Why managing emotion is such a crucial task

In the second of our Signpost series revisiting often forgotten publications, Professor Yiannis Gabriel considers what it means to manage health work. The article discussed here is Isabel Menzies' A case study in functioning of social systems as a defence against anxiety*, from 1960*

One of the consequences of the rise of the service economy has been a recognition of the emotional qualities of many aspects of paid work. This has given rise to a re-evaluation of people's lives and experiences in organisations. Instead of thinking of organisations as "iron cages of rationality" after Max Weber's daunting metaphor, scholars today increasingly look at them as emotional arenas, spaces where emotions are enacted and a great deal of the work done has an emotional quality.

The term "emotional labour" is now widely accepted as fundamental in describing the work done by numerous types of employees, from cabin attendants in airplanes to teachers and from undertakers to health and care workers. The management of emotions is widely seen as a vital part of a leader's and a manager's job – the reading, guidance and containment of emotions and their effective deployment to promote social ends.

Employees in the service sector, in addition to physical and mental labour, must take great care in reading the emotions of those with whom they come into contact and display the right emotions in delivering their service. Working with emotions, their own and those around them, is a vital part of the work they do and this in turn makes grave psychological demands on them.

Numerous authors have taken up the issue of emotional labour in connection with nursing and healthcare management. There always seems something that sets the emotional labour of health workers and their managers apart from that of debt collectors, police interrogators, retail and hotel employees. In nursing literature, vigorous debates are unfolding on the relative importance of clinical and professional skills as against emotional attributes.

These debates touch a much broader audience than academics, as exemplified by the Archbishop of Canterbury's sermon at Westminster Abbey for the Annual Florence Nightingale Commemoration Service: "You could say the modern profession of nursing was born out of a passion for human dignity – not just the sense of a practical job to be done but a serious conviction that what is due to people in situations where they are helpless, and even dying, is time, respect and patience, no less than practical skill... Specifically in the healthcare professions, a growing number of people now say that the personal and relational skills of healing are squeezed out in training and seriously undervalued in favour of mechanistic skills. And for nurses especially, this is a huge and damaging shift away from that fundamental commitment to the service of human dignity with which we began." (**click here**)

An author way ahead of her time in discussing the emotional demands of nursing work was Isabel Menzies (later Menzies Lyth). Based on research of nurses in a London teaching hospital, *A case study in functioning of social systems as a defence against anxiety* is a classic. Nurses, argued Menzies, operate in an emotional maelstrom of demands and expectations by patients and relatives – positive and negative emotions, rational and irrational ones, ranging from gratitude, respect and admiration to envy, resentment, contempt, rage.

"Entire health systems become charged with unrealistic expectations for miracles..."

In addition, nurses experienced profound and conflicting feelings towards their patients, including closeness and personal caring but also impatience, frustration and anger. These emotions are compounded by an awareness that mistakes can be very costly, that their patients may die or that they may be powerless to control the patient's fear, panic and anger.

> *"The work situation arouses very strong and mixed feelings in the nurse: pity, compassion and love; guilt and anxiety; hatred and resentment of patients who arouse these strong feelings; envy of the care given to the patient."*
> (Menzies Lyth 1988, p46)

Faced with such an emotional cauldron, many nurses are prone to primitive persecutory anxieties whose origins can be traced in the experiences we have as children. According to Klein, infants experience a tremendous rage when they discover their mother is not there to care for them. They respond by splitting the mother into two objects – the good mother and the bad mother – and the maternal breast into two separate breasts – the idealised good breast that is the source of life and the bad breast that threatens life. The bad mother and the bad breast (later the bad patient) become sources of acute anxieties, known as persecutory or paranoid anxieties.

Such anxieties are liable to resurface later in life when we are presented with life or death situations that precipitate splitting – precisely what happens in clinical encounters when the clinician is liable to split the patient into a good patient (obedient, pliable and grateful) and a bad patient (demanding, self-centred and ungrateful). And the patient is liable to split the clinician into a good nurse/doctor (life-giving, caring and wise) and a bad nurse/doctor (withdrawing, cold and indifferent). Nurses cast in the role of the bad nurse or believing themselves to be cast in this role are then liable to experience intense (and at times unbearable) anxieties from which they seek to defend themselves.

Menzies' decisive contribution was to

establish how an organisation's bureaucratic features – its rules, rotas, task lists, checks and counterchecks, hierarchies – act as supports for the defensive techniques. By allowing for ritual task performance by depersonalising relations with the patients, by using organisational hierarchies, nurses contain their anxiety. Thus a patient becomes "the kidney in bed 14" or "the tracheotomy in ward B". In this way, nurses limit the anxiety they would experience if each patient were to be dealt with as a full human being in need.

Yet, Menzies argued that such organisational defences against anxiety were ultimately ineffective and counter-productive:

> *The system made little provision for confronting anxiety and working it through, the only way in which a real increase in the capacity to cope with it and personal maturation would take place. As a social defence system, it was ineffectual in containing anxiety.*
> (Menzies Lyth 1991, p363)

The system's inadequacy is evidenced by its failure to train and retain nurses, chronically low morale, high levels of stress and burn-out and lack of work satisfaction. By contrast, institutional health is testified not only by performance and output indicators but by morale indicators and feelings of fulfilment from performing an invaluable service. Menzies believed skilful organisational consultants can restore an organisation to health by implementing several principles:

> *These principles match quite closely the criteria for a healthy personality as derived from psychoanalysis. They include avoiding dealing with anxiety by the use of regressed defences; more uses of adaptations and sublimation; the ability to confront and work through problems; opportunities for people to deploy their capacities to their fullest, no more or less than they are able to do; opportunity to operate realistic control over their life in the institution while being able to take due account of the needs and contributions of others; independence without undue supervision; and visible relation between efforts and rewards, not only financial.*
> (Menzies Lyth 1991, p377)

Menzies' prescriptions have been taken up with greater or lesser success by psychoanalytically led consultants. Countless instances of backfiring social defences against anxiety have been documented by writers working within this perspective.

In highlighting the importance of working with the turbulent emotions unleashed by clinical encounters, Menzies was well ahead of her time. Subsequent theorists, such as Obholzer and Roberts (1994) and Fotaki (2010) have built on her legacy demonstrating why not just nurses but entire health systems become charged with unrealistic expectations for miracles, health and even immortality, which generate immense anxieties for their all staff. Unless we develop ways of containing these anxieties without denying them or viewing them as indicators of weakness and failure, health workers will continue to be confronted with impossible and damaging demands.

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STUDY NOTES

Menzies' original article (see further reading) can be found in university social sciences libraries. Online access, by **clicking here**, requires payment or use of a university library password. A shortened version is **available here**. In addition to the seminal article outlined here, Menzies wrote works in which she examines the practical ramifications of social defences for the work of health managers (Menzies Lyth, 1988, 1991). Lökman et al have argued that Menzies' theory applies substantially to hospital doctors and administrators as well as to nurses.

The term "emotional labour" was first proposed by Hochschild (1979, 1983). Numerous authors have taken up the issue in connection with nursing (Aldridge, 1994; Henderson, 2001; Meerabeau & Page, 1998; Smith, 1992; Theodosius, 2008). Theodosius (2008) in particular offers an insightful account that extends and develops many of Menzies'. Theorists including Obholzer and Roberts (1994) and Fotaki (2010) have built on Menzies' legacy, showing why not just nurses but entire systems become charged with unrealistic expectations for miracles.

In my own work (Gabriel, 2004) I have proposed that effective health systems must find ways of reconciling the voice of the clinical expert, the manager and the patient.

FURTHER READING

● M Aldridge, 1994. Unlimited liability? Emotional labour in nursing and social work. *Journal of Advanced Nursing*, 20(4): 722-728

● M Fotaki, 2010. Why do public policies fail so often? Exploring health policy-making as an imaginary and symbolic construction. *Organization*, 17(6): 703-720

● Y Gabriel, 2004. The voice of experience and the voice of the expert: Can they speak to each other? In B. Hurwitz, T Greenhalgh and V Skultans (Eds.), *Narrative research in health and illness*: 168-186. Oxford: Blackwell

● A Henderson, 2001. Emotional labor and nursing: an under-appreciated aspect of caring work. *Nursing Inquiry*, 8(2): 130-138

● AR Hochschild, 1979. Emotion work, feeling rules, and social structure. *American Journal of Sociology*, 85(3): 551-575

● AR Hochschild, 1983. *The managed heart: Commercialization of human feeling*. Berkeley: University of California Press.

● P Lökman, Y Gabriel and P Nicolson, 2011. Hospital doctors' anxieties at work: Patient care as intersubjective relationship and/or as system output. *International Journal of Organizational Analysis*, 19(1): 29-48

● L Meerabeau and S Page, 1998. Emotion management and cardiopulmonary resuscitation in nursing. In G Bendelow and S J Williams (Eds.) *Emotions in social life: Critical themes and contemporary issues*. London: Routledge

● I Menzies, 1960. A case study in functioning of social systems as a defence against anxiety. *Human Relations*, 13: 95-121

● I Menzies Lyth, 1988. *Containing Anxiety in Institutions: Selected Essays*. London: Free Association Books

● I Menzies Lyth, 1991. Changing Organisations and Individuals: Psychoanalytic Insights for Improving Organisational Health. In MFRK de Vries (Ed.), *Organizations on the Couch*. San Francisco: Jossey-Bass

● A Obholzer and VZ Roberts (Eds.) 1994. *The unconscious at work: Individual and organizational stress in the human services*. London: Routledge

● P Smith, 1992. *The emotional labour of nursing: its impact on interpersonal relations, management and the educational environment in nursing*. Basingstoke: Macmillan

● C Theodosius, 2008. *Emotional labour in health care: the unmanaged heart of nursing*. Abingdon: Routledge