Introduction

Suspicion and exasperation, unless they are restrained by reason and charity, possess the sad virtue of causing the unfortunate to be seized as criminals, upon the vainest pretext or the most rash assertion.

Alessandro Manzoni, *The Column of Infamy*, 1840

The search for a scapegoat is the easiest of all hunting expeditions.

Dwight D. Eisenhower, 1952

One of the largest cruise ships ever built sinks near the coast after hitting some underwater rocks. Several people die in the accident. Who is to blame? When coping with negative events, organizations can choose between two strategies: they can either take responsibility and implement (expensive) remedial actions or blame those who were directly involved in the fact – the scapegoats.

Organizations and institutions must learn from failures if they want to avoid repeating them. However, one of the main limits to organizational and institutional learning is addressing systemic problems of an organizational nature with solutions targeting the individual. This approach favors inertia and the creation of "organizational scapegoats". Pursuing scapegoats without changing the system only ensures that the actors will continue to behave as they did before, and no virtuous learning from the events that have occurred will take place in the organization.

The purpose of this book is to systematically understand how and why organizations create scapegoats. In doing so, the book outlines a general theory of scapegoating in organizations.

The term *scapegoat* means, in the ideal-typical formulation, a sort of sacrificial victim, an animate being (man or animal), or even an inanimate object, to which the evils and faults of the community are attributed – evils and faults which the community, through this process of transfer, is able to rid itself of. Another use of the term refers

to situations in which an innocent person is punished for wrongful or guilty actions committed by someone else. In this book I will consider a third, widespread type: the scapegoat in organizations. It is a tool of organizational rationality to divert all the blame toward a single individual, or a small group of individuals, who were involved in the event. I define the organizational scapegoat as the subject who pays for faults that *also* pertain to others. The scapegoat in organizations is not, therefore, a complete innocent who must take the blame for others – something that would be neither credible nor possible. The organizational scapegoat bears responsibility for the disputed event, but this responsibility is exaggerated by the accusers, who underestimate the context in which the event took place and the role and actions of other agents. In some cases the scapegoat, for convenience's sake, consents to assume this role; in others, this consent is not given.

The concept of scapegoat encompasses both a static (the type) and a dynamic dimension (the construction process). In this book, after analyzing the different forms and types of scapegoats, particular attention will be paid to the dynamic dimension: namely, we will focus on scapegoating, and will analyze the reasons and interests that lead groups of agents (the *blamemongers*) to construct the scapegoat. Methodologically, I argue that the definition of scapegoating is inseparable from its explanation. The fabrication of an organizational scapegoat has a characteristic development process. Typically, the initial stage begins with the manifestation of a negative event (e.g., a crisis, bankruptcy, accident, scandal); next, the organization faces the risk of legal sanctions and severe costs; and finally, there is a stage characterized by the identification of one or more people as scapegoats. This latter move leads to an outcome for the organization, which is generally a positive one, such as avoiding or reducing sanctions, costs, stigma and negative social evaluations.

The organizational scapegoat emerges in particular when organizations undergo a crisis. Corporate scandals, accidents and, more generally, organizational failures, undermine the image and reputation of organizations, generating organizational stigma, legal risks and economic consequences, in addition to the damage caused by the event. Faced with situations of this type, organizations can adopt two strategies to manage or divert guilt, in the sense of responsibility for an act that is viewed negatively. The first is to admit responsibility for the event and its consequences and implement measures for

improvement and change: an organizational and institutional learning strategy. The second is to try to transfer responsibility to people immediately involved in the event – the *bad apples*. This can involve accusing the latter of negligence in the case of an accident, or of being *rogue employees* in the case of misconduct. This second strategy produces organizational inertia because by creating a scapegoat, the organization, and the ruling coalition in particular, will be safe: above all, they will not have to implement potentially costly remedial measures. Exemplary punishment of the scapegoat seems to be the solution identified by an organization to overcome a state of crisis. Blaming someone for what happened, or is happening, produces the feeling that the problem that caused the crisis has been solved.

The book focuses on scapegoating in organizations – the second strategy – but it also discusses the first strategy and its consequences for learning in Chapter 6. Scapegoating will be analyzed by examining a set of situations that favor this phenomenon (crises, scandals, accidents, and other types of organizational failures) and employing a perspective that considers the scapegoat as the outcome of a construction process by multiple agents, both internal and external to an organization. The indictment of individuals and their transformation into scapegoats becomes a useful expedient for delaying or avoiding structural changes, since public opinion is led to think that exemplary punishment of the person responsible for the error can serve as a deterrent in the future.

In the event of disasters characterized by the accidental or violent death of a large number of people, the creation of a political or social scapegoat seems inevitable: someone must be blamed. In such situations, the myth of the failure of the individual operator is particularly useful to deflect attention and blame from the leadership of the organization. It becomes relevant, therefore, to analyze the phenomenon of *blamestorming*,[1] which is the process aimed at investigating the reasons behind a failure and the allocation of blame. The problem of allocating blame is increasingly complex in contemporary societies – something that, according to Dingwall and Hillier (2016), could be a sign of a low level of social cohesion. The distribution of blame after negative events and organizational failures depends on the type

[1] The term *blamestorming* first appeared in the magazine *Wired* in 1997.

of interpretative frame: a different frame analysis produces a different candidate. Identifying a culprit in some way, a scapegoat, produces a sense of relief, a kind of catharsis that can help overcome the tragedy of the event (Douglas 1992).

While there are quite a number of anthropological and philosophical works on the subject of the scapegoat, there are few studies and little research on organizational sociology. The latter include the work of Bonazzi (1983a, 1983b), who was the first to tackle the issue from this perspective, followed by other scholars, including Boeker (1992) and Gangloff, Connelly and Shook (2016). Similarly, there is no great number of management studies concerned with analyzing processes aimed at transferring stigma to specific people to avoid damage to the organization's image (Warren 2007). Finally, research that analyzes the processes of collective, organizational, and inter-organizational construction of the scapegoat is even less common. This work intends, at least partly, to fill this gap.

The Theme and the Architecture of this Book

Two main questions drive the chapters in this book: Why and how do organizations create scapegoats? and, What are the limits of a purely individual response to systemic and organizational problems?

The first two chapters (1 and 2) concern the conceptual construction of the scapegoat in organizations as an instrument of organizational rationality, with the application of this construct to a few cases, and in particular to the *Costa Concordia* accident (Chapter 3). The two following chapters (4 and 5) deal with the problem of defining blame in organizations, and its sometimes perverse effects and related dilemmas (punishment/inertia vs learning/change). The concluding chapter (6) highlights the limits of dealing with collective problems through individual solutions and underlines the need for a different "civic epistemology" (Jasanoff 2005a) to account for organizational failures.

In more detail, Chapter 1 introduces the three different forms and types of use of the scapegoat concept: the archetypal figure/sacrificial victim; the innocent scapegoat; the organizational scapegoat.

Chapter 2 offers a detailed analysis of the characteristics of the scapegoat in organizations. In such contexts, it would not be credible for the scapegoats to be extraneous to the event that they are blamed for. It is therefore an individual, or a group of individuals, in some

way involved in the event, who is blamed. They are an instrument of organizational rationality, strategically deployed by the organization to minimize legal consequences and economic damage. However, blaming a scapegoat also benefits the leaders of the organization because their personal reputation can be damaged by their association with a guilty organization.

The chapter presents some situations that can favor the creation of scapegoats: accidents, business scandals, organizational failures, crises, and policy fiascos. These events, particularly if amplified by the media, tend to generate scapegoats with the greatest frequency.

Chapter 3 is dedicated to the reconstruction of the case of the *Costa Concordia* accident, which occurred on January 13, 2012, off the west coast of Italy, near the island of Giglio, and presents an analysis of the scapegoating process that involved the ship's captain. Sailing very close to the coast, the *Costa Concordia* foundered on a rock. The impact tore open a gash in the ship, allowing in water which put the engines out of action. After traveling a short distance, the ship ran aground near the island, listing over onto its side. Out of over four thousand people on board, thirty-two died. The dominant view of this case from the judiciary, the media, and public opinion, was that the ship's captain was the main and, in fact, almost the only, figure responsible for the accident and for the inadequate management of the emergency. This book challenges the conventional interpretation of the accident, providing a revised history of the event and at the same time putting forward a different explanation.

The dominant reconstruction presents three limitations. First of all, the absence of an organizational perspective leads the event to be considered as an isolated accident, rather than the unexpected but predictable outcome of a risky practice such as that of the sail-by salute. It is as if the event came as a bolt from the blue, precipitated by the sudden madness of the captain: the same captain whose name had appeared in a commendatory post on the company's website on the very day of the event. It was, instead, not a matter simply of individual mistakes and failures, but rather a "predictable surprise", a heralded disaster with a long period of incubation. Events were, at the same time, favored by organizational criticalities and by the underestimation of the risks by controllers and regulators.

The second limitation of the dominant reconstruction consists in the prevalence of a conception based on the "short history" rather than

on the "long history". The decision-making process in the three hours that preceded the disaster had a long incubation period, and needs to be looked at. It involves a "long history" that includes the progressive neutralization of several danger signals, such as the passage of a ship almost 300 meters long just a few dozen meters from the coast. These signals were seen as something to be rewarded and commended rather than as dangerous near misses. According to the various investigations (judicial, administrative, technical), however, as well as to expert reports, it seems that everything started at 18:27, just under three hours before the disaster, with the departure of the cruise ship from its last port of call.

Finally, the third limitation consists in the scapegoating of the captain of the ship by various collective agents. Certainly, the captain played a role, and an important one, in the accident, but the faults of others were also imposed upon him. During the emergency phase following the impact with the rock, mistakes were made and behavior inappropriate to the situation was displayed by the entire crew on the bridge. The organization was also responsible, for example, with regard to the selection and training of operators and to the provision of appropriate technology. For various organizational agents, a simplistic reading of the event irremediably stamped the captain with a stigma of immorality and made it possible to read the history of the accident in this light.

The morally negative portrait of the captain was instrumental in terms of increasing the credibility of accusations against him of disaster. Indeed, socially stigmatized people, as is known, are those most likely to become the scapegoats for a more widespread responsibility (Bartollas, Miller and Dinitz 1974). Processes of blame in organizations tend to redefine complex problems of a sociotechnical nature in terms of individual morality – thus, judgment regarding facts is replaced with judgment regarding people.

Chapter 4 illustrates some typical steps in the process of identifying organizational scapegoats and discusses the complex relationship between individual and organizational contribution in the etiology of critical events and organizational failures. In part, this involves the analysis of two emblematic cases: the torture of detainees that took place at Abu Ghraib prison and the scandal known as "Dieselgate". These two cases show that scapegoating is an organizational strategy that can be implemented by both private, for-profit organizations as

well as non-profit, governmental ones. These strategies can be used to cope with different crises ranging from (involuntary) incidents to (deliberate) violations of laws and moral norms.

Chapter 5 compares two different investigative logics that follow on from organizational failures: the accusatory approach, based on the person, and the system approach, aimed at organizational learning. It concludes by illustrating possible undesired effects of the accusatory approach through discussion of the widespread practice of defensive medicine.

To conclude, Chapter 6 discusses the limits of a purely accusatory approach in dealing with complex events such as the various types of organizational failure (except, of course, in cases of malicious intent and gross negligence) and its contribution, even if involuntary, to scapegoating. The accusatory approach renders organizational and institutional learning processes problematic, putting an end to complex events with the mere sanctioning of "bad apples".

To sum up, then, the book proposes a theoretical and methodological frame for the analysis of intra- and inter-organizational scapegoating, integrating the micro (individual) level with the meso (organizational) and macro (organizational field) levels. At the same time, the limits of a purely punitive approach are discussed (except, it is worth repeating, in cases of malicious intent and gross negligence) and the need to find alternatives to criminal investigation (alone) in order to explain, and find solutions to, complex social problems in organizations.

This book is part of a research path that I embarked upon toward the end of the 1980s, dedicated to the study of accidents and failures in organizations beyond the perspective of human error or technological failure (Catino 2003, 2005, 2006a, 2010a, 2010b). Parallel to the study of the factors explaining the organizational etiology of such events, I began to conduct research into post-accident consequences, in particular investigatory logics, the perverse effects of the blame culture, and the problems of organizational learning (Catino 2006b, 2008, 2009a, 2009b, 2011; Catino and Patriotta 2013). Scapegoating seemed to me a decisive subject to move forward within this interpretative framework.