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Abstract

The purpose of this article is to review the concept of emotional labour both from a theoretical perspective and as a conceptual device for examining the role of emotions in nursing and healthcare. The authors explore a range of perspectives on the concept of emotional labour, each of which identifies different aspects that influence the extent to which emotions are permitted, encouraged or deemed appropriate to be expressed in healthcare settings. They also look at the theoretical links between the emotional labour literature and the workplace bullying literature with specific reference to the emotional health and wellbeing of staff and service users, and to the quality of the care being provided, and discuss the role of effective leadership, team working and the management of change in creating a workplace culture which facilitates effective management of emotions and at the same time promotes high standards of quality care.

Key words: emotional labour; workplace bullying; communities of coping; care; nursing

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1 Current debates about the concept of emotional labour

Hochschild (1983) documented the institutionalisation of emotion, defining emotional labour as the induction or suppression of feeling in order to sustain an outward appearance that presents a socially desirable performance. The self-management of emotions in this way, just like physical labour, involves effort and hard work on the part of employees. She describes jobs with high emotional labour components as sharing three characteristics:

- Face to face or voice contact with the public;
- They require the worker to produce an emotional state in another e.g. gratitude, fear;
- They allow the employer through training and supervision to exercise a degree of control over the emotional activities of their employees.

Hochschild suggests there are two kinds of emotional labour achieved through surface and deep acting. In surface acting we consciously change our outer appearance in order to make our inner feelings correspond to how we appear. Deep acting requires us to change our inner feelings by a variety of methods so that they become our authentic feelings which we freely present to the outside world. In surface acting we may experience feelings of dissonance but this is not the case with deep acting because of the degree of authenticity achieved. A critical issue concerns the extent to which professionals should be trained to manage negative feelings in ways that lead to good quality of care while at the same time preserving the authenticity of their experience.

Since the publication of Hochschild's classic work, researchers in this field have tended to focus on the three main aspects highlighted above: i) the requirement of employees to have contact with people through face-to-face or voice-to-voice interaction; ii) the organisation's requirement that employees produce an emotional state in another person while at the same time managing their own feelings (for example, flight attendants ensuring that passengers feel cared for or debt-collectors inducing fear in those who owe the company money) iii) the organisation's pressure on employees to conform to its culture.

In response to this growing body of research, Bolton (2000; 2003) and Bolton and Boyd (2003) challenged Hochschild's original conceptualisation and expanded it by shifting the emphasis from *work environment* to *operating states*

within the work environment. They proposed that there are four different kinds of emotional labour in the workplace (Bolton and Boyd, 2003, p. 19): *presentational* (where emotions are managed according to social rules); *philanthropic* (where emotion management is offered as a gift); *prescriptive* (where emotions are managed in line with organisational or professional codes of conduct); *pecuniary* (where emotions are managed for commercial gain). The *presentational* and *philanthropic* states tended to lead to positive views of emotional labour, while the *pecuniary* state led to a negative view of emotional labour. The *prescriptive* state, arising from professional or organisational feeling rules, created both positive and negative outcomes. Within this framework, Bolton and Boyd (2003) propose that there are multi-situated systems of activity involved in the performance of emotional labour, including the degree of effort made by individuals in conforming to organisational emotion rules as well as individuals' resistance to demands for emotion management. In other words, the context influences the range of feeling rules that exist in the workplace and it may not always be the organisation that defines the emotional agenda. This idea represents a substantial departure from Hochschild's original theory.

With specific regard to healthcare settings, Bolton (2000, p. 501) argues that "the introduction of a market rationality into the management of the British NHS has led to the term 'emotional labour' being used as part of a 'business model' of healthcare where a nurse's caring skills are utilised as a resource", indicating the 'commodification of emotional labour' (Hochschild, 1983). However, Bolton extends Hochschild's (1983) concept of 'gift exchange' to show how the actors – in this case gynaecology nurses – engage in varying degrees of emotion work and therefore can *choose* what, when, where, how much and to whom they offer the gift of emotion. The nurses described how the therapeutic use of humour gave patients the opportunity to have a laugh in an 'emotionful place' that was a 'woman's world'. A ward sister confirmed: 'The essential basis of nursing is caring. You can't be a nurse if you don't care' (Bolton, 2000, p. 583). These extracts demonstrate the interaction between different levels of emotion management: as individuals these nurses were prepared to give patients extra time if they required it but at the same time worked hard to enact professional feeling rules to present the image of a professional carer.

Theodosius (2006; 2008), from a different theoretical perspective, claims that the concept of emotion management, although innovative in its time, ignored the unconscious processes taking place during patient-nurse interaction. She argues that working with emotions is integral to the way in which nurses construct their personal identity and proposes that unconscious process may underlie their decision to become nurses in the first place (Theodosius, 2006, p. 899). Theodosius's (2006) methodology attempted to recover these unconscious emotions from patients, nurses and other health care professionals by using diaries, interviews and participant observation. Theodosius was concerned that the early emotional labour research of nursing

(James, 1992; Smith, 1992), rather than exposing emotion work and making it visible, had marginalised it and driven it underground.

Theodosius (2008) extended the analysis of emotional labour to examine the nature of emotions that nurses feel and how they form a part of their social identity which goes beyond the presentational symbolic forms expressed through the emotion management framework first inspired by Hochschild (1983). She also suggests ways that nurses can be supported to learn to incorporate and manage complex, messy emotions as part of who they are in terms of both their personal and professional self through reflexive 'inner dialogue' to develop these theoretical perspectives. Theodosius demonstrates her approach through a series of powerful vignettes from which she concludes that 'therapeutic' emotional labour (which she distinguishes from 'instrumental' emotional labour) 'is still an important component to nursing care, that is still central to the nursing identity and that society in the form of those nurses care for – still needs and believes in it' (Theodosius 2008, p. 172). In the vignettes Theodosius describes complex and challenging situations where nurses are working at the extremes: from loving care to complaints; from trust and reciprocity with patients to feeling to be working at 'half measures' and being bullied by colleagues. Theodosius' in depth analysis can best be appreciated in reading it in its entirety but in summing up she highlights the essential nature of two way relationships between nurses, patients and their carers which contribute to the emotional labour process.

2 Organisational perspectives

However important it is to consider the interpersonal nature of the relationships in such healthcare contexts, no analysis would be complete without considering the organisation as a whole. Hochschild (1983) referred to this as 'collective emotional labour'. With regard to the management of emotions in the organisation, some emotional display rules are explicitly taught to employees through induction, training and supervision. Others, however, are implicitly learned through a process of observation of organisational rituals and processes. Where the situation is ambiguous, employees make their own judgements of what is allowed with the result that some rules are adopted while others are ignored. Korczynski (2003) develops Hochschild's concept of 'collective emotional labour' by investigating the phenomenon of informal communities of coping that workers form themselves in order to deal with the daily emotional pressures or even abuse that they experience from their customers or service users. Here Korczynski moves away from Hochschild's focus on the harm of emotional labour on workers in order to demonstrate how the communities of coping not only offer peer support but can also act as forms of resistance. The call centre workers in Korczynski's study dealt with abusive interactions from customers by turning to colleagues rather than supervisors for emotional support. In some instances, the communities of coping developed into informal systems for employees to share extremely negative emotions about the customers whom they served. In this way the informal communities of coping ran counter to

management policy since the organisation preferred workers not to vent their anger with peers but instead only to share positive feelings about customers with colleagues. Additionally, the communities of coping could facilitate collective resistance to some company proposals, for example, the introduction of performance-related pay. Trade unions, understandably, were likely to view such communal ways of coping with the pain of emotional labour as a potentially political basis for addressing the service user/manager/employee relationships.

Glaso et al. (2006, p. 257) take these ideas further by using the concept of emotional labour to study leader-subordinate relationships in organisations, proposing that the purpose of emotional labour is to influence other people's perceptions, emotions, attitudes and behaviour, and that displayed emotions are a tool for creating a mood, emotional reaction or experience in others. This can be used in both positive and negative ways depending on the intended outcome. For example, angry emotions can be directed towards an individual or a group by management or by the peer group (Bowie, 2000). Again, the use of emotional labour will be different if the commodification of labour takes place in an unequal relationship between employee and customer or service-user (Korczynski, 2002). Additionally, the climate of the organisation can have a strong influence on the ways in which emotions are expressed (Cowie et al, 2002).

From a similar perspective, Townsend (2008) argues that we need to take account of three sets of pressures on employees: management expectations, peers and the workers themselves. Managers and supervisors attempt to induce their subordinates to conform to the organisational culture and to follow certain rules. At the same time, co-workers who fit the organisational culture will also put pressure on employees to behave in particular ways and will engage in emotional labour to achieve this. Finally, employees will put pressure on themselves to behave in ways that management deems to be appropriate in order not to be perceived as outsiders. Each of these three sets of pressure involves emotional labour on a daily basis, with costs and benefits in varying degrees. Many employees, particularly those who have embraced the organisation values and culture, find benefit in their emotional labour. Those who do not fit for whatever reason, however, will experience costs, as we indicate in the next section where we explore the consequences of inappropriate emotional expression in healthcare contexts.

3. Negative consequences of inappropriate emotional expression in healthcare settings

In health and social care settings, the negative consequences of inappropriate emotional expression – whether towards staff or service users – can have a serious impact on the quality of care. In a care home or hospital, if inappropriate emotions have become the norm, nurses are likely to be less able to give of themselves emotionally to the people in their care, as Smith et al (2006) found in

their study of international nurses. The service users in turn will be more likely to experience parallel emotions such as fear, anxiety and helplessness, as Allan, Cowie, and Smith (2009, in press) observed in their study of the emotional responses of international nurses who had been socially excluded or marginalized by their colleagues, their supervisors and by the organization itself. These nurses found that not only were they bullied by supervisors but they received very little support from colleagues who chose instead to act as if nothing untoward were happening. Such bystander apathy simply added an extra dimension to the emotional suffering of the international nurses in this study. The nurses were often forced to seek out communities of support outside the workplace, for example in their local church. The findings are confirmed in the literature on workplace bullying (e.g. Einarsen, 2004; Zapf, 1999) by Mayhew (2002, p. 22) which documents a range of reasons why employees may choose not to report verbal abuse, for example through embarrassment or because of pressure from the organizational culture. Hochschild (1983) also writes of emotional numbness and alienation from the self when employees face constant verbal abuse.

Recent studies of violence in the United Kingdom (UK) National Health Service (NHS) have found significant levels of colleague on colleague bullying (e.g. Quine, 1999) but also of aggression on the part of patients towards healthcare professionals. The latest report on staff in the UK NHS by the Healthcare Commission (Healthcare Commission, 2008) found that 23% of NHS staff reported being bullied by patients, 18% by patients' relatives, 8% by managers and 13% by colleagues. Paradoxically, although the majority of staff knew how to report such episodes, a substantial minority never did so. This finding confirmed Einarsen's (2004) proposal that the culture of the workplace acts as a form of filter through which a range of behaviours come to be accepted or even tolerated, despite the fact that most employees experience a high degree of role conflict when they observe aggressive behaviour and report a poor quality of environment in these circumstances.

In the specific context of care for older people who are particularly vulnerable, the consequences of inappropriate emotional expression can be extreme, since many people become desensitised to others' suffering the longer they are exposed to situations where intervention does not take place. An example of the complex interplay of emotions in such contexts is described by Evers and Adams (2008) in their study of carers and nurses working with older people with dementia. They document the observation that carers and nurses may need to detach themselves from emotions such as revulsion at unpleasant smells and body fluids in order to survive. Evers and Adams (2008) refer to 'emotional labour tools' which they say workers use when dealing with situations such as toileting, washing and dressing which potentially can be distressing and embarrassing to carer and service user alike. These 'tools' such as listening and gentle persuasion are regularly used to preserve the older person's dignity and privacy. However, they can also be implemented as a means of

manipulating an older person to be more 'co-operative' within the limited time available to the carer. Where care staff and nurses are not trained and supported to manage emotions in this way, there is clearly potential for vulnerable and challenging service users to be subject to bullying and elder abuse.

Braverman (2002) suggests that organisations should manage specific incidents by training their staff to find solutions that respect the emotions of the recipients of care. Gazoni and colleagues (2008) for example demonstrate the need for systems to support staff in particularly stressful specialties such as anaesthesiology where the physician (and by inference nurse specialists) have to deal with the emotional impact of catastrophic events resulting in patient death. These authors identified evidence-based strategies including training programmes and open communication among colleagues, patients and their families to address profound emotions such as grief and guilt. The capacity of leaders to listen and learn facilitates the recognition and effective management of emotions and is germane to the development of a caring culture. In a study of patient safety (Smith et al 2009) in the environments described in both literature and case studies, patients and service users require complex levels of care and as Taylor (2006) argues the emotional toil of caring for people in sickness and as they die is rarely referred to in policy even though stress is inevitable when working with sick patients and their relatives.

At a wider policy level, therefore, the organisation must consider appropriate systemic interventions to take consistent account of the power of emotionally sensitive individuals to use their own and others' emotional states to prevent problems and find solutions to bullying and abuse. Such policies should emphasise the importance of interpersonal skills, teamwork and leadership in promoting an open culture that counteracts the tendency to scapegoat and blame individuals (for example, the older person with a continence problem) rather than adopt a systemic analysis.

The concept of emotional intelligence first described at length by Goleman (1995) is worthy of consideration in this respect. Huy (1999) has connected emotional labour and emotional intelligence theoretically and suggests that particularly at times of change the process of change can be facilitated by judicious attention to emotions (Huy 1999). He concludes that emotions are an integral part of adaptation and change and emotionally intelligent individuals are able to recognise and use their own and others' emotional states to solve problems.

Sakiyama (2009) following Fineman (2006) argues that emotional intelligence is not about emotions but about judging people's ability to deal with others implying they must only have a 'positive attitude in their interactions achieving this by changing their cognition rather than their emotion. Such intelligence is desired by organisations in order to deal with difficult situations.

4. Conclusion

The wealth of empirical studies inspired by Hochschild's ground breaking study have shown that there is a variation in how different types of emotional labour are valued and recognised within the healthcare workplace. For example the emotional labour of cancer care is dependent upon whether the person with cancer is being actively treated or has reached the palliative care stage (James, 1992; Kelly et al., 2000). It is perhaps because of the heightening awareness of the need for nurses and others to be able to be given emotional spaces to think and feel about their practice that there have been some criticisms of Hochschild's work which have described emotional labour as a 'technical fix', perpetuating the body–mind dichotomy and potentially separating out emotions from the technical and physical aspects of care. It could be argued that at the time when the topic was first being researched and written about, the language of emotions revealed the hidden world of nursing and learning to be a nurse. Subsequently emotional labour has since become 'normalised' and incorporated into the everyday language of nursing and care work and the current discourse of dignity and compassion (Smith, 2008)

Benner and Wruber (1989) propose a philosophical approach to the concept of care, which transcends the body–mind split and enables connection and concern between nurse and patient. Emotions are seen as the key to this connection because 'they allow the person to be engaged or involved in the situation The alienated, detached view of emotions, as unruly bodily responses that must be controlled actually cuts the person off from being involved in the situation in a complete way' (Benner and Wrubel, 1989). Views such as these represent a trend over the past decade amongst nurses in the USA and Europe to move to a more holistic approach to care and away from the over-reliance on high tech medicine. This trend has continued over the intervening decades with increasing attention to the role of emotions in nursing and caring. Three characteristics of this trend can be noted. The first characteristic illustrated by Theodosius' work is the role of the unconscious and psychoanalytic and psychodynamic approaches to emotions. Phenomenology and embodiment as characterised by Benner's (1984) work continues to be acknowledged as important for nursing. The symbolic interactionist and Marxist stance of the cognitive approach to emotions characterised by Hochschild's work has attracted increasing theoretical critiques in particular the risk that emotions become marginalised and normalised and detracts from what is given 'freely' as part of who one is and what one is paid to do (McClure and Murphy, 2007).

Recent empirical work refutes this view as one that potentially encourages nurses and women to give over and above what they are supported to do both personally and professionally. The emotional labour analysis pays attention to the division of labour within the health service and the gendered nature of care. Hochschild's recent analysis of the four models of care is important in this

respect, which she describes as a cultural continuum of 'traditional', 'post modern', 'cold modern' and 'warm modern' solutions to the care deficit. The traditional solution reverses the changes that have taken place in women's entry into the workforce and places them very firmly back in the home, absolving men from any of the responsibility to care. The post modern solution demands the removal of the central image of the caring mother figure, leaving men and women in the workforce and the need for all sectors of society to learn to live without care. The cold modern solution institutionalises all forms of human care while the warm modern model values care at the individual, family and public level supported by systems and processes in which nurses and other professionals operate (Hochschild, 2003).

A number of conceptual questions remain about the nature of care, each of which is fraught with contrasts and contradictions (Smith and Cowie, 2009). If care is seen as a right can it be professionalised? Is it morally right to control or manage emotions and who decides what is appropriate and what is permissible? Indeed emotional intelligence would seem to suggest that emotions are controlled by the needs of the organization. The bullying literature is useful here for providing insights as to the ways in which workers can both resist control and yet be controlling. The essential message seems to be how to keep the balance between rationality and emotion while at the same time providing leadership to create a culture founded in care, respect and compassion to enable those at the front line to both feel cared for enabling them to care for others.

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Contributors

HC and PS shared equally in the writing of this article.

Conflict of Interest

None