

## **Chapter 2**

# **Introduction to Literature and Key Concepts**

### **An Anatomy of Emotions: Understanding Emotional Labor in Health and Social Care**

The review of literature touches upon contemporary notions of care and examines the emotional labor of nurses and social care staff in the National Health Service and in community social work. This involves looking at the social and political changes in society and the health services: for instance, the ways that staff, patients, and families view emotional labor as shaping therapeutic relationships and defining care. The summary of literature assesses the significance of emotional labor in health and social care as well as addressing some shifts in the philosophy and education system of nursing.

With the focus at present on interdisciplinarity in the health and social services (UKCC 1999a, 18; DoH 2000a, 2004, 2006, 2008), a vital point of review is the way that different professions provide and manage emotional support with patients and families. Emotional labor varies and should be compared in different clinical, situational, and interprofessional contexts. Critical attention also needs to be given to the potential for emotional care to be used as part of the commercialization of health and social care associated with the introduction of the internal market and the increase in privatized forms of labor (Saks 1990; James 1989). Interdisciplinarity expands the roles and responsibilities of nurses and social carers in areas such as emotional labor, emotional awareness, authenticity, befriending, companionship, and other forms of psychosocial support (James 1993a, 98; Firth-Cozens and Payne 1999; Aldridge 1994; Mamo 1999; Benner 1994). The review of a range of subject areas and social science sources of information will therefore have general appeal and help exemplify the multidimensional nature of emotions in the workplace (Fineman 1993; Clarke and Wheeler 1992; Phillips 1993; Bendelow and Williams 1998). In reviewing these and other issues, the study evaluates the benefits and problems that are associated with close interpersonal contact in the health and social care sectors. This is certainly of empirical and practical significance, in so far as emotional care, labor, and stress are factors that effect the retention of much

needed staff, are influential in effectiveness and good team working in the health and social work environments, and influence the quality of lives of families, children, and patients (Scheid 1999; Newton 1995; Elstad 1998; Bendelow and Williams 1998; James 1989). Intellectually, the review examines the medical and social frameworks of emotional labor. This involves looking at the growth of new disciplines that shape conceptions of emotion and the professionalization of nursing and social care. The study explores the ways in which conflicts and relationships in the health services and community social care may be better appreciated by extending the social sciences to examine emotions in nursing and social work practice. Interdisciplinarity is again a key theme, in so far as literature will draw on the traditions of sociology, psychology, psychotherapy, and social anthropology. This increases the empirical scope and focus of inquiry, especially as it is important to compare the horizons and limitations of a variety of models and different clinical and community contexts of care.

The project not only explores the ways in which emotional labor relates to conceptions of the self, identity, and the meaning of health and illness, but also assesses redistributions of knowledge and power between medicine and the public as well as divisions of emotional labor in and between the health and social care professions. The literature is therefore helpful in the initial examination of cultures of caring and also of changing techniques of health, social inclusion, and healing in British society. In the field of nursing, social work, and doctoring, this will assist in appreciating the everyday ethical and emotional dilemmas that face staff when supporting patients and families.

## Defining Emotions in Public Health and Social Care

How is emotional labor best defined? Is emotional labor the same as emotional care? In what ways do different traditions contribute to our present understanding of emotional labor and how may models of emotional labor be influential in nursing and social care? Hochschild suggests that emotional labor involves the induction or suppression of feeling to sustain an outward appearance that produces in others a sense of being cared for in a convivial safe place. Emotional labor is particularly typified by three characteristics: face-to-face or voice contact with the public; it requires the worker to produce an emotional state in another; it allows the employer through training and supervision to regulate a degree of control over the emotional activities of workers (Hochschild 1979, 1983; Smith 1992, 7). James writes:

The phrase 'emotional labour' is intended to highlight the similarities as well as differences between emotional and physical labour, with both being hard, skilled work requiring experience, affected by immediate conditions, external controls and subject to divisions of labour... Emotional labour is an integral yet often unrecognised part of employment that involves contact with people. It has been argued, and counter-argued, that emotional labour demands and individualized but trained response which exercises a degree of control over the emotional activities of the labour, and thereby commodifies their feelings (James 1993a, 95–96).

Certainly, these definitions of emotional labor require discussion and clarification. The history, division, and application of emotional labor to nursing and social care require study to “grapple with the conceptual complexity of defining care, especially in relation to its emotional components and demands” (Smith 1992, 9). It means concentrating on the tacit and uncoded skill of emotional work and raising questions that many nurses, doctors, and social care professionals have been explicitly discouraged from asking in the past (Haas and Shaffir 1977; James 1989; Elias 1978).

A combination of sociological, psychological, and psychotherapeutic models of emotional labor apply to the examination of professional practice. Models of emotional labor, emotional care, stress, and the like are certainly not without their differences. After all, sociology, psychology, and psychotherapy have different approaches and points to raise that are relevant in different clinical contexts of health and social care. Some models, such as the discourse of stress, are more popular and are suggested by Newton (1995) and Elstad (1998) to appeal to management groups, individualization and political decontextualization. However, taking a range of approaches and models of emotional labor into account encourages continuing discussion and explanatory variation in the social sciences (Fineman 1993). Sociology, psychology, psychotherapy, and social anthropology all have a part to play in ensuring that we are not missing the different types of emotional work that are being carried in different contexts and in the changing sociopolitical climate. A nurse counselling a patient or informing a relative of someone’s death is obviously different to the emotional demands in the accident and emergency ward. A social care professional dealing with child abuse or neglect is asked to labor much more emotionally than when setting up a family’s activities and daily chores because of the inability of parents to allocate time, finances, and resources. The model of emotional labor, whether sociological, psychological, psychotherapeutic, or anthropological, must correspond to the experience and social context so as to be relevant to improving practice and the ways professionals interact with people on the frontline.

## **Gender, Race, and Emotions**

Historically, a pathway to understanding emotional care and the role of nurses and social carers in providing emotional support has been closed down by a variety of social, psychological, and political factors in academic and clinical contexts (James 1989; Ellis and Bochner 1999; Oakley 1984). For example, emotional labor has traditionally been identified with women’s work and the role of the mother in the family. This is especially significant given that images of nursing and social care still reverberate with that of the caring female, particularly with the prototype of

Florence Nightingale (Smith 1992). Nursing and social care are not autonomous but crucially affected by balances of power in wider society, which become represented in the health and social care systems. According to Navarro:

Professional power was and is submerged in other forms of power such as class, race, gender and other forces that shape the production of the knowledge, practice, and institutions of medicine (Navarro 1988, 64).

The portrayal of care as an entirely natural activity is certainly related to the devaluation of emotional labor in cultural, gender, and economic terms (Oakley 1974; Smith 1992; James 1989; Gray 2010). Davies and Rosser (1986a, b) suggest that clerical staff in health and social care, although in a menial and low-skilled occupation, often carry out a large number of difficult and significant responsibilities but that the eventual economic reward and power goes to male seniors. Such undervaluing occurs because frontline emotional skills are perceived as being acquired as a result of women's life experiences instead of via formal education, academic qualifications, or occupational training. If work lacks formal trappings it is usually assumed to be of little value and deskilled. Caring, in either the public or private spheres, is assumed to involve disparate and menial activities of little economic worth (Graham 1983; Oakley 1974, 1984). In hierarchical social work services and a medicalized National Health Service the care component of emotion work is not seen as learnt and employed as a therapeutic technique by staff. Care is not seen to involve both emotional and physical labor with expressive and instrumental outcomes, such as the healthy survival of patients or support of marginalized families (Smith 1992; James 1989, 1992, 1993b; Phillips 1996; Gray 2009a, 2010).

Nurses and social work staff from ethnic communities are also a highly invisible part of the workforce and have received little attention for the vital part they play in providing care, emotional labor, and support. In a similar manner to gender imbalances there has been a "racialization" around the care-cure divide. Nurses and social care staff from ethnic minorities are employed as a disadvantaged labor reserve. Employment of ethnic minorities cheapens the high costs associated with health and social care in labor-intensive sectors, especially where low wages and the difficult nature of frontline work deters recruits (McNaught 1988; Doyal et al. 1981/1982). Social closure and discrimination promote individual and collective mobility for White men and women. Ethnic minorities are drafted into care work with little or no formal training and education. Care is deskilled, low paid, and low status. Such treatment of workers from ethnic communities mirrors that of women, with a heightened emphasis on social control and exclusion (Williams 1987).

The divisions between mind and body, knowledge and emotion, the sacred and profane, and the head and heart also present barriers to understanding, not least in terms of dealing with emotional labor in challenging environments of health and social care that sometimes break psychosocial boundaries and Western taboos, such as bodily contact, feelings, sexuality, transmission of disease by fluids and blood, and social fears involving death, dying, and bereavement (Lawler 1991; Gabe 1995; Twigg 2000; Douglas 1984). Science and medicine, viewed as a rational and objective enterprises, cannot countenance the irrational and subjective components of

human feeling (Oakley 1981, 1984). In this book, case studies of mental health, AIDS/HIV, managing perceptions of a good death in children's oncology, refugee exile, and child abuse will illustrate the complexity of dealing with taboos, stigmas, and managing emotional dilemmas of work on the frontline.

Even today the tendency in research and the professions is to concentrate on the more visible aspects of care and palpable outcomes of biomedicine. The emotional labor of nurses is invisible compared to the "real" work of medicine. According to Oakley:

In a fifteen year career as a sociologist studying medical services, I confess I have been particularly blind to the contribution made by nurses to health care. Indeed, over a period of some months spent observing in a large London hospital, I hardly noticed nurses at all (Oakley 1984, 26).

Classical studies suggest that nursing, as a historically and gender-subordinated occupation, has been pressurized and constrained by the medical profession (Katz 1969; Davis 1966; Friedson 1970; Devereux and Weiner 1950). The neglect of nursing and invisibility of emotional labor not only is an injustice to the frontline staff who provide care but also limits the development of policy and sociological analysis on changing systems of care. Health and social care are undergoing rapid restructuring in industrialized countries, so reordering professional relationships and generating new challenges, interprofessional conflicts, and emotional demands with patients and families. The nature of emotion work and patterns of learning to care are undergoing drastic change, so transforming relationships and placing new demands and responsibilities on frontline staff.

In health care, in Smith's (1992) study, emotional labor was a prime role of the sister and charge nurse. The sister and charge nurse not only provided clinical knowledge but their interpersonal skills also informed the student nurse about how nurses care and what nursing was all about. The therapeutic potential of nurses' interpersonal involvement with patients is certainly a central feature in what is widely known as the "new nursing." Salvage (1990) traces the origins of "new nursing" to the 1970s, describing it as transforming relationships with patients away from the biomedical model toward a holistic approach promoting the patient's active participation in care. The "new nursing" is a systematic, consultative, and intellectually rigorous approach to patients' changing healthcare needs that aims to improve service delivery and therapeutic practice (Salvage 1990; Salvage and Kershaw 1986, 1990). An integral part of the "new nursing" is an attempt to establish a new knowledge base independent of biomedicine and other healthcare professions. "New nursing" and liberal feminism challenge patterns of traditional subordination of registered nurses by biomedicine and nurse management (Reverby 1989; Armstrong 1983a; Beardshaw and Robinson 1990). Professionalization is a catch-twenty two struggle around the dominance of the medical model, the subordination of women's care and the significance of emotional labor, because for nursing:

To escape subordination to medical authority, it must find some area of work over which it can claim and maintain a monopoly, but it must do so in a setting in which the central task is healing and controlled by medicine (Friedson 1970, 66).

Many say that the “new nursing,” if properly overseen, will generate positive outcomes for staff and patients (Benner 1984; Bingold 1995; Staden 1998; Salvage 1990; Salvage and Kershaw 1986, 1990). Critics suggest that the “new nursing” may be flawed in some respects and may place too many demands on the nursing role (Mackintosh 1998; Aldridge 1994; Craib 1995; Wiggins 1997). The radical potential of the “new nursing” is suggested by Baxter (1988) to widen social divisions within the nursing workforce, marking out sharper divisions between basic and clinical care, with the possibility of creating a White and middle-class nursing elite. Care is handed to healthcare assistants as a menial and economically unrewarded labor. Wiggins (1997) noted dissonance and emotional tensions because of the conflict between “new nursing” and basic clinical nursing. The studies of Cotton (2001) and Gilbert (2001) suggest that supervisory processes and reflexive sessions on emotions in nursing have the capacity to be hegemonic, so preventing grass roots nurses from expressing their feelings, perspectives, and challenging their nursing seniors. Supervision which does not allow dialogue is little more than a ritualized confession of emotions so will be an act of surveillance whereby senior nurses control grass roots.

To be sure, the “new nursing” still remains a bone of interprofessional contention and therefore a central point of review. It is part of the task of the present study to begin such a review, relating the “new nursing” to the ways in which student nurses learn to deal with emotions and the ways that emotional labor is guided by seniors and colleagues (Williams 1999; Smith 1992; Wiggins 1997; Gray 2009b; Gray and Smith 2009). De Lambert writes:

Nursing is a strange trade, in which mundane and ordinary concerns and activities are mixed with awareness and responsibility for matters of acute significance...., such as suicidal despair, self-starvation, violent impulses, bewilderment and withdrawal from others.... The closeness, immediacy and apparent ordinariness of the nurse's work with patients engages the nurse's natural unguarded self... The recognition and valuing of responses and feelings enable nurses to use them for better understanding of interactions and relationships. The therapeutic relevance of nursing is often manifested within the seemingly ordinary experience of getting together with patients over shared activities. This is the base for the nurse-patient relationship, once rather overlooked, now much more recognized as a crucial element in nursing work and its effectiveness (De Lambert 1998, 212).

When asked, many say they are “too upset” or disturbed to engage with feelings. Emotions are too difficult, unreliable, unmanageable, unreasonable, and threatening to our ratiocination and psychosocial stability. Nurses are suggested by Oakley (1984) to largely follow the biomedical model, which is accorded higher status and prestige as high-technology work (Oakley 1984).

Emotions are professionalized to present an impersonal approach of medicine to staff, patients, families, and wider society (Hochschild 1983; Haas and Shaffir 1977; Elias 1978). This professionalization is certainly one strategy to cope with difficult medical and social care experiences, particularly of death and dying (Sudnow 1967; Mamo 1999; Thomas et al. 2002; Laakso and Paunonen-Ilmonen 2001), the pressure of making mistakes (Bosk 1979; Bolton 2001; Marangos-Frost and Wells 2000), and with the uncertainties involved with the exercise of medical knowledge

(Fox 1980). However, emotional labor in such a stifling situation is largely hidden behind a “cloak of competence” (Haas and Shaffir 1977) while the efforts of nurses and social workers to provide interpersonal and emotional support are devalued. Many nurses and social workers spoken to in the course of this research project regarded the display of emotions as a “weakness” to be concealed from patients, families, and colleagues. This negation of emotion and emotional labor is, it should be emphasized to the utmost, not just a matter of individual choice or a personal decision of whether to disclose the depth of one’s feeling about a difficult situation. Denial is neither a complete escape nor an evasion from one’s emotions. Denial is just one strategy and repertoire of dealing with difficult experiences and emotions in health and social care.

Emotional labor, as well as being at the heart of each individual, is also a social matter in so far as emotions are regulated in the health and social services as part of managing the closeness of staff contact with the public. There are social components to emotional care that are transmitted from the past in ideas of appropriate and inappropriate nursing and social care. Elias (1978) calls such an emotional enculturation a civilizing process:

We... find in our own time the precursors of a shift towards cultivation of new and stricter constraints. In a number of societies there are attempts to establish a social regulation and management of the emotions far stronger and more conscious than the standard prevalent hitherto (Elias 1978, 187).

## Emotions Are Hard Work

At separate interviews a senior grade nurse who worked in oncology and an educational social worker echoed James’ (1989, 1992) studies by repeating exactly the same phrase: “Emotions”, they both said, “are hard work.” Although there is a growing shift toward the psychological and social aspects of patient care, an important gap in understanding is the centrality and strain of emotional care in the lives of families and patients in health and social care (Bingold 1995; Smith 1999a; Gray 2009b; Gray and Smith 2009). In many clinical and community contexts, nurses and social care staff have to deal with close interpersonal contact and even issues of dying, death, and bereavement from day to day. Addressing staff and the public’s narratives may certainly add further weight to the argument that study needs to extend an appreciation of emotional care so as to allow a more explicit focus on systems of social and emotional support (Fineman 1993).

James (1992, 1993a, b) suggests that there is a need to highlight the relationships between emotional and physical labor, seeing both as difficult and strenuous activities that require many years of experience. The health and social care settings, in which emotional labor is an important part, need to be looked at as subject to external controls and emotional divisions of labor between professions. These emotional divisions of labor are often a source of interprofessional rivalry and everyday contestation. Such divisions are often expressed in crude, loaded, and highly emotive



terms: for instance, on the one hand “doctor bashing” is a term in common use by nurses that describes those that regularly make deprecatory comments about the emotional stiffness and intellectual arrogance of senior consultants; on the other hand, frontline nurses and social care staff are often described by doctors and senior social work managers as “emotionally and psychologically weak” or “too close to the patient or client.” Both of these stereotype the others position, while at the same time consolidating the split between the head and heart and reinforcing patriarchal attitudes involving gender divisions of emotional labor.

To return to the main point, though, emotions are arguably hard work and require a high degree of flexibility when dealing with people on the frontline. According to James:

Emotions can be regulated with varying sophistication and with various outcomes... Like other skills, emotional labour requires flexibility and adjustment. It involves anticipation, planning, pacing, timetabling and trouble-shooting... At its most skilled emotional labour includes managing negative feelings in a way that results in a neutral or positive outcome (James 1993a, 95–96).

There are certainly examples of neutral or positive outcomes in the present study, where nurses and family support workers are called upon to manage people’s feelings and negotiate negative emotions.

The length and uncertainty of some medical treatments and social interventions, together with the often repressed feelings that people may have about very difficult experiences, mean that professionals inevitably adopt strategies to manage emotion and stressful situations (Staden 1998; Smith and Kleinman 1989; Newton 1995). Sometimes professionals may attempt to deny the difficulties that are inherent in medical and nonmedical contexts, as well as avoiding their emotional attachment to the patient, the family, and the quality of their client’s life (Swallow and Jacoby 2001). Such denial of emotion, when not appropriately reflected upon as a necessary strategy for dealing with very uncomfortable events, avoids a context in which understanding and ways of coping may be developed (Benner 1994; Benner and Wrubel 1989; Morton-Cooper and Palmer 1999; Tolich 1993).

Parkes’ (1986) exploration of bereavement is just one example of how valuable the expression of emotion is as a means of healthy survival. While the repression of emotional attachment and a stance of affective neutrality may seem more economical (Elias 1978), and may certainly be expedient as a vehicle for gaining distance and space for reflection in social work (Aldridge 1994), this does not imply that emotions and emotional labor merely disappear. Concealing (Elias 1978; Haas and Shaffir 1977) our emotions, working so as to hide the difficulties of our experiences, is just one strategy among many that may be used in managing the medical and interpersonal demands of the health and social care settings. The task of looking at emotional labor involves the assessment of the strategies of emotional regulation that are available to health and social care professionals. This includes the analysis of how staff manage their own and the patient’s emotions and how they come to terms with the difficult processes that are an unavoidable part of sustaining support and care. Such research will have to explicitly deal with uncomfortable and sometimes conflicting



emotions that nurses, health and social work professionals, patients, and families have to face (James 1989, 1993a, b).

## **Immersing in Emotions Through the Befriending Relationship?**

A polar opposite of distance in emotional labor is advocated by Bingold (1995) in so far as the model of the staff relationship to the client is seen to be one of befriending. Bingold says that specialist pediatric oncology nurses (SPONs) learn to befriend and that this enables the diminution of formality in the relationships of professional and client. This erosion of interpersonal barriers may in some cases entail a closer and more reciprocal relationship. Many studies suggest that this consequently opens up contexts of democratic partnerships in care (Bingold 1995; Bolton 2000; Williams 2001; Luker et al. 2000; McQueen 2000). Similarly, Benner says that nurses should be in touch with the emotional relationships that they maintain with their patients. Studies suggest that the ability to attend to the patient's feelings not only puts the patient at ease but also works as an aid to nurses in making vital clinical decisions (Benner 1984; King and Clark 2002; Phillips 1996; Scott 2000; Marangos-Frost and Wells 2000).

Many social work and family support schemes in the UK and abroad have been shown to be at the frontline with families and have been described as nonstigmatizing, nonintrusive, and responsive to the ethnicity, views, and specific social care and health needs of families (O' Brien 2000; Bond 1999; Ferguson 2001; Johnson et al. 1993; Taggart et al. 2000; Barker 1988; Olds 1992). This is largely because staff match their client group very well, in terms of gender, age, ethnicity, background, language, and point of view. Social care and family support professionals befriend families and win their trust, engaging practically and emotionally with mothers and children. Because social care professionals befriend and engage emotions, families often feel more comfortable to disclose. This elicits rich narratives on the nature of social exclusion, poverty, child welfare, and racism (Featherstone 1999; Taggart et al. 2000; Hicks and Tite 1998; Hillier and Rahman 1996; Hillier et al. 1994). Because in trusted relationships at the frontline with families, social carers and workers who befriend are able to gather in-depth understanding of cases and inform risk and child protection assessments (Holland 2000).

By way of contrast, learning to befriend the client also increases the emotional demands made upon nurses and social work professionals. Befriending undoubtedly creates new problems in the role and scope of health and social care (Bingold 1995; Aldridge 1994; Wigen 1997; Bendelow and Williams 1998). The clinical, social, and emotional demands made upon health and social care staff have been subject to great historical changes and ideological shifts in philosophy. Learning to befriend the client, however, still remains as a task that many nurses and social workers have to deal with in a variety of clinical and nonclinical environments.

Indeed, failing to befriend and engage with the client in some settings is very socially awkward and uncomfortable for all parties involved (Allan 2001; Swallow and Jacoby 2001; Forrest 1989; Thomas et al. 2002).

## **Building a Language and a Picture of Emotions**

If emotional labor is devalued and avoided then the health and social services not only become static as regards the relationships of its workforce but also become blind to the emotional needs of patients and families in difficult medical and non-medical contexts. James writes:

The British National Health Service is an intriguing indicator of Western changes in negotiations over the expression of emotion (James 1993a, 112).

The disavowal of the emotional labor of the professions and the experiences of people in apparatuses of health and social care leave personal stories unheard and possibilities for discussion sealed. The medical framework has been suggested as needing the supplement of social, psychological, and sense-making accounts that draw upon the narratives of patients, families, and staff (Ellis and Bochner 1999; Smith 1992; Fineman 1993; Leight 2002; Staden 1998). This will no doubt be an unsettling journey for many, but if health and social care professionals silence emotional labor and ostracize the personal stories of staff and patients, the consequences may be far more serious. Denial of emotional labor also denies the possibility of opening up new approaches and avenues of debate that may in turn influence alternatives of healthcare and social work practice. Ellis and Bochner write:

To move in the direction of a narrative, evocative, medical sociology, is to give more room to the sense-making struggles of people whose illusions of prediction and control have been interrupted by illness or death. The move means giving up the notion that our work should protect us from the pain and difficulty of living. It requires our willingness to be uncomfortable and vulnerable along the way... In the end, all of us might feel better and know more (Ellis and Bochner 1999, 235).

This means that the complex emotional relationships between professionals and their clients should be assessed. This would allow professionals to come to at least an adequate appreciation of the strategies that people adopt in difficult medical and social care contexts. There is a profound need to bridge the gap between the medical and emotional aspects of care, not least because of the difficulties and stresses that are placed on all involved during treatment (Newton 1995; Elstad 1998; Thomas et al. 2002; Smith 1999a). The task is to identify the relationships that sustain the emotional labor.

To clarify the emotional labor of nurses and social work professionals the views of students and qualified staff are therefore crucial. If, as Staden (1998, 154) says, "a language to communicate care work does not exist," then we must investigate the ways that emotions are dealt with in a variety of therapeutic and supportive settings. This not only influences the understanding of the practices and standards of care,

but also shapes our modern images of nursing and social care. It guides understanding of the types of emotionally informed care that are available in different clinical contexts and community situations of the health and social care sectors. By addressing emotional labor staff will learn to cope more adequately with the pressures and stresses of caring for patients, families, and their children (Benner and Wrubel 1989; Cheahy Pillete et al. 1995; Forrest 1989). If, as Staden suggests, there is no language or terminology to communicate care work, then study must ask professionals and people on the frontline to begin to communicate and talk about their difficult emotional experiences in the health and social services. The first-hand accounts and narratives of professionals, patients, families, and children are fundamental to understanding the complexity of emotional labor. The first-hand accounts of people in this study are a first step in communicating a language of care work and understanding the multifaceted and gendered aspects of emotional labor (Garfinkel 1967; Schutz 1972; Fineman 1993; Leight 2002; Gattuso and Bevan 2000; Froggatt 1998; Bolton 2001; James 1993b).

## **The Reproduction and Distinction of Emotions in the Workplace: The Social Theory of Bourdieu**

Hochschild's work is North American in origin and her social theory has quite rightly become the benchmark and almost a status quo on the exposition of emotions in organizations. However, Hochschild does not elaborate or make the concept of care explicit, which is left to social scientists such as Smith (1992, 2005), Fineman (1993), and James (1989, 1993a, b). These social scientists examine the social structures, educational methods, inequalities, work relationships, and gender divisions that are involved in generating and reproducing patterns of care in health and social work.

To radicalize and address the multifaceted aspects of emotional labor, so as to take into account divisions and interprofessional distinctions in the practice of emotional labor, Hochschild's conservationist notion will be challenged by the more critical European social theory of Bourdieu. An outline of some of the chief similarities and differences of Hochschild's (1979, 1983) and Bourdieu's (1977, 1984, 1993) social theories will help compare their key ideas: including, for Hochschild (1983), notions of emotional labor, the managed heart, and emotional regulation through training; and, for Bourdieu, the concepts of cultural reproduction, cultural capital, field, habitus, distinction, and symbolic violence.

Once a brief comparison of some of the work Hochschild and Bourdieu has been made this will allow a synthesis and possibly a final reconceptualization of emotional labor. The aim of the study in this respect will be to present a new and innovative model of emotional labor in the concluding chapter, which synthesizes an appreciation of Hochschild's and Bourdieu's work relevant to emotions in organizations. The synthesis of Hochschild's and Bourdieu's key concepts will mean that study will be able to sketch a new model of emotions that is relevant to health and

social care work. The views of participants will also be pivotal in reconceptualizing emotional labor. The perspectives of people who took part in interviews and qualitative research are central to proposing a relevant and sympathetic model of emotional labor that is rooted in people's first-hand accounts and experiences of health and social care. The broad aim is therefore to reformulate emotional labor in the public services, such as health and social care, in modern capitalist societies.

Certainly, a chief similarity of Bourdieu's and Hochschild's politics is that they are both "left-leaning" and have been described as "soft" Marxist. Both examine the dynamics involved between the personal and political in large-scale capitalist organizations. Both are particularly interested in methods of training, education, and implicit inculcation that regulate and reproduce organizations and groups in capitalist societies (Bourdieu 1992, 1993, see also Elias 1991). Both Hochschild and Bourdieu link everyday social and emotional experiences to social structures, such as systems of education, reproduction of values, and techniques of emotional and knowledge-based regulation available in organizations through supervision and pedagogy. Both focus on the managerial and educative functions in processes of inculcation into society and the professions.

Hochschild's notions of emotional labor, the managed heart, and the regulation of feeling in organizations have already been described. It will be fruitful to now sketch four of Bourdieu's (1977, 1984, 1993) central tenets that relate to cultural reproduction, which in simple terms means the way that organisations or groups maintain and reproduce consistent patterns of action, thought, policy, ethos, and more importantly their everyday and taken for granted practices. Bourdieu's key concepts include many neologisms, possibly because he admits to originally classifying his own work as philosophical and not anthropological (Bourdieu 1977, 1984). These neologisms may at first make his work seem inaccessible, but his terminology is really quite easily apprehended and always relates to the maintenance and transmission of culture in organizations of capitalist society. Bourdieu's principal concepts which are involved in cultural reproduction are cultural capital, field, habitus and symbolic violence.

Bourdieu's (1977, 1984, 1993) concept of cultural capital is similar, though not the same as the function of economic capital in modern industrial and postindustrial capitalism. It is a complex notion and worth discussing at some length. Marxist theory has often been pilloried for failing to recognize the importance of culture. Many detractors argue that crude Marxism favors the superstructure over the agent and economic reductionism over cultural or anthropological understanding. In attending to the economic, the mode of production that governs relationships of production in Western a society, as the foundation of that society Marxism reduces culture to an epiphenomenal and secondary status. Culture is treated as a mere reflection of the economic base of society. Culture is ideologically driven and the ruling ideas in every age are dominated by the ideas of the ruling class of elites or bourgeoisie.

Bourdieu builds on the notion of capital and purely economically driven conception which emphasizes material exchanges to include immaterial or noneconomic forms of capital, which he describes as cultural and symbolic capital. Bourdieu

suggests there are forms of capital and details the ways in which the different types of capital can be gathered, accrued, exchanged, and converted. Because the organization and distribution of capital also represent the inherent structure of the social world, Bourdieu argues that an understanding of the multiple forms of capital will help elucidate the structure and functioning of the social world. Cultural capital represents the collection of noneconomic forces such as family background, social class, varying investments in and commitments to education, different resources, and the like which especially influence academic success.

Bourdieu (1984) describes cultural capital as a form of knowledge, an internalized code or intellectual acquisition which provides an empathy, appreciation, taste, and competence for deciphering cultural artifacts or cultural relations. A work of art, for example, is not naturally or immediately appreciated. It has symbolic meaning and special interest especially for those people who have the competence, acquired taste, or code into which the work of art is encoded. The possession of this code, Bourdieu (1984) suggests, is cultural capital. This cultural capital, which unlocks relationships and cultural artifacts, is accumulated through a long process of inculcation that includes the pedagogy of family members (family education), educated peers (diffuse education), and social organizations (institutionalised education). This process of inculcation is both invisible and every day as well as being carried out formally and explicitly in methods of education and training (see also Elias 1991).

Bourdieu also distinguishes three forms of cultural capital. The embodied state is directly related and incorporated within the individual and represents what they know and what they can do. Embodied capital can be increased by investing time into self-improvement in the form of learning. As embodied capital becomes integrated into the individual, it becomes a type of habitus and therefore cannot be transmitted instantaneously. The objectified state of cultural capital is represented by cultural goods and material objects such as books, paintings, instruments, and machines. They can be appropriated both materially with economic capital and symbolically via embodied capital. Finally, cultural capital in its institutionalized form provides academic credentials and qualifications which Bourdieu suggests creates the formal certification of cultural competence. This confers the bearer of cultural capital with conventional, constant, legally guaranteed, valued, and respected symbolic power. Academic qualifications can then be used as a rate of conversion between cultural and economic capital in the labor market. Throughout discussion of cultural capital, Bourdieu favors a nurture rather than a nature argument. The ability and talent of an individual is primarily determined by the time and cultural capital invested in them by parents. This point is particularly worth noting as the study's focus is emotions in health and social care, which are not usually explicit on syllabi.

Individuals' social capital is related to the size of their relationship network, the sum of its cumulated resources in both cultural and economic terms, and the success and speed the individuals can set them in motion. According to Bourdieu, social networks must be continuously maintained and fostered over time so that they may be called upon quickly in the future. In his discussion of conversions

between different types of capital, Bourdieu suggests that all types of capital can be derived from economic capital through varying efforts of transformation. Bourdieu also states that cultural and social capital are fundamentally based in economic capital but can never be completely reduced to an economic form. Social and cultural capital remain effective because they conceal their relationship to economic capital.

Cultural capital, in a similar manner to economic capital, is unequally distributed among class fractions and social classes, by gender and in relationships of production. All human actions take place within a field, which are arenas for the struggle of resources. Individuals, institutions, and other agents try to distinguish themselves from others and acquire cultural capital which is useful or valuable in the field. In modern societies, there are two distinct systems of social hierarchization. The first is economic, in which position and power are determined by capital and property. The second system is cultural or symbolic. In this status is determined by how much cultural or symbolic capital one possesses. Culture is therefore a source of domination, in which intellectuals play a key role as specialists of cultural production and creators of symbolic power. Even taste, of a painting or piece of music, is an acquired cultural competence and is used to legitimate social differences. Taste functions to make social distinctions. Crucially, Bourdieu's concepts suggest that emotions are acquired, reflect an exchange of cultural capital (an exchange of emotional "goods" between people and commodification of emotions), and are a contested product in health and social care organizations.

Bourdieu also outlines a notion that is similar to a feeling or disposition of belonging, which he terms *habitus*. Bourdieu formally classifies and describes the concept of *habitus*:

The structures constitutive of a particular type of environment... produce *habitus*, systems of durable, transposable *dispositions*, structured structures predisposed to function as structured structures, that is, as principles of the generation and structuring of practices and representations which can be "regulated" and "regular" without in any way being the product of obedience to rules, objectively adapted to their goals without presupposing a conscious aiming at ends or an express mastery of the operations necessary to attain them and, being all this, collectively orchestrated without being the product of the organizing action of a conductor (Bourdieu 1977, 72).

*Habitus* is in simple terms a type of cultural habitat which becomes internalized in the form of dispositions to act, think, and feel in certain ways. Bourdieu sometimes suggests that *habitus* is like a feel for a game or a practical sense that moves agents to act in a predisposed and unconscious way. *Habitus* is a disposition, learnt through pedagogy and implicit over long periods of invisible inculcation such as in the everyday family, that generates and reproduces familiar practices and perceptions. *Habitus* is important in study that inquires about how individuals and groups implicitly learn to care.

*Habitus* is a set of culturally determined dispositions which have no representative content and at no stage pass through consciousness. Individuals are not normally consciously aware of *habitus* but may become aware through conscious reflection or through being in an alien or anthropologically strange environment. In this reflective

state individuals are not transforming the habitus itself into a set of representational mental states (beliefs, desires) rather the reflector is acquiring beliefs about the habitus (which is and remains inherently nonrepresentational). This certainly has implications for patterns of reflective learning, which dominate supervisory processes in health and social care and guide student nurses and social carers into the ethos of care. Habitus is acquired through acculturation into certain social groups such as social classes, race, a profession, a particular gender, our family, a peer group, and a feeling of belonging to a nation. There is a distinct habitus associated with each of these groups. Each individual's habitus is a complex mix of other different habitus together with certain individual peculiarities.

Symbolic violence is related to dispositions and feelings of belonging in a social field, particular group or profession. The hierarchical nature of health and social work evince professional struggles around defining the importance and therapeutic value of care. Each habitus and social field is structured by a set of unspoken rules of what can be validly uttered or perceived. Relationships in the National Health Service, for instance, are noticeably structured by the care–cure divide, where nurses provide emotion work and doctors are primarily biomedical experts offering diagnosis. Unspoken rules operate as a mode of symbolic violence in so far as they involve a subtle, almost invisible form of violence, which is never recognized as crude violence as such. Symbolic violence is invisible because it is not so much undergone as chosen, involving the violence of obligation, personal loyalty, hospitality, gifts, confidence, gratitude, piety, and credit. In the field of education, symbolic violence operates not through the teacher speaking abusively or ideologically to students, but by the educator being seen as in total possession of an amount of cultural capital which the student needs to acquire. The educator is seen as a repository of cultural capital which forms a hierarchy of knowledge and structures unequal relationships between teacher and student. Education implicitly contributes to reproducing the dominant social order not so much by the viewpoints it holds, but by this regulated distribution of cultural capital. A similar form of symbolic violence is in play in the whole field of culture, where those who lack the appropriate knowledge and tools are unobtrusively excluded, relegated to shame and silence. Symbolic violence certainly has implications for the gendered nature of emotions and the way women's emotional labor is invisible at home and at work.

Symbolic violence is unrecognizable as violence as such, as it exists in common and everyday forms of expectation, obligation, and imperceptible, gentle exploitation. In the case of gender, symbolic violence may involve a learned misrecognition in relationships of power between men and women, such as the interpretation of patriarchal expectations as being for women's own good or as patriarchal protection. Symbolic violence may involve expectations of how women should behave in the workplace, such as in patriarchal views of women's emotional labor as a natural obligation, or may involve stereotyping emotional labor as inferior to the more important biomedical work of doctors, who are perceived as practicing in a male-dominated occupation.

There are certainly implications for updating and redrawing the concept of emotional labor if one takes into consideration Bourdieu's suggestions of cultural



reproduction, cultural capital, field, habitus, and symbolic violence (Bourdieu 1977, 1984, 1993). Links between emotional labor and cultural reproduction will be made more plain in the course of study by attending to qualitative interviews that elicit the perspectives of health and social care professionals as well as families.

Hochschild admitted in a letter to a colleague that she was “a conservative with a small ‘c’” (Smith 1999b). Bourdieu’s critical approach allows deliberation of the horizons and limitations of Hochschild’s (1979, 1984) conservationist account of emotional labor. There are certainly plain differences that stem from Hochschild’s North American conservationism and Bourdieu’s more radical thought which is in the vein of the critical European tradition. Bourdieu’s notion of habitus allows a focus much more on interprofessional differences, rivalries, and distinctions in terms of the perceived appropriateness of expressing emotions in health and social care organizations. Symbolic violence is not addressed by Hochschild, whose politics has much more in common with North American theory and is centered around maintaining the continuity, status quo, and management of emotions. Symbolic violence, particularly involving gender and emotion, will be an issue to review as will the negotiation and struggle around defining emotional labor in unequal systems of health and social care. Emotions remain largely implicit, unpaid, and invisible as a labor in nursing, health and social care (James 1993a; Smith 1992; Gray 2002a, b, 2010). Study will observe the emotional labor of health and social service professionals and will examine the techniques that are employed to reproduce an invisible culture of care in the National Health Service and social services.



<http://www.springer.com/978-1-4614-3401-6>

Face to Face with Emotions in Health and Social Care

Gray, B.

2012, XII, 192 p., Hardcover

ISBN: 978-1-4614-3401-6