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Emotion management, institutional change, and the spatial arrangement of care at a psychiatric residential treatment facility

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ABSTRACT At Psychiatric Residential Treatment Facilities (PRTF), the neoliberal reorganization of health and social care provision has come with increasing demands for financial efficiency, cost-containment, and evidence-based practices that affect workers' performance of emotion management and their spatial relationship to the PRTF as a place of identity and connection. In this article, data collected via semi-structured interviews and autoethnographic methods are used to examine how long-term workers at a PRTF were affected by and responded to a merger that generated conflicts between the workers' and new management's values, norms of emotional conduct, and spatial understandings of the institution. The standard theories and analyses of emotional burnout in the human services argue that value conflicts between workers and organizations cause the former to withdraw from their clients. In contrast, drawing on Bolton's multidimensional theory of emotion management in the workplace, this paper finds that in the face of value conflicts and increased coerciveness in the workplace, certain dimensions of emotion management—namely workers' engagement with one another and with the children and adolescents in their care—can become more apparently pleasurable and serve as sites of resistance and compensatory solace. Building on work on the geographies of care that troubles the boundaries between public and private space, this paper finds that long-term workers constructed the pre-merger institution as an "anthropological place" and coped with the new regime's efforts to commodify it by reaffirming their relationships and memories.

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Introduction

Work at a Psychiatric Residential Treatment Facility (PRTF) is emotionally demanding. To provide what they consider effective therapeutic care, therapists and other staff members manage the emotions of residents and themselves. At PRTFs, the neoliberal reorganization of health and social care provision has come with increasing demands for financial efficiency, cost-containment, and evidence-based practices—and managerial strategies for meeting them—that affect workers' practices of emotion management and their spatial relationship to the PRTF as a place of identity and connection. In this article, I use data collected via semi-structured interviews and autoethnographic methods to examine how long-term workers at a PRTF were affected by and responded to a merger that generated conflicts between long-term workers' and new management's values, norms of emotional conduct, and spatial understandings of the institution as a place of care.

In 2009, due to fallout from the economic crisis of 2007 and the transition to managed health care, Woodland Hills[1] was forced to merge with a larger, more corporate player—Helping Hands, Inc., a national non-profit dedicated to helping youth with emotional and behavioral issues. The new managerial regime instituted practices of surveillance and standardization and new disciplinary norms of emotional conduct that conflicted with long-term workers' personal and professional values. Standard theories and analyses of emotional burnout in the human services argue that "chronic mismatches" between the values of workers and their workplaces deplete workers' capacity to respond to service recipients' needs (exhaustion) and lead workers to withdraw from relationships with service recipients and develop negative feelings about them (depersonalization) (Maslach et al., 2001; Schaufeli et al., 2009; but see Scheid, 2004, 2010). In contrast, drawing on Bolton's (2005) multidimensional theory of emotion management in the workplace, I find that in the face of value conflicts and increased coerciveness in the workplace relationships with service recipients can become more apparently pleasurable and serve as sites of compensatory solace.

Research on the geographies of health care has pointed to the importance of people-place interactions in the caregiving relationship (Milligan et al., 2007; Milligan and Wiles, 2010; Twigg, 2000) and examined how the spatial dimensions of this relationship are affected by market extension and other changes in the institutional landscape of health care provision (Lawson, 2007; Milligan, 2003, 2005, 2009; Williams, 2002). Most place-based health care research focuses on how unpaid, informal caregivers and their dependents, typically older persons, experience the spatial ordering of care as it transitions between domestic and community settings, and largely overlooks formal paid workers, their managers, and their work environments (on the neglect of workers in geographies of healthcare see Andrews and Evans, 2008; and Connell and Watson-Roberts, 2016; but see Twigg, 2000). While there is an abundance of research examining how paid health care workers manage their emotions in different institutional settings, most of it treats workers' relationships to those settings per se as secondary or immaterial to their findings.[2]

This article focuses squarely on the practices of formal workers and contributes to research on the geographies of care and emotion by examining the spatial connotation of conflicts between long-term workers and their new managerial regime in a treatment facility for youth. Building on work that troubles the boundaries between public and private space, I find that long-term workers constructed the pre-merger institution as an "anthropological place" (Auge, 1995) and coped with the new regime's efforts to commodify it by reaffirming their relationships and memories.

Before turning to the substantive discussion of my findings, I review the relevant literature on emotion management, institutional change, and the spatial arrangement of care and then outline my data and methods. I conclude by suggesting that research on workplace emotionality and the geographies of care should pay greater attention to how the relationship between systems of managerial control and workers' performance of emotion management is shaped by the purpose and form of organizations where care is emplaced.

Literature review

Over the past 20 years, social scientists have studied how system-wide restructuring to a "managed care" model affects health care provision in the United States (Scott et al., 2000). Managed care is the health care sector's response to institutional demands for efficiency, measurable outcomes, and cost containment, "whether for profit based systems or to save 'scarce' public funds" (Scheid, 2003); it is a component of a broader trend toward "medical neoliberalism" (Fisher, 2007). Under Medicaid managed care arrangements, the state contracts with managed care organizations, which are usually for-profit insurance plans, to deliver services through providers that receive a set capitation rate (Medicaid.gov). Along with other economic pressures, the transition to managed care led to consolidation among healthcare providers in the 1990s and 2000s (David et al., 2002; Fuchs, 1997; Gaynor, 2011). This transition placed competing technical and normative demands on health care workers and affected the form of their emotional labor.

As Scheid (2008) demonstrates, mental health organizations strive to integrate two models of care: the commodity model, which reflects the demands of managed care organizations and is consistent with the now widespread reliance on market mechanisms for delivering human services, and the community model, which emphasizes quality services and reflects professional logics of care (Scheid, 2008). As a result, workers may encounter conflicts between organizational and professional values. Empirical research on psychological burnout has demonstrated that value conflict, which "occurs when there is a mismatch between the requirements of the job and our personal principles" (Maslach and Leiter, 1997, p 16), leads workers to experience emotional exhaustion, adopt an uncaring attitude toward their work and clients, and/or lose their sense of personal efficacy (Leiter and Maslach, 1999; Leiter et al., 2009).

Building on Hochschild's (1983) germinal work on emotional labor, most burnout research on the human services argues that conflicts between organizations' excessive demands for emotional investment in the work and workers' emotional resources cause workers to become callous toward clients and cynical toward their jobs (Scheid, 2010). In contrast, in a 4-year longitudinal study of one public sector mental health care organization, Scheid (2010) finds that increased psychological burnout is a consequence of increased monitoring and curtailment of workers' emotional involvement with patients under systems of managed care, whose emphasis on cost-containment conflicts with the professional treatment ideologies of providers. Similarly, Bone (2002) finds that system-wide restructuring of health care provision has decreased nurses' opportunities to interact with patients and simultaneously increased demands for emotional competency to ensure patient satisfaction. The impulse of a commodified health care system—where patients are customers and nursing services are products—is to rationalize and standardize nurses' emotional labor, which Bone (2002) contends will reduce nurses' tacit knowledge to a one-size-fits-all model that misses the nuances involved in therapeutic care. In a study of caregivers in a private

residential nursing facility, Johnson (2015) finds that despite the company's naturalization of emotional labor and failure to provide adequate economic rewards for its performance, care workers emotionally identify with residents, imbuing them with a sense of "moral righteousness in defending the moral interests of the residents against the commercial interests of their employer" (p 123).

Researchers who study the effects of neoliberal policies on workers in long-term care homes for older persons find that standardized performance assessments (Deforge et al., 2011), investor ownership (Harrington et al., 2001), marketization (Harrington et al., 2016; Harrington et al., 2017), and new regulatory technologies (Banerjee and Armstrong, 2015) have negatively affected the interpersonal caregiving relationship in U. S. and Canadian nursing homes. Deforge et al. (2011) find that legislated accountability mandates create a "culture of compliance" that ultimately leaves frontline workers feeling unable and afraid to care. To deal with these feelings, workers develop "workarounds", or short-term solutions, like the administration of sedatives to clients (Deforge et al., 2011). Lanoix (2009) argues that such quick fixes should be understood in relation to the moral ambiguity—the "grayness"—generated by the contemporary organization of care labor, which objectifies the care receiver, medicalizes and rationalizes care, and instrumentalizes the caregiving relationship.

Like these authors, I find that the neoliberal reorganization of health and social care provision has resulted in a values conflict between workers' professional commitment to being emotionally available to patients and coworkers and organizational demands for financial efficiency, cost-containment, and evidence-based practices, which limit the time available for meaningful worker-client/coworker interaction. I find that most long-term workers responded to this conflict not by distancing themselves from clients and one another as standard theories of job burnout would predict, but rather by managing their emotions in a manner that allowed them to continue finding their work meaningful.

Boltons (2005; see also Bolton and Boyd, 2003) theory of emotion management offers a multidimensional approach to organizational emotionality that resists the reductionism of both functionalist and voluntarist accounts of individual actors' control of their emotions.[3] She combines insights from labor process analysis (Braverman, 1998/1974), which focuses on the capacity of managerial control to transform labor power into labor (or the capacity to work into work effort), with Goffman's (1990/1959) ideas about the complex ways that actors regulate their emotions in organizational life. In the emotional labor process, workers own the means of production, which spurs the development of managerial techniques to channel or eliminate emotion in the workplace to meet the organization's aims. Workers are not dupes or hapless victims in this process, but skilled emotion managers constrained by organizational feeling rules that are embedded in broader cultural beliefs and values (Bolton, 2005, p 78).

In the context of health and human services, workers perform what Bolton (2005) calls "pecuniary emotion management" when they comply with managerial dictates that emphasize efficiency, cost-cutting, and customer satisfaction and follow commercial feeling rules that demand only perfunctory interactions (p 128). Pecuniary emotion management often comes into conflict with 'prescriptive emotion management,' which entails a typically sincere commitment to offering care and support that is motivated by altruism, professionalism, or habit. Market extension has come with increasing demands for pecuniary emotion management, measurable by quantifiable targets, which conflict with workers' professional and personal values (Bolton, 2005). These conflicts generate indeterminacy in the emotional labor process, which, in the case of Helping Hands-Woodland Hills (HH-WH), management attempted to mitigate through techniques of standardization and surveillance that devalued and deprofessionalized workers' emotional engagement with the youth in their care. Workers coped with organizational demands for pecuniary emotion management by continuing to manage their emotions in accordance with normative commitments to being available to care-recipients. In the process, I argue, their performance of prescriptive emotion management also became what Bolton refers to as "philanthropic emotion management," i.e., an unusual effort to maintain practices that "offer a sense of stability and ontological security to participants" (2005, p 97). By examining the emotional tenor of workers' responses to neoliberal labor management strategies, my research contributes to recent work on how care workers retain and use discretion in highly regulated and prescriptive work environments (Banerjee and Armstrong, 2015; Daly et al., 2016).

The new managerial regime's techniques of surveillance and standardization not only rationalized and limited the time workers had to interact with clients and one another but also threatened to commodify the facility and transform it into a "non-place," or "a space [that] cannot be defined as relational, or historical, or concerned with identity" (Auge, 1995, p 77). Research on the geographies of care has illuminated the effects on informal caregivers and care recipients of moving the locus of care from semi-public institutions to the private home and vice versa (Milligan, 2003, 2005, 2009; Twigg, 2000; Williams, 2002). This research also demonstrates how transformations in the sociopolitical arrangement of care provision have blurred the boundaries between public and private spaces (see also Armstrong and Armstrong, 2005); specifically, the shift toward care within the home has altered its symbolic and social meaning as elements of institutions—objects without history—enter and resignify the home.

As the "anthropological place" par excellence, it makes sense that health geographers privilege home as a place of care and consider how the movement of people and objects into and out from it affect the caring experience. However, the private home is not the only space in which identity materializes (see Young, 2005, p.156ff on home as the materialization of identity). Workers, particularly those with long tenure, may also practice a version of 'homemaking' in their workplaces, defined by Iris Marion Young (2005) as "the activities of endowing things with living meaning, arranging them in space in order materially to facilitate the projects of those to whom they belong, and activities of preserving these things, along with their meaning" (p 156). At HH-WH, new management repressed long-term workers' homemaking activities by renovating the facility in ways that did not materially support their therapeutic projects and removing objects in which workers' identities materialized. Some workers responded by reaffirming their relationships and memories of the pre-merger organization as a "family," which they contrasted with the "corporate" culture of the new regime.

Location

In the 3 years leading up to its merger with Helping Hands in 2009, Woodland Hills saw a 10% decrease in its total assets and its total expenses consistently exceeded its total revenues. Its biggest losses in revenue were in the program services category, which encompasses income generated by the provision of healthcare and educational services and government contracts. By contrast, in the same time period, Helping Hands' total assets increased by sixty-four percent and the gap between its revenue and expenses consistently grew in a positive direction. Its greatest gains in revenue were in the program services category, demonstrating its skill at winning government contracts (IRS filings).

Providers like Helping Hands, which stresses outcomes-assessment and evidence-based therapies and benefits from economies of scale, can more easily accommodate the technical demands of the managed care system than providers like Woodland Hills, which did not have the tools to contain costs and was more committed to a professional logic of autonomy and care than meeting technical criteria for efficiency. The inability of Woodland Hills to contain costs, coupled with increased economic pressures resulting from the Great Recession, forced it to merge with Helping Hands. Helping Hands implemented a variety of measures to ensure technical efficiency and cost-containment, including introducing evidence-based rehabilitation models, "delayering" the organization (Sennett, 2006), placing all employees on salary to deny them overtime pay, and managing the labor process through increased surveillance and standardization. This article focuses specifically on managerial attempts to control the emotional labor process, but also touches on the other efficiency measures mentioned here.

HH-WH is a PRTF for children and adolescents, ages 6 to 21, suffering from severe emotional and behavioral issues combined with other needs. The campus sits on over a thousand wooded acres and is located outside of a major southeastern city. The facility has 120 beds, but its census typically falls somewhere between 90 and 120 patients/clients. Prior to the merger and the movement of Medicaid to managed care, patient lengths of stay often lasted for more than a year. Now, the typical length of stay is between 60 and 90 days. Though some patients/clients are permitted to leave the facility to attend a local school, the majority attend an accredited school on campus.

The youth participate in a variety of experiential therapies in addition to more traditional individual and family sessions, where the primary clinical approach is Dialectical Behavioral Therapy. Helping Hands promotes other evidence-based treatment models, which are incorporated into individual and group therapy and on the milieu or unit. These models, on which all staff are continually trained, include Cognitive Behavioral Therapy, Seven Challenges for youth with substance abuse issues, Preparing Adolescents for Adulthood for teaching life skills, and Motivational Interviewing for working with youth who are reluctant to change their behavior.

Many of the youth are adjudicated to HH-WH as an alternative to a Youth Detention Center. Others are sent by their families (foster or biological), with the assistance of social workers, because of uncontrollable behavior in their home. The vast majority of the youth at HH-WH live on locked units and all of the youth are supervised 24 h a day. Youth are not allowed to leave the facility until the duration of their treatment is complete, and when a child runs away the police are informed and he/she is sent back to the facility or to jail upon retrieval. In this sense, the facility is both carceral and therapeutic.

The Woodland Hills campus has over 300 full and part-time employees, and as a national organization Helping Hands has over 2000 employees. At HH-WH the career advancement track goes from counselors, who are the direct care staff, to supervisors, who monitor direct care staff, to therapists, who provide individual and family sessions, and, finally, to program managers, who are part of the campus management team and oversee the documentation and ensure adherence to the treatment model by all staff below them. As workers move up the career ladder, they become more responsible for training, monitoring, and managing staff, and for enforcing documentation completion and compliance standards.

I selected HH-WH as the location for my research because, as I explain in greater detail below, I worked there as a life skills instructor prior to beginning my fieldwork. I arrived as an employee 1 year after the merger, when changes to the facility were still unfolding and many of its consequences, particularly in terms of lost personnel and diminished autonomy, were still fresh for long-term workers. Over the course of my time as an employee I became interested in the emotional consequences of work restructuring for my fellow workers, particularly those who had been working there for years, and the youth in our care.

Beyond my work experience, the distinctiveness of HH-WH as an institution of carceral care makes it a revealing case study for examining how broader changes in the nature and spatial arrangement of care work shape the rules regulating emotion management and how workers respond to those changes. As Small (2009) notes, qualitative researchers often attempt to appease their quantitative critics by arguing that a case is representative of a certain population such that the results will be generalizable, thereby satisfying the demand for "in-depth studies that somehow or other speak to empirical conditions in other cases (not observed)" (p 10; italics in original). Small (2009) argues that given the criterion for statistical representativeness, finding a single workplace (he uses "neighborhood" but the same rule applies) that is representative of an "average" workplace is impossible. A better alternative is to find distinctive cases, which can offer ways to extend theories, and make causal or logical inferences, which provide ways of identifying empirical facts.

Analyzing a distinctive case like HH-WH, where the neoliberal reorganization of work and consolidation of healthcare providers has resulted in value conflicts but not in the forms of emotional withdrawal predicted by theories of burnout, helps develop theories about the relationship between systems of managerial control and workers' performance of emotion management. Moreover, it enables logical inferences about how the place of care mediates this relationship.

Methods

The findings in this article derive mainly from analysis of semi-structured interviews. I also worked as a life skills coach at HH-WH for 11 months from September 2010 to August 2011, which made possible what social scientists have variously referred to as "retrospective participant observation" (Bulmer, 1982), "autobiographical sociology" (Friedman, 1990), and "autoethnography" (Adams et al., 2014). All three of these terms describe a method of doing and communicating research that draws heavily on the researcher's personal narrative. My experience working at the facility was a conduit to questions, ideas, and data. Probing and documenting my experience as a life skills coach led me to identify connections between shifts in the nature of work at the facility, the relationships among staff and between staff and patients/clients, and forms of emotion management. That is, my background as a life skills coach allowed me to formulate a general research topic to explore.

My status as a former employee provided me with a basis for gaining institutional approval to do qualitative research at the organization, which has its own research department that conducts studies that the organization finds valuable, mainly about the outcomes of its clients. It afforded me a familiarity with the language research participants used to convey the content of their work, which often involved references to buildings and people on campus, as well as site-specific acronyms. Most importantly, it reassured the workers I interviewed that I was trustworthy and sympathetic. Understandably, in the aftermath of significant layoffs and amidst ongoing concerns about the intentions of upper management, workers might be reluctant to speak candidly to a researcher about their difficulties at work; my prior employment experience likely encouraged workers to see me as "one of them."

In total, I conducted eight formal interviews and four informal interviews in December of 2012 and January of 2013 (on formal and informal interviews see Curley and Royle, 2013). I recorded and transcribed the formal interviews, three of which took place face-to-face in the workers' respective offices and five of which took place via Skype. The length of the interviews varied from one to two hours. All the participants had worked at the facility for at least 5 years at the time of their interview, placing them there for at least 1 year before the merger. Two of the participants were men and six were women. They held a variety of positions at the facility: two were therapists, two were educators, two were unit supervisors, one was a direct counselor, and one managed a volunteer program but was a former direct care counselor. Two of my participants are Black (one of the supervisors and the direct care counselor) and the other six are White. All of my participants had at least a Bachelor's Degree and three held graduate degrees.

The formal interviews were semi-structured, meaning that they were "partially prepared" and "largely improvised" (Wengraf, 2001, p 3). Semi-structured

interviewing is an appropriate method of data collection for researchers who want detailed information about a specific topic—in this case emotion management and its relation to shifts in managerial control—but also want to keep the style conversational and leave space for probing questions that more thoroughly unpack respondents' answers. On a continuum from unstructured to fully structured interview protocols, my interviews were lightly structured to allow for the emergence of grounded concepts (Glaser and Strauss, 1967; Corbin and Strauss, 2008) and theory building (for more on this continuum, see Wengraf, 2001, particularly chapters four, six, and seven). Nearly all my interview questions were comparative and called on respondents to compare different elements of their jobs and workplace before and after the merger. I framed the questions to elicit participants' main concerns and solutions in the context of the merger. My questions focused on how workers understood and navigated changes in training, performance assessment, level of autonomy, quality of care, and the practice of emotional support.[4] I ended each interview by asking the respondent to reflect on the two most positive and two most negative changes since the merger.

I also had more casual conversations with former colleagues about their perceptions of changes in the arrangement of work at the facility. These four informal interviews lasted around 20 min each and while I did not record or transcribe them, I did make written notes immediately after each one. I conducted the first of these informal interviews face-to-face with my former supervisor, who worked intermittently at the facility between 2007 and the time of data collection and therefore did not fit my selection criterion of 5 years of continuous work at the facility. She was, however, my principal informant and distributed my recruitment script to all staff who had been working at the facility for more than 5 years. I conducted the other informal interviews with a teacher and two former teaching assistants. The teacher's informal interview took place via Skype before a scheduled formal interview, which ultimately never happened because of lack of response. Both teaching assistants worked at the facility before and after the merger but were no longer working at the time of data collection; I interviewed them face-to-face. The findings generated by the informal interviews were consistent with those derived from the formal interviews.

To understand the context of changes at the facility, I reviewed policies and secondary sources related to the transition to managed care in the United States and the state in which the facility is located. I also reviewed IRS filings for Woodland Hills and Helping Hands to gauge the impact of these changes on the financing of these organizations.

Methodologically, I approached the data using elements of grounded theory (GT) and thematic analysis. Like traditional GT researchers, I had a predefined research topic informed by my experience and discovered the research problem by asking participants about their core concerns and solutions (Christiansen, 2007, 2008). As I collected data, I analyzed it using a method of constant comparison between text-incidents, a method common to both GT and thematic analysis (Bryman, 2008). I used similarities and differences to create categories, which I continually redefined to fit the additional data. I wrote analytic memos to connect the categories that emerged in data analysis to my retrospective observations. As is common in GT, I then identified the relevant literature for conceptual comparison. The thematic categories that emerged from the coding process, which are the focus of subsequent sections, highlight the relationship between strategies of managerial control and workers' performance of emotion management. Consistent with autoethnography, I occasionally use personal narratives to frame findings from interviews but always clearly distinguish my retrospective ethnographic observations from my interpretations of interview data.

"You can't work here and not be emotionally involved": the multiple dimensions of emotion management

All my respondents described emotionality as central to their work; as a program manager told me, "you can't work here and not be emotionally involved." Before examining how the merger affected workers' performance of emotion management, it is important to note a characteristic of the spatial arrangement of care work that remained consistent at the facility before and after its structural transformation, i.e., its relative invisibility.

The labor effort of workers at HH-WH was and is largely invisible (Daniels, 1987). As care workers, their jobs are constructed as feminine and filled predominantly by women, which, as England et al. (1994) demonstrate, means their skilled labor is culturally devalued as natural gendered traits they self-select into care work to express. The population that they serve is subjected to the structural, symbolic, and intimate violence (Bourgois and Schonberg, 2009) of exploitation and inequality, which is routinized through the "everyday violence" of bureaucratic procedures and societal indifference (Scheper-Hughes, 1996). The naturalized, feminized, and thus devalued status of their jobs, coupled with the vulnerability of the population they serve, renders invisible the labor that workers at HH-WH perform. Furthermore, the geographic location of the campus—set-back in the woods far from any main road—keeps their work hidden from public view. The invisibility of work at HH-WH conditions the character of its organizational emotionality; workers are emotionally invested in their jobs, but not because their care work is rewarded with praise, recognition, or substantial remuneration.

Appropriate emotion management requires that workers learn to take for granted their clients' traumatic histories, to fend off negative feelings about their clients' families, and to naturalize the performance of physical restraints—to do what Hochschild (1983) calls "deep acting." Ms. Walker, a unit supervisor, stated that the biggest challenge she faced when she began working at the facility was learning to manage her emotional and physical reaction to clients' violence toward themselves and others. "Restraining kids" was not natural, but instead something she had to learn was helpful and assimilate into her repertoire of appropriate techniques for interacting with clients:

> My first situation was a girl [who] tried to commit suicide and she was hanging in the bathroom and [someone said], "Get her down! Restrain her!" and I'm like, "No! Don't you see her hanging?" She was turning different colors. I panicked. I didn't know what to do. That's just not natural to want to restrain somebody…once I realized I was doing it to help them and it was a preventive measure than I was able to get the hang of it.

The emotional demands of interactions with clients lead workers to seek emotional support and stability from their colleagues. In interviews, and during my time working at the facility, long-term workers described the pre-merger facility as a "family" and lamented the encroachment of what they referred to as the "corporate" culture of the new managerial regime. Ms. Roberts, a direct care counselor, explained how this transition affected workers relationships with one another and the sense of meaning she derived from her work:

> I think the staff [was] in better spirits [before the merger]. So, our job was what it is. We have difficult things that we work with, but when you're dealing with difficult staff and the kids, it's not a good combination. So I miss having support from my team, the old team…I think right now everybody is out for self. It's we come to work, we work as a team, and when we do vent to each other it's bullshit… Before I felt like I was doing something, I was making a change […] I miss feeling like I made a difference and I don't feel that anymore.

Ms. Roberts pointed out that work at the facility has always been difficult, but that changes in the relationships between staff, due specifically to increased individualism, have made the difficulty of the work more visible and the sense of making a difference less durable. Her statements that "everybody is out for self" and that her coworkers' venting is disingenuous suggest that workers felt pressured to cynically comply with the demands of pecuniary emotion management, which under the governance of managed care require and reward an emphasis on documentation that consumes the time workers previously spent building community and providing care. Although Ms. Roberts expressed a sense of despair, she later conveyed that she decided to stay in her position because of the relationships and memories she could maintain.

The new regime of managerial control implemented strategies of surveillance and standardization to ensure cost-containment, financial efficiency, and, ultimately, compliance with the demands of managed care companies. In contrast to the pre-merger institution, which long-term workers described as prescribing and

facilitating workers' spending time with youth and each other, the post-merger organization prescribed only perfunctory interactions. Management sought to standardize not only therapeutic practices, but also the spatial arrangement of care, altering the physical environment in ways that affected workers' identification process. New management's demands for documentation and attempts to rationalize workers' performance of emotion management made the difficult parts of workers' jobs more obvious, leading some workers to seek stability and compensatory solace in remaining emotionally available to clients and one another.

Responding to standardization and surveillance

Following the merger, work at the facility was reorganized under a new regime of managerial control that used two primary strategies to reduce the indeterminacy of labor: standardization and surveillance. For most of my interview respondents, these strategies were coercive and disenchanted their work. In many organizations that deliver human services or provide public goods, workers are pressured to pay increasing attention to the satisfaction of their clients/patients (e.g., Korczynzki and Bishop, 2008), but managerial control at HH-WH steered workers away from being available to their clients and each other; for the new regime, anything but perfunctory emotional investment was inefficient, undisciplined, and unscientific, and this perspective materialized in their adjustments to the spatial arrangement of care in the facility.

For workers, emotion management was a site to both accommodate and cope with the new regime. For most of my respondents, remaining accessible to youth, which was formerly prescribed by the organization prior to the merger, became a source of compensatory solace as the new regime emptied the work of its other enjoyable components. Finally, as the organization's prescribed feelings rules shifted, workers were compelled to defend, redefine, or reform how they understood the meaning of their jobs and professions. For workers whose professional commitments prescribed emotional accessibility and involvement, its sustained performance offered a way to simultaneously defend their views of what it meant to be a professional, subvert or resist the new regime of managerial control, and continue doing what they enjoyed most about their work.

People vs. procedure: standardization and worker response. At HH-WH, managerial techniques of standardization transformed the organizational culture, rationalized care, and altered the physical environment. Standardization and the depersonalization that ensues from it are central features of rationalized work organizations. In the late nineteenth and early twentieth centuries, Frederick W. Taylor developed the idea of scientific management, which Ford engineers would later apply on the assembly line. Taylorism, or the scientific management of work, emphasized replacing inefficient traditional production methods with methods based on efficient means-to-ends-calculations. In addition to greater efficiency, Taylorism focused on increasing predictability through the creation of well-defined standards (based on optimum means to ends calculations) that every worker could and would follow to ensure they all did a given job the same way (Taylor, 1947; Ritzer, 2008, pp 29 f). In a broader sense, scientific management transferred both explicit and tacit knowledge of skill, materials, production processes, and the like from workers to technical observers, engineers, and ultimately management. This is one way in which an emphasis on "efficiency" is designed to extract value and elicit compliance from workers, reduce the bargaining power of labor through deskilling (Braverman, 1998/1974; Wright, 2005), and produce "docile bodies" (Foucault, 1977).

Traditionally, organizations that adopt Taylor's methods reduce their labor costs; the standardization of methods, whether of production or treatment/care, means that organizations do not have to rely on professionals or workers with certifiably high skill levels, who are the most expensive employees. Standardization and the spread of formal rationality—the tendency to make decisions according to rules and in terms of means and ends—facilitates deprofessionalization (Ritzer and Walczak, 1988), or "the process by which highly educated and skilled professionals are first displaced and then replaced with individuals of inferior training and compensation" (Dionne, 2009). Deprofessionalization can also occur through the institutionalization of manuals for "evidence-based practices," which instruct workers on how best to do their jobs, occasionally in ways that conflict with or hinder the use of their professional judgment. Standardization of workers' environments and practices also operates to suppress deviance, which in a work organization can be "any act [that] expresses an identity beyond that of worker, which therefore may escape the requirement to submit to control" (Jackson and Carter, 1998, pp 59–60).

Before the merger, workers expressed their identities by bringing objects of personal meaning to the workplace and arranging the workspace to support their therapeutic activities. In this sense, workers engaged in a form of "homemaking" at work (Young, 2005) and made the facility an "anthropological place" (Auge, 1995) of connection and identity. Just as domestic space took on the characteristics of a non-place as it became a site of formal care in Milligan's (2003) study of dementia care, HH-WH lost some of its place-ness and was divested of personal identity by Helping Hands' impulse to standardize. Ms. Honness, a veteran therapist, recounted Helping Hands' efforts to depersonalize and commodify the facility—to turn it into an end in itself—immediately following the merger:

> Whereas Woodland Hills…was just this little entity on its own so there was a much more personal, much more intimate kind of work environment…Now I think it's much more impersonal…Like, our building…you can walk into our campus and you know it's a Helping Hands building [and] program if you've been to anywhere else. These programs all look the [same], buildings are all painted the same, they have the same interior decorator…like one person kind of decorates all these buildings, all these facilities, you know they all look alike. One of the earliest examples was when they came in and changed offices, when they came over we all had to get rid of our furniture [and] we all had to have the same kind of furniture in our offices. We weren't allowed to have personal items. All the offices really kind of needed to look the same if somebody stuck their head in…Somebody even took some personal items out of somebody's office because they weren't supposed to [be there]…

The new managerial regime undermined workers' homemaking activities by removing their personal items—signs that they had identities as people beyond work—and steering their performance of emotion management toward identification with the restructured organization rather than a sense of "self." Standardization of the physical environment also affected how space was arranged to support workers' therapeutic projects. When I arrived at the facility, Helping Hands had just finished renovating four of the residential units on campus to match the buildings at their other facilities across the country. During my initial tour of the facility, my boss, a long-term worker, grumbled that the renovations included flat screen televisions and video game systems. Although initially I interpreted the new technology as a treat for the youth at the facility, I came to learn that

expensive technologies disrupted the therapeutic process; clients often attempted to destroy them when they were upset, resulting in the use of more physical restraints by staff who were required to prevent the youth from harming property. The televisions and games also caused conflicts between clients, who argued over their use, forcing staff to devote already-limited time to adjudicating these conflicts.

Moves to standardize physical space were paralleled by efforts to standardize treatment/care and homogenize labor, making workers vulnerable to a kind of interchangeability. Alluding to this vulnerability, Ms. Walker, a unit manager pointed out that whereas Woodland Hills was about "the people," Helping Hands was about "the process." For HH-WH, what mattered was that the tasks were completed according to procedure instead of the people who complete them.[5] Helping Hands' procedural orientation was instantiated by their regular managerial development trainings and manuals for evidence-based practices that provided standardized solutions to both managerial and clinical problems. Ms. Walker recounted the many kinds of training she had received from Helping Hands, including one that prescribed "social styles" for interacting with coworkers based on the identification of one's own personality type and the personality type of the other person(s). Whereas at Woodland Hills, she learned to be a manager from her "role models," Helping Hands taught her that she was a "structurer" and "how to meet an analytical person" and "have a conversation with a person without thinking you're arguing."

The standardization of rules for interpersonal interaction among workers was paralleled by the concomitant standardization of clinical practices through the institutionalization of evidence-based practices. This process has had a particularly pronounced effect on the ability of workers to be available to the youth in their care. Ms. Kenn, a therapist, explain that before the merger she had no "organizational structure" to say, "this is what you're supposed to do" and that it was more a question of "a staff person modeling it for you." Unlike the rest of the long-term workers that I interviewed, Ms. Kenn viewed this transition as a positive change, remarking that she no longer felt the need to "spend tons and tons of time with the kids" because "if my goal is to help them go faster, then I don't need to become their parent… the way to do treatment plan development now is based on evidence-based practice."

In contrast to Ms. Kenn, Mr. Halsey, also a therapist, affirmed his professional expertise as an authority on how to provide emotional support to youth and conveyed that he would resist pecuniary challenges to his philosophy, which draws legitimacy not from compliance with a manual or standard treatment model but from kids who are his former patients/clients. "Helping Hands is not going to tell me to do it differently," he stated, "they may tell me to do it differently, but I know what works, I know how it works, and I've got letters and I've got kids who've come back [and approved my approach]." Unlike Lee-treweek (1997), who finds that care workers use standards—specifically, the "lounge standard" of a clean and quiet resident—as a justification for not responding to patient's emotional needs, I find that workers at HH-WH saw standardization as an impediment to providing emotional support to the children and youth in their care.

At HH-WH, upper management used surveillance to facilitate the enforcement of standards through normalizing sanctions. The paired labor management strategies of surveillance and standardization transformed organizational emotionality at the facility. Whereas Woodland Hills prescribed availability and considered it a mark of professionalism, Helping Hands' emphasized standardized managerial and clinical practices that made spending time with kids and coworkers an act of philanthropic emotion management—a "gift"—rather than a practice the organization considered valuable. Most of my respondents resisted this redefinition of their professional identities, but, as I demonstrate in the following section, Helping Hands' techniques of surveillance made it difficult for workers to continue performing availability as a professional act. Interestingly, however, for most of my respondents these surveillance tactics made availability more attractive as the remaining source of enchantment in work that was being gutted of its other enjoyable components.

Paperwork, paperwork, paperwork: surveillance and availability. Since the merger with Helping Hands, managers, therapists, counselors, and patients/clients have been subjected to a managerial surveillance strategy that combined elements of observation, measurement, and standardization, or what Foucault (1977) calls "examination". The counselors, or direct care staff, completed documentation on the youth and their paperwork was assessed by their supervisors, who completed scorecards, which were documents about the quality of counselors' documentation. These scorecards, as well as other documentation prepared by program managers, were assessed by the campus director and the director of residential services, who prepared reports, i.e., more documentation, for the Helping Hands research department and the state, which contracted with managed care companies.

The therapists completed documentation on the youth in their care, which was assessed by their supervisors, but they also completed consultations with psychiatrists, who since the merger have become contract employees, making them the exception to the general move toward making people salaried employees. The increased supervision and consultations were meant to ensure compliance with the company's standards and the scorecards acted as normalizing sanctions, particularly because they were used in promotion cases. Supervisors and consulting psychiatrists reviewed their subordinates' documentation and created scorecards based on how well the staff's documentation and the therapists' treatment plans followed the rules, regulations, and manuals. Worker performance was therefore measured by how well-disciplined workers are, that is, how completely they complied with the demands of work discipline in terms of both process/practice and documentation. In this sense, "performance review" was really a compliance review and not an effort to document productivity/output/outcomes in terms of client well-being. The latter is evaluated by Helping Hands' research department, which assesses the outcomes of its programs and services—not the worth of individual employees' practices—to produce evidence of its achievements for potential and current funders.

These techniques of surveillance were linked to deprofessionalization in complex ways. First, because HH-WH hired less-experienced staff and therapists as a cost-containment measure, it put more pressure on management to more closely oversee workers' practices. Second, workers' performance assessments were based on how well their documentation and treatment plans conformed to the manual, not on the quality of their interactions and therapeutic interventions with youth. Third, by turning what were once full-time psychiatrist positions into contracted positions, Helping Hands reconstructed these positions as less clinical/therapeutic and more supervisory. In fact, Helping Hans reconstructed the entire facility as less clinical/therapeutic and more custodial, a point alluded to by my respondent's remark that "at Woodland Hills, the therapists were over the managers, [but] Helping Hands is vice versa, the managers are over the therapists." In a facility that prioritized treatment, one would expect the first hierarchical formation.

In their study of new regulatory technologies in residential care of older persons, Banerjee and Armstrong (2015) find that one of

nurses' most common concerns was the amount of 'meaningless' paperwork that made work less enjoyable and kept them from spending time on direct care. Like these authors, I find that at HH-WH the shifting management structure and the amount and type of required documentation made it difficult for workers to be available to kids and one another. Ms. Roberts, a counselor who at the time of the interview had worked for the facility for close to a decade, talked about how the reorganization of the institution and the ensuing emphasis on surveillance and paperwork has affected her ability to be there for youth who seek her attention.

> So it's like listen, sometimes [the kids] come in [saying], "Ms. Roberts, can I [talk to you]?" and I can't because I have to get paperwork done, this has to be caught up and you know everything has to be done by 3:30. I think every Monday they pull these particular papers to take to some meeting or that have to be e-scanned so by the time they get to this meeting it's all there and if it's not there, like I said, we hear about it. So, this is what our day is basically about, paperwork! And making the place look good.

Ms. Roberts' final comment about "making the place look good" was echoed by other respondents who talked about the centrality of appearances to the new disciplinary regime of Helping Hands. Its preoccupation with appearances evokes Young's (2005) description of the "commodified home," which supports identity as "the mark of one's social status" and is "an end in itself" (p 132); Helping Hands invested in the physical appearance of the facility to market itself and impress philanthropists, whose donations it reinvested in the physical appearance of the facility.

In closely regulating workers' time through paperwork and training grids, the new managerial regime affected workers' relationships with kids and one another. My respondents cited numerous examples of instances where time pressures made it difficult for them to offer what they perceived to be an appropriate level of emotional support to kids and one another. They also described occasions where they shirked organizational demands for time discipline and carried on providing emotional support in a manner they saw fit. One of my respondents, Ms. Barley, who is an educator, decided to forego paperwork to remain available to kids.

> I just decided I'm going to be with kids, and if they ask me to do paperwork on everything I do I will, but until they do I'm just going to serve the kids. The paperwork is very important to the corporation, but I don't think I'm real important to tell you the truth, so they're not looking at my paperwork […] I work with the kids individually, I'm offering them services and I'm putting little notes in their education chart and I go to their therapist and I report to the therapist, who does the note. I think that's completely adequate and I can spend more time with kids.

Ms. Barley's decision to resist the demands for paperwork was based on her assessment that she was not "real important" to the corporation and therefore did not have to do what is "very important" to the corporation, namely, paperwork. Instead, she persisted in doing what is important to her, which is being available to work with kids. Her extra effort to remain emotionally accessible, then, became a kind of compensation for losing her sense of personal importance to the organization. Many of my respondents found compensatory solace in their relationships with clients and one another as the reorganization of the facility emptied their work of some of its most enjoyable aspects.

Increased surveillance gave almost all my respondents a sense of lost autonomy, comfort, and sociability at work. As long-term employees (some with tenures over 10 years), they had a unique perspective on how "things used to be," and articulated connections between the managerial strategies of the new regime and increased stress at work. When Woodland Hills merged with Helping Hands, many long-term employees were replaced by incumbents in the Helping Hands administration; others' positions were eliminated to cut costs. The loss of some long-term employees and the resulting speed-up contributed to a palpable sense that what was once a "family" had become a "corporation," a sentiment expressed by a therapist who told me that what he missed most about his work before the merger was the "passion of working with these kids [and] the amount of people who were here, you know, 10 or 30 years because they loved Woodland Hills, they loved how we did things, why we did things, and they loved the kids that we worked with and the philosophical part of it, but also the family atmosphere." For Mr. Halsey and most of my respondents, passion for being with the kids and supporting one another was normative at Woodland Hills but had been replaced by what Mr. Halsey later in the interview called a concern for "the bottom line, as opposed to what's best for the youth, for the kids."

As the merger depersonalized the work and emptied it of some of its most pleasurable aspects, many workers have continued to follow the prescribed feelings rules of the old regime, which also comported with their sense of professionalism. Despite negative sanctions for remaining available, workers continued to do it because it offered them compensatory solace. Describing how she coped with the merger, one of my respondents said "anytime I feel off-task or unfocused, I just center myself in the midst of the kids. I have to remember why I'm here, which is the kids. I'm like I could care less about y'all [the new administration]. Let me on my unit, I'm good." For this respondent, being "in the midst of the kids" was a way to manage her emotional response to the new regime; she used it as a coping mechanism for dealing with organizational change. To refocus her work efforts, she drew on her emotion memory that she was there for the kids.

At HH-WH, workers drew on their emotion memories of their relationships with clients and one another to manage their emotional responses to organizational change. During our interview, Ms. Honness explained to herself and to me how she "disassociate[d]" from her anger and kept it "in check" and why she chose to stay at the organization.

> the organization is out there and it's doing what it's gotta do and I have like a little micro piece of that and that's like [my] little [unit] or something. [I have to] kind of focus on that and my kids and my team. And, I'm choosing to do this. I'm choosing to be here […] If I was younger in my career or something and if I was maybe interested in [the career ladder] it might be a different ballgame […] It's still worth it to kind of just go through this stuff so I'm still choosing to do it. It really is just a matter of choice. So, umm, but do I love the kids? Yes! Do I love the sessions? Yes! Do I love the families? Yes! Do I love Ms. Walker and my team? Yes!

Ms. Honness elected to stay at the facility because she still had her "micro-piece" of the organization, which was the unit comprised by her kids and her team. Her assessment that "it is still worth it to just go through all this stuff" was based not on the career ladder that the reorganized institution could offer her, which due to her age was unappealing, but rather her love for the kids, the sessions, the families, and her team. The persistence in being available to the kids and her team offered her compensation for the organizational changes and a way to cope with them.

Concluding remarks

In his sociological study of the culture of the new economy, Sennett (2006) remarks that "even in dysfunctional institutions like those of the American welfare state, public service workers will stay in the belief that they can make a difference. Is this an illusion? Perhaps, but no adult can proceed without it" (pp 36–37). In addition to economic reasons, workers chose to remain at HH-WH because they believed that they could make a difference. For most of my respondents, demands for pecuniary emotion work and the imposition of rational labor management strategies of standardization and surveillance made it difficult to manage their emotions in accordance with their personal and professional values. However, workers' relationships with youth and one another became more apparently enjoyable as a site of refuge and resistance that is closely tied to workers' professional philosophies. Whereas theories of job burnout predict that values conflict would lead to emotional withdrawal from clients, workers at HH-WH reinvested meaning in their relationships with clients and one another. In so doing, their performance of prescriptive emotion management also became philanthropic, an extra effort to infuse the workplace with a sense of self.

In an examination of restructuring in Canadian social service organizations, Baines (2004) argues that the implementation of new public management strategies within the Canadian non-profit sector has created a "compulsion-coercion continuum" along which the workforce operates. Like at HH-WH, standardized and routinized models of work organization have gutted social service work of its caring content. They also lowered the costs of labor by making it easier for volunteers and those without credentials to do the work. As a result, workers often do unpaid care work because they are coerced by fears of losing their jobs and/or because they are compelled by a sense of obligation and moral commitments to care.

Though most of the long-term workers I interviewed certainly felt compelled to care, they did not report feeling coerced to "fill the 'caring gap' created by standardized and thinly staffed paid caring service work" (Baines, 2004, p 268). I suggest that two of PRTFs' structural features facilitated workers' construction of it as an anthropological place and help explain why (a) long-term workers did not turn away from their relationships with service recipients in the face of pronounced value conflicts and (b) they did not report feeling coerced into performing unpaid emotional labor.[6]

First, PRTFs are carceral-therapeutic organizations and workers view being physically and emotionally available to clients as central to the therapeutic dimension of their work. The merger instituted standards and performance measures that devalued this dimension of their work, making its carceral dimension more pronounced. By diminishing the organizational importance of availability to clients and colleagues, the new managerial regime ended-up highlighting to workers' the meaningfulness of the caregiving relationships at their workplaces. The carceral aspect of the facility also makes it a difficult and unattractive place to volunteer, minimizing the threat of volunteers taking positions of paid workers.[7]

Second, PRTFs serve children[8] in a residential environment. I aver that the institutional categorization of clients as children diminishes their perceived responsibility for their behavior and circumstances in the eyes of workers, whom the residential nature of the care environment imbues with a sense that they are like parents to their clients, evinced by workers' frequent references to "my kids." The age, emotional vulnerability, and therapeutic schedules of the residents also make the institution a difficult place to volunteer. Future research on workplace emotionality should pay greater attention to how the relationship between systems of managerial control and workers' emotion management is shaped by the spatial arrangement of care, which conditions how workers can manage their emotions to resist or comply with managerial demands.

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Notes

1 I have changed the names of all organizations and their locations to protect the anonymity of my research subjects. "Woodland Hills" refers to the organization before the merger, "Helping Hands" refers to the organization with which "Woodland Hills" merged, and "Helping Hands-Woodland Hills" refers to the post-merger organization.
2 Lanoix (2009), for example, writes that "Care activities are structured similarly whether they are performed in someone's home or in an institution" (p 32).
3 The functionalist conception of organizational actors portrays them as entirely colonized by managerial prescriptions or "feeling rules." The voluntarist interpretation of organizational emotionality overstates workers' agency and has an under socialized view of choice.
4 Following Bone (2002, p 141), I asked each of my respondents what emotional support meant to them.
5 Though "process" was the native category employed by my respondent, what she described is closer to the meaning of "procedure," which is a specified way to do a task, whereas a process is a set of tasks that transforms inputs into outputs.
6 The facility may certainly have coerced workers into performing other kinds of work, such as learning new data management systems during off-hours and days.
7 The facility has hosted an AmeriCorps program since 2001, well before the merger and the transformation of work at the organization. AmeriCorps members are educational tutors.
8 How the state constructs childhood and determines the amount of coverage they receive depends on recipients' income, location, and diagnosis. Children are eligible to receive Medicaid up to age 18 in families with income below 138 percent of federal poverty guidelines. Children are eligible to receive insurance up to age 19 through the Children's Health Insurance Program, which is administered by the states and serves children in families with incomes too high to qualify for Medicaid (income eligibility requirements vary by state). Medicaid covers PRTF services for children up to 21 if they meet diagnostic criteria, which vary by state but generally include a longstanding psychiatric diagnosis with symptoms that are pervasive and persistent.

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Data availability

The data that support the findings of this study are not publicly available because they contain information that could compromise research participant privacy and the researcher did not receive participant consent or IRB approval to release interview transcripts.

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Additional information

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