The risk of risk management: Adopting critical theories to explore clinical risk concerns in mental health care.

Purpose. The paper will present critical risk theories and explore their application to risk concerns in mental health care. This will contribute to the ongoing debate about risk management practices and the impact these might have on recovery and social inclusion. Notably, whilst risks like suicide can be therapeutically addressed, risk management may involve paternalistic practices that excludes the participation needed for recovery.

Design/methodology/approach. A viewpoint of key risk theories will be presented to provide a critical eye about clinical risk concerns in mental health care. Implications for recovery and social inclusion will then be discussed alongside direction for practice and research.

Findings. Clinical concerns can involve difficulties with uncertainty, holding onto expertise, and the Othering of patients through risk. These concerns suggest the patient voice might become lost, particularly within the backdrop of clinical fears about blame. Alternatively, a relational approach to risk management could have merit, while patient expertise may develop understanding in how to improve risk management practices.

Originality/value. Clinical concerns appear more than managing potential harms; it can involve appraising behaviours around societal norms, explaining to an extent why mental illness might be addressed in terms of risks. Whilst the points raised in the paper support existing findings about risk management, the underlying reasons drawing on the critical risk theories are less explored.

Keywords. Risk; Governmentality; Cultural Approach; Risk Society; Social Inclusion; Patient Voice.

1. Introduction.

The paper will explore several key critical risk theories to understand why risk might be a clinical concern in psychiatry, and its impact on recovery and social inclusivity. Before doing so, risk as an overall concept will be outlined alongside purpose, and some critique, of risk management. Following the introduction, the critical risk theories will be presented leading

to a discussion about the implication of the theories to care. The paper will then conclude with suggestions for risk management and research.

1.2 Risk.

At the heart of human development has been the ability to master risk and make informed choices believed to either mitigate danger or create new opportunities. What signifies risk can be contingent on time and place, hence, has not always concerned harm, but also been inclusive of some gain, notably as part of ventures that might reap rich rewards. Merchants in the 1800s for example, saw risk involve estimating gains from dangerous voyages to reach new countries and set up enterprises (Bernstein, 1998). Broadly, risk appears defined in terms of estimating the likelihood of a phenomenon through benefits and/or costs. Wide-ranging events or actions are analysed from financial acquisitions to dangers that touch human lives (Van de Poel and Fahlquist, 2013). Given the definition, risk in psychiatry appears to have a narrow scope, focusing on intentional harm to self and others that can result from mental illness (Dixon, 2015). Risk is seen through some calculability, in that predictions can to an extent be made to ascertain the likelihood of a risk, and tend to involve suicide, self-harm, and violence (Gilbert *et al.* 2011). The purpose is to generate patient safety, alleviating risks detrimental for self or others via interventions informed by assessments (Gilbert *et al.* 2011).

Despite some helpful practices (Deering *et al.,* 2020), highlighted further in the paper, risk management in psychiatry has been criticised (Perkins and Repper, 2016). Concerns range from patients lacking involvement with risk assessment, that practices are paternalistic, and restrictive through interventions such as physical restraint and seclusion (Royal College of Psychiatrists (RCP), 2016). Emphasis on mental illness as the solitary cause for risks can be problematic, overlooking the social context of the patient. Risks like suicide may result from a breakdown of intimate relationships and loss of employment, while violence within inpatient settings may be in reaction to perceived oppressive practices, or difficulties with navigating frustrations due to ward environment (McKay *et al.* 2021). Underlying reasons for these practices are what the paper aims to address; exploring critical risk theories to build understanding about clinical risk concerns and their possible impact on patient care. Drawing on the analysis, recommendations for care and research will then be provided.

2. Critical risk theories.

Critical theories emerged in response to traditional ways to considering risk. Rather than focus on calculation and prediction, societal mechanisms are examined in how risks might be perceived and decided upon, as well the impact on people in their comprehension of each other (Lupton, 2013). The Risk Society will be the first theory discussed, addressing risk through a sense of foreboding in society. The theory can help to consider risk in terms of uncertainty, and proposed later in the paper, it may feature in clinical concerns when managing risk (Szmukler and Rose, 2013).

2.1 Risk Society.

The Risk Society explores why risk anxieties are so widespread. For its founder Ulrich Beck (1992), risks have impact on life owing to globalisation, portrayed as the current era of progressive interconnected global societies. It demonstrates a shift with considering risk, involving uncertainty from unexpected hazards that materialise from human progress. Notable is the Covid pandemic, and association with factory farming, transforming into adverse events, that yet, appeared invisible to the senses (Bowness *et al.* 2020). Risk can evoke something of a mystery owing to its ability to materialise far away despite having global ramifications. Expertise has also altered involving debates about the different causalities of risks (Beck, 1992). Through these circumstances, risk anxieties have intensified because human progress attributable to risks permeate most areas of life, from armaments to food production (Beck, 1992). This is while the ambiguity of risk is channelled through intricate pathways of global communication, like social media (Constantinou, 2021). Thus, the threats posed by risks can seem ubiquitous, yet indiscriminate as well.

Reflexivity is pivotal to the Risk Society, adopting amongst things, a mistrust towards scientific expertise blamed for the progresses that trigger risks (Beck, 1992). Mistrust also serves to propagate globalisation via the creation of international strategies to address risk related concerns (Lupton, 2013). Through worldwide conversations about the moral ills that proliferate global adversities, reflexivity cultivates citizens who substitute local affairs for the global stage. Hence risk is viewed as part of a larger picture in which diverse worldviews associated with globalisation contributes to thinking about how to live. This gives rise to further risks as more choices are navigated, while the autonomy to self-monitor and shape

life beyond local communities supersedes social connectivity (Farrugia, 2013). As a result, individuals feel they ought to take more control over their lives, despite life appearing less certain (Lupton, 2013).

2.2 Cultural Approach.

Cultural examinations involve how and why risk is contextualised around danger and a threat. Mary Douglas, a leading exponent of cultural approaches to risk, was interested in underlying meanings of human communication, in how it might symbolise risks by social groups (Benthall, 2018). Despite the dangers that many risks pose, it was of interest to Douglas in the way ideas about risk were politicised, and how some risks anxieties arose whereas others lay dormant (Douglas, 1997). Whilst the likelihood of the risk may correlate to anxieties about it, Douglas criticised this position for ignoring the nuances of culture in how risk formed within people's perceptions (Douglas, 1997). Such knowledge can be attributable about how historic ideas and beliefs permeates the significance of the risk, especially around risk objects, involving people seen with some capacity for harm to society (Douglas, 1997).

The metaphors of purity and contamination are pivotal in how risk was examined by Douglas. Likewise, to when maritime exploration was an opportunity to improve life, risk perceptions can be influenced in how they morally pollute the purity of customary thoughts within various times and places (Douglas, 1992). Society can create voids in what is perceived customary or not, to mitigate risks representing moral pollutions (Lupton, 2013). When this space is breached, it signifies a risk object owing to some moral infraction to society (Douglas, 1992). To minimise these risks, societies exact rules and pressures that fit customs to control moral infractions (Douglas, 1997). This is while risks with ambiguous properties, are categorised to reduce fears about uncertainty, and build moral barriers around them. However, when people do not succumb to societal customs it might result in blame given a lack of moral responsibility to society (Douglas, 1992).

Otherness according to Douglas (1992), is another facet of identifying people as risk objects, making distinctions between people professed safe and familiar against those seen different and dangerous. Otherness, or Othering, the shaping of the Other, explains the evolving language of risk about social groups and the extent they should be feared (Leistle, 2015). Risk anxieties derive from positions of power and surrounds the 'strangeness' that lies beyond

what is perceived customary, adding credence to what human behaviours act like moral pollutants (Douglas, 1992). Hence, risk gravitates toward a heightened vigilance about particular social groups owing to risk perceptions about them, while risk is constructed around infractions of moral rules and customs set by those in positions of authority (Douglas, 1992).

2.3 Governmentality.

Governmentality is a way to understand how power is distributed and subsumed by citizens, through techniques of instilling self-discipline and promoting normalisation (Foucault, 1990). Power involves languages that elicit human behaviours by evoking what is customary in consideration of what is said and what is not (Ewald, 1990). This includes shared ideas in how people govern themselves by internalising what might be expected from social order. Expert knowledge is also central to Governmentality, as Ewald (1990) proposed, risk expertise suggests proficiency in foreseeing future events and generating disciplinary methods to lessen uncertainty. Through this expertise, a varied network of institutions, knowledges, and practices embed how risk should be realised in society (Raffnsøe *et al.* 2019). This appears a means to grasp risk in terms of some inaction, resulting in a poor quality of life. In response to expertise, individuals engage in diverse self-regulation techniques to ensure some productivity in society, taking on social responsibilities like improving their own health (Rose 1998). However, the categorising of at-risk groups includes the degree people have strayed from fulfilling these 'national obligations.'

Focus on actual danger, according to Castel (1991) has shifted onto at-risk groups, to identify threats by pooling particular people together, irrespective of dangerous behaviour (Lupton, 2013). This involves anticipating and minimising risks to support normative behaviours, while risk assessments serve to transfigure the person into risk estimates and aggregate people together based on subversive social identities, like the 'mentally-ill' (Rose, 2000). The person may become lost through data about risks, to ensure submission to expertise and self-correct risk behaviours (Castel, 1991). When seen defiant, the person may face sanctions contingent on the subversive identity, for example detention in a psychiatric hospital (Rose, 2000). While risks are shaped into consciousness, they also inform practices to minimise risk. However, these operate to highlight risks further involving risk minimisation rather than necessarily tackle underlying causes, like social inequalities and suicide (O'Malley, 2008).

3. Risk concerns and mental health care.

Despite a rich variety of theoretical perspectives, several themes can be extracted from the theories, and their application to risk concerns, and patient care, will now be further explored. The specifics of these clinical concerns, in how they may impact on recovery and social inclusion will then be discussed, concluding with some direction for practice and research.

3.1 Uncertainty.

Traditionally, uncertainty and risk have been seen as distinct scientific concepts, in that risk must have calculable properties to ensure it can be measurable (Knight, 1921). Yet the theories highlighted that uncertainty can be a concern, involving difficulties with navigating the pervasive threat of risks in society. In psychiatry tendency exists to have reliance in the predictive power of assessment despite criticism that correlations to illness and risk, as well validity of actuarial factors - demographic details in what are indicative with risks - are no better than chance (Szmukler and Rose, 2013). As Castel (1991) argues, aggregating people together dependent on diagnosis might overlook the person, underexploring nuanced personal issues that increase risks. Amongst such decision making, the precautionary principle may enter the picture, whereby uncertainty could still be present if all precautions have been addressed (Green, 2006). In drawing on the work of Mary Douglas, precaution might involve mitigating blame, suggesting clinicians may lean towards risk aversion in some circumstances to tackle fears about culpability (Slemon *et al.* 2017).

To aid prediction, according to Rose (1998), led to risk categorised in terms of low, medium or high from the 1970s onwards. Initially conceived to lessen conflation of dangerousness, and hospital admissions, it may result in anxieties explored by the Risk Society, for seeing all patients as a risk raises fears about the omnipresent threat of adverse events (Markham, 2021; Rose, 2002). Douglas adds accusation of irresponsibility can occur when critical of the certainty of risk prediction tools, for they come with “a spurious claim to be scientific” (1992:14). Alternatively, practitioners might be on constant guard for inklings of risk, said to lessen trust within patient-clinician relationships, in part, owing to “the scale of professionals’ accountability for risk” (Langan, 2010:95). That is, adverse events like suicide can have a life-long impact on clinical reputation, or the way clinicians perceive their abilities to practice. As

such, the culture of blame with healthcare organisations is suggested to influence a mistrust of patient intentions, and may increase restrictive practices, particularly within the backdrop of uncertainty (Slemon *et al.* 2017).

3.2 Expertise about safety.

Given safety is somewhat defined in terms of alleviating intentional harm in mental health care, there is growing debate in who holds expertise in what safety entails (Slemon *et al.* 2017). As highlighted, the three critical theories suggest expertise has a place with understanding risk. Whilst the Risk Society proposes scientific expertise might be less adhered to, it nevertheless generates responses to tackle societal risk concerns (Beck, 1992). However, the other theories, particularly Governmentality, acknowledges that what a risk might mean, and its significances, is swayed by those with power to make such interpretations.

Although risk illiteracies associated with mental illness raises concerns if patients understand their own safety, this possible disorientation may fluctuate and likely varies person to person (Davies *et al.* 2006; Tenkin, 2014). It seems feasible therefore, that opportunities do exist to collaboratively discuss risk concerns and how patients might feel safe. This is important, for proposed by the Department of Health (DH) (2009) policy, patients require opportunity to discuss their sense of safety with risk management practices. Patients lacking a voice in how practices are devised can limit this sense of safety, while a perceived lack of tolerance to discuss risk, in that disagreements might increase risks like aggression, is a reason given why clinicians sometimes exclude patients (Nyman *et al.* 2020). However, it is shown that patients can view disagreements as a part of developing therapeutic relationships, not too dissimilar from other relationships people might have (Deering *et al.* 2020).

Despite Governmentality exploring power beyond coercive practices, it can investigate governance mechanisms that address dissenting approaches to citizenship. The inextricable link with minimising risks like violence to ideas about safety is implicated as such a governance technique, to tackle intentional harm to self and others seen to defy notions involving social responsibility (Gilbert *et al.* 2011). Risk management, it is suggested, symbolises practitioners adopting roles based on expertise involving safe ways to act in society (Dixon, 2015). Within this view, lies an assumed proficiency with safety and risk, a comprehension in light of

professional knowledge, that has authority over patient views (Miller and Rose, 2008). This expertise, it seems, rationalises the practitioner takes some control, so that patients engage in self-correcting behaviours to address risk concerns (Miller and Rose, 2008). Hence, resulting in safer behaviours, in terms of being more accepted within society. When this does not occur, risk concerns can be raised, leading perhaps to further paternalistic and restrictive practices (Tonkens, 2011).

Through Governmentality, it can somewhat be understood why patients might lack a voice in what safety entails. It may serve for expertise to be held by clinicians, to retain power about the knowledge of safety, and shape normative behaviours through practices seen less safe by patients, like seclusion and physical restraint (Dixon, 2015). Since responses to risk are in their subtexts with the theories, it is not necessarily the case people are mindful of their actions. Clinicians may feel a societal obligation to take part, although a moral distress might result via awareness that some risk management practices are distressing for patients (Slemon *et al.* 2017).

3.3 Othering.

How patients came to be viewed as risks are suggested by the theories to materialise from a rich tapestry of historic ideas about mental illness. It is recognised discrimination in society exists, and patients having risks to a degree appears to do little to challenge these views. Some authors propose it does, however, serve to 'other' patients in some form as the risks associated are seen to challenge traditions like not damaging one's own health in society (Walsh and Foster, 2020). An influential part of history involving this view it is said, involves degeneration in the 19th century, adopted to explain the mentally ill, via destitution, excessive alcohol use and violence to name a few (Pick, 1989).

Rather than considered via social inequalities, the aforementioned behaviours were seen dangerous by those in authority owing to the potential impact on social order (Pick, 1989). Degeneration appeared applied, according to Rose (1998), to explain these behaviours through some faulty hereditary, Othering the mentally ill (Hutchison, 2016). Although risks from the period can cause patient distress, what the points aim to highlight is that some of these risks are still assessed. This is while statistically risks like violence occur less with those with mental illness, instead, are more likely to be the victims of such crime (Varshney *et al.*

2016). Given the interpretations about the impact on social order, it is suggested alternately to empirical verification; addressing these risks is figurative in how practices have lineage to historic ideas. That is, patients are people on the outskirts of society, while risk management derives from historic concerns about correcting behaviours, to uphold customs and traditions in society (Chaney, 2011).

In thinking about the theories, Othering involves vast past and present data streams, like media reports on homicides, unproductivity via 'reliance' on the state, to clinical discussions about 'problem patients' when risks are difficult to navigate (Roberts and Schiavenato, 2017). A picture can be built around patients as risk objects, lessening emphasis on personal needs involving risks that vary person to person. Aggregating people together via risk assessments, is argued to further such Othering to highlight a population to be feared, strengthened by uncertainty that risk events may materialise at any moment. This might result in patients not seen as an equal, allowing moral boundaries to be built around them as to be kept at arms-length about conducting risk management practices (Felton *et al.* 2018). These boundaries arise, according to Douglas (1992) from risk concerns, and can be a means to limit some form of contamination. Given a possible mistrust of patient risk views, by limiting involvement, it seems, mitigates being tainted with blame should an adverse risk event occur.

In short, clinical risk concerns according to the theories, derive from an intricate web about ways to act in society, and to an extent rationalised when constituted through professional knowledge. This knowledge also appears to serve the justification for restrictive practices to limit risks. The patient voice can become lost given amongst things a general mistrust where risks are concerned. Hence to conclude, the paper will explore the impact a lack of voice may have on recovery and social inclusion, alongside recommend some direction for mental health care and research.

4. Impact on recovery and social inclusion.

Recovery and social inclusion bring about the view that a hopefulness can materialise from participatory practices building a sense of belonging in society (Stickley *et al.* 2018). For recovery and social inclusivity to flourish, a safe space is required to share views and exercise choices about ways patients wish to be treated (Stickley *et al.* 2018). However, as highlighted by the theories, it is difficult to see how clinical risk concerns with recovery and social inclusion

can be reconciled. Tensions can impact on hopefulness, through patients internalising the position of a risk object leading to withdrawing from significant others suggested to increase harms, notably suicide (Lyon and Mortimer-Jones, 2021). Instead, a purposefulness in life might result with feeling a place in society contributing to reasons to live (Joiner and Silva, 2012).

It also remains to be seen how a lack of participation aids patient awareness in what is expected of them. Risk management appears an elusive enterprise, and patients lacking involvement denies their voice in what are risks and the ways these can be navigated. Patient views can vary from clinical perspectives involving risks like iatrogenic effects of treatment, stigma, financial issues, and difficulties with personal relationships (RCP, 2016). These are not too dissimilar in what concerns most people yet can be less explored. There are suggestions that risks in psychiatry are responses to personal difficulties and when considering suicide, it can result from isolation and feeling a burden to others (Joiner and Silva, 2012). It seems reasonable therefore that promoting social inclusivity could be a way to tackle this risk (DH, 2009).

Giving a voice to patients raises opportunities for recovery and social inclusivity to feature with risk management (Perkins and Repper, 2016). Within this view, expert by experience appears significant in which patient beliefs and values inform ways to helpfully address risk. However, the societal apparatus of risk goes beyond mere mitigation of harm, involving fear of blame, alongside some duty to hold onto expertise. A clinical suspiciousness may arise that patients lack comprehension of risk, rather than have different views, while a lack of participation appears unsafe for patients leading to perhaps distrust about clinical intentions (Dixon, 2015).

5. Suggestions for practice and research.

Taking into consideration psychological safety, it could expand interpretations of safety enabling people to thrive through the security of human relationships. Cultivating social connectivity is already part of some practices, and by strengthening relationships with significant others, is shown to diminish risks like suicide (Joiner and Silva, 2012). Thinking about this method, provides opportunity to consider recovery and social inclusivity through a

relational approach to risk management (Perkins and Repper, 2016). A fertile ground could be generated to build trust alongside openness involving varying views about risk. Honesty is significant to build trust, while might involve some reciprocity, in that the clinician shares willingness to listen, and such genuineness is reciprocated by the patient speaking openly about their risk interpretations (Sandhu *et al.* 2015).

Collaboratively working with patient views may also raise a sense of worth, in that the individual internalises the respect provided improving the way they might value themselves (Sandhu *et al.* 2015). Exploring risk in this manner, seeking collaborative means to navigate risk, may bring about some sense-making, in how risk management could align to personal interpretations of recovery and social inclusion. However, given clinical fears about blame, support is required to expand how risk might be addressed. Clinical supervision could assist, a practice which supports practitioners and helps to improve care. By facilitating catharsis in supervision, it may lessen the emotional burden associated with blame, and aid exploring relational approaches to risk management that otherwise could be obstructed by the practitioner's risk anxieties (Rimondini *et al.* 2019).

When reflecting on risk management research, clinical views tend to be gathered (Vandewalle *et al.* 2018). Whilst helpful to understand why practices occur and the support needs of clinicians, patients require involvement given the significance of expert by experience. For the utility to understand recovery and social inclusion, perspectives are sought through patient experiences, because in terms of practice, recovery and social inclusivity are experienced by patients, while clinical views may be eclipsed with concerns about mitigating risks and blame. Hence recommendation is for a shift towards patient expertise to understand how recovery and social inclusion might coexist with risk management, be it even hypothetically, to spark ideas to improve its practices.

Conclusion.

An outline of critical risk theories was provided, highlighting aspects of a societal apparatus that influences normative behaviours, while risk appears in some sense not adhering to these norms. Underlying reasons for some clinical risk concerns and resulting practices were explored to understand the impact on patient care. These involved difficulties with

uncertainty, holding expertise, and Othering patients through risk. Patients lacking a voice was also investigated involving recovery and social inclusivity, noting risk management could be counterintuitive, with patients perhaps feeling less part of society. Ways forward were also highlighted, expanding the interpretation of safety via secure social connections, while recommendation for research surrounded developing understanding of patient views. Given patients are impacted by clinical risk concerns, and also have expertise about their care, it is feasible that rich ideas will emerge from patient involvement, surrounding how risk management might align with their interpretations of recovery and social inclusivity.

References

Beck, U. (1992). *Risk society: towards a new modernity.* London: Sage Publications.

Benthall, J. (2018), “Mary Douglas and the diversity of purity frameworks”, *Anthropology Today,* 34(2) pp. 27-28.

Bernstein, P.L. (1998). *Against the gods: the remarkable story of risk.* London: Wiley.

Bowness, E., James, D., Desmarais, A.A., McIntyre, A., Robin, T., Dring, C. and Wittman, H. (2020), "Risk and responsibility in the corporate food regime: research pathways beyond the COVID-19 crisis", *Studies in political economy,* Vol. 101 No.3, pp. 245-263.

Castel, R. (1991). *From dangerousness to risk,* In Burchell, G., Gordon, C. and Miller, P. (Eds), The Foucault effect: Studies in governmentality. Chicago: University of Chicago Press.

Chaney, S. (2011), "Self-control, Selfishness and Mutilation: How ‘Medical’ is Self-Injury Anyway?", *Medical history*, vol. 55 No. 3, pp. 375-382.

Constantinou, C. S. (2021), “People Have to Comply with the Measures”: Covid-19 in “Risk Society”, *Journal of applied social science,* Vol. 15 No. 1, pp. 3-11.

Davies, J. P., Heyman, B., Godin, P. M., Shaw, M. P. and Reynolds, L. (2006), “The problems of offenders with mental disorders: A plurality of perspectives within a single mental health care organisation”, *Social Science and Medicine*, Vol. 63 No. 4, pp. 1097–1108.

Deering, K., Pawson, C., Summers, N. and Williams, J. (2019), "Patient perspectives of helpful risk management practices within mental health services. A mixed studies systematic review of primary research", *Journal of psychiatric and mental health nursing,* Vol.26 No. 5-6, pp. 185-197.

Department of Health. (2009). *Best Practice in Managing Risk*, Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/478595/best-practice-managing-risk-cover-webtagged.pdf.

Dixon, J. (2015). *Balancing risk and recovery in mental health,* In Chamberlain, J. M. (Ed) Risk, Discourse and Power. London: Routledge Ltd.

Douglas, M. (1992). *Risk and Blame: Essays in Cultural Theory.* New York: Routledge.

Douglas, M. (1997) *The Depoliticization of Risk,* In Ellis, R.J. and Thompson, M. (Eds), Culture Matters: Essays in Honor of Aaron Wildavsky. London: Routledge.

Ewald, F. (1990), Norms, Discipline, and the Law. *Representations*, 30, pp. 138-161.

Farrugia, D. (2013), The reflexive subject: Towards a theory of reflexivity as practical intelligibility. *Current Sociology,* Vol. 61 No.3 pp. 283-300.

Felton, A., Repper, J. and Avis, M. (2018) “The Construction of people with mental health problems as risk objects: findings of a case study inquiry*”, Journal of psychiatric and mental health nursing,* Vol. 25 No. 9-10, pp. 558 – 568.

Foucault, M. (1990). *The history of sexuality, vol. 3, The care of the self.* London: Penguin.

Gilbert, E., Adams, A. and Buckingham, C.D. (2011), “Examining the relationship between risk assessment and risk management in mental health”, *Journal of Psychiatric and Mental Health Nursing,* Vol. 18 No.10, pp. 862-868.

Green, J. (2006) "Avoiding a spiral of precaution in mental healthcare", Advances in psychiatric treatment: the Royal College of Psychiatrists' journal of continuing professional development, Vol.12 No.1, pp. 1-4.

Hutchison, S. (2016), "Degeneration Theory at the Fin de Siècle", *English literature in transition, 1880-1920*, Vol. 59 No.3, pp. 396-399.

Joiner, T. E. and Silva, C. (2012) *Why people die by suicide: Further development and tests of the interpersonal-psychological theory of suicidal behaviour.* In Mikulincer, M. and Shaver, P. R. (Eds), Meaning, mortality, and choice: the social psychology of existential concerns. Washington: American Psychological Association.

Knight, F. H. (1921). *Risk, uncertainty and profit.* Boston: Houghton Mifflin.

Langan, J. (2010), "Challenging assumptions about risk factors and the role of screening for violence risk in the field of mental health", *Health, Risk and Society,* Vol. 12 No. 2, pp. 85-100.

Leistle, B. (2015), Otherness as a paradigm in anthropology, *Semiotica,* Vol. 2015 No.204, pp. 291-313.

Lupton, D. (2013). *Risk Second edition.* London: Routledge Ltd.

Lyon, A. S. and Mortimer-Jones, S. M. (2021), "The Relationship between Terminology Preferences, Empowerment and Internalised Stigma in Mental Health", *Issues in mental health nursing,* Vol. 42 No. 2, pp. 183-195.

Markham, S. (2021), "The omnipresence of risk and associated harms in secure and forensic mental health services in England and Wales", *Social Theory and Health,* Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8207492/.

McKay, K., Ariss, J. and Rudnick, A. (2021), "RAISe-ing awareness: Person-centred care in coercive mental health care environments—A scoping review and framework development", *Journal of psychiatric and mental health nursing,* Vol.28 No.2, pp. 251-260.

Miller, P. and Rose, N. (2008) *Governing the Present: Administering economic, social and personal life*. Cambridge: Polity Press.

Nyman, M., Hofvander, B., Nilsson, T. and Wijk, H. (2020), "Mental Health Nurses' Experiences of Risk Assessments for Care Planning in Forensic Psychiatry", *International journal of forensic mental health,* Vol.19 No.2, pp. 103-113.

O'Malley, P. (2008). *Governmentality and Risk*, In Zinn, J. O. (Ed) Social Theories of Risk and Uncertainty. London: Blackwell Publishing.

Perkins, R. and Repper, J. (2016) "Recovery versus risk? From managing risk to the co-production of safety and opportunity". *Mental health and social inclusion,* Vol. 20 No. 2, pp.101 – 109.

Pick, D. (1989). *Faces of degeneration: a European disorder c.1848-c.1918*. Cambridge: Cambridge University Press.

Raffnsøe, S., Mennicken, A. and Miller, P. (2019), "The Foucault Effect in Organization Studies", *Organization Studies,* Vol. 40 No.2, pp. 155-182.

Rimondini, M., Busch, I.M., Mazzi, M.A., Donisi, V., Poli, A., Bovolenta, E. and Moretti, F. (2019), "Patient empowerment in risk management: a mixed-method study to explore mental health professionals' perspective", *BMC health services research*, Vol. 19 No. 1, pp. 382-382.

Roberts, M.L.A. and Schiavenato, M. (2017), "Othering in the nursing context: A concept analysis", *Nursing open,* Vol. 4 No. 3, pp. 174-181.

Rose, N. (1998). *Inventing ourselves: psychology, power, and personhood.* Cambridge: Cambridge University Press.

Rose, N. (2000), "Government and Control", *The British Journal of Criminology,* Vol.40 No.2, pp. 321–339.

Rose, N. (2002). *At risk of madness.* In Baker, T and Simon, J. (Eds), Embracing Risk. Chicago: University of Chicago Press. pp. 209-237.

Royal College of Psychiatrists. (2016). *Assessment and management of risk to others.* Available at: https://www.rcpsych.ac.uk/docs/default-source/ members /supporting-you/managing-and-assessingrisk/assessmentandmanagementrisktoothers.pdf?sfvrsn=a614e4f9_2.

Sandhu, S., Arcidiacono, E., Aguglia, E. and Priebe, S. (2015), "Reciprocity in therapeutic relationships: A conceptual review*", International journal of mental health nursing,* Vol. 24 No.6, pp. 460-470.

Slemon, A., Jenkins, E. & Bungay, V. (2017), "Safety in psychiatric inpatient care: The impact of risk management culture on mental health nursing practice", *Nursing inquiry*, Vol. 24 No.4, pp. 1-10.

Stickley, T., Wright, N. and Slade, M. (2018), "The art of recovery: outcomes from participatory arts activities for people using mental health services", *Journal of mental health,* Vol.27 No.4, pp. 367-373.

Szmukler, G. and Rose, N. (2013), "Risk Assessment in Mental Health Care: Values and Costs", *Behavioral Sciences and the Law*, Vol. 31 No. 1, pp. 125-140.

Tekin, Ş. (2014), Self-insight in the time of mood disorders: After the diagnosis, beyond the treatment. *Philosophy, Psychiatry and Psychology,* Vol. 21 No. 2, pp.139–155.

Tonkens, E. (2011). *The embrace of responsibility*, in Newman, J. and Tonkens, E. (Eds), Participation, Responsibility and Choice: Summoning the active citizen in Western European welfare states. Amsterdam: Amsterdam University Press.

Van de Poel, I and Fahlquist, N. J. (2013). *Risk and Responsibility,* In Roeser, S. (Ed), Essentials of risk theory. Dordrecht: Springer.

Vandewalle, J., Malfait, S., Eeckloo, K., Colman, R., Beeckman, D., Verhaeghe, S. and Van Hecke, A. (2018) "Patient safety on psychiatric wards: A cross-sectional, multilevel study of factors influencing nurses' willingness to share power and responsibility with patients", *International journal of mental health nursing, V*ol. 27 No. 2, pp. 877-890.

Varshney, M., Mahapatra, A., Krishnan, V., Gupta, R., and Deb, K.S. (2016) Violence and mental illness: what is the true story? *Journal of Epidemiology and Community Health,* Vol. 70 No.3, pp. 223-225.

Walsh, D. and Foster, J. (2020), "A Contagious Other? Exploring the Public's Appraisals of Contact with 'Mental Illness'", *International journal of environmental research and public health*, Vol. 17 No. 6, pp. 1-18.