between philosophies, structures and actions. These are each considered permeable, interrelated and recursive such that institutions can be created, disrupted and maintained (Lawrence & Suddaby, 2006; Lawrence, Suddaby & Leca, 2009).

In exploring the theory of institutional work, institutions, organisations and actions are all considered. The notion of work implies effort, intentionality and agency. What institutional work theory alone does not consider however, are the impacts of emotions and actions upon the actors in influencing
their work. Theories of emotion work offer a way of incorporating this into a strengthened framework applicable to the study of institutional settings where emotions might run high, such as mental health services and particularly secure and high secure hospitals containing reluctant inmates.

Emotion Work
The ideas of Arlie Russell Hochschild are often cited as seminal to the study of emotion work. Hochschild distinguishes between the ‘private’ and ‘public’ presentation of emotion, akin to the Goffman’s ‘The Presentation of Self’ (Goffman, 1959). Whereas Goffman uses the analogy of theatre and stage to explore every day interactions – front stage to describe the visible social actions where a performance takes place; backstage where real feelings and hidden interactions may be revealed – Hochschild uses concepts of emotion work and emotional labour to describe the efforts required in presenting oneself in ways that are socially acceptable and indeed desirable within private and public spheres. She uses the term ‘emotion management’ to describe ‘the management of feeling to create a publicly observable facial and bodily display’ (Hochschild, 1983: 7).

Hochschild’s distinction between emotion work and emotional labour is based on context. She proposes that emotion work takes place in the private realm such as at home, while emotional labour is sold as a commodity and takes place specifically in the context of the workplace. The management of emotions is learnt through ‘feeling rules’; learning how one is supposed to behave in certain contexts and thus requires individuals to act in ways that may be different to what they actually feel. Emotion work and emotional labour are therefore perceived as being greatly influenced by organisational rules and individual perceptions of organisational demands upon them.

Hochschild distinguishes between ‘surface acting’ and ‘deep acting’. She defines surface acting as the superficial display of emotions using ‘the ability to deceive others about how we are really feeling without deceiving ourselves’ (Hochschild, 1983: 33). Deep acting in contrast is where individuals induce feelings through imagination in a way that such feelings become deceptive to ‘ourselves about our true emotion as we deceive others’ (Hochschild, 1983: 33). Surface acting relates to ‘how people try to appear to feel’ (Hochschild, 1979: 560). Deep acting, in addition, refers to the effort required in ‘how people try to feel’ (Hochschild, 1979: 560). Using the language of institutional theory, surface and deep acting may therefore be considered the processes and intensities by which an individual becomes increasingly ‘institutionalised’ as they depart from their personal values and internalise institutionally held expectations, norms and beliefs.

Emotion theorists argue that either type of acting can be destructive, both to the individual and the recipient of individual action, particularly where genuine feelings are necessitated as part of the workers’ role (Hochschild, 1979; 1983; Bolton, 2005; 2009). Superficial acting results in the inauthenticity of one’s actions. Deep surface acting has the effects of self-induced alienation and estrangement from one’s genuine feelings, emotions and actions. Comparable to institutional theory, actors engaged in emotion work are seen to be influenced and constrained by their institutions and organisations (Hochschild, 1979; 1983). Emotion work is performed in light of institutional expectations, whether these expectations are real or perceived by the actor. Emotion work is therefore most apparent when institutional and organisational expectations differ most prominently from personal values, raising questions and concerns about the validity of workers’ emotional displays, and the authenticity of workers’ actions (Hochschild, 1979; 1983; Bolton, 2005; 2009).

In bringing together theories of emotion and institutional work, it is recognised that emotions affect actions and actions affect emotions (Fineman, 1993). This approach offers a much broader scope than a simple dichotomy between actors and organisations. Furthermore, by including the concept of institutional work, emotion work is no longer confined to the organisation itself, but is also seen to be influenced by wider environmental and institutional factors. By collectively considering theories of
institutional and emotion work, emphasis is placed on effort whilst at the same time considering both emotions and actions as ‘work’. Through viewing institutions and organisations as having both enabling and constraining effects of emotions and actions, emotion work within this context not only encompasses workers’ management of their personal emotions in accordance with organisational and institutional expectations but also the emotions of colleagues and patients. Emotion work in this context may as such be viewed as being not only the management of personal feelings, but also the displays of institutionalism and professionalism. Again, this is a highly suitable way of considering ‘work’ in contexts such as the conduct of coercive measures in mental health settings, particularly secure ones.

**Applying Institutional and Emotion Work Theories**
The recursive interactions between institutions, organisations and actions inherent in theories of institutional and emotion work highlight the importance of context - the positioning of an individual in relation to their physical and socio-cultural environments. This lends itself to a broadly constructivist grounded theory approach which recognises that although attempts can be made to study phenomena objectively, it is impossible to be completely value free. Instead, importance is placed on acknowledging and being sensitive to the particular time, space and situation that frame the phenomena under investigation. These are incorporated into the analysis and development of emergent concepts. Parallel to the recursive relationships between the institution, organisation and actors, a constructivist grounded theory approach views the relationships between theories, findings and analyses as interactive processes, whereby each informs the other (Glaser & Strauss, 1967; Strauss & Corbin, 1990; 1998; Glaser, 2001; Bowen, 2006; Corbin & Strauss, 2008; Charmaz, 2011). Against this methodological background, theories of institutional and emotion work have been used to:

i) Examine the institution of forensic psychiatry

ii) Explore the organisational arrangements of a high secure hospital

iii) Analyse the practices, processes and efforts of healthcare professionals required to manage their emotions and actions within a high secure hospital environment.

**Interviews, Ethics and Analytic Processes**
Twenty eight interviews were conducted with healthcare professionals. These adopted a narrative, broadly constructivist grounded theory approach to inquiry. Exploratory questions were asked concerning respondents’ experiences of working within a high secure hospital, their thoughts and feelings towards the uses of restrictive or coercive practices, and more specifically, how these related to their roles. Respondents were predominantly staff nurses and nursing assistants but a smaller number of team leaders, ward managers, responsible clinicians, psychologists and social workers were included. All worked with male patients with a primary diagnosis of ‘mental illness’, as opposed to ‘learning difficulty’ or ‘personality disorder’. All respondents work full-time.

Ethical approval was granted by the National Research Ethics Service Committee (Ref: 11/EM/0322). Participants were given information sheets about the study and any questions were answered before consent forms were signed. All interviews were digitally recorded and transcribed by the researcher. Digital recordings and transcriptions were kept in password protected, locked files in keeping with information governance regulations.

A narrative approach allowed participants greater freedom to speak about their thoughts, feelings and experiences concerning their work. Reflecting methodological strategies of emergence and the embeddedness of prior knowledge the interviewer remained open to new ideas emerging from the participants’ narratives, asked further questions about these ideas, whilst being aware of the framework offered by institutional and emotion work theories. Constant comparisons were made.
between data, analysis and theory. During this iterative process, the researcher became increasingly immersed in analytic inquiry, such that data and theory were mutually influencing and co-constructed. In adopting a reflexive approach towards the analytical process, field notes and reflections were recorded. These are summarised below.

Field notes, Reflections and Observations
The investigator is a registered mental nurse but in order to work within the high secure hospital, she was first required to undertake additional mandatory training. This was a one week induction of education and preparation concerning the values and expectations of the hospital; the security measures, hospital policies and procedures, as well as physical training in personal protection and the management of violence and aggression.

This was followed by a four week placement, where for the first time she experienced the intensity of the day-to-day workings of a high secure environment. After one week of training, she was working fourteen hour shifts, responsible for her own set of keys, the locking of heavily reinforced doors and high fences, with a mental list of do’s and don’ts – the breach of these potentially resulting in instant dismissal. These, she was told, were things she would get used to.

Her time gathering data was an interesting experience. The first two weeks of attempting to collect data were perhaps the most challenging. She was working across four wards, each with different rules, routines and layouts. To complicate matters further her role was not one of a ‘typical nurse’ – she happened to be a researcher with a background in mental health nursing who had chosen to study for a social science PhD. She had neither a conventional career nor a conventional role. Her background in mental health nursing certainly seemed to help in becoming an ‘insider’, her role as a researcher however, often meant that she was left on the ‘outside’.

I was struck by the frequency at which individuals would talk to me ‘off the records’ whilst being reluctant to participate or be recorded ‘officially’. Often, this was due to staff concerns at being identifiable. An anxious culture seemed to remain where being recorded was concerned. This was juxtaposed by the interviews themselves. During the interviews I was primarily struck by how open and honestly individuals talked about their personal feelings and emotions in relation to their work; how openly they expressed the fears, anxieties and anguish they face in being at work and the potential risks and harm they subject themselves to on a daily basis. This was in stark contrast to my initial experiences of working in this environment and my observations of how members of staff behave amongst the general ward milieu. I had grown accustomed to observing individuals bantering, responding apparently fearlessly to alarms and incidents, sitting outside seclusion rooms appearing calm and collected, in what might generally be referred to as ‘masculine’ environment – one of bravado, machismo and an obvious body building culture. To listen to these ‘hidden’ feelings and emotions was therefore a privilege. As a researcher, I was given the rare opportunity to gather rich data within a unique environment. As a nurse and on a more personal level however, I often felt helpless. Despite being aware that individuals were not alone in their feelings, I did not feel able to reveal this to participants at the time of the interviews for fear of betraying what others had so honestly told me – the ultimate irony being that there were emerging parallels between the tensions I felt in relation to my ‘work’, the theories used to explore institutional contexts and the findings from this study.

Actors’ Roles and Experiences
Three main themes emerged from the interviews; isolation, formal and informal roles, and containing emotions in contained places.
Isolation
It was apparent that working in a high secure hospital can be an isolating experience. Respondents described isolation in both physical and emotional terms.

Physical Isolation
Physical isolation was described through the language of the ‘inside and outside’. A sense of detachment from the outside was described as influential in two ways. Firstly, in creating ‘tighter bonds’ between the workers, and secondly, as reminding them of the unusual places in which they work and that their roles occupy:

‘We are detached from the rest of the world. We’re in our own little bubble, so I’m an expert [in here] but out there I’m a novice, I wouldn’t know, I wouldn’t cope out there’ (SN - male)

‘We don’t see what happens outside, that within other services we just don’t see, we don’t deal with’ (SN - male)

‘I think it creates stronger bonds between people when you’ve been involved in them sort of incidents together... I’ve got some friends that are in the army and they say, friends, you know, mates that they’ve made when they’ve been in war zones together, I mean, they say it’s a relationship that other people can’t understand, you know, I suppose it’s like that but on a much extreme scale isn’t it’ (NA - male)

Emotional Isolation
Emotional isolation was revealed as two subthemes; emotional isolation from work and colleagues, and emotional isolation from family and friends.

Emotional Isolation: Work and Colleagues
Fear and anxiety were common amongst all of the respondents. Paradoxically, these were considered unacceptable public displays and those who displayed these emotions were spurned by observers. To reveal fear and anxiety was considered a weakness through which confidence, trust and respect between colleagues could be lost. Respondents described concealing these emotions, while trying instead to appear confident and in control.

‘I know people, I personally know people that are fearful, fearful of restraint, fearful of that kind of, “can I?” and when those incidences do happen, they shy away from being involved... some people sometimes develop an aversion, I know quite a few people here that have, and it’s not healthy, it’s not healthy, you’re in the wrong environment to be here to develop an aversion to that’ (SN - male)

‘I mean you hear of some people where if there’s a situation some people just go and lock themselves in the toilet or just disappear... they’re scared, so they just go and do a runner... they just run away and hide or whatever and bury their head in the sand and run away from it all’ (NA - male)

‘Your heart’s absolutely racing, you think, oh god, I just want to get it right’ (SN - female)

‘What always plays on your mind is just to make sure you are doing things right, you know, it’s a volatile situation whereby emotions are running high, up and down, but still as staff, you just keep on reminding yourself that, you know what, you have to do things right’ (SN - female)
‘I’d have been very anxious and wanting to leg it, or fight or flight, whatever you want to say, but since I’ve been here, I won’t say that I don’t get anxious with the situation, but because it happens so regularly, my anxiety is nowhere near as high and I can, I would say, appear calm but like a duck under water, I’m going like mad’ (SN - male)

Emotional Isolation: Family and friends
On the face of it this suppression of emotions appeared to strengthen relationships between workers. However, in creating this façade of coping, respondents felt increasingly isolated from colleagues, family and friends. They spoke of ‘outsiders’ being unable to understand or comprehend the work involved in a high secure hospital.

‘I mean maybe you might go home and talk to your family and friends about it... I mean, I don’t personally... I don’t, I like speaking to work, I think it’s something that only people that work here can understand if you know what I mean, I wouldn’t really try and discuss it with family or friends’ (NA - male)

‘You can’t really tell people that don’t understand, so you can’t take it home with you, because they don’t understand the process, they don’t understand the things that you’re going through and that you’re dealing with’ (SN - male)

These feelings of isolation suggest the emergence of alienation and estrangement, both from the healthcare workers’ personal self, and also in relation to others. This distancing suggests work and effort in managing personal feelings and maintaining professional roles, whilst façades mask the tensions, conflicts and fragilities that accompany them.

Formal and Informal Roles
Respondents frequently described differences between policy and practice, as well as between training and reality. These exposed differences between institutional expectations and the realities of how these expectations were practiced. They alluded to formal and informal roles; what ‘should be’ and ‘what actually occurs’.

Formal Roles
Respondent were adamant that their roles were of healthcare and those contained were patients.

‘We’re nurses, we’re not bouncers, we’re not soldiers, you know, we’re nurses... it’s a very different role, but we’re not prison guards’ (SN - male)

‘We’re dealing with patients not prisoners’ (SN - male)

‘It isn’t a prison, it’s a hospital and that’s the difference, these people are poorly you know, and we have to remember that’ (SN - male)

The realities of working within a high secure hospital setting however, frequently created tensions and conflicts between care and containment. Security imperatives contradicted and frequently undermined the supposed priorities of care.

‘It does clash, especially the balance between somebody being safe and secure and the interventions that as a nurse you need to do... in some respects it’s about doing the
nursing stuff when it’s okay to do the nursing stuff, keeping everybody safe and secure and you have to forget that (nursing) intervention’ (SN - male)

‘I think there’s a real tension... I think there is this real custodial emphasis’ (RC - female)

‘The security sometimes governs the nursing, if you know what I mean, so things that you might do in other hospitals, you have to do differently here because of the security measures’ (NA - male)

‘The major issue with the job is maintaining security and safety essentially... maintaining the security and safety of all is the primary role of this, the nursing is secondary’ (SN - male)

Informal Roles
Despite parallel obligations to forensic and psychiatric work within the combined discipline of forensic psychiatry, respondents continually sought to distinguish between the ‘mad’ and the ‘bad’.

‘I think people, the more mentally unwell you are, unfortunately, the less you know what you’re doing, in general terms, people who are more mentally ill than maybe just not a very nice person’ (NA - male)

‘Very often it’s the nature of the illness, if it’s illness related. Sometimes it isn’t illness related, it’s behaviours that they engage in’ (SN - male)

‘We deal with some very poorly people but we also treat some extremely difficult people that present with some terrible behavioural issues, so in that sense it’s quite a challenging environment to be involved with’ (TL - male)

Such judgements of patients, along with how practitioners interpreted and managed their roles influenced their actions and emotions. Although formally, it was recognised that care should be prioritised over containment, respondents acknowledged that individual differences meant that institutional ideologies were practiced differently by different people and also between different wards within the organisation.

‘I think you’ve got a sort of continuum expressing the two extremes that there are some staff who are very custodially orientated and can be quite negative about the patients - the kind of patients we get here and almost punitive towards them, so they’re here to be told what to do and there’s that end, and can sometimes be quite aggressive and unsympathetic, and then there’s the other extreme which is the more therapeutic, which has to be balanced’ (RC - female)

‘Different staff react to things differently, and the management, they make you work differently as well, like how the wards are run’ (NA – male)

‘I think the challenges are how a restrictive environment still allows people to progress within those restrictions and to get the line right between putting boundaries in to keep people safe but then not becoming oppressive. So I think the challenge can mean the challenges that come from patients but can also mean the challenges that come from the philosophy of the environment’ (SW - female)

Containing Emotions in Contained Places
Respondents spoke of challenges committing themselves to restrictive practices within already restrictive places. These were discussed in relation to restraint and seclusion which were practiced when patients did not conform to organisational expectations. These challenges were referred to in two ways; heightened emotions and emotional blunting. Each of these resulted in physical and emotional toll.

**Heightened Emotions**
There was a heightened sensitivity to emotions in relation to work within the high secure hospital, which was commonly revealed through the language of preparedness, apprehension and being ‘switched on’:

‘When I first came to work on here, I found it quite daunting at times, the thought of being attacked, the thought of restraining patients... For want of a better phrase, I suppose I found it quite scary you know, it used to make me anxious... I’d feel anxious, my palms used to sweat... it would not be a pleasant experience really’ (NA - male)

‘[It’s] a constant state of, you know, like, just having to be prepared to whatever, which we tend to have on a daily basis anyway because of the types of patients we work with’ (SN - female)

‘I always come into work and I always try and switch on, as soon as you come through the fence, you switch on, because it has the potential to be a very volatile place... you’re alert, you’re there, why are they doing this for, constantly questioning things and stuff like that, so that’s what I do to try and keep myself safe, is being alert to what can go on’ (NA - male)

**Emotional Blunting**
A lack of emotion became apparent through descriptions of becoming increasingly detached and desensitised from work and personal feelings. This was described in terms of self-preservation and professional integrity. Self-preservation amounted to distancing as protection from uncomfortable feelings that could arise from tensions between personal and professional values. Professional integrity referred to distancing in order to conduct expected duties and role.

‘You do get desensitised to it the more incidents you get involved in. If I revert back to the first incident when I worked on acute, I was shaking afterwards, sort of like what’s happened there sort of thing, whereas now, you just kind of get on with it you know, I know that might sound a bit mechanical but that’s how I react now’ (NA - male)

‘You just kind of, like I say, develop a certain set of skills where you don’t really let anything, you don’t really let it bother you too much I suppose’ (NA – male)

‘It doesn’t affect you after a certain amount of time, you just have to, you learn to deal with situations and not let them affect you... I’ve got a job to do, it’s another hat that I’ve got on, that I have to wear when I come to work... I can work around it by making sure that I’m coming here to try and do a job’ (SN - male)

**Physical and Emotional Toll**
The tensions and obligations involved in balancing institutional expectations, organisational rules and personal values required work and effort. These were considered to be ‘part of a job’ and something workers ‘have to make peace with’. However they also took their toll, physically and emotionally.

‘You kind of have to take it in your stride, and I think there’s a certain element where you have to make your peace with it... you have to make your peace with it irrespective of your feelings about it, and do it to the best of your abilities, you know’ (SN - male)

‘It is part of the job, you don’t enjoy it but you know it’s there and you deal with it, try and make a bit of light of it afterwards, as a coping mechanism more than anything’ (NA - male)

‘It’s not the easiest of jobs, sometimes, it’s very difficult to, when you have to be physically involved in restraining patients, that doesn’t initially sit very easily with how you’re first educated to what nursing is, it doesn’t, you know, they don’t sit comfortably together’ (TL - male)

‘At this point, it’s draining... I’ve had enough, it’s repetitive, if I’ve been here a lot, it can seem quite soul destroying, it just gets too much to bear after a little while... you can only take so much, so much arguing, so much abuse, so much violence, so much of this every day before it starts wearing you down... I think it should be short term plan for staff as well as patients, a couple of years I think in this sort of environment’ (SN - female)

‘It is a tough environment, you’ve got very difficult patients down there and you do have to be very careful of a) your own stress levels and b) the stress levels of other staff that you’re with... I’m a big believer that in that really stressful environment, everyone has their shelf-life date’ (TL - male)

Institutional Maintenance, Reinforcement and Reproduction

Conventional approaches to mental health difficulties and services which respond to them tend to focus upon the individual, without giving due consideration to their wider social, organisational and institutional contexts. A constructivist approach framed by institutional and emotion work theories has provided a way of doing that in a highly specific and informative context. By examining the discipline of forensic psychiatry at institutional, organisational and individual levels, some of the recursive nature of these influences is revealed. Within the context of the high secure hospital, the institution and organisation are maintained through governance, policies and training. The care delivered within the hospital is governed by NHS regulations whilst the security standards are audited by, and must conform to, those of the Criminal Justice System (Department of Health, 2008; 2010). Policies set out ways in which staff must practice and reinforce the institutional expectations and rules they must abide by. The training, experience and indoctrination of staff within the hospital further endorse the principles, interests and ideologies of the institution. These each serve to legitimise the institution as a specialist discipline and the organisation as a necessary place of containment.

By scrutinising the practices of forensic psychiatry as encountered in a high secure hospital, it is clear how this institutionally embedded organisation is maintained through regulatory mechanisms. As healthcare workers feel increasingly isolated, alienated and estranged from those who do not understand their work, feelings and roles, distinctions are made between the inside and outside. In turn, insular communities are formed within. These communities are both regulated by organisational rules and are self-regulating by how workers act and react towards the perceived expectations of them. These institutionally governed expectations, values and practices impinge upon and affect workers’ emotions, actions, work and efforts.
The actions and physical work of healthcare professionals are highlighted through the everyday security practices and restrictive measures that are both sanctioned by the institution and depicted throughout the interviews. These do not always conform to the healthcare professionals’ personal values, and where do they do not, greater work and effort are required to conduct institutionally expected actions and practices. The emotion work of healthcare professionals in this context is illustrated through displacing personal emotions of fear, anxiety and apprehension, with institutionally accepted displays of confidence, coping and dependability. This façade enables them to perform their professional duties by providing three main functions; the maintenance of institutional values and expectations, the preservation of confidence and relationships between colleagues and self-preservation.

By suppressing real feelings and instead displaying institutionally expected emotions, workers maintain an institutional veil. It is through these displays of confidence and bravado that relationships between colleagues were strengthened and reputations for dependability and reliability developed. These have the effects of being protected and looked after by colleagues. Through working on how they are supposed to feel, the worker becomes increasingly institutionalised and detached from conflicting personal emotions but these achievements come, it would seem, at a cost.

The interviews revealed that those who are unable to manage their personal emotions either leave, are rejected by their co-workers, or become exhausted. Those who are better able to manage their emotions however, become increasingly institutionalised, isolated and removed from their personal feelings and values. In focusing their efforts on how they should feel rather than how they actually feel, the healthcare professional becomes increasingly detached, desensitised and emotionally blunted. Through the processes of institutionalisation, a lack of personal compassion, empathy and care ensues, and as a result the healer effectively becomes a custodian. The tensions between personal and professional values, the pluralistic institution of legal and healthcare work, judgements and labelling of the ‘mad versus bad’, along with individual interpretations of institutional values were exposed as a continuum between caring or more custodially orientated actions. These influences each have the effects of disrupting and reconstructing institutional ideologies in practice.

Implications for the Relationship between Psychiatry and Social Sciences
This particular examination of psychiatric practice using social scientists’ lenses offers its own contributions to the edition’s core questions: “What does social science teach us about mental health practice?” and “How has this investigation of mental health practice informed social theory, and what related opportunities does it suggest?”.

Theorising institutional and emotion work allows closer considerations of the relationships and interactions between the institution, organisation and actors. In doing so, attention is drawn towards understanding how institutions are maintained, reinforced and reproduced. By combining theories of institutional and emotion work as a framework for investigating professionals’ experiences of working in a high secure hospital three important themes emerge:

- At a superficial level, healthcare professionals working in a high secure hospital organisation appear confident in their work. The fragility of the institution however, is exposed when staff reveal their real feelings towards their work and roles and institutionally expected actions are revealed as a façade in concealing private emotions
- The concealing of real emotions creates an institutional veil that masks the private despair and turmoil that workers frequently experience as a result of working time spent in this or quite possibly related environments where emotional work is particularly demanding.
As workers become increasingly institutionalised and embedded within an organisation that demands emotional numbing, questions are raised as to whether healthcare professionals are able to act as authentic healers or become obliged to act as custodians.

Each of these have implications for the well-being of the mental health workforce. Although the particularities of a high secure hospital bring this into special relief concerns raised by this study have wider implications. Through studying healthcare professionals’ emotions in relation to their practice, attempts can be made to understand how practitioners reconcile their personal values and professional roles. Institutional and emotion work theories encourage questions to be asked of the organisational expectations placed upon practitioners. Not only do they expose the detrimental effects of workers’ suppressing their emotions, they also reveal paradoxes between the language of care and the practices of containment which are found throughout mental health services. Though presented as a ‘healing’ enterprise, much of psychiatry is obliged to respect social and institutional expectations of risk management fulfilling these obligations not uncommonly requires a more-or-less paternalistic if not custodial approach. This application of institutional and emotion work theories could be broadened to reveal how these seemingly irreconcilable ideologies might be more constructively brought together in the interests of both practitioners and clientele.

Similarly, this investigation of staff experiences informs social theory by bridging two previously disparate areas of scholarship; institutional and emotion work. In doing so it has exposed limitations of considering either of them alone, and the complementary strengths of each when combined. It would be irrational to study psychiatry without due considerations of individual feelings and emotions (Hochschild, 1979; 1983). Likewise, feelings and actions cannot be considered without a given context (Hochschild, 1979; 1983; Lawrence, Suddaby & Leca, 2009). Mental health services provide particularly vivid illustrations of the interactions between institutional work and emotional self-management, and wide range of opportunities to explore them.

References


