FEELING SQUEEZED: DILEMMAS OF EMOTION WORK IN NURSING UNDER MANAGED CARE

by

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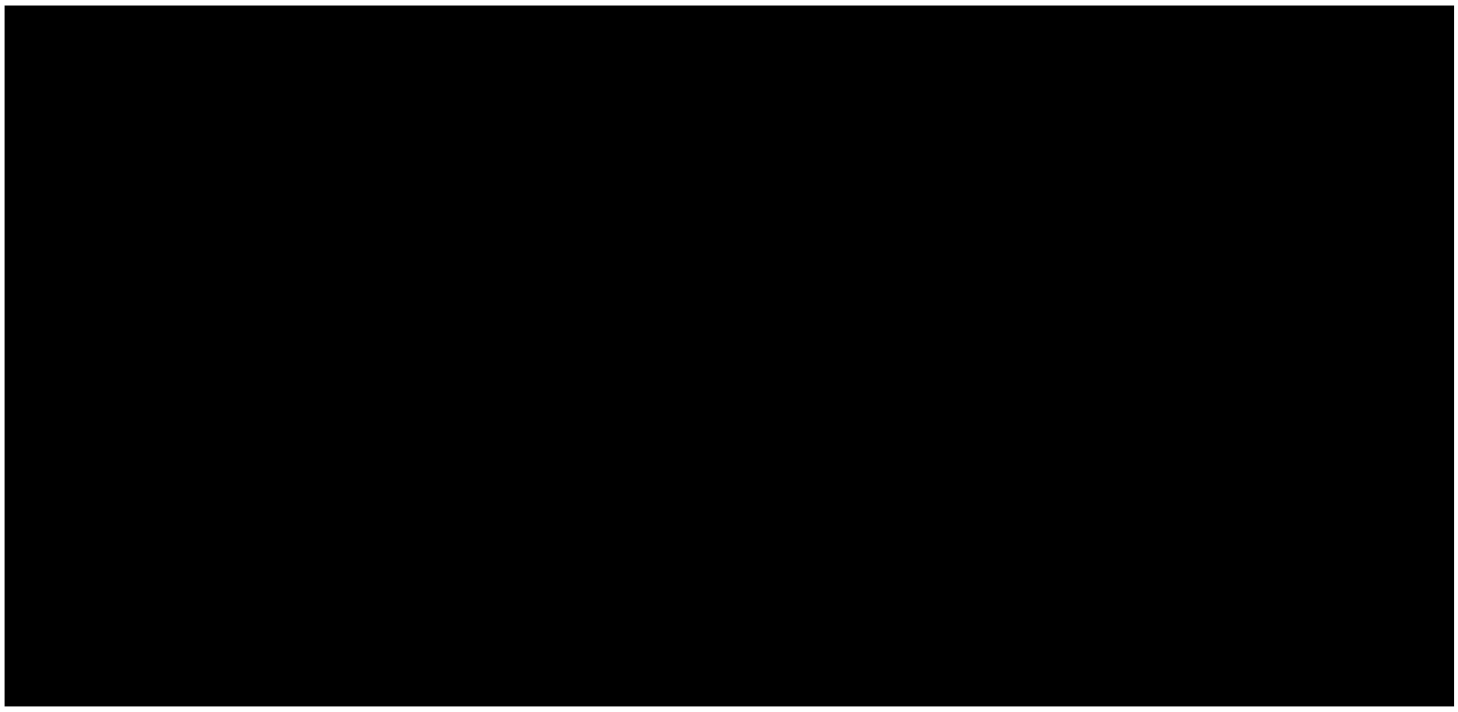

To my daughter Amber,

for helping me to open my heart

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Abstract of Dissertation

Feeling Squeezed: Dilemmas of Emotion Work in Nursing under Managed Care

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This dissertation concerns feelings of loss expressed by nurses during the massive work reorganizations of managed health care. The inquiry is framed by the concept of emotion work (Hochschild 1983), defined as the management of feelings according to socially mediated rules. Providing highly interpersonal work, nurses manage their own and patients' feelings with therapeutic and bureaucratic outcomes in mind. My investigation explores meanings and practices of emotion work and makes visible important dynamics of emotionality during the current moment of historical transformation.

This qualitative interview study is grounded in the stories of eighteen practicing nurses. In addition, content analysis of selected nursing texts was used to identify discourses about emotion since the late nineteenth century. Integrating levels of symbol and practice, I asked these expert nurses what they did as emotion work and how they called it. I first profiled sets of skills and knowledges used to perform therapeutic emotion work, and then traced significant micro manifestations of recent macro changes. Notably, these nurses reported not having enough time to provide emotional support according to previous standards of care, and worried that emotional concerns remained low priority. Connecting emotionalities performed with structural conditions of their enactment, I examined nurses' accommodations to reorganization and their frustrations about losses of feeling, and feelings of loss.

I explored theoretical and substantive implications for both service workers and nurses as postmodern economies of flexible capital accumulation, and bioscientific management of bodies and populations proliferate. Nurses are both subjected to and agents within systems that are reconfiguring patients as customers. This recoding signals changes in allocations of resources and shifts in material practices of giving care. Nursing

is seen as one example of multiple identities, flexible selves and emergent emotionalities working the new service economy.

The question is not whether nurses will do emotion work, or whether there will be designer emotionalities, but rather, under what conditions, according to whose design, constituting which meanings, and by what practices will this work be accomplished? How might nurses guide their own and patients' feelings within parameters of profit-making? What other criteria for emotions and wellness might intervene?

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Chapter I Introduction

> In fairy tales, donning the cloak of invisibility confers formidable powers on the hero, but for nurses invisibility underlines their subordination. A good nurse traditionally is one who is not noticed, but quietly and in a self-effacing way goes about her allotted tasks.
>
> Mick Carpenter (1993:95)

> Nursing's contribution must be defined in the language of outcomes, for that is how services will be evaluated and reimbursed. If nursing cannot define its contribution, then, as far as the reimburser is concerned, the contribution does not.
>
> Marilynn E. Doenges, and colleagues (1997:4)

> At its best the sociology of the emotions may be able to make connections between the observable and the unobservable, challenge the juxtaposition of emotional and rational, and create a space for fruitful theoretical and methodological agendas which engage the fundamental issues of social science.
>
> Veronica James and Jonathan Gabe (1996:5)

The interrelated stories I have quilted together in this dissertation emerge from a place of profound grief and concern. They are stories about invisibility and loss, lack of recognition and subordination. They are also stories of knowledges, skills, perseverance and possibility. They are stories of women's work, nursing work, and the endeavor of this native gone sociologist to make sense of efforts and transformations witnessed during twenty years of work and service in the health care industry. Informed by analytic frameworks of sociologists, anthropologists, feminists, philosophers, psychologists, healers, nursing theorists, health policy analysts, therapists, journalists, and other students of culture, I weave a tale of work and power, of gender and discourse, of economics and healing.

At the hub of this tale is the concept of emotion and its 'material referent' of embodied/discursive responses to human experiences. I have chosen to read nursing through emotion in a deliberate shift of perspective away from medical science and reason

and toward the embodied and experiential aspects of doing the work of health and healing. My goal is not to rehabilitate the 'inferior' aspect of the dualism, nor to suggest some comfortable synthesis, but rather to rupture the opposition as inaccurate and dangerous. Deeply inscribed assumptions about what counts as knowledge and truth are embedded in binary oppositions of emotion/reason, body/mind, subjective/objective and affect what gets seen and what is rendered invisible. Without disruption of these frameworks, some aspects of nursing work cannot be adequately recognized and valued.

Catherine Lutz (1990:69) has suggested that the organizing category of 'emotion' is so closely associated with the female that "any discourse on emotion is also, at least implicitly, a discourse on gender." Emotion is *both* devalued in relation to reason and thought *and* exalted as the warm, sensitive and authentic side of human nature, summoned to counteract the cold hard-heartedness of pure science or economics. Dilemmas of emotion work (Hochschild 1983) in nursing intersect with other considerations about what counts as work and which skills merit what kinds of reimbursement. Foregrounding emotion in healthcare challenges 'the bifurcation of the medical and the social' (Fisher 1995) and asks which 'needs interpretations' (Fraser 1989), based on what kinds of knowledges best inform patient care. This effort to reposition emotion work in nursing also challenges dominant definitions of emotion as purely private and interior, pointing to interrelations between sociocultural and psychobiological dimensions of health and healing.

Juxtaposition of nursing and emotion provides a rich vantage point from which to investigate the meanings of both: as micropolitics, in a political economy, within gendered divisions of labor, and as sites of discursive intervention. Highlighting emotion work is an attempt, among other things, to influence the attribution of value to complex practices of nursing at a time when directives for clinical efficiency and cost effectiveness are transforming interpersonal relationships and changing the dynamics of nursing expertise. More broadly this story tracks meanings and performances of emotionality in (post)modern economic contexts. Strategies of capital accumulation in many service industries involve commodification of interpersonal exchanges between workers and customers. Nursing today, then, is one instantiation of larger cultural struggles over

interpretations of human needs, gendered divisions of labor, and the distribution of social and economic resources.

The term 'nurse' comes from the Latin, *nutrire*, to nourish, and refers to "1. An individual who provides health care." As a verb, it means: "2. To feed an infant at the breast. 3. To perform the duties of caring for an invalid. 4. To care for a young child" (Taber's Cyclopedic Medical Dictionary, 1997). Contained in these definitions are strong images of character and personal involvement. A 'kind of person' who provides, who cares, who undertakes performance of duties. A woman who offers the embodied nourishment of her breast, who tends to young children and invalids. These are uses of self that stake out positions of morality, service, attentiveness, hard work, and righteousness. They are based on gendered assumptions and embedded in particular models of womanhood and femininity that shape the ideological, social and economic contexts of nursing. They also underlie an 'ideal type' of what nursing work is 'really' about.

Although nursing theorists have attempted to define nursing work on its own terms, struggles for meanings and scope of practice continue to take place in relation to the powerful Other of medicine. A recent nursing textbook offers the following definitions:

> Nurses deal with "the diagnosis and treatment of human responses to actual or potential health problems," whereas medicine is primarily concerned with the diagnosis and treatment of illness or injury. The emphasis for nursing is the *response* of an individual or group to an actual or potential health problem rather than to the disease process itself. (McCash 1996:3, emphasis in original)

Here nursing is identified as occupying an interpersonal turf, while medicine is given domain over clinical arenas of diagnosis and treatment. Dominant epistemologies of experimental science reinforce the validity of certain types of clinical knowledge over experiential know-how, leaving other kinds of nursing knowledges and skills largely invisible, undervalued and taken for granted.

Historically, nursing leaders have struggled for legitimacy by identifying alternately as a science, based in logic and reason, and as an art, encompassing the warmth, compassion and moral superiority of female ministrations. On the level of practice, nursing work has taken place within gendered divisions of labor which have generally *assumed*

that contributions of feminine nurturance would accompany other caregiving tasks. Usually described in relation to masculine forms of biomedical science and bureaucratic organization, nursing exists within systems that have acknowledged some activities as legitimate but have lacked languages and appreciation for others. Defining themselves under conditions not of their own making, nurses have developed, sustained and passed on 'invisible' knowledges and skills alongside more 'officially' recognized work of their profession.

This study investigates clusters of meanings and practices within and surrounding work performed by nurses for which there are no easy vocabularies. It involves perceptions, expressions and activities engaged by nurses in interactions with patients, family members, doctors, colleagues or other employees. It concerns a wide range of sensitivities and interventions that one investigator (Strauss et al. 1985) grouped together as 'sentimental work.' Some contemporary nursing leaders (see for example Benner 1989; Watson 1985) have developed vocabularies of 'caring.' Others have used social science languages, speaking of 'psychological,' 'interpersonal,' 'relational' or 'psycho-social' dimensions of care. Many textbooks describe these aspects of nursing as 'the nurse-patient relationship.' I have chosen to build on Arlie Hochschild's (1969; 1975; 1983) concept of 'emotion work' to explore these complex knowledges and practices within contexts of rapidly changing managed health care.

Hochschild defines emotion work as the management of feelings according to socially mediated display and feeling rules that indicate what can or should be felt and expressed, by whom, and under what circumstances, especially in contexts of employment. She notes that in the highly interpersonal work environments of many contemporary service jobs, employees are expected to control and manage their own as well as customers' feelings with commercial outcomes in mind. Within institutions restructured by for-profit managed care, nurses confront overlapping and contradictory dynamics regarding uses of self and productions of emotionality in their work. Earlier discourses about serving patients' needs are being overlaid with organizations of work that now frame 'customer satisfaction' as a product to be sold, ultimately, for the benefit of stockholders. One nursing leader explained,

> Third-party payers are beginning to request patient satisfaction information to make decisions about which health care provider to choose. ...Therefore, as consumers demand greater interpersonal service, we [nurses] must become more adept at achieving patient satisfaction. Consumers want more than excellent clinical skills; they also want and have come to expect personalized, empathetic care (Kerfoot 1996:59).

Emotion work may shift from invisibility to requirement, but in both instances it remains problematic. Individual nurses interact according to a variety of emotion scenarios in employment settings where multiple, overlapping and contradictory discourses about 'emotions' and 'work' shape what enactments of self/selves are possible. As health care services are being redesigned according to the directives of managed care, paradoxical trends of reduction of and increased attention to emotion work can be simultaneously noted. On the one hand, institutional support is lacking for contingent and unpredictable aspects of work not easily rationalized for economy and efficiency. On the other hand, employees are taught sophisticated means of self-surveillance and expected to give stylized performances of hospitality and niceness that may be precursors, in this historical moment of rapid economic and structural change, of new forms of emotionality. The transformations are societal, linked to fundamental shifts in economic and social organization that some have called late capitalism or postmodernity (Harvey 1989; Jameson 1992).

In this study I track concepts/processes of emotion and work in nursing in order to historicize and analyze the interplay between structures and emotions, taking into consideration both macro and micro dimensions of societal transformation. Nursing work in particular, and service work more generally are sites in which the 'commodities' marketed are both discursive productions *and* sets of material relations that involve emotional labor between workers and customers. Therefore, I weave analyses of various 'definitions of the situation' with explorations of embodied feelings, expressions and enactments implicit in the *doing* of the work. Tracing how newer configurations are nested in older meanings, assumptions and enactments, I focus on *both* structural and organizational factors *and* interpersonal dynamics that are shaping emotionalities of participants. This combination is requisite to historicize emotion work in late capitalism.

Both emotions and nursing are dynamic, complex, and contested clusters of meanings and practices. Both are discursively linked to the feminine and are undergoing transformations. But to suggest that certain kinds of emotion skills and knowledges *matter* and that their loss is consequential for processes of health and healing is to risk invoking a classic double bind. If women are defined as inherently emotional, and it is their natural proclivity to do such work, *and* emotion is defined as less valuable than reason, then any affirmation of the importance of emotion work is also an implicit acceptance of subordination. The history of nursing is riddled with different versions of this double bind.

As a nurse seeking to reclaim these aspects of work yet evade at least the worst excesses of this double bind, I hope to identify ways that emotions transgress boundaries between mind and body, social and individual, thought and feeling. I propose to investigate the historicity of emotionality, noting ways that feelings and expressions are not innate, but depend on context and circumstance. I contend that new vocabularies and possibilities for enactment are needed that contribute neither to invisibility nor to surveillance, but rather open pathways toward kinds of emotionalities and selves that can promote health and healing.

Theoretical and Methodological Approaches

In order to study intersections of emotion, nursing and work, I have conducted a qualitative study of experienced working nurses focused on changes evoked by managed care and related shifts in practices. Theoretically, I draw on literatures and analytic frameworks from several disciplines. To look at emotion, I ground this study in constructionist and interactionist perspectives in sociology, with particular attention to contributions from the sociology of emotions. Theories that focus on contextual, interactive, and interpretive frameworks, while distancing emotion from positivist, intrinsic, and psychobiological explanations, have been most helpful. Philosophers have debated the nature of emotion, referred to previously as 'the passions,' since classical Greece. Some dilemmas raised long ago continue to be relevant to the study of emotion. Anthropological studies of emotions have drawn attention to cultural and historical variations, to connections among languages and emotions, and to issues of embodiment and emotion. A more complete review of theories of emotion is found in Chapter Two.

To explore meanings and practices of nursing across time, I have read nursing histories and theories, tracking perspectives on interpersonal aspects of patient care from early twentieth century texts to recent policies and procedures. Clinical nursing literature provides insight into dominant psychological, neurological and biomedical knowledges about the physiology of emotions, often linked to theories about stress. Feminist, philosophical and nursing literatures address problems of ethics, caring and empathy in healthcare, all of which touch on emotions. Feminist theories that clarify issues of gender, narrative, and considerations about studying women's experiences have been especially helpful, as have discussions of epistemology, knowledge practices, and difference. Medical sociology, economics and health policy offer perspectives on the political economy of health care and its impact on nursing.

Examining work and workers, I refer to the sociology of work, occupations and professions, especially symbolic interactionist perspectives on these. Classical studies of alienation and bureaucracy, as well as recent (post)Marxist explorations of work processes, technologies, informatics and management sciences provide perspectives on today's service society. Foucault's (1972; 1973; 1978; 1979) writings on power/knowledge, discipline, surveillance and social control offer valuable frameworks for examining body, emotion and work. Postmodern and cultural studies address questions of self, identities and subjectivities, suggest multicultural approaches, and offer analyses of the 'cultural logics of late capitalism' (Jameson 1992).

This study, then, is an interdisciplinary project, weaving its stories from a broad range of substantive and theoretical perspectives. Important threads that help tie them together are a focus on the interconnections among meanings and practices, and an appreciation for the interplay between macro and micro, between structures and interactions. Emotions are conceptualized as complex discursive/embodied enactments that transgress boundaries of inner and outer, and link psyche to context as well as to action. Emotions are actually verbs more than nouns, and 'doing emotions' is 'doing sociality' in ways that *both* shape *and* express subjectivities.

Another understated theme concerns the presence of paradox, and the *both/and* that informs many aspects of contemporary life. Multiplicity, ambiguity and contradiction

are among the most constant features of postmodern landscapes. Amidst deconstruction and transformation, residual and emergent forms coexist and interact in both predictable and surprising ways. Perhaps concepts of emotionality appeal because they reflect the flexibility and mutability of our time.

My investigation of the meanings and practices of emotion work in nursing is grounded in the stories and reflections of eighteen nurses working in a variety of northern California health care settings. This qualitative interview study was conducted with an 'opportunity' sample of informants selected from contacts made through acquaintances and associates. I did not attempt to be 'representative,' but instead chose nurses who were either self-identified or identified by others as having well developed 'emotion skills' and as proponents of providing 'emotional support' to patients. I wanted to learn from the 'experts' what they did, how they spoke about it, and how it fit in with the overall demands of their work. I presented myself as both nurse and sociologist, inviting collaboration and dialogue in this quest to give language to under-acknowledged and often unspoken aspects of nursing work. In addition, I was able to draw on my twenty years of experience as a practicing clinical nurse to frame questions, structure analysis, and validate conclusions.

After making initial contact by telephone, I arranged informal meetings of one to two hours with each nurse and conducted semi-structured interviews which were held between Fall 1995 and Spring 1996. A list of general areas of inquiry and probes was developed to guide these conversations. The Interview Guide can be found in Appendix A. I adapted a grounded theory approach (Strauss 1987; 1990) to structure the investigation. The interviews were audiotaped, transcribed, coded and analyzed, moving from categories and comparisons to concepts with properties and dimensions. It soon became apparent that a major theme concerned transformations in emotion work that have accompanied the various efficiency and cost containment measures being implemented under managed care.

All but one of the nurses interviewed had been working as a nurse for more than five years, and the majority had been practicing for at least twenty years. There were many comments comparing 'days gone by' with 'this day and age,' situating patient care

practices within recent structural reorganizations. While these nurses were working in a variety of settings, all spoke of new dynamics and constraints resulting from economic changes. I interviewed only one man, who worked in a dialysis unit. Of the women, six worked in oncology, four in obstetrics, five in public health and home care, and two were hospital supervisors. Several of the clinical nurses had held mid-level supervisoral positions at some time; one was also a nursing instructor.

This sample provided both benefits and limitations. Consisting largely of long-term nurses, the respondents were able to compare and contrast current working conditions with previous expectations and practices. They were all willing and motivated to speak about emotional aspects of their work, and considered them to be important. Coming from a variety of specialties and institutions, they offered a valuable range of variation within common perceptions about nursing practices and meanings. However, other specialty areas might have presented different emotion cultures. Informally, nurses have long recognized that some clinical areas are more technical, while others demand higher interpersonal skills. Nevertheless, there is emotion work in all areas, and managed care is affecting work organization throughout the health care system.

The limitations of this sample were derived in part from its small size. All of the nurses interviewed lived and worked in northern California. Given that geographical differences can also reflect cultural differences, it is possible that some emotion standards vary significantly by location. Additionally, all of the nurses interviewed were white, making it impossible to include observations of racial or ethnic variations. Nursing culture is disproportionately a white culture, though African-American, Latina and Asian practitioners are found in both urban and rural contexts (Glenn 1996, Hine 1989). In this study, I have foregrounded the impact of managed care on interpersonal relations of all kinds. I contend that the transformations discussed in this investigation would be found across racial and ethnic categories.

In order to broaden the investigation, and to situate languages, expectations and emotion standards within an historical framework, I did a content analysis of selected American nursing texts from the early twentieth century to the present. In addition, I examined brochures and announcements of continuing education courses and seminars

currently offered to nurses that touch on themes of emotion management. While the reflections of a small group of nurses cannot be taken to represent all of nursing, the credibility of their comments lies in the repetition of common themes as well as in a range of variation that touches on many of the ideas, attitudes and behaviors of nurses regarding emotionality and their work found in these nursing texts as well.

This triangulation of individual and local expressions of emotional experience with more generic understandings and expectations within nursing's own literature about itself further helped me to integrate levels of symbol and practice. Of course, what people say and what they do are not the same. Dilemmas of representation are compounded when the 'material referents' are as elusive as nuances of feeling. Despite attention to various formal and informal discourses *about* emotion, I remain challenged by "the inadequacies of available language" (Lather 1995:50) to capture complex and inchoate emotionalities.

Building my analysis on the *words* of this group of nurses, I lean more toward the discursive than the phenomenological. This is not an innocent choice. My personal motivation to translate and expose practices of 'therapeutic emotion work' has been tempered by concern to protect these fragile activities. Under potential conditions of surveillance and control, even if it were ethnographically possible, simply 'rendering visible' becomes a problematic strategy. I address some of these theoretical and methodological issues further in Appendix B.

Overview

The presentation of conceptual and substantive findings of this inquiry is organized into five main chapters. Chapter Two examines what nurses have done as emotion work, and what it has been called. I begin with a review of theories about body, mind and emotion, situating 'research agendas in the sociology of emotions' (Kemper 1990b) and tracing new hybrid conceptualizations that destabilize classical mind/body separations. Nurses' uses and understandings of emotion are situated within these overlapping and contradictory discourses. In the second section of Chapter Two, I trace the history of nursing conceptualizations of those elements of nursing practice that in contemporary language might be called emotion work.

In Chapter Three, I turn to the narrative accounts of nursing work provided by eighteen contemporary nurses. I look at work as a link between visible and invisible activities and explore meanings and practices of 'therapeutic emotion work.' I inquire not what emotion *is*, but what these nurses *do* and how they name and describe it. I situate emotion work in relation to concepts of caring, and highlight what Hochschild (1995) has called a contemporary 'care deficit' in both public and private life.

Despite problematic allocation of resources and support, nurses use complex skills and knowledges to provide emotional support to patients in times of illness and life transition. I explore nurses' accounts of 'ways of being, doing and knowing' that are hard to validate and resist standardization. Many of these dispositions and activities are taken for granted and seen as commonplace, barely worth mentioning. Upon closer examination, much of this work not only defies separations of emotion and reason, but also takes place within multiple heterogeneous interpretations of patient needs (Fraser 1989). I end the chapter with a discussion of emotional dissonance, experienced as tensions between disparate and contradictory feeling expectations. For many nurses, these discomforts have been exacerbated by recent changes in their work environments.

Chapter Four focuses on transitions to managed care and nurses' explicit responses to health care restructuring. Corporate strategies for capital accumulation have reorganized health care as a commodity and reconceptualized patients as customers. Emotion work is not alone in being squeezed, but it is subject to regimes of accountability that are less formal than for other tasks. I explore micro manifestations of macro changes, and provide detailed accounts from nurses about ways that their practices of emotion work have changed. Issues of time management, prioritization and self control are discussed.

In Chapter Five, I examine accommodations developed by nurses in response to work intensifications, and explore frustrations expressed about what is lost. Highlighting strategies used by these nurses to 'make it work,' I investigate both institutional tactics and individual efforts. Developing shortcuts, setting limits and keeping personal feelings separate from professional attitudes reflect processes that discipline emotions. While nurses adapt to organizational changes, they also become burned out, glazed over and shut

down in response to work intensification and lowered standards of care. The chapter ends with a discussion of competing definitions of nursing in light of these economic and cultural transformations.

Chapter Six situates dilemmas of emotion work in nursing within broader contexts of late capitalism and the service economy. Theoretical implications of managed care redesign, new subject positions and emerging emotionalities are discussed. Using nursing as one example of societal changes, I trace shifts in the organization of work and workers from modernist to post-industrial forms. For example, nurses working within constraints of cost containment priorities have experienced losses of identity and impediments to being 'the kind of person' they expect to be. What new vocabularies of emotion might reframe meanings and practices in nursing?

Concluding with Chapter Seven, I review the terrain covered, address potential implications for policy and suggest directions for further research. But enough of anticipation; let the story begin...

Feeling Squeezed: Dilemmas of Emotion Work in Nursing under Managed Care

Chapter II What Have Nurses Done as Emotion Work, (and what have they Called it)?

> To tell nursing like it is, is a project that poses seemingly insuperable difficulties for the technologies of representation.
> Kim Walker (1994:53)

> Invisible nursing may be defined as the human side of nursing--that side of nursing having to do with the finer points in the work of the nurse--those things over and above the purely professional and mechanical. ...Some of us give such care without being aware at any time of so doing. Others give it with awareness, and still others, unfortunately, never attain it.
> Martha R. Smith (1937:40)

> The project of making experience visible precludes analysis of the workings of this system and of its historicity; instead, it reproduces its terms.
> Joan W. Scott (1991:777)

In order to explore what, as early as 1937, Martha Smith called the 'invisible' dimensions of nursing, I need a vocabulary that allows me to speak about them. This is immediately problematic, for symptomatic of this invisibility is the absence of an adequate language to evoke and analyze these phenomena. This is hardly an innocent omission. Rather, it emerges from particular configurations of knowledge about what it means to be human, to work, and about the arenas in which tending to sickness and health take place.

Those aspects of nursing that interest me have been called many things over time. It is about the 'intangible' things that go on between a nurse and the person she is caring for. It includes her own feelings and attitudes, her ('non-physical') work tending to the conditions of her patient, and often her relations with other people involved in the patient's care as well. Nursing theory has called this the domain of 'nurse-patient interactions.' Other names refer to 'humanistic,' 'psychological,' 'interpersonal,' 'relational,' even 'spiritual' care. More technical terms refer to 'affect,' 'communication,' 'psycho-social dimensions,' and the 'psychosomatic' side of illness. One important

approach in recent nursing theory has been to subsume these aspects of nursing into a concept of 'caring.'[1] I discuss caring theories in relation to this study in Chapter Three.

Finding vocabularies for the invisible work of nursing is a project that takes place on several levels simultaneously. On one level, there is the problem of translating and representing interpersonal relations that are felt and expressed in verbal and non-verbal ways. As Martha Smith points out, some of the knowledges and activities of this 'invisible' nursing escape the awareness of the participants, occurring in the realm of the 'tacit' or 'taken for granted' (Benner 1984; Garfinkel 1967). So a first layer of this project is to make explicit and render visible these efforts and experiences through examination of actual practices.

To heed Scott's (1991) admonition, however, it is not enough to elicit meanings of this work using the terms of the nurses, even though that *is* part of my intention. Rather, on another layer, I must examine the historical, cultural and ideological conditions that produce *both* silences *and* vocabularies in order to understand how they are maintained through discursive and institutional practices. Furthermore, I must confront often tacit premises about representation that render some experiences invisible, and explore the social, political and economic implications of these lacunae.

Literatures of oppression[2] have found social invisibility linked to reification and naturalization of unequal power relations. Particular discursive formations about 'human nature' allow those in dominant social positions to dismiss alternate 'takes' on 'reality' as inaccurate or insignificant. In the instance of nurses' invisible work, many of those skills and knowledges have been naturalized (and ambivalently devalued) as feminine. Without 'naturalizing' them, how *are* we to talk about experiences that seep beyond the categories of their naming?

The naming that is central to this investigation is the category 'emotion.' Building on the concept of emotion work, developed by Arlie Hochschild (1969; 1983) in *The*

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[1] See for example (Brykczynska and Jolley 1995; Chambliss 1996; Chipman 1991; James 1992; Olson 1993; Phillips and Benner 1994; Smith and Agard 1995; Thomas 1993; Tronto 1990; Tronto 1993; Ungerson 1983; Ungerson 1990; Wood 1994)

[2] See for example (Butler and Scott 1992; Collins 1990; Grewel and Kaplan 1994; hooks 1984; Mohanty, Russo, and Torres 1991; Moore 1994)

Managed Heart, Commercialization of Human Feeling, I contend that this invisible work must be understood *both* in contexts of divisions and exchange of labor, *and* as examples of embodied enactments of the sociality of emotion in given interactional settings. Attempting to de-essentialize emotion, I am interested in the genealogy of this concept, situating it within larger theoretical deconstructions of mind/body dualisms. What reconfigurations of the concept of emotion might contribute to revaluing the invisible work of nurses?

Historical shifts in the meanings and practices of emotion work in nursing are exemplary of connections between discursive formations, structural conditions and subjective experiences. During this current time of rapid change in health care organizations, nurses need vocabularies to redefine and affirm their/our complex healing activities. Understanding the many-layered social production of emotionality is central to this process. At stake are the experiences and enactments of subjectivity of patients and practitioners alike.

In this chapter, I begin by reviewing historical and contemporary theories of emotion, focusing particularly on the writings of sociologists and anthropologists. I examine nineteenth century views that identify emotions as physiological responses within organisms, then look at interactionist and contructionist perspectives that emphasize cognitive and social aspects of emotions. I next explore hybrid approaches that link body to sociality, and both to the emotions, looking for vocabularies that might better describe aspects of nursing work that so often remain invisible.

In the second section of this chapter, I review the history of nursing, focusing on ways that nurses have theorized interpersonal aspects of their work. Drawing on content analysis of selected nursing texts, as well as other historical analyses, I situate nursing within Victorian ideologies of womanhood and domesticity, and explore assumptions about female ethics and character that shaped early expectations about nurses. I discuss dilemmas of professionalization, noting ways that nurses sought scientific bases and legitimation. I examine technical and managerial strategies that contributed to structural changes in the organization of nursing work, and psychosocial theories that gave more

systematic language to interpersonal work. I suggest that for contemporary nurses, meanings of emotion draw on multiple perspectives from philosophy, psychology, and medical and social sciences, as well as from reflections on the practices themselves.

Body, Mind and Emotion

Theoretical interest in the emotions has grown steadily over the last three decades as writers from a variety of disciplines have re-examined the relationships between self and society, nature and culture, body and mind. Multidisciplinary investigations from psychology, neurology, sociology, anthropology, philosophy, history and feminist studies have questioned the diverse and complex set of feelings, expressions, behaviors and attitudes commonly known as 'the emotions,' attempting to determine what they are and how they function in human life.[3]

As philosopher Amelie O. Rorty (1980:1) observed, "emotions do not form a natural class," referring to the heterogeneous group of 'social things' (McCarthy 1989) that have been grouped under this name. Indeed the wide range of human feelings, experiences and expressions called emotions defy traditional classification systems, rooted in the Cartesian separation of mind and matter. Emotions seemingly concern both cognition and sensation, but many theories have tended to privilege one aspect or the other.

[3] See for example (Calhoun and Solomon 1984; Franks 1989; Harre 1986a; Harre 1986b; Harre and Parrott 1996; Hillman 1960; Kemper 1990b; Lutz and White 1986; Marks and Ames 1995; Rorty 1980; Schwartz, White, and Lutz 1992; Schweder and LeVine 1984; Solomon 1993; Thoits 1989; White and Kirkpatrick 1985)

Organismic theories

Ever since the philosophers of classical Greece, debates over 'the passions' and their relation to reason in human affairs have continued (Calhoun and Solomon 1984). Later philosophers, and then scientists, took up the discussion. In the late nineteenth century, Charles Darwin, William James and Sigmund Freud each developed theories emphasizing the physiological or organismic aspects of emotion. Here I draw on Hochschild's (1983) summary of their work. For each of these theorists, emotions are classified as biological processes that exist in the organism *prior to* any social or cultural influence. Building on their theories, researchers have identified and labeled the particular qualities of specific emotions independent of context or temporality.

Darwin defined the emotions as a kind of instinct, common to animals and man, linked to visible gestures. These gestures were the evolutionary vestiges of acts; for example scowling and the baring of teeth were reminiscent of biting and linked to anger. James felt that emotions were the brain's response to instinctual, visceral changes. Environmental stimuli thus triggered autonomic responses in the body. These bodily perturbations and visceral feelings were perceived and felt as emotions. In these models, the emotions were autonomous and prior to the thinking self. In Freud's work, the emotions were linked to the libido. He postulated instinctual drives that would build up from excess stimulation then need to be discharged as emotion. The ego was challenged to control these forces. Anxiety served as a model for the emotions and represented the anticipation of danger. Ego defenses served to protect the self from these real or imagined dangers.

Such organismic models of the emotions are compatible with liberal humanist views of the individual self inherited from Enlightenment philosophers of the seventeenth century. The Cartesian separation of mind from body, Kantian distinctions of reason from emotion, and the elaboration of 'natural law' and the 'rights of man,' all enabled the conceptualization of a rational, utilitarian, gain-maximizing 'self' at the core of each autonomous free man. The concept of a unitary reasonable self has been sustained in part by a strategic separation and differential treatment of the emotions. Disowned and

relegated to the periphery of what counts as 'higher self,' emotions become residual categories for those dimensions of human experience that are Not Reason.

Organismic theories such as those of Darwin, James and Freud thus conceptualize the emotions as physiological responses located within the individual and thereby separate actors from their situations of relationships with other people and non-human objects. Claims that emotions are universal serve to reify behaviors and attitudes that originated in historically situated and particular patterns of interaction. Organismic models of emotions tend to postulate an inner hierarchy within the individual, whereby emotions are reduced to impulses that must be 'released' or 'controlled' by a cognitive self. Much experimental research on the emotions in psychology, physiology and medicine has been based on such organismic models. For example, pharmacological agents have been developed that alter psychological states. Therapeutic interventions focus on release or control as dominant approaches to working with the emotions. Commonsense understandings of the emotions indicate a wide acceptance of the organismic model in Euro-American society. Many assumptions about emotions found in nursing texts are based on these models (for example, Potter and Perry 1989; Thompson and al. 1989).

Constructionist and Interactionist Origins

In contrast to organismic theorists, who have in the past and continue to identify emotions as psycho-biological entities, interactionist and constructionist theorists have conceived of emotions as emergent processes and experiences, explicitly situated in social and cultural contexts from which their meanings are derived. Here emotionality is understood to be an aspect of social interaction between people. Like language, its meanings are *prior to* the individual and held within interpretive communities. As with language, "[w]e can do only what our linguistic resources and repertoire of social practices permit or enable us to do" (Harre 1986a:4). In the case of emotions, the 'phonemes' are bodily sensations and gestures, voice intonation, and verbal and nonverbal cues. How they are combined, under what conditions, and with what meanings are empirical questions.

In the first half of this century, several important theorists contributed to a sociological perspective in which personal meaning is inseparable from social situation,

making arguments that meaning is socially constructed. Without specifically emphasizing the study of the emotions, the works of American pragmatists John Dewey, and George Herbert Mead, sociologists William and Dorothy Thomas, and others set the stage for conceptualizing emotion as social. Dewey rejected the "dualism between sensation and idea," suggesting that "what the sensation will be in particular at a given time, ..will depend entirely upon the way in which an activity is being used. It has no fixed quality of its own" (cited in Meltzer, Petras, and Reynolds 1975:18). Dewey's concept of habit, "an acquired predisposition to *ways* or modes of response; ...standing predilections and aversions, rather than the bare recurrence of specific acts," (cited in Meltzer, Petras, and Reynolds 1975:17) is useful in understanding the situational varieties and complexities of emotional responses.

Emphasizing the importance of shared meanings, William and Dorothy Thomas argued in 1923, "if men define situations as real, they are real in their consequences" (in Stone and Farberman 1970:154). G.H. Mead developed the concept of the 'generalized other,' internalized within the self, and divided into the spontaneous 'I' and the reflective 'me.' He said "the self is not something that exists first then enters into relationship with others, but it is, so to speak, an eddy in the social current and so still a part of the current (Mead 1934/1962:182). Mead explains "that mind can never find expression, ...except in terms of a social environment" (p. 223).

Still without focusing on the emotions specifically, sociologists continued to develop perspectives showing how interpretive dynamics, cultural patterns and historical conditions shape the meanings of human experience. C. Wright Mills identified in 1940 what he called 'vocabularies of motives' (in Stone and Farberman 1970) taken not as private states, but as socially acceptable explanations for actions. Mills called on the sociological imagination to link private troubles with public issues by studying the intersections of biography and history (Mills 1959). Berger and Luckmann (1967) questioned positivist assumptions about social worlds, pointing to the social construction of reality.

Herbert Blumer built on the work of G. H. Mead to develop what he named symbolic interactionist sociology. He replaced the term 'social act' with the term 'joint

action,' conceived as a process with trajectory through time. He emphasized uncertainty, contingency and transformation as part of ongoing interpretation. For Blumer, "all objects are social products in that they are formed and transformed by the defining process that takes place in social interaction. ...The meaning of the objects ...is formed from the ways in which others refer to such objects or act toward them" (Blumer 1969:69). It is in this sense that emotions are social things (McCarthy 1989).

Erving Goffman (1967) used dramaturgical metaphors such as backstage, frontstage and face-saving to elaborate the rituals of face-to-face behavior including demeanors of emotionality. Socially imposed rules of conduct constrain the actions of individuals and are felt as obligations or expectations. Through impression management, individuals manage their presentations of self according to interactively negotiated rules. Infractions lead to feelings of uneasiness, negative social sanctions and embarrassment. These rules are not always consciously recognized but represent a powerful form of internalized social regulation.

Rapprochement of the Social and the Emotions

Critiques of positivist, behaviorist and other deterministic models for understanding the complexity of human activity stimulated renewed attention to the study of emotions in the social sciences. Kemper (1990b) dates the arrival of this research agenda in sociology to 1975, the year of several early publications (Collins 1975; Hochschild 1975) as well as the first session on emotions at the American Sociological Association meetings. The subsequent appearance of numerous articles and anthologies on the subject (Franks 1989; Harre 1986b; Kemper 1990b; Shott 1979) merits examination, both from the perspective of new conceptualizations proffered, and in answer to the historical question: Why now? I address the new conceptualizations in the section that follows. The historical question will be considered in Chapter Six.

Renewed interest in the emotions reflected *both* the concern that social theories could not fully understand human actions without an appreciation of the emotions, *and* concerns that emotions were linked in important ways to cognitive and linguistic (and therefore social and cultural) faculties, in addition to their apparently physiological characteristics. In other words, sociology needed the emotions as much as emotions

needed sociology. Entering turf previously dominated on the one hand by philosophers, and on the other by psychologists, sociologists have sought to define the emotions in terms that reflect their social origins and enactments. Mirroring other debates within sociology, theorists have framed the emotions along a continuum ranging from constructionist to positivist approaches (Harre 1986a; Izard 1990; Kemper 1990a). The former tend to emphasize cognitive, intentional, and therefore mental aspects of the emotions, while the latter explore ways that emotions are ('physically') invariant, automatic responses to social stimuli.

With such a wide range of definitions, Thoits (1989:318) notes that most authors refer to emotions in terms of their components, which usually include:

> a) appraisals of a situational stimulus or context, b) changes in physiological or bodily sensations, c) the free or inhibited display of expressive gestures, and d) a cultural label applied to specific constellations of one or more of the first three components. All four components need not be present simultaneously for an emotion to be experienced or to be recognized by others.

Invoking temporality and memory, Hochschild (1983:219) suggests that emotional responses to situations create and convey social meanings according to a 'template of prior expectations.' Individuals learn to enact the emotional repertoires of particular social settings, consisting of narrative plot structures, stereotypes and 'paradigm scenarios' (Sarbin 1986). They come to know complex sets of words, gestures, facial expressions and postures as well as the social rules for display and enactment by whom, for what audiences, under which circumstances.

Emotions situate the subject in relation to something contextual. "..We are afraid of..., mad at..., jealous of..., chagrined because..., sad about..., grieved for..., proud of... and so on" (Harre 1986b:8). They signify intentionality of some kind and denote evaluations of a moral, aesthetic or prudential (as in warning) type, indicating that something is 'intensely meaningful' in culturally significant ways. Emotions provide a 'gut level' sense of the situation, and convey (through disgust, envy, joy, fear, anger or shame) the "local moral order, namely, local systems of rights, obligations, duties and conventions of evaluation" (Harre 1986b:8).

Far more than physiological impulses or drives, emotions reflect awareness of and occur in response to cultural prescriptions, constraints and expectations. These patternings of emotionality have been called 'feeling rules' (Hochschild 1969), 'display rules,' (Ekman and Oster 1979), 'emotional standards' (Stearns 1994), and 'emotion culture' (Gordon 1989), and reflect shared meanings of historically and culturally situated social groups. Anthropologists (Desjarlais 1992; Lutz and White 1986; Lutz 1988; Lutz and Abu-Lughod 1990; Schweder and LeVine 1984; Strathern 1988; White and Kirkpatrick 1985), examining ethnopsychologies of Western and other cultures, have observed that emotional meanings are embedded in cultural understandings about self, gender, social relations and activities.

The groundwork for these and many valuable social studies of the emotions was laid by Hochschild (1983) in her investigation of the 'emotion work' required of airline flight attendants to manage their feelings as part of their job. She distinguished between the feeling rules governing private interactions and the ones required in commercial situations, such as displaying pleasant emotions to 'make the customer happy,' or expressing anger to induce compliance, as with bill collectors. Hochschild noted that social actors are skilled at modifying and managing both the 'outer' expression and the 'inner' feeling of emotions to fit expected scenarios. In surface acting, the actor simulates an emotion, while with deep acting, the actor uses the imagination to alter and realign what is felt, in a sense *becoming* the expected emotion. Employers rely on these capacities of employees, especially in service occupations, and identities are shaped through their performances.

Vocabularies of emotion are used by participants to describe their feelings and their interpretations of the feelings of others. They reflect the ordering of inchoate, non-verbal sensations within various local and cultural meanings and take shape in the unfolding enactments of scenarios, performances, expectations, and resistances. Discourses *about* the emotions (Lutz and Abu-Lughod 1990) influence common sense interpretations (displayed and reinforced in popular culture), as do expert understandings about the emotions (such as those provided by the social sciences, medicine and

philosophy), and contribute to the cultural repertoires of feeling and display rules available to social actors.

The semiotic functions of verbal and non-verbal communications are culturally specific and laden with social meanings. Non-verbal displays, such as facial gestures, crying or a fist, may have more 'illocutionary force' (Austin, cited in Harre and Gillett 1994) than the verbal equivalent. Yet both verbal and non-verbal components of emotional expression are learned, social responses, so constructionists conclude that emotions are inseparable from cognition. "As emotions become lived experiences, they are cognitively understood, linguistically labeled, socially situated, and ethically and pragmatically evaluated, as they become elements of social acts." (Perinbanayagam 1989:76). Self, emotion and social situation are interwoven as feelings and their linguistic expression become meaningful in the interpretive moment. Furthermore, emotion, taken from the Latin *to move*, is seen as a motivator that generates the energy to act or react, punctuating relations between social meanings and social acts.

By transmitting norms and expectations, emotions figure prominently in both the dynamics of social solidarity and social control. For example, 'empathic role-taking emotions' motivate activities of helping and service, while 'reflexive role-taking emotions' motivate acts of self-control and containment (Shott 1979). Gendered, raced, classed, and other social positionings both influence and are influenced by emotional experiences and expectations. Displays of fear, anger, compassion or envy are sanctioned in some contexts and forbidden in others. Relationships of power and status elicit emotions (Kemper 1990a), and they enter into negotiations of 'social place' (Clark 1990). Feelings and expressions of shame, belittlement, pride or empowerment convey information about local social ranking, expected attitudes and anticipated treatment. Emotional strategies and exchanges of emotional 'gifts' can create, sustain or alter social placement.

Emotion strategies are reflected in languages *about* emotion, through which speakers express their motives, intentions and interpretations. In extended interviews with women and men, Lutz (1990) found striking gender differences in the 'rhetoric of emotional control' participants used to describe their own emotional lives. In their talk, women play the role of controller and controllee, identifying themselves as both

undisciplined and capable of self-discipline. Lutz (1990:74) suggests that "the construction of a feminine self includes a process by which women come to control themselves and so obviate the necessity for more coercive outside control." bell hooks (1993) writes that a black mother will punish her children not because she is angry, but because she is concerned that they behave 'appropriately' in public (white) places. Self-sanctioning, in the guise of emotional control is a powerful cultural form of social control.

'Emotional deviance' is the experience and expression of emotions that "differ from that which is expected, conventional or obligatory to feel and display" (Thoits 1990:181). Members of subcultural or protest groups mobilize the participants' deviant feelings to create and legitimize new emotion norms. These 'outlaw emotions' (Jaggar 1989) such as rage or pride, can be subversive and empowering. They represent alternative definitions of the situation and can be the impetus for fruitful social action (Burfoot 1994). People with multiple roles and social locations may have contradictory or incompatible feeling expectations that result in deviant emotions (Thoits 1990) or ambivalence (Weigert 1991). As Hochschild (1983) so vividly noted, the context of work is one in which conflicts arise between private feelings and expected public displays.

Bringing the study of emotion into the arena of work and organizations disrupts separations of private from public, inner from outer, and subjective from objective (Fineman 1993). It juxtaposes emotion with rationality, and highlights definitional dualities that separate feeling from thought, emotion from reason, and the expressive from the instrumental (Putnam and Mumby 1993). Local and extra-local assumptions about the meanings of emotion influence what counts as work, who should do what aspects of interpersonal labor and how. "What is of most interest is how the concept of 'emotion' is used or invoked rather than the search for definitions, either in general or in particular" (Hearn 1993:146).

Critical for the study of nursing as an occupation are gendered assumptions linked to the "concept of emotion ...a master cultural category in the West" (Lutz 1988:54). Lutz outlines how gender ideologies and power relations are sustained in a series of oppositional definitions that contrast emotion with reason, cognition, logic and thought. Associated with the irrational, the subjective, the physical, and the uncontrollable, emotion

is aligned with the feminine side of these classic dualisms. The emotion work of nurses takes place within a context of hegemonic ideas about women's 'natural' characteristics and the 'private' world of feeling. Lutz explains further that a contradiction runs through these definitional pairs. On the one hand, emotion is devalued in relation to reason and thought, on the other hand, it is exalted as the warm, sensitive and authentic side of human nature, contrasted romantically with cold, alienated hard-heartedness.

Traditionally, organizational models have reflected bureaucratic rationality, which "succeeds (by) eliminating from official business love, hatred, and all purely personal, irrational, and emotional elements which escape calculation" (Weber in Gerth and Mills 1946:216). While emotional exchanges accompany all social interactions, the 'mix' of reflexivity and emotional expression varies according to the situation (Mills and Kleinman 1988) and there is always the potential to call something 'emotion' or not (Hearn 1993). 'Rational behavior' and 'affective neutrality' are management styles that have been valued as detached and objective. Adopted by professionals, managers, scientists and such, this stance is used to project authority through performances in which emotions are controlled or hidden.

Masculinity tends to be constructed in situations where cognition is constructed as high and emotion is low, giving an impression of control. By contrast, definitions of femininity and emotionality are entwined, reflecting alternately irrational and nurturing aspects of emotion. The concept of emotion work is gender neutral, but the emotional performances associated with different types of emotion work are likely to be deeply shaped by gender considerations. In addition to gender, family background, class position, race, ethnicity and other socio-historical factors influence how individuals, situations and social actions are classified and played out.

Constructionist theories about emotions contribute to a rapprochement of the social and the emotions by emphasizing the cognitive component of emotions and distancing them from reductionist physiological views. Linguistic approaches compare vocabularies of emotion and examine their situated uses by whom, for what purpose, noting cross-cultural variations and their relative, hence non-'natural' constructions.

Discursive approaches highlight the ways that cultural themes about emotion are embedded in definitional framings and classification schemes, shaping and shaped by local meanings. Interestingly, all of these theories draw heavily on cognitive aspects of the emotions and represent efforts to legitimize emotion and its study in the heavily rationalized social sciences.

Emotion as Embodied Sociality

> Emotion can be studied as embodied discourse only after its social and cultural - its discursive - character has been fully accepted. (Lutz and Abu-Lughod 1990)

While the study of emotion has benefited significantly from perspectives that have disaggregated its framings from organismic reductionism, a second set of considerations about the social body and embodiment[4] provide signposts for its reinsertion into the body. Feminist philosopher Elizabeth Grosz (1994:xii) resists models and metaphors that remain committed to a dichotomy of mind and body. She proposes the image of the Möbius strip, an inverted three-dimensional figure eight, and asserts that "bodies and minds are not two distinct substances or two kinds of attributes of a single substance but somewhere in between these two alternatives." It is the context of such an 'imagined elsewhere' (Haraway 1991a) that the production of emotionality must be studied.

The theoretical work of destabilizing categories such as mind and body is hampered by a lack of appropriate terms outside of pre-existing oppositions and dualisms. In the spirit of transgression, I seek to identify emotion as neither/both mind/body, culture/nature, outer/inner, social/personal. Efforts to name the hybrid in question include 'embodied thought' (Rosaldo 1984), the 'mindful body' (Scheper-Hughes 1987), the 'expressive body' (Freund 1990), 'embodied subjectivity, psychical corporeality' (Grosz 1994), and the 'somatization of social relations' (Lyon and Barbalet 1994). Tiptoeing through conceptual minefields of reductionist 'body' and reified 'society,' I seek to

[4] See for example (Calhoun and Solomon 1984; Franks 1989; Harre 1986a; Harre 1986b; Harre and Parrott 1996; Hillman 1960; Kemper 1990b; Lutz and White 1986; Marks and Ames 1995; Rorty 1980; Schwartz, White, and Lutz 1992; Schweder and LeVine 1984; Solomon 1993; Thoits 1989; White and Kirkpatrick 1985)

reconfigure the emotions as mercurial border-crossing messengers among these complex interwoven entities.

Emotions are simultaneously linked to sensation, expression and perception, as in the experiences of 'lived body' explored by a variety of phenomenological and psychological theorists (Gallagher 1956; Merleau-Ponty 1962), *and* related to dynamics of social control, as in practices of surveillance, inscription and incorporation (Foucault 1972; 1973; 1978; 1979; Hayles 1992). Languages must be developed that allow back-and-forth understandings of felt responses to lived experiences, and recognize these formulations as emergent negotiations of identity, situation, constraint and possibility. Suggestive of directionality, emotions seem to move from within to outside and from outside in, though close examination of the constructed nature of embodiment problematizes such dynamics.

Denzin (1990) calls for a phenomenological interpretation of emotional experiences that is at once embodied, cultural and historical. He proposes to investigate the feelings of the lived body and distinguishes four aspects of the body: the physical body, the body felt from within by the person, the body as it acts and is seen by others, and the body as it expresses the self for the person. "Emotional practices are embodied, embedded actions, ..codified in social and cultural texts, ..that produce feelings of the lived body, value-feelings and feelings of the moral person" (Denzin 1990:89). Noting that emotional experiences are gender specific, Denzin suggests that cultural texts, such as films, can be read as examples of "how concrete individuals are constituted as subjects who have particular emotional experiences in specific emotional sites" (p. 94).

Accessing the embodied, emotional experiences of another (or one's self) poses methodological questions as well as ontological and epistemological ones. Merleau-Ponty distinguishes between the physiological body and the lived body, stating that the latter cannot be localized or objectified. The lived body is known through implicit or tacit knowledge in a pre-reflective way that implies 'ownedness' ('my' hand) but not in a way that makes 'me' the subject and 'my body' the object (see Gallagher 1956). According to Merleau-Ponty, a 'body-image' or 'corporeal schema' allows 'me' to be spatially located in relation to that which surrounds me. "It is by means of my body that I am able to

perceive and interrelate with objects; it is my mode of access to objects" (Grosz 1994:92). The body itself, however, cannot be known as an object to itself, but rather in position and in movement in relation to the world.

By analogy to, and indeed in association with, the body, an 'emotional schema' might be that which allows us to form a picture in our mind of how we are feeling. Here feeling rules, interpretations, memories, habits, expectations and scenarios shape and are shaped by bodily sensations to form lived experiences of emotionality. Languages, gestures, tone of voice, tears, nausea, shivers and other modes of expression are the communicative 'stuff' available to self and others for interpretation and meaning making. Ellis (1991a) proposes an 'emotional sociology' that would seek to evoke 'self-feelings' through thick descriptive narrative texts. This 'interactive introspection' (Ellis 1991b) would access private, inner dialogue and the publicly shared symbols that help to shape it.

Introspective investigations of 'lived emotional experience' are a rich opportunity for evoking and expressing personal and social meanings of emotionality. They rely primarily on language in the form of story and narrative to convey the complexity and ambiguity inherent in emotional processes. Here, approaches to human experience espoused by the arts and humanities are invaluable. Philosopher Nussbaum (1990:296) claims that emotions emerge from beliefs about what is valuable and important and that these beliefs are embedded in and taught by stories. "Narratives, ...(in) their very forms are themselves the sources of emotional structure, the paradigms of what, for us, emotion is."

Taking shape at intersections of body and story, emotions are historically and culturally specific 'structures of feeling' (Williams 1973) embedded in bodily sensation. Bourdieu (1977) describes the *habitus* as a series of regulated improvisations whereby 'history is turned into nature.' Characteristic ways of gesturing or moving are part of the early socialization of children into appropriate gender and other culturally specific modes of being in body. The 'unconscious' is the *forgetting* of the history whereby embodied knowledge is durably installed, without being recognized as such. Bourdieu warns that the language of *interaction* alone can omit relationships of *objective structure* that link members of a group or class. The embodiment may *appear* to take place individual-to-individual, but is in fact the product of collective history. Individual experiences will vary,

and dispositions of class or gender are embodied in *both* durable *and* flexible manner. Bodily memories remain in the body as *habitus*, below conscious awareness, resistant to intellection.

The body is enculturated through *both* inscribing and incorporating practices. Highlighting tensions between discourse and materiality, Hayles (1992:157) discusses the interplay between constructions of the body and experiences of embodiment. "(I)ncorporating practice (is) action that is encoded into bodily memory by repeated performances until it becomes habitual." These practices are improvisational, contextual and highly resistant to change. They are screened from conscious view because habitual, and obscure to cognition while defining the boundaries within which conscious thought occurs.

Approaches to understanding embodied, lived experiences of emotion risk taking these experiences as unproblematic and given, falling into naturalizing or essentializing stances. It is therefore necessary to couple explorations of corporeal perspectives with inquiry into knowledge productions and social practices of emotionality within historical contexts, noting ways that cultural inscriptions participate in shaping body and emotion.

In Foucault's (1972; 1973; 1978; 1979) work the body is taken to be an inscriptive surface, produced through deployments of power/knowledge embedded in all social interactions. Genealogies of sexuality and the disciplinary practices of such social institutions as the military, religious orders, prisons, clinics and schools, explore historical changes in Europe since the seventeenth century that have resulted in increased bodily surveillance and control of individuals. Professional knowledges and disciplines of law, medicine, science and education have disseminated and enforced certain conceptualizations of 'human nature' that constitute and reinforce 'relations of ruling' (see also Smith 1990).

An effective way to control populations is to control the way its members feel. The 'confessional technologies' (Foucault 1979) perfected in psychoanalysis, as well as the self-help methods of popular psychology, are powerful stories that frame/are framed by body/emotion. Practices encouraging disclosure and normalization are often designed to expose feelings of the weak while hiding the feelings of the powerful. As with sexuality

(Foucault 1978), clinical codification of emotion is the result of knowledge/power practices that encourage introspection under the medical gaze. Widely disseminated psychological perspectives identify isolated individuals and their personal emotions as the primary site of social concern, displacing awareness of collective subjugations *and* affiliations.

Numerous authors have explored how the knowledges and practices of biomedicine have shaped contemporary conceptualizations of the body, human nature and the relations between self and society (Conrad and Kern 1990; Fox 1994; Freund and McGuire 1995). Medical models have perpetuated philosophical and ontological separations of soma from psyche (Good 1994; Lock and Gordon 1988), prioritizing materiality and objectivity as site and method for their facts. Yet neurologists, physiologists and behaviorists, in identifying biochemical responses and neurological pathways that correspond to various felt or lived emotions, are beginning to identify suspected connections between body, mind, emotion and environment (Dunbar 1947; Rossi 1986; Temoshok, Van Dyke, and Zegans 1983; Van Dyke, Temoshok, and Zegans 1984).

Complex relations between neural pathways, limbic, endocrine and immune systems are being mapped (Damasio 1994) that reconfigure understandings of the body and its functions in important ways. Stress, placebo effect, relaxation response and other psychoneuroimmunologic mechanisms affecting mind/body healing have been demonstrated. If biomedical experts have been slow to take up the implications of this research, popular, self help and alternative practitioners have widely elaborated on the connections between emotions and health (Padus 1986; Ruskan 1993). Views of the body as a collection of organs hierarchically organized under a central command system, overseen by the mind are being replaced by images of an interconnected immune system.

For anthropologist Emily Martin (1992; 1994), these new conceptualizations of the body as a complex, flexible system of chemical and neurological communication and feedback are also indicative of new socioeconomic conditions within which these bodies are living. Suggesting that scientific models emerge from within the particular historical conditions under which they are created, Martin traces the shift from Fordist forms of

economic production to the global flexible accumulation strategies of late capitalism. She demonstrates the emergence of the flexible body as model and ideal type described in both medical and economic contexts.

In order to examine changes in the meanings and practices of emotion work by nurses, I follow Martin's framework of linking conceptual understandings of body and emotion to socioeconomic conditions of production. As service industries in general, and health care services in particular adopt organizational models of managed care, new conceptualizations and performances of emotionality are emerging that alter experiences of self and formations of identity in workers and clients alike. But before addressing the conditions of contemporary nurses, it is necessary to trace the history of nursing and to situate concepts of emotion and work within already fluctuating sets of meanings and practices.

Concepts of Emotion in Nursing

Origins

When Descartes distinguished between the *res cogitans* (mind) and the *res extensa* (substance or body) in 1637 (cited in Damasio 1994:248), he did so in part to absolve scientists interested in performing dissections on cadavers from any transgression that these activities might represent in the eyes of the Roman Catholic Church. Leaving care of the soul to the ecclesiastics, medicine sought to claim the physical body as its object of study. Nursing, however, continued to evolve out of a different tradition, that of ministering to the suffering of the sick.

> In the first and second centuries, the visiting of the sick was a part of the duty of all Christians but especially the deacons and deaconesses, who took the poor and homeless members of the group into their own homes and cared for them there. No technical preparation was considered necessary for such service. All that was asked was devotion to the faith, brotherly love, and obedience to the Christian law of hospitality and service (Isabel Maitland Stewart, cited in Donahue 1985:88).

The Greek verb *daikonein* 'to serve' meant, among early Christians, to distribute alms or 'minister' to the poor. During the first centuries of the Church, deaconesses were unmarried women or widows, usually mature, from well-born families whose primary

work was to assist with the adult baptism of newly converted women. In addition, they "provided food, money, clothing, medicines and physical and spiritual care to those in need" (Donahue 1985:105). From the fourth and fifth centuries, there are records of an ascetic community of women devoted to prayer, study, and charitable works, including care of the sick that was established by a group of independently wealthy Christian matrons in Rome.

As the organization of the early Church expanded, it became the practice for each bishop to establish a *xenodocheion*, or charitable institution that included such services as travelers' inns, hospitals for the sick and insane, care for orphans, the elderly, the deformed, widows, and the poor. Here widows and nuns lived and served, tending in their wards to the needs of body and soul. By the end of the Middle Ages, hospitals, organized and run by religious orders, were established in most large European cities. During the twelfth and thirteenth centuries, secular nursing orders included groups of knights, dedicated to the care of sick and wounded crusaders, and groups of women in Belgium, known as Beguines, who lived communally, caring for the poor and ill. While outside the direct control of the church, these groups resembled monastic orders in many ways and continued to treat spiritual and physical care as part of the same charitable work (see Donahue 1985).

Less formally, women cared for the old, the infirm, and attended those birthing and dying, in their homes and villages. Knowledge of herbs and first aid, charms and rituals were passed on as part of the lore of how to live. Healing was connected to magic and sorcery. Even medieval science was guided by alchemy, astronomy and theology. However, when physicians, surgeons, barbers and apothecarists formed guilds to regulate their trades, women were largely excluded. While a few female physicians were well known, most women healers were not allowed access to medical training or early forms of official sanctioning of the healing arts (Achterberg 1990). Women's healing work was categorized as domestic service and their knowledges were simply part of household management.

The separation of female, domestic healers from the precursors of medical science escalated during the Renaissance. Building on the persecution of Jews and heretics, Pope

Innocent VIII declared witchcraft a heresy in 1484, furnishing inquisitors with the *Malleus Maleficarum*, a manual that identified the crimes of witches. Midwives and herbalists, often from the lower classes, were among those tortured and burned throughout Europe (Starhawk 1982). During this same period, the Catholic Church eventually lost its long-held monopoly on the approval of knowledge. New professional elites created exclusive institutions of higher learning and licensing procedures that were effectively segregated from the Church and served to limit general access to secular and scientific knowledges, including medicine. In most instances, women were excluded from these formal educational and professional institutions.

During the sixteenth century, disruption of feudal economic and social stability in northern Europe was far-reaching. The influx of foreign capital from colonial ventures, the enclosure of formerly common agricultural lands, the disruption of peasant life and the beginnings of industrial production for wage labor were contemporary to theological changes of the Reformation. While poverty and destitution were widespread, previously organized Catholic systems of care for the poor and suffering were often dismantled. Simultaneous to the loss of lay healers during witch hunts, some monastic religious orders were closed. When nuns and monks were scattered, knowledges and practices of organized caregiving were dispersed.

For example in 1540, shortly after the establishment of the Church of England, Henry VIII confiscated the property of over 600 Roman Catholic charities. The City of London petitioned in 1547 to take over several of these institutions for care of the poor and sick, but there was no organized staff to run them (Donahue 1985). In desperation, nurses were recruited from the least educated classes to do this demanding work. In some instances, women accused of petty crime could choose between serving a prison sentence or being indentured to care for the sick. According at least to nineteenth century reformists, low standards, lack of training, drunkenness and filth were common in English hospitals for the next 300 years.

In America, during colonial times, nursing care was provided informally by family members and neighbors. Overseeing nutrition, hygiene, first aid and convalescent care were among the household skills women settlers were expected to have--as women. In the

southern states, some of these services were provided by domestic slaves (Hine 1989). Colonial missionaries from Catholic Spain and France created charity hospitals run by religious orders in some areas. In the English colonies, secular institutions, such as the Philadelphia Almshouse founded in 1731, "cared for the sick, the indigent, the insane, the infirm, prisoners, and orphans" (Donahue 1985:270). Here, attendants were often from the same poorest segments of the population as the inmates, and conditions were reputedly disorderly and unsanitary. Public 'nursing' served only the most destitute, while women in families and from communities privately tended the majority of the sick.

The early history of nursing tells of women healers involved in activities to alleviate suffering and promote health in informal and formal settings. Informal knowledges, used to provide care for the majority of people, included nutrition, herbs, hygiene and a variety of common sense practices. Formal medical knowledges, available primarily to the wealthy, were largely kept from women. Formal nursing knowledges, passed on through religious orders, included organizational and spiritual dimensions, as well as practical physical considerations. Need for charity was not limited to illness, and a variety of social conditions were also addressed. Primary qualities and attitudes required for doing this work were devotion, piety and commitment to service. Hierarchical order and discipline were generally accepted as part of some divine plan. The concept of emotion as an individual response to external factors would have made little sense in a worldview dominated by God's will.

The Emergence of Modern Nursing

Modern nursing began to take shape in Britain and the United States in 1854 when women responded to war efforts first in Crimea, then in the American Civil War, by tending wounded and sick soldiers in field hospitals. Florence Nightingale, and her American counterparts, Dorothea L. Dix, Clara Barton, Louisa May Alcott and others, undertook the improvement of appalling unsanitary conditions, lack of supplies, and disorganization. These competent leaders and middle class reformers returned home with the goals of improving health care services, and establishing nursing as a suitable employment for respectable women. For Nightingale, the first priority was to establish rigorous training with strict entrance requirements. Imitating the professional exclusivity

of medicine, Nightingale affirmed that nursing had its own set of knowledges and skills. Separate yet unequal, nursing was to be self-regulating and autonomous; although nurses would obey the medical orders of physicians.

The Nightingale Training School for Nurses opened in London in 1860. By 1873, the first three U.S. nursing schools, based on the Nightingale model, had opened in New York, Boston and New Haven (Reverby 1987). This expansion of secular nursing in the late nineteenth century coincided with several societal shifts. In newly industrialized and urbanized areas, poverty and family disruptions made hospitals a likely care option of last resort. Scientific medicine, though still in its infancy, was gaining influence and prestige. A wide variety of diagnostic and treatment techniques were utilized, some of which were well adapted to institutional settings. Women from both middle and working classes, usually for quite different reasons, were seeking to be usefully and gainfully employed. Hospital trustees from the capitalist class were available with sufficient wealth to fund hospital growth and the establishment of nurses' training schools. They were also direct beneficiaries of this disciplined labor force.

Opportunities for paid employment for middle class women were almost non-existent when Nightingale codified nursing practices and principles in her 1859 *Notes on Nursing*. Emphasizing the need for *both* good character *and* training, Nightingale summoned the prestige of class and special knowledge, without disrupting Victorian images of womanly virtue. She drew on previous concepts of devotion, avocation, order, obedience, and duty, from religious and military models of service, to describe proper attitudes for nurses to adopt. Thus women found new possibilities for work outside the home, but ideologies of domesticity, subservience and obedience within hierarchy followed women into this work.

Linda Hughes (1990:26) summarizes four central themes of domesticity: "the dichotomy between home and work, the home as woman's proper place, the moral superiority of women, and the idealization of motherhood." Women's duty to safeguard moral and spiritual values reflected a 'natural' gendered division of labor, based on biological characteristics, in which men engaged in the competitive world of commerce and business, while women presided over family, home and hearth. Embodying similar

feminine qualities to her counterparts at home, the proper 'character' for nurses was a sense of duty and obligation to care. As Reverby (1987; 1990) points out in her book tellingly entitled *Ordered to Care*, this emphasis on women's moral duties obscures the perspective of their right to define and control the conditions of their work.

Student nurses attending the early hospital training programs lived a regimented, semi-military life style, received on-the-job training for two or three years, and provided the majority of care in hospitals. With few therapeutic regimens, basic physical ministrations and moral support comprised the bulk of care provided. Chores of cooking, cleaning, fire-making, lamp-lighting, and laundry required as much attention as direct physical care of patients. The specific 'scientific' activity of nursing, hygiene, was kept outside of medicine (Hektor 1994), and could be seen unthreateningly as an extension of the 'good lady' maintaining proper housekeeping. Attention to ventilation, warmth, cleanliness, light, noise and sewage removal were critical for recovery of the patient. As were a cheerful demeanor and good manners.

The term 'emotion' was not commonly used in early nursing literature, though discussions of certain qualities, attitudes and approaches to nursing work refer to such a terrain. Recommendations about the etiquette and ethics expected of nurses, and advice on how to act in particular situations, found in early writing about nursing, suggest that many behavioral expectations and 'feeling rules' (Hochschild 1969; 1975) were imparted during nursing training. Mental states and moral imperatives encompassed attitudes and feelings as well as thoughts. Clearly the nurse's 'whole person' was to be trained for this rigorous and rewarding work.

"Evidence of good training will be a broader judgment, a clearer insight and foresight, decision and poise of manner, [and] skill in the performance of professional duties," wrote Charlotte Perry (1905:861-2). Rooted in the empirical, Perry encouraged nurses to develop "the power of observation," noting "[w]e learn by what we *see*, and we learn in the *doing*, not in the dreaming of what we might do under favorable circumstances. ...Practical instincts," added Perry, were more important than "education and social experience." Thus it was understood that the richness and the particulars of nursing would be known experientially.

Personal qualifications included physical, mental and moral strengths. "Mental training ...enables one to think for one's self; to be discreet; to possess judgment; to know, instinctively, the right thing to do, or the right decision to make; to know how to receive merited criticism and profit by it" (Brown 1914). Efforts were made to identify the kinds of character, attributes, habits, and manners considered necessary for those involved in nursing. These included poise, confidence, courtesy, dignity, honesty and purity (Brown 1914; McIsaac 1901). 'Natural' traits, combined with training, would make a good nurse. "Education and practical ability are indispensable; but character and *motif* tower above all other requirements" (Perry 1905:451, emphasis in original).

"[W]illingness to submit to strict discipline and perform hard work, ...an element of self-sacrifice, effacement" (Brown 1914:2), along with physical stamina would enable a nurse to do the work. Obedience and self control were necessary. "It is expected of all in training to do what they are told; no more, no less" (Perry 1905:452). Faced with difficult situations, a nurse must not lose control.

> While others are standing shocked and helpless, her presence of mind will not desert her, and she will at once suggest the right thing to do, and will proceed to do it in a cool and collected manner. The example she sets, in keeping her own nerves well under control, will go far toward steadying those about her (Hampton 1893:290).

Tensions between personal self and professional self were acknowledged: "in spite of your sympathy and sincerity, you cannot afford to lose one atom of your professional bearings" (Vandergon 1910:105).

Yet discipline and obedience were not enough.

> [C]arrying out orders, though most important, is only part of what a nurse can do toward the restoration of the patient's physical and mental health, and her kindness, consideration, tact, and gentle firmness will be important factors in the re-establishment of his normal condition (Donahue 1912:22).

Nurses were reminded of the impact of the smallest gestures: when receiving a new patient, she should "speak a few reassuring words" (Donahue 1912:23). When caring for a nervous patient, she must remember "the influence of mind upon mind is great" (Shepperson 1905:239), and therefore should avoid too much conversation, yet remain

open to receive confession, if the patient so desired. And above all, "[a] nurse must be cheerful and talk of cheerful things" (Stoney 1900:21).

Instructions were given regarding courtesy toward the patient:

> Do not leave him standing in the middle of a long corridor in bewilderment, nor condemn him to wait endlessly before the object of his coming to the hospital is certified or attended to (Perry 1905:862).

Regarding the superintendent: "Always receive any hospital officials standing, and remain standing like a sentinel on duty until they have left the ward or room" (Stoney 1900:23). As for nursing colleagues,

> Absolutely nothing in the way of personal feeling toward each other should be shown among the staff of nurses. It is equally objectionable to be on too friendly or familiar terms while on duty. A dignified and kindly attitude toward one another should prevail (Hampton 1893:58).

Rigorous attention given to the behavior and attitudes of nurses was indicative of and in preparation for the attention and careful observation of their *patients'* conditions that nurses were expected to acquire with practice.

> The appearance or expression of the face ...should become a study to the nurse, for, coming as she does in contact with so many different people, she will find it of great use to be able to interpret correctly the different expressions of the countenance both in health and disease (Hampton 1893:348).

Nurses learned to monitor the expressions of others, and how to modify their own manners through "the training and control of the voice, speech, and touch, the eye, and even the expression" (M.A.N. 1901:764), forging a style of comportment to meet the criteria of this highly interpersonal work.

Early nursing leaders felt strongly that doing this work required both ways of doing and ways of being. They borrowed scientific languages to describe the skills of observation and hygiene, they reflected bureaucratic considerations in detailing the order and discipline required, and they used Victorian ideals of morality and feminine virtue to identify the necessary personal qualities. The situations and responses described in terms of ethics and etiquette a century ago involved uses of the self that today might be called emotion work. Tensions between these intangible qualities and the more readily visible technical skills of nursing have been, and continue to be, problematic in determining where

and how to place the emphasis when defining nursing. What did it mean to be a womanly professional? Which aspects of nursing work might bestow the class status and privilege of a profession? Were these the same for the elite nurse as they were for the common nurse?

The Profession of Nursing

Early nursing reformers in America, building on Nightingale's work in England, sought to define a new grade of women as nurses, replacing unskilled, lower class women with trained, morally virtuous ones. Nursing education was designed, among other things, to impart class-defined behaviors and attitudes called 'character,' in specifically gendered feminine forms. A cadre of elite, white, nurse leaders overcame the resistance of physicians and hospital trustees to training nurses in part by emphasizing that nursing was an extension of accepted domestic duties. Yet this was the first widely accepted opportunity for women to enter formal training that would lead to economic self-sufficiency.

Although many nineteenth century nurses worked in their patients' homes, the development of nursing as a profession is tied to the emergence of the hospital. By 1880 there were 15 nursing schools in the United States; there were 35 in 1890, 432 in 1900, and 1,775 in 1920. By the mid-1920s, 17,000 trained nurses had graduated from these schools (Hine 1989; Reverby 1990). During that same time, over 2200 black graduate nurses completed training in 37 segregated schools, many finding work in the nearly 200 black hospitals in the South, Midwest and Northeast (Hine 1989).

This growth in training opportunities both reflected, and contributed to, the growth of hospitals during the same period. There were 178 hospitals in the United States in 1873, there were 4,359 in 1901, and 6,830 in 1923. In addition, nurses continued to provide home care for middle and upper class Americans as private duty nurses well into the 1930s. Struggles to define nursing as an occupation and a profession were linked to the work histories and career trajectories of thousands of women. All of those who received formal training did so in a hospital, and many continued to work there long after graduation.

Early in the twentieth century, nursing leaders had embarked on a number of strategies designed to professionalize nursing. Of course, there had never been a female

profession, and nurses mounted an impressive campaign to demonstrate that this work merited the consideration of other liberal professions, such as medicine or law. The ideology of professionalism had taken on greater significance during the economically turbulent nineteenth century. Middle class practitioners of skilled occupations sought to increase their social status, promote economic prosperity, and distinguish themselves from all levels of industrial workers. Attributes included "guardianship of a specialized body of knowledge and commitment to an altruistic service ideal" (Hughes 1990). Building on free market ideologies of capitalist individualism and meritocracy, professionals hoped to achieve work autonomy and social mobility through educational credentialism and 'proper behaviors' (Goodman-Draper 1995).

Early nurses were quick to clarify the uniqueness of nursing knowledge and skills, as distinct from medicine, and drew on popular beliefs in the moral superiority of women to gain public trust. Formal arguments emphasized their equivalence with other professions. As expressed by one nursing leader:

> We claim, and I think justly, the status of a profession; we have schools and teachers, tuition fees and scholarships, systems of instruction from preparatory to postgraduate; we are allied with technical schools on one hand and here and there a university on the other; we have libraries, a literature, and fast-growing numbers of periodicals owned, edited, and published by nurses; we have societies and laws. If therefore we claim to receive the appurtenances, privileges, and standing of a profession, we must recognize professional responsibilities and obligations which we are in honor bound to respect and uphold (Nutting, 1905, cited in Donahue 1985:378).

Despite effective social and political negotiations, attaining the prestige, power and exclusivity of professional status was problematic for nursing. An early challenge to the professionalizing agenda in nursing was the diversity in training and class origins of those calling themselves nurses. Initially there were divisions between those presumably older and/or poorer nurses who served without formal training, and the new, modern graduates of hospital-based programs. Organizing efforts to consolidate this new cadre of workers began in 1894 with the creation of the Society of Superintendents of Training Schools for Nurses in the United States and Canada, and in 1896 with the founding of the Nurses' Associated Alumnae of the United States and Canada for graduates of two year training schools.

The alumnae association sought "to establish and maintain a code of ethics; to elevate the standard of nursing education; to promote the usefulness and honor, the financial and other interests of the nursing profession" (cited in Hine 1989:91). By 1910, about 15,000 nurses belonged. In 1911, the group was renamed the American Nurses' Association and eligibility was limited to graduates from three year programs who were also members of a state association. This last stipulation had effect of excluding black nurses because they were denied membership in the white state organizations of the South. This led to the establishment of the National Association of Colored Graduate Nurses in 1908. Thereafter, the history of professionalization in nursing remained racially divided until 1950, when black nurses were supposedly integrated into the American Nurses' Association, though institutionalized racism continued to limit their practice primarily to Southern and black urban contexts.

One major goal of the Associated Alumnae was to coordinate the political efforts of state nursing societies to persuade (male) legislators that laws regulating nursing education and practice be enacted. By 1914, forty states had passed laws that would create a board of examiners to evaluate levels of training, issue registration certificates, and oversee interstate reciprocity. These accreditation and registration procedures remained voluntary in that it was not illegal for unlicensed nurses to care for the sick, but only those who passed certification could be called 'registered nurse.' In any event, state registration served important legitimation functions, established potent professional gatekeeping and provided a measure of employment security for these workers.

However, nurses employed under hierarchical hospital and medical orders never attained the recognition or autonomy characteristic of male professions. As a *female* profession, nursing has never resolved certain inherent contradictions in the definition of profession as male. Celia Davies (1995) identifies elaborate gendered codings that underlie both the concept of profession and the characteristics of bureaucracy. She notes how both of these models for organizing work are coded for 'masculine' qualities while nonetheless depending on gendered divisions of labor for their accomplishment. Nurses typically provide many forms of 'adjunct work' that *enable* masculinist claims to expertise, autonomy and impersonality. "This work is rarely acknowledged or well conceptualized;

from the point of view of the gendered professional ideal it is regarded as trivial or as 'support'" (Davies 1995:61). Notably, in the context of health care delivery systems, this 'handling the details' includes tending to the emotional needs of bureaucrat, professional and client alike. It is valued, taken for granted, and rendered invisible.

Since the early campaigns to 'professionalize domesticity' (Hughes 1990), uneasy tensions between claims to a distinct, authoritative, objective knowledge base, and innate, special feminine qualities have coexisted in nursing. Productions of the professional attributes of rationality, distance and objectivity have mingled sometimes incongruously with nurses' gendered gifts of care. Nurses have sought legitimation beside, and complementary to, medical professionals and hospital administrators. The dual provinces of patient care and ward management were carefully limited to 'nursing concerns.' When turf skirmishes erupted, nurses were reminded to focus on their role of providing bedside care, while doctors attended to the important scientific work of diagnosis and treatment, and bureaucrats retained control over hospital operations and procedures. Despite professionalization, doing nursing has also been doing gender.

Working within the constraints of these inherent contradictions, leaders instilled a strong sense of professional identity from within nursing, blending claims of scientific authority with assertions of moral and aesthetic qualities. By the 1920s, American nursing was a well established and respected occupation. It was one of a handful of opportunities for training that led to paid employment for women and, despite significant racial segregation, was available to candidates from a variety of racial and class backgrounds.

Most hospitals were still staffed by student nurses, while graduates worked in private duty or public health settings. Nursing texts from this decade reflect the scope and comprehensiveness of a well established practice. The following summary, abstracted from the 1924 textbook of Bertha Harmer (1924), graduate of Columbia University and Instructor at St. Luke's Hospital Training School for Nurses in New York, describes some of the ideals at the core of the profession.

> Nursing is rooted in the needs of humanity and is founded on the ideal of service. Its object is not only to cure the sick and heal the wounded but to bring health and ease, rest and comfort to mind and body, to shelter, nourish, and protect and to minister to all those who are helpless or handicapped, young, aged or immature (p. 3).

> The nurse finds herself not only concerned with the care of the individual but with the health of a people. ...the final test, as portrayed in the last Day of Judgment, is a social test--did ye visit the sick, the poor, the hungry (p. 3)?
>
> Many years ago Florence Nightingale taught "that all disease...is a reparative process." ...Nursing is concerned with and includes: the care of the patient's surroundings, ...the personal care of the patient, ...assisting the physician, ...the administration of special diets, drugs and treatments ordered, ...teaching, and ...making provision for the convalescence of patients at home (p.4).
>
> [The] spirit of sympathy, kindliness and helpfulness ...must be very carefully cherished and developed. If we neglect it and, day by day, in the rush, strain and fatigue, feel impatience and indifference, *we may become incapable of feeling, and hardened.* ...It is distinctly a woman's work--the one profession which women are admitted by all to excel men (p. 5, emphasis added).
>
> A cheerful, optimistic spirit is also very helpful both to the patient and the nurse. ...It is our part *not only to do the right things but to enjoy, to look and act as though we enjoyed.* ...Sick people are very sensitive to the actions and presence of those around them. Happy persons bring new courage and give a new hold on life and this valuable... (p. 5, emphasis added)
>
> [Other qualities needed include:] •The Spartan spirit which will not flinch from duty, ...•A professional spirit--a feeling of loyalty ...to the whole profession, ...•A scientific spirit which promotes a love of truth, ...*not influenced by sentimentality*, [it] promotes a wholesome spirit of inquiry, *but never loses a feeling of wonder and reverence for the human body.* ... •A spirit of appreciation of the work ...including an esthetic appreciation, ...an appreciation of human nature, ...and intellectual appreciation, [but] our intellectual pleasure in learning may cause us to regard the patient as a "case" forgetting that he is a human being. "The intellectual faculties of memory, judgment and criticism in studies--leaves the learner cold--*he knows, but it does not make any difference to him, he lacks sympathy and understanding.*" ...•A democratic spirit which leaves class and race prejudice behind (p 6-7, emphasis added).

Nursing reflected the ideals of Christian charity, but secularized into social work and a public health mission. Goals of democracy, egalitarian treatment and racial tolerance were included as precepts of nursing. Nursing work encompassed a wide variety of activities that would create optimum conditions for healing to take place, and the importance of attitudes and feelings in accomplishing this was acknowledged. While scientific knowledge was valued, nurses were warned of the coldness of knowledge separated from sympathy. They were also warned against the hardness and indifference

that might come from fatigue and overwork. Again emphasizing the interpersonal qualities needed, Harmer added that there must be

> [a] real interest in people, a desire for their welfare and the *faculty of making this felt*; tact, cooperation, the ability to handle people and get along with them--if this is lacking, all the other virtues, capacities and knowledge may be of little value (p.7, emphasis added).

For Harmer, nursing knowledge is grounded in practice and doing. After her experiences training on the ward, Harmer asserts that a nurse "feels that she has a firm grasp, which can never be taken away from her, and which cannot be bought or found in books" (p. 8). *Both* scientific *and* embodied, this learning, acquired through

> close observation of facts, of cause and effect, lifts nursing far above a mechanical, routine, unintelligent practice, and places it upon a scientific, professional basis. It depends upon knowledge and understanding, upon sympathy and insight, upon experience, and upon a trained eye and ear, sense of smell, and touch (p. 45).

Without mentioning emotion, these descriptions suggest synergistic ways to think/feel that mobilize complex aptitudes and capabilities.

As recently as the 1920s, emotions were conceptualized very differently from today's psychological formulations. Early references to the emotions in nursing drew on philosophical arguments and were presented in the context of discussions on ethics and conduct. In a book on ethics written for nurses, James Brogan (1924:52) wrote a description of the 'human faculties:'

> The sense-faculties are the seat of the passions. ...These passions taken in themselves are neither good nor bad morally; by the control of the will they can be directed to either good or evil.

Following Aristotle, he said "they must be moderated and utilized" (p.53). He explained that the passions are located in a hierarchy of faculties.

> As the intellect rises above sense-perception, so also we have a spiritual appetite that rises above sense-appetites, and controls them. It is the will, our free faculty, that power by which we are master of our own acts (p. 54).

Brogan goes on to locate the emotions "midway between ...sense and spirit, [they] are really higher sensibilities. ...[T]hey are also beneath our volitional acts" (p.55). He clarified that

> [t]he emotions, as distinguished from passions, do not so much spring from the lower regions of animal instinct but are induced from above as an accompaniment and a response. ...They do not always obscure the judgment, but rather give it keenness and intensity; they do not always impede the exercise of deliberation and free will, but rather facilitate it when they accompany it in the choice of the right (p. 56).

He concluded his discussion by saying, "[t]hese powers and activities I have classed as part of our nature or nature's equipment" (p. 57). Emotions were thus distinct from instincts yet naturalized and less deliberate than the will.

In another treatise on *Ethics and the Art of Conduct for Nurses*, Edward F. Garesche (1929) provided a philosophical taxonomy of the passions for nurses. He used the term emotion to refer to a specific passion, such as anger. Again the passions are located in the body, but they are to be distinguished from "the motions of the soul which resemble them" (p. 66). In any event, "our body and soul form one being, whatever affects the one, is likely to stir the other" (p. 66). The passions were seen as both beneficial, because they can strengthen the will, and as problematic, in that they can lessen the freedom of our action, thereby lessening our accountability.

> Speaking perhaps paternalistically to his nurse-readers, Garesche advised that
>
> much human nobility and charm come from the passions, well controlled. Eloquence and song, music and drama, the interest of friendly conversation and the fervor of patriotism, owe much to the passions. Then, too, the struggles which our passions cause us, to keep them in subjection, are a splendid discipline for character. Our will becomes strong in subduing our passions, just as the muscles of a charioteer grow firm as steel by checking and guiding his impetuous steeds. Again, it keeps us industrious and humble to be forever watching and controlling the vagaries of our passions (p. 68).

So, nurses were encouraged both to recognize the value of the passions, and to develop habits of self control. Located between body and soul, the passions were understood to be under control of the will and distinct from the intellect.

At this point, the passions addressed were those of the nurse, in relation to her own conduct and disposition. These authors offered philosophical definitions and behavioral prescriptions for both expression and control. Recommended character development for nurses included appreciation for and self-monitoring of the 'passions' in human affairs. Emotional control was part of expected ethical conduct and assured that

these 'female professionals' would behave appropriately in the scientific and bureaucratic settings of their practice.

In terms of patient care, some of these aspects of human nature were subsumed under the term 'mental state.' In today's nursing language, many of these concerns would be called psychosocial. For instance, a chapter on "The Patient's Comfort" in a 1926 textbook (Goodnow 1926:89-90) began by saying that

[c]omfort is both physical and mental, and a nurse's responsibility does not end with physical care. ...Some of the causes of mental disquietude are: homesickness, timidity, sensitiveness, lack of privacy, undue exposure, fear of pain, fear of death, worry about finances, anxiety about home conditions, suspense, confusion, Goodnow continues,

> Too often a nurse feels that she has nothing to do with the patient's mental state, and so gets no results from her good physical care. Mental state has probably more to do with physical well-being than any other factor (p. 90).

She give a long list of specific advice, including: "Notice when your patient is worrying, and tactfully discover the cause, if possible" (p. 91). It is only after addressing the 'mental state' of the patient, that Goodnow begins a discussion of 'handling patients skillfully,' meaning physical handling, speaking of how to give a rub, undress a patient in bed, make a comfortable bed, etc.

I have reviewed the content of select nursing texts to highlight definitional parameters and locate consideration of the emotions in its early affiliation with the passions. These were philosophically aligned with both the senses and the will. Discussions of the management of the passions fell under broader concerns about morals and conduct. These in turn were situated in relation to the imputed moral superiority of women in the Victorian ideology of domesticity, and in contrast with the masculinist coding of bureaucracy and profession. In fact, in the 1920s, references to the emotions were not greatly initiated in the writings of nurses. Here, considerations of the patient's mental state, attitudes of sympathy and helpfulness, and attention to detail were the pragmatic framings of those activities associated with 'non-physical' dimensions of care.

In the 1930s vocabularies of emotion from Freudian psychology and psychiatric nursing were used to elaborate emotional aspects of nursing care (Flood 1981:241). In this

historical period, newer conceptual frameworks were brought into nursing during the same time that a number of significant structural modifications in the delivery of health care services took place. Organismic models of human emotion were compatible with systematic, technical/managerial approaches to the organization of work.

Nurses as Workers under Technical/Managerial Strategies

During the economic depression of the 1930s, important shifts in the delivery of nursing care took place. Families could no longer afford private nursing care. Gradually, insurance payment plans began to cover hospitalization costs for middle and working class employees. The institutionalization of scientific medicine brought patients into hospitals for increasingly complex interventions. Workplaces that had previously been staffed primarily by students began to retain a staff of graduate nurses. The era of the private duty entrepreneur nurse came to a close.

Everyday nursing consisted of "a combination of care for the physical comfort of patients, the execution of doctors' orders, and the maintenance of the rhythm of collective ward tasks" (Flood 1981:231). Ideally, the patient was treated as an individual, not just a disembodied disease. But in fact, the shift to general staff nursing intensified the workload; each nurse was expected to accomplish more than a student, and hours were reduced while the tasks to be accomplished remained. Concerns about salaries, hours and volume of work, and the quality of supervision superseded 'loftier' goals. "The 'womanly service' model of nursing lost ground to the professional conception of nursing as well as to the 'paid work' concept" (Flood 1981:338).

Since the 1920s, methodologies of scientific management had been promoted in a variety of industrial settings. These models for efficiency and production were adapted for nursing practice. Some managers used this strategy to upgrade the image of nursing as scientific without intruding on the medical terrain of the doctors. A task-oriented approach to nurse work was the result of Taylorite time and motion studies, extending into hospital wards the colonized domesticity of household efficiency elaborated in Lillian Gilbreth's home economics (Reverby 1987). Rationalization and standardization altered nurse priorities and changed the context of patient interactions. Providing patient care was squeezed to meet ideals of efficiency.

These altered working conditions exacerbated class divisions within nursing. While some nurses rose to the bureaucratic, managerial positions of overseeing work on the wards, others were positioned in lower-grade jobs. Registered nurses differentiated themselves from less trained licensed vocational and/or practical nurses, and from nursing assistants or aides whose tasks were considered still less skilled. A hierarchy of technical, clinical, managerial and interpersonal work demarcated worker domains, with the 'dirtiest' (Hughes 1984) housekeeping chores holding the least status. Jocalyn Lawler (1991) examines the intrinsic embarrassment about bodily functions that accompanies much of nursing work. The most shameful aspects are often considered the most dirty and might well be assigned to the lowest class of workers.

Nona Glazer (1991) documents the development of a segmented nursing labor force that was formalized in part by the creation of different types of nursing degrees, and traces a gradual polarization within nursing work.

> Between 1900 and 1940, RNs increased from 11 percent to 73 percent of nursing workers, but in 1940, after reaching 73 percent of all nursing personnel, their percentages began to decline. By 1980, RNs were only 44 percent of all nursing workers. ...[By contrast], between 1940 and 1980, nursing assistants increased from 9 percent to 41 percent of all nursing personnel (1991:356).

By 1994, "health organizations employed 1.8 million registered nurses (RNs), 370,000 licensed practical nurses (LPNs), and 1.5 million nurse aides/assistants, orderlies and attendants" (Buerhaus and Staiger 1996:1487). Roughly 70 percent of the RNs were employed in hospitals, with LPNs and aides concentrated in nursing homes, offices and clinics, and home health. In 1994, only 40 percent of LPNs and 22 percent of aides worked in hospitals (Buerhaus and Staiger 1996). Racial and ethnic prejudice and segregation, both inside and outside nursing contexts contributed to segmentations within the occupation. Education, training and employment opportunities continue to be highly stratified. If hospital administrators and physicians supported ideologies of professionalism among nurses, these served in part to reinforce class and race separations among nurses, rather than worker solidarity.

By the end of World War II, scientific management techniques permeated hospital work. The creation of specialties, both within nursing and ancillary to it, resulted in an

overall deskilling of nurses. Team nursing reduced tasks to their component parts and minimized employee control of working conditions. Even the later-developed system of primary nursing tended to intensify nursing work by reducing the help available (Brannon 1994). Employment opportunities for nurses expanded as health care delivery systems diversified in the post-war years. Individual nurses found themselves positioned differentially, ranging from low-end service work to highly skilled and educated professional and managerial positions.

In response to these industrialized working conditions, Goodman-Draper (1995) traces three distinct organizational strategies used by nurses, depending on their class position. Hospital staff workers have borrowed from models of trade unionism, middle managers have favored a modified professional unionism, while upwardly mobile, university educated nurses have pursued models of professionalization. Nurses who identified primarily as workers sought to gain control of the conditions of their work through union organizing and collective bargaining. Mid-level managers and professionalizers sought to "enhance the image of nursing by ridding it of the 'dirty' menial tasks (later to be known as 'nonnursing tasks')" (Goodman-Draper 1995:44), and by identifying with models from scientific medicine and/or scientific management. In any event, womanist models of devotion and service had clearly become passé.

On the other hand, nurses sought to retain a sense of the 'art of nursing' alongside of the science. In 1930, Shirley Titus voiced concern that 'invisible' nursing not be neglected despite intensified working conditions.

> It must be remembered that time is to the nurse what the delicate, finely adjusted instrument is to the surgeon. Without sufficient time to render the high quality of nursing that belongs to the realm ...described as 'invisible nursing', the art of nursing becomes as great a travesty as does the art of surgery when the surgeon lacks the proper instruments. (cited in Flood 1981:245)

Models for these 'indiscernible' aspects of nursing care began to emerge that incorporated vocabularies from psychology and the social sciences, displacing 'woman's intuition' with objective, intellectual approaches. Older notions of 'character' resurfaced as 'personality' and 'interpersonal skills,' but now with a scientific basis.

Nursing texts began to speak of patient care as a process based on scientific knowledge of

> all those things which enter into the nourishing of his body physically and mentally. The nurse no longer ...should care for her patient on the basis of tradition alone. Bacteriology, ...chemistry, ...anatomy, [and]...psychology will bring an understanding of behavior necessary to the intelligent care of all persons, doubly so when those persons are ill (Smith 1937:39).

Psychosocial needs of the patient were integrated into nursing care.

> The patient may be in far greater need of correct adjustment to life and its problems than of physical nursing care; the nurse ...should use whatever opportunities present themselves; but she must never forget that her professional duties come first and that anything else she does for the patient must be done most *tactfully and quietly* (Smith 1937:194, emphasis added).

The nurses' mission was thus conceived as social work beyond sick care, as needed and as feasible. Interestingly, part of the very effectiveness of this psychosocial work was taken to be its invisibility. The nurse would quietly attend to emotional needs *without* drawing attention to herself.

While the organization of nursing work stressed efficiency and the accomplishment of an expanding number of technical and bureaucratic tasks, theoretical models were emerging that conceptualized the patient as a 'whole person' with a variety of 'needs' to be met. These framings of nursing work were anchored in *scientific* claims about human nature imported from the social sciences, most especially psychology.

Introduction of Psychosocial Theories into Nursing

The 1950s and 1960s brought economic and theoretical consolidation of scientific-yet-uniquely-nursing articulations of the nursing process. Employment opportunities followed the exponential growth of a powerful new "medical-industrial complex" (Relman 1990), fueled in part by the first extensive federal investments in health care delivery (Rice 1990). The Hill-Burton program, begun in 1946, provided matching funds for hospital construction. The passage of Medicare and Medicaid in 1965 reimbursed health care costs for the elderly and low income citizens. In addition, successful collective bargaining efforts made private health insurance a common fringe benefit for the working class. In addition, government subsidies of school construction and education promoted a dramatic increase

in training opportunities for health care personnel at all levels. Efforts to provide baccalaureate and graduate education for nurses were well underway, providing the context for theory development and research.

From a practical point of view, nursing work continued to involve caring for the patient, carrying out doctors orders, and overseeing the smooth functioning of hospital routines. 'Basic' nursing referred primarily to activities supporting the physical comfort of the patient. 'Technical' nursing concerned activities more closely aligned with medical care. The scientific basis of the work was derived from medical and biological sciences, as well as newer developments in microbiology, pharmacology, and other specialized areas of scientific inquiry. Nursing leaders, still confronting the 'professional predicament' (Davies 1995) of nurses, sought to develop scientific languages and theoretical bases that would further legitimize their demands for professional recognition and treatment, as well as serve to guide the organization and practice of doing nursing work.

Hildegard Peplau, a diploma nurse who then received a BA in interpersonal psychology, an MA in psychiatric nursing, and a doctorate in nursing education (from Teachers College, Columbia University in New York City), is credited with publishing, in 1952, one of the first theoretical accounts of nursing since Nightingale's *Notes on Nursing* had defined the field in 1859. Peplau's model of *Interpersonal Relations in Nursing* drew from the works of Sigmund Freud, Harry Stack Sullivan, Carl Rogers, Abraham Maslow, Erich Fromm and others, to conceptualize nursing as a psychodynamic process. She highlighted the importance of the nurse-patient relationship as an interactive process that would first define, then meet, 'felt needs' of the patient. Needs were conceptualized as physiological, psychological and developmental (Torres 1986). Providing emotional support was loudly and clearly a core component of meeting patient's needs.

Following Peplau, a number of important nursing theories were introduced, all of which sustained the integration of social science knowledges and perspectives into nursing (Wesley and McHugh 1992). Gradually, psychological understandings of the emotions were adapted to give insight into nursing situations. If medicine focused on disease and cure, nursing was responsible for nurturing the patient as an individual, and for developing an interactive relationship that would help the patient's trajectory through the illness

process. Understanding the patient's emotions was seen as one aspect of the nurse-patient relationship.

A 1954 text (Price 1954: 65) characterized the "relationship between nurse and patient [as] largely that of teacher-pupil regardless of the age, education, or experience of each person concerned." The patient was seen as dependent on the nurse who would guide the relationship.

> The understanding nurse will recognize that restlessness, ill temper and other symptoms of emotional strain are a part of the patient's reaction to the fears and anxieties brought about by physical pain or sudden illness (Price 1954:66).

Advice was given about good manners, conversational ability, and other interpersonal and usually feminine qualities that would facilitate this work. It goes without saying that the nurse was expected to be understanding and accept the ill temper, reasonable or otherwise.

The same text continues the discussion of emotions in a chapter on the "Spiritual Needs of the Patient," suggesting that the nurse should understand "the very close relationship between religion and the emotions" (p. 711). Interestingly, talk about emotions became a secular, more scientific way to refer to dimensions of human experience also and/or formerly classified as spiritual. Apprehension, fear, loneliness, anxiety, worry, guilt and hostility were described in psychological terms as factors that might indicate spiritual needs. "Facial expression, restlessness, and other physical signs" might warrant a call to a clergyman, friend or relative (p. 714). "Frequent tears or moods of depression, even disobeyance of routine regulations in the ward" (p. 714) were considered other indicators of spiritual need. Nurses were reminded not to argue with patients regarding religious beliefs or practices, expressing again the ideal of treating patients without prejudice or discrimination.

In another text that combined discussion of emotional and spiritual needs, 'the art of listening' was recommended as a therapeutic measure.

> If the patient finds someone to whom he can talk, someone with whom he can share a deep feeling, someone he can trust, talking is therapeutic in that he is able to lighten his burden even if for only a short period of time (Fuerst and Wolff 1964:314).

The authors explain that a good listener does not pass judgment or make personal interpretations of the other.

> It means listening and watching for emphasis as well as the inflections, the gestures and the facial expressions used during the conversation. It means listening with all the senses and trying to understand the real meanings and feelings behind the words (Fuerst and Wolff 1964:315).

Clearly, the nurse is being instructed to listen for feeling as well as cognitive content.

Other advise offered to nurses for handling patients' emotional and spiritual problems included giving reassurance and prayer, bringing books, including the Bible, and flowers. Locating the jurisdiction of these problems pointed to a potential boundary issue.

> [E]motional factors--strangeness, loneliness, anxiety, fear, questioning, guilt, hostility and grief--may or may not be experienced as *religious* problems. They are nevertheless matters with which religion deals. ...These intangibles fall especially within the province of the ministers of religion (Montag and Filson 1953:357).

With increased specialization among health care personnel, the association of emotional problems with religion began to suggest a possible division of labor between nursing and chaplain services in this new era of scientific nursing.

However, the more prevalent boundary issue remained that of distinctions between skills defined as 'technical' and the 'intangibles.' Building on Faye Abdellah's typology, a 1964 text devoted a chapter to 'covert' nursing problems.

> Overt nursing problems tend to fall into a category requiring physical and manipulative skills, whereas covert nursing problems require an analysis of behavior which demands that the nurse possess psychological or interpersonal skills (Matheney et al. 1964:43).

The authors explained that physical and psychological problems are interrelated and that "[t]he patient as a *total* person remains the central focus of any nursing care plan" (1964:44, emphasis in original). Covert problems are framed in terms of *needs*: to identify feelings, to accept the interrelatedness of emotions and organic illness, to communicate with others, to progress towards personal spiritual goals, to experience a therapeutic environment, and to have feelings of self-worth. Behaviors indicative of covert problems were described in the language of psychology: regression, crying, criticalness, hostility, depression, dependency, or indifference, and were seen as emotional symptoms that needed to be observed and understood as much as physical symptoms.

Articulation of psychosocial dimensions in nursing became more prevalent as leaders and educators sought to reconcile tensions between demands for increased technical capabilities and concerns for interpersonal aspects of the work. Emphasis was placed on treating the patient as a particular person with individual psychological needs in the healing situation.

> There can be no set rules or techniques to determine the nurse's responses to patients. Each response is made according to the individual and the situation (Shafer et al. 1967:6).

Sensitivity to difference was acknowledged,

> [c]ultural background is related so closely to emotional response that it must always be considered in determining the basis for the patient's behavior (Shafer et al. 1967:7).

Both new vocabularies and guidelines for handling the emotional side of patient care were offered. In practice, this dimension of the work was highly subject to individual interpretations and inclinations. Clinical textbooks provided introductory chapters on nurse-patient interactions, patient-centered care, and communication but their main focus remained the increasingly complex nursing interventions associated with medical diagnosis and treatment of disease.

By the 1970s, the therapeutic importance of the nurse-patient relationship was well delineated, and accounting for the patient's emotional responses to illness was considered an integral part of good patient care. Now emotion was (re)defined in physiological and clinical terms.

> An emotion is a bodily state involving highly motivated feelings and behavior. Most responses to emotion operate through the nerve cells and fibers of the autonomic nervous system. ...Both the parasympathetic and sympathetic impulses act during emotion. ...The hypothalamus also plays a part in emotional responses, as does the cerebral cortex (Fuerst, Wolff, and Weitzel 1974:109).

Drawing on role theory from functionalist social science, emotions such as fear, anxiety, stress, feelings of helplessness, anger, and hostility, were seen to influence sick people in their 'role as a patient.' Nurses were expected to know that "[e]motional responses evoke widespread visceral changes affecting the circulatory, respiratory, digestive, and glandular systems as well as the skeletal system" (Fuerst, Wolff, and Weitzel 1974:117). This

apparent materiality of the emotions implied a physicality of psychosocial needs and validated nursing attention to these aspects of patient care.

The development of communication skills was elaborated as "a message delivered from one person to another" (Fuerst, Wolff, and Weitzel 1974:120). Verbal and non verbal forms, including touch, were taught. "Communication is the vehicle by which a nurse learns to know her patient, to determine what her patient's needs are, and to meet his needs" (p. 123). The nurse was expected to know and resolve her own feelings in order to "communicate genuine caring and warmth to another person in ways that are nonjudgmental and unconditional" (Sorensen and Luckmann 1979:33). Ways to convey warmth include:

> maintaining eye contact, soft but clearly audible voice volume, a gentle but not condescending voice tone, ...body position that brings your face at the same level as the patient's face, ...listening more than talking, occasional gentle touching of the patient's hand or shoulder (Sorensen and Luckmann 1979:33).

Unlike earlier nursing texts, womanly virtues were not mentioned, but the gendered content of these behavioral instructions in emotion work is hardly obscure.

In adapting psychosocial theories for nursing practice, leaders imported legitimized social science vocabularies to describe and delineate practices of interpersonal relationship, attention to 'non physical' dimensions of the 'whole person,' and the skills of observation and communication necessary for establishing a 'therapeutic' healing environment. The nursing expertise to do this work was grounded in practice and passed on through apprenticeship learning as well as formalized in classroom learning. The doing of this work took place simultaneous to and in conjunction with other dimensions of providing patient care in the heavily medicalized contexts of a modern hospital.

Many nurses internalized a sense of duty and a knowledge of professional standards that valued this 'invisible' work. However, workplace realities were rarely shaped by nursing priorities, and nurses often found that in practice, attending to the emotional needs of patients was an undervalued element of a labor intensive job. Hardworking and minimally compensated, nurse-workers have become exasperated with the lofty ideals, devotional or professional, promoted by nursing leadership. Yet many nurses describe these aspects of their work to be the most rewarding. And from the

perspective of the patient experiencing illness, these activities are invaluable. It is in the context of these tensions that I examine, in Chapter Three, the meanings and practices of emotion work as told by eighteen long-term practicing nurses. There I focus initially on the 'ideal type' of doing this work under the best of circumstances. What are the ways of being and doing involved in therapeutic emotion work? What other work feelings accompany the job? I also consider the literature on caring and its intersections with the concept of emotion work.

Nursing practice, however, cannot be examined in isolation. As I have attempted to show in this brief review of nursing history and the meanings of its often 'invisible' emotion work over time, conceptual practices, structural conditions and historical framings are interwoven. As nursing struggles to define itself and safeguard its occupational turf, hospital managers and leaders of the health care industry continue to be motivated by economic considerations. Since the late 1980s, financial backers of contemporary medical practices have groaned under the rising costs of providing health care services. Their attention is turned to the twin pursuits of profit making and cost containment. Nursing care services, as one of the highest figures in hospital operating budgets, have undergone major scrutiny. The impact of health care restructuring and managed care approaches on the doing of emotion work in nursing are addressed in Chapter Four. What are the constraints and what strategies have nurses utilized to make it work?

Both historically and today, the doing of emotion work is different from physical or mental work. It involves uses of the self that seem to be deeply embedded in one's sense of identity. Contemporary theory about the emotions is poised to rupture mind/body dualisms and propose more accurate conceptualizations such as 'embodied thoughts' or 'enfleshed socialities' that account for the tenacity and complexity of emotions. On the one hand, emotion has served as Other to reason, on the other hand, it has served as place marker for the feminine, aligned in paradoxical ways with gendered divisions of labor. These explorations of the emotion work of nurses at this historical juncture of intensified rationalization under managed care are uniquely positioned to track the interplay of discursive practices, structural conditions and identity formations. What kinds of

workers/selves, what performances of emotion and what meanings of emotionality might be emerging as new systems of commodified service provision assume greater share of gendered emotion work? Through what alternative manifestations and collateral circulations might the underground aquifer of 'invisible work' flow this time? These questions will be addressed in Chapter Six.

Summary

This chapter began in quest of a vocabulary with which to speak about 'invisible' nursing. I have chosen to focus on the term 'emotion' because it is one of the concepts used in nursing theory to identify this work and because, in sociology, the concept of 'emotion work' allows me to situate performances of emotion within the context of paid employment. Emotion is examined both as a framework for meaning making, and as a practice and a doing. Meanings of emotion have a long history in philosophy and psychology, the humanities and the arts. Neurology, sociology and anthropology are relative newcomers, as is this cultural studies-influenced effort to work the disciplinary boundaries of understanding. Representational practices are particularly challenged by this intangible yet palpable dimension of human experience. In attempting to reconfigure meanings of emotion, I am hampered by the necessity of using the same terms that I seek to redefine.

Groping through terrain at the intersections of language and lived experience, I have been struck by the simultaneously arbitrary and precise nature of words to shape without ever fully capturing the meanings they intend to convey. This is particularly true in the arena of the emotions, depending as they do on subjective experience, interpersonal communication, and cultural context. Due to the nature of their work, many nurses learn to navigate this terrain effectively, despite the lack of adequate languages. In fact, this work is *not* particularly invisible to nurses, who have obligingly adjusted frameworks over time as they/we have patiently attempted to express and legitimize what it is we do. Perhaps the pertinent question is not why but to whom is this work invisible? What divisions of labor, power relations, cultural values, and distributions of resources reinforce, and are reinforced by, this invisibility?

In this chapter, my investigation traced two primary threads to frame my study. The first was to provide a review of sociological theories about the emotions and the second was to situate conceptualizations of 'invisible' work within the history of nursing. Implicit in these reviews is the notion that emotion as we know it is both a relatively recent phenomenon and a contested one. Earlier configurations of human experience covered similar terrain but organized understandings and meanings differently. One set of origins for nursing can be found in the charitable activities of Christian service, ministering to the suffering of the poor and sick. Here, this work was part of the spiritual project of salvaging souls. Another set of origins was in the domestic care provided by women for sick and dependent household members. When biomedical scientists and surgeons began to develop scientific medicine, the work in both of these arenas was defined as irrelevant to the 'real' work of diagnosis, treatment and cure.

Secular nursing was begrudgingly allowed to take hold in the nineteenth century in part because it affirmed a separate sphere of female knowledge, and in larger part because it took care of the dirty work of patient care. The separate female sphere was associated with moral superiority and womanly virtues, and taught to nurses in the form of ethics and etiquette. Following Aristotle, the passions were located somewhere between body and soul, and needed to be controlled by the will. Early nurse reformers and educators emphasized the development of 'character' and sought professional status on intellectual and moral grounds. Not as yet labeled 'emotion', the interpersonal work of nurses did not fit with masculinist definitions of professional or bureaucrat, as in scientific medicine or hospital management, but it did figure into the implicit divisions of labor in both of these systems.

As nursing used concepts from psychology and the social sciences to describe the nursing process, previously 'intuitive' ways of knowing were reframed cognitively. Nurses continued to learn experientially, but increased academic training of elite nurses promoted research and development of theories. Early theories emphasized the patient as a 'whole' individual with needs, including emotional ones, to which the nurse would respond

through the nurse-patient relationship. Later theories positioned the emotions physiologically, within a biological framework of the patient as a body.

Segmentation of the labor force led to polarization of nurses who identified mainly as either workers or supervisors. Scientific management techniques contributed to specialization, team nursing and other task oriented approaches to doing the work. These structural configurations altered working conditions and affected the emotional content of nurse-patient interactions. Discrepancies between theories and practice were perhaps felt most intensely by those near the bottom of hierarchical divisions of labor within nursing. Experiences and performances of emotionality span wide ranges of variation in nursing work, and differ depending on the context and meanings of their enactment.

Characterizations of the scope and content of emotion work risk overgeneralization, simplification, and abstraction, yet common themes and tensions may be identified that shed light on the meanings, silences and practices of emotion and emotion work in nursing. I have identified some of these aspects of nursing, and how they have been both talked about and kept in silence. I have considered accounts of the history and practices of nursing, as well as theories and advice given to nurses, that at least partially have reflected and shaped their understanding of emotion work and emotions. I turn now to narrative accounts of this work as told by eighteen contemporary nurses, highlighting the terms, expectations and 'ideal types' that (most likely) represent what is done 'under the best of circumstances.'

Chapter III Saying and Doing Emotion: Nurses Talk about what Works

> The central insight of Anselm [Strauss]'s research is not that the visible can be restored--for it was never lost--but that the visible and the invisible are dialectically inseparable. *Work is the link between the visible and the invisible.*
>
> Susan Leigh Star (1991:265, emphasis in original)

> [W]omen learn to 'translate' when they talk about their experiences. As they do so, parts of their lives 'disappear' because they are not included in the language of the account.
>
> Marjorie L. Devault (1990:101)

> [Emotional] labor requires one to induce or suppress feeling in order to sustain the outward countenance that produces the proper state of mind in others.
>
> Arlie Russell Hochschild (1983:7)

Tracking the 'invisible work' of nursing involves an exploration of languages and of activities. As Devault points out, the 'categories available' for articulating lived experiences "are often incongruent with women's lives" (1990:96). Like her study of 'feeding the family,' my investigation of nursing involves "activities that most women [and nurses] learn to take for granted, activities that are normally only partly conscious, learned without explicit attention" (p. 100). Devault warns us against 'labeling' women's experiences with inadequate or inaccurate terms, yet I must work within existing linguistic frameworks, even as I attempt to reconfigure their meanings.

I have chosen two core concepts to guide my research that are particularly helpful to my exploration of meanings and practices of nursing. They are 'work' and 'emotion.' Building on Pragmatist philosophy and symbolic interactionist sociology, Anselm Strauss (1993) developed a theory of human action in which *work* as activity and interaction took a central position. His definition of work is explicitly inclusive of enterprises that are not necessarily part of an occupation or profession. Rather, he explores, in a variety of

contexts, the 'social mechanics of work' (p. 52), meaning the efforts people make to accomplish their own and/or collective goals.

Strauss (1982; 1985; 1993) identifies and names complex activities such as biographical work, articulation work and sentimental work that all involve effort, temporality, negotiation, and meaning-making. These kinds of work, such as that of creating and maintaining identities, aligning the activities of multiple participants, or tending to the 'sentiments' of others involve implicit and explicit interactions not often recognized as work. Analyzing Strauss' writings, Star (1991:265) notes that for him work is a way of framing "the relationship between the empirical/material on the one hand, and the theoretical/abstract on the other." She suggests that important understandings can be gained from giving systematic attention to the work of "making and managing invisibles" (p. 266). In this inquiry, I examine 'emotion work' as dense nodule of practice and discourse, and site of (in)visibility.

The invisibles that Hochschild (1983:27) has highlighted in her research are those experienced and expressed as emotions. At once a 'bodily orientation,' "feeling [is] ...something we *do* by attending to inner sensation in a given way, by defining situations in a given way, by managing in given ways," hence a kind of work. Prior considerations of work distinguished between mental and physical work as a means of justifying class divisions of labor, attributing higher status to mental tasks (Aronowitz and DiFazio 1994; Braverman 1974). In female occupations, emotion work is often a prominent feature. Hochschild examines emotion work in both personal and commercial contexts, drawing attention to social interactions and uses of self that are particularly prevalent in 'service' occupations, many of which have gendered dimensions.

Pam Smith (1993) found these concepts well suited for analyzing the complex skills, tasks and productivity that go into nursing care. Smith studied student nurses in a British teaching hospital, situating emotion work within formal and informal knowledges that were taught and acquired during nurses' training. She found that "emotion work was neither formally recognized nor valued as part of nursing. But nurses still engaged in it" (Smith 1993:68). In fact, the ideal nurse was a 'people-oriented person' who handled both techniques and feelings skillfully. She found that students encountered competing

management styles in different wards, ranging from 'assembly line care of the sick' to emphasis on 'nurturing' people. Often ward sisters (head nurses) were instrumental in setting the tones of emotion work learned and performed in particular, local sites.

In a later essay, Smith (1995: 181) distinguished between work and labor, suggesting that nursing practice encompasses both.

> Nursing work is an extension of the caring work done in the private or domestic sphere, largely by women. Labour denotes the selling of nursing work for a wage, in the public or private sectors.

If work is the activity of doing what nurses do, then labor is the production of this work sold as service and commodity. Tracking the 'invisible' in nursing takes us first into an analysis of the work itself, and then to an investigation of its marginalization as an exploited product, subject both to market forces in a for-profit health care system and to state controls in national health systems.

I begin this chapter with a discussion of connections between emotions and caring. I turn next to an analysis of nurses' stories about the work they call 'providing emotional support,' focusing on 'ideal types' of skills and knowledges utilized to provide optimum care when possible. I explore ways of being, doing and knowing that are at the heart of 'therapeutic emotion work,' and investigate a number of nursing activities in which emotional sensitivities play central roles. I conclude with a discussion of emotional dissonance, highlighting tensions between interpersonal dynamics of doing nursing 'work,' and organizational demands of providing nursing 'labor' under commodification of health care services. These latter dilemmas are more fully addressed in Chapter Four.

Emotions and Caring

Nursing leaders have struggled since the nineteenth century to define and legitimize the full array of activities that nurses *do* while tending to the health and healing of the sick. Tasks relating to therapeutic technique, physical comfort and ward management have been easier to classify than intangibles, such as 'making welcome,' 'reassuring,' or 'establishing trust.' The incorporation of psychosocial vocabularies into nursing theory after about 1950 allowed further elaboration of 'non-physical' tasks, referring specifically to psychological states and needs, but there is still no consensus

about how best to frame nursing work. A number of nurses and feminist theorists have grouped their consideration of these activities under the term 'caring' and have explored both significations and devaluations of care in contemporary culture. The concepts of 'emotion work' and 'caring' are different, yet issues raised by one overlap concerns of the other.

The concept of 'care' covers a wide range of activities and feelings that include both caring *for*, as in tending to, and caring *about*, which implies an affective component. Feminist writers (Finch and Groves 1983; Graham 1985; Stacey 1988; Ungerson 1983; 1990; Waerness 1984) have examined caring as informal, unpaid work and as undervalued, paid labor in an exploitative labor market. Theorists of 'difference' have suggested that care and connection with others are an aspect of 'womanly' identity (Chodorow 1978; Gilligan 1982; Ruddick 1980), while others have emphasized the ethics of care (Noddings 1984; Tronto 1990; 1993). Theories of caring have been used to understand and teach nursing as an activity that encompasses skill, attentiveness, human engagement and moral values (Benner 1989; Leininger 1984; Phillips and Benner 1994; Watson 1985).

While caring is a promising framework for understanding this complex and partially 'invisible' work, it is also problematic. As Reverby (1987) has pointed out, nurses were 'ordered to care' without controlling the conditions in which caring would take place. There is concern that commitment to any naturalization of caring reinforces the assumptions that 'women' are the ones who care (Devault 1991). Despite an appreciation for the focus on values, some nurses claim that 'caring ethics' remain vague, without really clarifying what to care about or how the care is to be given (Allmark 1995). Unlike more specific tasks, the open-endedness of caring makes it difficult to establish criteria for performance standards (Aldridge 1994). During times of budget cuts and downsizing, nurses who internalize values of relationship and caring as an individual responsibility are more vulnerable to economic exploitation (Smith and Agard 1995). Emphasizing the need to care also risks leaving nurses with personal commitments to act in ethical ways that are incompatible with the structural conditions under which they serve and are employed (Chambliss 1996).

The concepts of 'emotion work' and 'caring' are related in a number of ways. Most caring involves emotion work, but there are activities of caring that are not usually about emotion. For example, keeping clean linen under an incontinent patient represents caring for and about the patient, but may not involve emotion work; however, helping this patient with her embarrassment does involve emotion work. Caring may motivate certain kinds of emotion work, but some emotion work may have nothing to do with caring. For example, a nurse may display caring by asking a patient how her husband is handling her hospitalization. However, removing an anxious spouse in order to accomplish a therapeutic procedure may require emotion work on behalf of hospital rules that have little to do with caring for or about the patient.

Both caring work and emotion work are gendered and certain kinds of both activities have been essentialized as feminine. Both caregiving and emotionality have been paradoxically esteemed *and* devalued, in both instances through gendered associations and divisions of labor. In popular usage, caring is generally taken to be directed towards someone or thing outside the self, while emotions are seen as attributes of the self. Caring is often associated with moral expectations, whereas emotions are likely to be affiliated with behavioral norms. The experience and expression of ethical concerns may be accompanied by emotions, but 'feeling rules' do not have the same moral implications as caring. Within nursing, both terms have taken on new meanings as structural conditions of their enactments have shifted.

Referring ironically to invisible contributions of emotion work and caring by nurses, Pam Smith (1995:199) borrows the words of Joni Mitchell's song, 'you don't know what you've got till it's gone.' Are we precisely aware of emotion and caring at this historical moment because we can no longer take them for granted? In what ironic ways has invisibility served both to protect and to obscure these activities? Nursing, a female occupation with ongoing ideological and pragmatic struggles for legitimacy and recognition is an ideal site in which to track historical transitions and definitional debates about these 'feminine' qualities and activities.

Nineteenth century assumptions about 'womanly virtues' and the requisite 'good character' of nurses were key articulations of implicit skills, knowledges and activities

later rendered more explicit, if only as 'invisible nursing.' As discussed in Chapter Two, early nursing leaders subsumed interpersonal relations under notions of etiquette and comportment. Terms of 'emotion' were used very little in nursing until after the 1930s. Vocabularies of 'caring' are also relative newcomers to nursing theories.

Thomas Olson (1993) has questioned the contemporary tendency to call 'caring' the 'historic core' of nursing. He examined the terms and phrases used to describe job performance, skill mastery and patient interactions in the written evaluations of over 500 women in a nursing training program in St. Paul, Minn. from 1915 to 1937. He found that the most common expression of praise was for 'handling patients' well, followed by 'controlling' or 'managing.' Accomplishing physical tasks such as 'tidy rooms' and 'presenting a finished appearance' were highly valued. Olson found *no* mention of qualities such as nurturing, soothing and comforting associated with "the current rhetoric of caring" (1993:71). He concluded that 'caring' is one of several competing meanings of nursing in a field that has had as many divisions as rallying points. While we can only surmise what the bedside practices were then, we can ask why call it caring? And why now?

Caring has become an issue in what Hochschild (1995) calls the contemporary 'crisis in care.' Shifting the discussion from moral to political ground, she investigates social and structural conditions that are contributing to a 'care deficit.' In both private and public life, she asserts, the supply of care has decreased while the need for care has expanded. She outlines four competing cultural images of care, traditional, postmodern, cold-modern, and warm-modern, and their corresponding models for the social organization of caring that are currently vying for attention and support in an ongoing cultural politics.

The traditional solution is to return women to their 'proper roles' as unpaid care providers. In contrast, the postmodern solution is to deny the need for care and alter notions about human well-being. Cold-modern efforts minimize familial demands by institutionalizing care of dependent elderly, sick and young, while warm-modern models spread the 'burdens' of caring among multiple personal and public arrangements. Cold and warm refer to the emotional tones of these simultaneous and overlapping structural arrangements currently available for the care of people that are too old, too young or too

sick to care for themselves. Affirmations of care and caring as valuable and important come at a time when the collective will to support these efforts is waning. Nurses are among a number of 'helping professionals' for whom allocation of resources and support have become increasingly problematic.

Struggles to define meanings and practices of nursing take place within these larger cultural debates about who will care for dependents and under what conditions. Nurses have used moral languages of care, along with technoscientific languages of specialized skills, as organizing tools to defend the value of their/our work. Attention to *emotion work* focuses on aspects of caring that emphasize efforts of *doing* more than moral obligations to provide. In addition, concepts of emotionality as social are an attempt to reweave feelings into political and economic contexts (and vice versa), and to displace the individualism of many discussions about caring.

Concepts of care and politico-economic dilemmas of caregiving are implicated in discussions about emotions and health. Choosing to read nursing through emotion and emotions through nursing situates this analysis adjacent to, and overlapping with, concerns of caring and nursing. Yet the focus on emotion and work invites explorations of a slightly different cultural terrain, and opens possibilities for a different intellectual journey.

Asking Nurses about Emotion

In asking nurses about emotion, I did not seek to determine what emotion *is*, but rather to learn how they *do* emotion, what they *call* emotion, and how these figure into the social organization of accomplishing their/our work. Using an inclusive understanding of 'emotion,' I wanted to know what common encounters with patients and colleagues were considered emotional and how nurses talked about their own emotions in relation to the doing of the work. This effort is as much a matter of situating emotion work within the practices of nursing as it is an attempt to follow emotionality as it accompanies the various activities of doing nurse-work. As Anselm Strauss (1993:31) noted,

> There is a tendency both by laypersons and social scientists to distinguish between emotions and action, thus implicitly denying a crucially significant attribute to action. This translation of an adverb (emotional) into a noun (an emotion, or emotions) is easy to understand, for many languages include routine ways of referring to 'emotions'--anger, anxiety, joy, and so forth--as if these were entities.

> ...Such reification, though, complicates the difficulties of understanding the complexities of interaction. Just as there is no interaction without symbolizing, there is little without 'accompanying emotions.'

Nurse-work involves highly interpersonal activities, some but not all of which are understood by nurses to concern 'the emotions.' Other aspects of the work are less likely to be seen as emotional, even if they include 'emotion work.' These silences contribute to the invisibility of the work and point to the definitional fluidity of these practices.

Nursing expertise (Benner 1984) is grounded in practices that may be articulated through multiple, competing discourses. Part of the expertise in any given situation is selecting and acting upon a hybrid of interpretations regarding multiple 'feeling rules,' goals and priorities embedded in each encounter. From my observations, I have found that the nurse relies on partial perspectives, inadequate information, and felt and expressed emotions as tools for the job. She may draw on languages from nursing or other professional discourses, popular lay psychologies, and/or local shop-talk to 'define the situation' and act on/in it. Exploring emotion work takes place on levels of both symbol and practice. Nurses work the theoretical/abstract level by listening to, assessing and articulating vocabularies of emotion; they work the empirical/material level by attending to embodied responses and physiological indicators in themselves and their patients.

Of primary concern to nurses, and distinct from many other occupations with high levels of emotion work, is the professional intent to provide *therapeutic* care. From the Greek *therapeutes*, 'one who administers,' the American Heritage Dictionary defines therapeutic as 'having or exhibiting healing powers.' In other words, (at least some of the time) nurses are involved in emotion work with (at least implicit) goals of 'managing the emotion of others' (Thoits 1996) for *therapeutic* purposes. While nurses perform a wide range of emotion work, my first attention goes to the activities and understandings of 'therapeutic emotion work' as an 'ideal type.' What do nurses do under the best of circumstances? What do they consider to be 'good' emotion work? How do concepts about emotions frame the work? What activities might be considered emotionally therapeutic? Do they count as work? To whom? Under what conditions?

The Interviews

I conducted eighteen semi-structured interviews between Fall 1995 and Spring 1996 with registered nurses working in a variety of northern California health care settings. All but one of the nurses had been working as a nurse for more than five years, and the majority had been in practice for more than twenty years. The one man had worked in a dialysis unit for sixteen years as a tech before obtaining his RN license two years ago. Of the women, six worked in oncology, four in obstetrics, five in public health and home care, and two were hospital supervisors. A number of the clinical nurses had held mid-level supervisoral positions at one time, and one was also a nursing instructor.

It was a 'snowball' sample, with names gathered through acquaintances and professional associates. I did not seek to be 'representative' but instead selected nurses who were either self-declared or recommended by others as having particularly noticeable 'emotional skills' and as advocates of a style of nursing strong in providing 'emotional support' for patients. I wanted to learn from the 'experts' what was involved in this kind of care and how it is fitting in with other exigencies of current health care delivery systems.

After initial telephone contact, informal meetings of one to two hours were scheduled with each nurse in various locations convenient to the informants' home or place of work. Please see Appendix A for the Interview Guide that outlines general areas of inquiry and probes used to conduct the interviews. These semi-structured conversations were audiotaped, transcribed, coded and analyzed. I presented myself as both nurse and sociologist and was easily accorded insider status based on my own familiarity with nursing perspectives and practices. All of the respondents expressed gratitude for and support of my commitment to write about emotion work and nursing. I am very grateful to these nurses for taking time to dialogue with me about their/our work. There was a general sense that the topic, though important, is often neglected in favor of supposedly 'more pressing' concerns. In part I felt that they entrusted me with their stories and insights in hopes that I might clarify and make known the full range and intensity of efforts, skills and knowledges embedded in this work.

Ways of being, doing and knowing

Questions of nursing knowledges, knowledge practices, and practical knowing must be explored both on their own terms and in the larger context of knowledge practices within medical and social sciences. Foucault's (1970; 1973) archeologies of the human sciences and the knowledge practices of clinical medicine situate these particular regimes of truth in historical, political and economic contexts. Hierarchies of knowledge generated within the field of nursing, like all knowledge projects, reflect larger social contours that produce and often prioritize objective, experimental and techno-scientific approaches to knowing (Star 1995). Feminist writers (for example Alcoff and Potter ; Haraway 1991b; Hawkesworth 1989; Stanley and Wise) have proposed alternative epistemologies and debated how best to speak about the multiplicity of knowledges.

The knowledges that interest me here are those ways of knowing that are informed by emotionality. I am not interested in proposing a uniquely female knowledge, but rather in exploring the dynamics of practical knowing described by nurses as part of doing their work. They are not generating universal or absolute knowledge, but rather learning experientially what to do next, how to respond, what is likely to be effective in the particular set of circumstances of each unique situation.

These knowledges defy dualisms of objective/subjective, for they contain elements of both. Hochschild (1983:29) asserts that "emotion, like seeing and hearing, is a way of knowing about the world." It is a signal and a cue that "locates the position of the viewer" (p. 30) in relation to "certain culturally taken-for-granted ways of seeing and holding expectations about the world" (p. 28). Rosaldo (1984) calls emotions 'embodied thoughts' that are distinguished from cognition by their *involvement of the self* in social worlds. Stanley and Wise (:193) point out that emotionality is a product of culture and remind readers that "an experiencing feeling subject [is] at the centre of all intellectual endeavour."

These embodied ways of knowing are processual, emergent, situated and contingent. They are felt in bodies of selves that are historically, culturally and contextually specific. My question is then, how do 'material-semiotic actors' (Haraway 1991b) called nurses collaborate to produce/enact selves, patients, emotions and

interactions in contexts of contemporary managed health care systems? What knowledges are produced/inform these activities? How are they called by the nurses, and what are the consequences of their classification?

The most explicit reference to emotion in conventional nursing discourse is the notion of 'providing emotional support,' so I began the interviews, after obtaining basic biographical information, by asking each nurse what emotional support means to her. This generic term serves as an umbrella for a variety of attitudes, behaviors and understandings that I am calling ways of being, doing and knowing. Broadly, these *ways* of conducting self-as-nurse are not specific or particular, but rather refer to an overall approach to doing/being. They are a disposition and fully anticipate the contingent nature of the work. They are also taken for granted and almost invariably prefaced in speaking about them with '...just.'

> Emotional support is just being there for patients and for families, being open and being able to listen and just give them whatever they need that I can and feel comfortable with giving (#8, p. 1).

> Sometimes just being there and listening. Sometimes not even speaking but just your physical presence with someone (#6, p. 1).

> I think it's helping the patient to cope with their situation (#9, p. 1).

> Part of the emotional work is just making the person comfortable in the hospital (#4, p. 1).

> I would say emotional support is meeting someone where they're at, trying to figure out where is this person at and meeting them there (#13, p. 14).

The 'just' implies that these qualities are self evident and that not much goes into them. Not many details were given about how to 'be there' or 'be with' someone, although it was assumed I would know what they meant. When asked to elaborate on any particular strategies used, a common answer was, "just spending time; making an effort to be more available" (#1, p. 15). Useful skills were knowing "how to be more patient, how to express yourself better, and what to say when, or what not to say; when to be there" (#1, p. 19). How to *be* was understood to be local and contextual; as one nurse explained, "You have to figure out in that situation what that person is going to need" (#12, p. 34).

She continued, "It depends on the patient, everybody's so different, and there's no pattern" (#12, p. 41). This part of nursing resists standardization, making it largely incompatible with uniform care plans and systematic work organization.

'Being there' refers to a kind of presence, an attentiveness to the other as well as bringing the self of the nurse into the situation. One labor nurse said, "I go, and identify myself as having been there. It's so reassuring" (#3, p. 4). Another labor nurse said, "I talk with assurance. In the beginning I didn't talk with assurance. That makes a difference" (#16, p. 6). She spoke of using her own strength to ground the fear of the patient, saying "They are looking for somebody to give up their fears and their whatever. ...I tell them I'm going to take it. I've had three children. ...Let me worry for you, I will worry for you" (#16, p. 24). Another nurse said, "I can really be present. It's my gift and my light. It's my duty, really, my service to the world" (#12, p. 9). For another nurse, it's about respect, "I have developed a *way of being* I guess, around my patients that just has a lot of respect for them, who they are, ...letting them know that I'm there for them (#4, p. 2, emphasis added).

What nurses actually *do* to provide 'everyday' emotional support was seen as banal, hardly worth mentioning. An oncology nurse commented, "It's just helping the patient to (pause) whatever (pause) they aren't happy with their lunch, or whatever the issue is" (#9, p. 7). It's doing the 'little things,' and also a *way* of doing the 'technical' things. A labor nurse explained, "Even as I am doing certain things, there's a manner in which those interventions can be done that can either arouse fear or calmness, or at least neutrality" (#4, p. 15). She emphasized the importance of handling an emergency with ease, stating

> I calmly just do what needs to be done, and I explain why we're doing it, and get anything I need, give oxygen. There's a way in which I don't get panicked and then usually they don't get panicked, which I think is important, because I think the adrenaline is bad for the baby (#4, p. 15).

Here the legitimacy of producing calmness is reinforced by its physiological benefits.

Many of the intentional efforts and gestures made by nurses that contribute to the patient or client's emotional well-being were not labeled as such. One nurse commented, "Emotional stuff comes up if they're frustrated, teary-eyed and they're getting depressed.

But if it's not physically visible, it doesn't come up" (#16, p. 14). If the patient's emotional status was deemed worth mentioning, it had become apparent by being a 'problem.' A nurse explained, "We give report every shift, and if there is any emotional problem, or any problem at all, that is the number one thing that we'll talk about" (#8, p. 7). But routine encouragement, reassurance, kind words or gestures were taken for granted, hardly worth mentioning. Furthermore, they didn't officially count as work. A visiting nurse explained,

> Medicare wouldn't pay just for that unless it's a psych[iatric] nurse. But yes, 'altered coping' or one of those [conditions], 'emotional distress' and all of those, are part of our 'problem list.' But generally speaking, if it's not a psych[iatric] nurse, they have to have something else that we're doing besides just that, or Medicare doesn't pay for it. They don't pay just for that (#10, p. 7).

Nurses use terms like 'altered coping' and 'emotional distress' when documenting problems in an official capacity. This lends legitimacy to activities that may otherwise seem like idle chatting and socializing. Boundaries between professional and personal often become fluid, overlapping and contradictory.

Nurse leaders have worked extensively to provide a standardized vocabulary to identify and document nursing diagnosis and process (Timmermans and al. 1994), in hopes that these activities might gain recognition through greater visibility. For example, the North American Nursing Diagnosis Association (NANDA) classified Feeling as one of nine taxonomic categories of human response patterns. Beyea (1990:101) expressed concern that "[e]lements of feeling closely relate to Perceiving, Knowing, Exchanging, Moving, Communicating, Relating, Valuing, and Choosing" making it difficult to extract a distinct operational definition of this complex human phenomenon. Furthermore, diagnostic categories may be relevant within nursing parameters, yet unacknowledged within medical, scientific or bureaucratic systems that have power to define the scope and activities of nurses. Nurses *do* many things with and for patients, but, named or un-named, only some of these are reimbursed.

Nurses acknowledged in various ways the recently and increasingly diminished status of emotion work in relation to other more 'substantive' tasks. One nurse, speaking of a patient whose blood pressure went up in labor, recounted that sometimes this

elevation can be caused by stress, "but in this case it was a physiological problem, it wasn't *just* emotional" (#13, p. 10, emphasis added).

In their responses, these nurses used vocabularies that reinforced dualisms, contrasting technical with emotional aspects of the work. One nurse said, "You've got the very exact science and the very human patient. And it can get very hectic sometimes" (#6, p. 6). Hectic refers here to the accelerated pace of many clinical settings that pushes nurses to 'prioritize' their care. Another nurse reflected, "On busy days you just don't have time to do anything but the technical things that you have to do" (#9, p. 7). The enormous importance of time in doing emotion work will be developed in Chapter Four.

In the context of these interviews about emotion work, nurses expressed disdain for other nurses who avoided the so-called emotional or humanistic side of patient care. A labor nurse recounted, "There's one nurse that will say ...don't give me any social factors. I don't want to know, *just give me the facts*" (#3, p. 11, emphasis added). She went on to explain that some nurses "are so self-centered themselves that they can't step out of that to see what's needed, *other than mechanically*. They tend to get ...very task-oriented" (#3, p. 11, emphasis added). Another nurse, speaking about taking the medical history of a new patient, valued

> getting *personal* with the person, finding out more about their lives. ...There's also a *way* to ask those personal questions that are also medical, *not* being like an automaton efficient nurse" (#4, p. 5, emphasis added).

These (expert) nurses did not want to separate their style of doing from the content of their work, though they were clearly aware of other competing models of productivity and efficiency.

Providing emotional support was seen as a way of attending to the patient that involved the self of the nurse in interaction with the patient. It meant personalizing a contact that might otherwise be routine, indifferent, efficient, or technical. It implied treating the patient as more than a diagnosis or a set of tasks. The nurses I studied framed their ideal type of nursing care in ways that were consistent with descriptions of the nurse-patient relationship in nursing literature (Potter and Perry 1989; Scherer 1991). However, most of them emphasized that they learned how to do/be nurses through experience.

Benner (1984) sought to identify nursing knowledge embedded in clinical practice. She distinguished between 'knowing that' and 'knowing how,' suggesting that "from having observed the clinical course of many similar and dissimilar patients, nurses may learn to expect a certain course of events without ever formally stating those expectations" (p. 7). With experience, nurses developed tacit embodied know how, distinct from abstract knowledge. For example, 'knowing the patient' was having "an *involved*, rather than detached understanding of the patient's situation and the patient's responses" (Tanner, Benner, and Chesla 1991:9, emphasis added). This practical knowing was distinct from the rational models of practice used in nursing care plans and standard protocols.

An oncology nurse explained that "[w]e can learn things in our education theoretically. They're OK and it's a place to start, but I think you learn more by experience of having done it" (#9, p. 15). One nurse emphasized, "I learn so much from the patients" (#8, p. 4). Another said she learned a lot "from observing other nurses" (#12, p. 29). Further, this learning is cumulative, "the more experience you have with people in very stressful emotional situations, you sort of build on that experience. What's been helpful with people, you learn from" (#9, p. 2).

A number of the nurses interviewed referred to knowledges gained through feeling as intuition. A labor nurse said, "Sometimes a room can be very, very quiet and yet intuitively I can feel what is going on there. ...I'll just use my experience to sense the direction to go--the approach with a particular family" (#3, p. 4). Another respondent spoke of a kind of detective work:

> People tend to want to hide their problems, in a way, so you have to be able to just be intuitive and, what's going on with this person? What do you need to get in on? What information do they need?" (#10, p. 5).

In the hospital setting, it is important for nurses to make contact quickly. Asked about meeting a new patient, one oncology nurse said "I can pretty much tell within the first 10 minutes of talking to a patient [what they need]. ...I always make the first move because they are afraid and they don't know" (#8, p. 2).

Asked how she knew, one nurse said

> I don't know exactly how. It's almost like you listen to how the person expresses what they're saying and sort of know if they're just venting, or if they're looking for a response, or, it's like getting a feel for, paying attention to their body language, and their tone of voice, ...or if they outright tell you. A lot of times they don't outright say anything (#12, p. 35).

Initially when asked, nurses were vague about this kind of knowing. When pushed, they could list cues and indicators that informed their knowing. A nurse hesitated, then explained:

> To give emotional support. I don't know. You know when they're with you and when they're not. I could tell you when they're not with you, they're looking away from you, they're not interacting with you. You could tell, they're just not there. I think eye contact has something to do with it. I haven't really thought about that, but eye contact does have something to do with it. You can sense from their tone of voice whether they're being helped. You can sense from their tone of voice whether they have been offended. You can sense from even the words that they say, whether they want you there or whether they don't. ...And *you can't always get them on your side* (#16, p. 26, emphasis added).

Here the nurse is making a key distinction in emotion work. It is not necessarily about aligning herself with the patient, or the patient with the nurse. More complex than simply 'friendly,' emotion work is a negotiated relationship with unpredictable outcomes.

> These nurses described emotional ways of knowing as felt and sensed.
>
> It's not a concrete thing always that you can describe. Sometimes it's like a sixth sense, or a perceptiveness. You can get a 'take' on somebody, and you can't really pinpoint it (#12, p. 28).

These 'takes' are not uniform or obvious, "you kind of have to go on your own and read between the lines" (#1, p. 6) Yet they are also down-to-earth and practical. As one nurse noted, "I think it's a problem-solving ability and you gain experience at problem-solving as you have more experience" (#9, p. 16). Ultimately, it is about the nurse sensing and engaging with the patient as well as the nurse knowing her own feelings in a particular situation.

Ways of being, doing and knowing are about tone and manner and disposition. They are about a kind of attentiveness that engages the feelings of self in interaction with other selves. A nurse commented, "I've learned how to have a certain way of behaving. Noticing what works, what makes people relax. I can just perceive it in their being when

they feel OK" (#4, p. 5). Although nurses might attribute these abilities to something almost mysterious, these capacities are learned through experience and reinforced through repeated inter-enactments. However, as one nurse pointed out, "it's been hard for nursing to validate the knowledge that we get from the doing" (#11, p. 26). These seasoned nurses spoke of what they do therapeutically that engages dimensions of themselves and provides an environment for patients that may enable health and healing. They also spoke with frustration about the obstacles they encountered.

Providing an Environment for Healing

Florence Nightingale's instructions to nurses focused on the importance of establishing a physical environment with proper ventilation, adequate light, sufficient warmth, control of noise and appropriate removal of wastes (Wesley and McHugh 1992). In addition to pleasant physical surroundings, she suggested the patient would benefit from stimulating activities and soothing interactions with others. In today's hospitals, the physical environment is no longer the nurse's responsibility, but creating a comfortable psychological space has become a factor considered important and even therapeutic in the nursing literature.

The emotion work of managing patients involves goals of gaining compliance, cooperation, and hopefully, patient satisfaction. Nurses are responsible for maintaining orderly conditions among their patients and/or clients. In addition to providing therapeutic benefits, emotion work is a tool for assuring social control in the potentially volatile situations that accompany the disruptions of illness. The nurses studied operated within parameters of implicit 'feeling rules' about their own comportment and transmitted expectations tailored to the particular 'extenuating circumstances' they anticipated seeing/feeling in their patients.

Some nurses were explicit about creating a supportive environment for their patients. One nurse spoke about a recent shift she had spent with a laboring woman: "She just needed to know that she was safe and I had made it a safe environment to her" (#3, p. 8). Another labor nurse said that patients should have

> a milieu that allows them to feel like they can really be themselves and relax; and kind of trust me. ...To develop a sense of trust, I think how I do that is, well direct contact, eye to eye contact" (#4, p. 4).

Verbal and nonverbal interventions were mentioned. "I provide encouragement with touch and with my words" (#13, p. 14). Often there is not much time for these interactions. "It's kind of critical that you get that [trust] across fast, ...because they need to trust me to be able to labor well" (#4, p. 2). Establishing trust is therapeutic emotion work that easily remains invisible.

In the public health context, one nurse spoke of how difficult it is to gain trust with teenagers and socio-economically unstable patients. Speaking of teenagers, another nurse said

> you have to be around for a little while. You have to have numerous contacts. Once they trust you, you might be able to get some information that would help you provide emotional support (#11, p. 6).

Here information means knowledge about the client/patient. Some patients who don't fit behavioral norms are wary of overly involved social service 'helpers.' In general, sick patients are vulnerable and may feel insecure about their treatments and outcomes. An oncology nurse said, "I know there are people, it's not easy to get them to trust you" (#12, p. 16).

Nurses told of various strategies used to establish a good rapport and create a beneficial emotional environment for their patients. The process of welcoming a new arrival lays the groundwork for what follows. An oncology nurse explained,

> Let's say a patient who came in for the first chemo[therapy treatment]. A lot of times they'll bring him to the room and say, 'Here's your bed, here's your...', you know, and they're clearly scared, they look scared, they're acting scared. ..So I'll walk them around the unit, show them the kitchen, you know, things that make them a little more comfortable, introduce them to people as we pass, just to make them feel like they're coming into someplace that cares about making them familiar (#12, p. 38).

And a labor nurse described,

> When someone comes in, they walk down the hall, they have a big belly, maybe they have to stop on the way, breathe, they're in labor. They're already kind of distracted and consumed. Hopefully there's a room open, so it's meeting them with a real welcome. It's a fine line between giving them a feeling of welcoming

> and yet not jumping in their space. ...It would be things like trying to get her in a room quickly so she doesn't have to hang out in the hall. She doesn't have to get a sense of what else is happening in the unit. She can have that safe feeling, she doesn't have to be exposed, she can go right in her room (#4, p. 13).

The skills of making someone feel comfortable are so 'basic' that they are easily overlooked. Yet they are part of an infrastructure that makes the rest of the work go smoothly. Anselm Strauss (1985) called this kind of arranging and coordinating articulation work.

A dialysis nurse spoke of letting his patients know he was available by saying "I'll be around, just let me know if you want to talk" (#18, p. 8). A visiting nurse spoke of being

> someone they can talk to about what's going on with them, and someone who'll listen without any kind of prejudices. ...A lot of what I do with my patients is listening and validating them as a person, [showing] that they're of value (#10, p. 6).

An oncology nurse pondered about the odds of succeeding at reassuring her patients.

> Sometimes if I can spend twenty minutes with them, I think they just feel more secure. ...Sometimes it doesn't make a bit of difference. ...Like the person I described before, all the efforts I put in yesterday meant nothing. Yesterday and the day before, it was like she didn't hear a thing (#12, p. 15).

These nurses suggested that part of maintaining a therapeutic environment was to accept patients as they are. Said one, "I try not to judge, and try not to criticize, and try not to shame them" (#15, p. 23). A visiting nurse spoke of disarming the embarrassment expressed by elderly patients when she entered their homes by saying: "Don't worry about it, I'm not company" (#10, p. 14). Another nurse, caring for a terminally ill AIDS patient, spoke of needing to contain her disgust and revulsion at seeing his emaciated body. One public health nurse mentioned the credo she tries to use to guide her practice: "Show up, pay attention, speak the truth without blame or judgment, and be open to the outcome" (#15, p. 26).

Several nurses mentioned the value of humor in managing difficult emotional situations. One nurse recalled the dark humor she used in response to a laboring patient who cried out, "I'm gonna die, I'm gonna just die"; she answered, "Well, not since I've been here ...nobody's died in childbirth" (#16, p. 13). Speaking of ways to connect with

patients, an oncology nurse said, "I use a prop a lot of times. You find out what kind of work they are interested in, or their kids, then you go back with 'I have this book...'" (#1, p. 15).

Several nurses mentioned using touch as a nonverbal way to connect, however "some people do not want to be touched, and some people do it all on their own" (#16, p. 9). Sometimes the best patient support is putting the patient first when s/he cannot or will not. For example, a nurse can send visitors home. One labor nurse noted, "if it seems like the people are just there for the entertainment, I get extra people out of the room and get them to go home" (#13, p. 4). These approaches are highly contingent and individualized.

In referring to specific strategies they used to create and maintain a warm interpersonal environment, these nurses indicated implicit emotional standards that informed their practices. These activities were meaningful in several ways. They contributed to making the patient as comfortable as possible. They gave the nurse further information that was helpful in pursuing other therapeutic goals. They reassured the patients and contributed to maintaining compliance with hospital or medical routines. They gave satisfaction to these nurses who valued contact with the patients.

When asked how these supportive gestures and attitudes matter, one nurse responded,

> I think they matter a lot. I think that emotions are (pause), I'm a real believer in stress and illness and disease and I think that stress plays a role. So there are some stressful emotions that I guess I would say (pause) I'm not sure which comes first [stress or illness] (#9, p. 4).

Her hesitations may result from more than the personal observations of one nurse. Medical and nursing literature is more and more saturated with references to the interactions of mind and body in illness. Popular journals and alternative or complementary therapies publicize perspectives on health and healing that influence the attitudes and understandings of nurses. These nurses consciously sought to integrate emotional support into their work.

Yet many nurses were articulate about the ways that doctors, and clinical environments more generally, are less than helpful. They noted that doctors often did not interact with awareness or intention about their emotional impact on patients. In fact, one aspect of the emotion work provided by nurses was to buffer patients in various ways

from untoward consequences of clinical environments. These nurses were quite aware of the stress hospitalization causes most patients. As one nurse put it,

> Patients deal with uncertainty and fear. On a basic day to day level, they deal with frustration of treatment and hospital systems; information, lack of information, those kinds of things. Where nurses really help patients a great deal is in trying to smooth those things out, or trying to get them the information they need, get their questions answered, be a liaison between other departments and physicians (#9, p. 2).

A public health nurse spoke of helping clients get what they need.

> The system can be a very user-unfriendly environment for people who are already stressed and already sick to have to deal with. So I can act as a buffer between the client and the system (#7, p. 7).

She gave the example of a woman who came to clinic without the proper unemployment paperwork and

> she just had a tantrum right in the waiting area. She was so frustrated. She was so fed up with the whole system and said, 'This is it, I am not coming here anymore. I've had enough of doctors.' .. So I was able to go and talk to the [social work] people and talk to the triage nurse and get her in very quickly. She could have done it herself, but she was so out of sorts by the whole situation, she was ready to walk out. Then we kind of sorted out what she needed to do in terms of the paperwork and getting what she needed to get it together. It wasn't as overwhelming after we sat and walked her through (#7, p. 7).

In another instance, it was the home health service that had not done a good job. The public health nurse was angry when she had to cover for poor quality work from the only agency authorized by her client's insurance.

> I got a call one day that he [my client] was waiting in a puddle of urine and he was curled up in the fetal position, moaning. He had no pain medication whatsoever. I went out there and it just took all day for me to get him squared away (#7, p. 14).

Here (and elsewhere) emotion work overlaps with comfort work and administrative work.

Hospital nurses sometimes do what Goffman (1952) called 'cooling out the mark' as they persuade patients to adjust and accept various indignities of institutional life. For example, in the oncology ward, one nurse reported dealing with frustrations

> because [of] how things in the hospital don't work. Like waiting since 10 o'clock in the morning until midnight for a CAT Scan [radiology] is probably the biggest problem--and everybody gets angry because they can't eat and they can't go, and they're waiting (#1, p. 13).

Yet patients are expected to be cheerful and understanding. As Goffman points out, "there is a norm in our society persuading persons to keep their chins up and make the best of it" (p. 461).

Sometimes a nurse will cover for the shortcomings of another nurse. One informant remembered

> one time when I just gave a dinner break to a nurse, and the patient was so upset that I was going to leave at the end of the dinner break, because she got so much support from me, and the other nurse didn't see it as part of her role to give her [the patient] that emotional support in labor (#4, p. 19).

More often than covering for other nurses, the interviews highlighted implicit divisions of labor that assumed nurses would take care of emotional issues while doctors attended to clinical matters. One respondent said,

> I think doctors are quite focused on the clinical aspects of the disease. Not that they aren't good with patients or interested in the patients, ...but the doctors don't identify that [emotional concerns] as the primary problem (#9, p. 5).

A nurse explained that patients expect different emotional interactions from doctors than from nurses.

> I don't know why, but people will tell nurses--complain to the nurses for seven hours--and the doctor will walk in and they go 'everything is fine.' ...For whatever reason, they will tell the nurse (#6, p. 14).

A public health nurse spoke of the same dynamic: "They don't often tell the doctor or even the midwife what's going on, they wait to talk to us" (#5, p. 5). A labor nurse did not expect doctors to engage emotionally with patients,

> basically the doctor is in and out of there. I mean my job is to call the doctor at the latest possible minute because it's the middle of the night, and then clean up afterward. They take the placenta out, they do the suturing, and they're gone. So it can be very quick. If there's any emotional problems, then we deal with that (#13, p. 13).

Another labor nurse spoke of the importance of encouraging and reassuring labor patients:

> I really believe in the positive reinforcement theory, as opposed to the negative. [I don't] like [how] some people say, 'you're not pushing well enough, you have to do more,' or 'I don't know if you can bring this baby down' (#4, p. 5).

She went on to express that "a lot of times those negative messages come from the doctors. ...It's amazing to me that they don't realize the power of their words" (#4, p. 6). Asked if the doctors were supportive of her work, a labor nurse replied,

> Supportive of what I'm doing? I don't really think they care. I don't even think they know. And that's a hardship for me. ...I really feel like I don't get any appreciation or acknowledgment for my effort basically. They come in, it's not a thank you, not really a good-bye, and that doesn't feel very good (#13, p. 19).

In a teaching hospital, one nurse mentioned that

> most of the docs we deal with are residents and they are not too interested in the emotional side of anything. They just need to be in the room doing their assessments. Writing orders. ...The residents and the interns are so worked up on understanding what to order and what to do that they don't (pause), they think that the nurses will handle it (#8, p. 30).

Another nurse pointed out that working with young doctors required additional emotion management. "They're still learning. And you have to be really assertive with them, ...I think you do have to be emotionally strong ...to deal with [these] people" (#12, p. 32).

Nurses work with patients to smooth things over after rough interactions with doctors or other hospital personnel and situations. They routinely attempt to manage emotions of doctors to get the orders or treatments they deem necessary for patients. These activities are part of larger efforts to maintain a healing environment for the patient. One term nurses commonly use to describe systematic attempts to understand the patient is 'assessment.'

Assessments that Defy Separation of Emotion and Reason

Nursing process has been broken down for the purposes of teaching and learning into components consisting of: assessment, nursing diagnosis, planning, implementation and evaluation (Potter and Perry 1989). These steps can be applied to any aspect of providing care, whether addressing physical, psychological, social or even spiritual dimensions of illness and well-being. A key concept at the core of nursing process is 'need.' Building on Maslow's (1968) hierarchy of needs, nurses have developed a systematic approach to identifying 'patient needs,' from the most basic physiological survival needs, to a level of safety and security needs, to 'higher' needs for love and a sense of belonging, to a complex level of needs for self-esteem, usefulness and

achievement, and to a final goal of self-actualization. By framing the patient's circumstances as needs, the nurse is positioned to help meet those needs.

Nurses perform a variety of activities as part of the assessment process. Efforts to 'get to know' the patient, as mentioned previously, could be considered part of an assessment, as are any practices that allow the nurse to construct her 'knowledge' of the patient. Nurses are trained to perform skilled observations of signs and symptoms of illness, usually with therapeutic goals in mind. Involvement of the nurse's self, through communicative interaction, witnessing, empathy and compassion contribute to this, as do assessments of aversion, disgust, anger or dislike. Emotions experienced and expressed by the nurse may be consciously assimilated into the assessment process or occur spontaneously without further acknowledgment. Emotionality of the patient might be the *object* of investigation, especially in cases of potential or diagnosed psychological disorders or imbalances, or it could be seen as a form of *expressivity* conveying nuance and specificity about the patient's overall situation.

Many of the nurses' comments about 'patient needs' implied that these would be universally recognizable and identifiable. However, there was also the possibility that one person's assessment might produce a very different set of needs than another. For instance, medical priorities were often different from nursing ones, and both were often different again from family views. Nancy Fraser analyzes the 'politics of needs interpretation,' pointing out that "*who* gets to establish authoritative, thick definitions of people's needs is itself a political stake" (p. 202, emphasis in original). This is of course reflected in the unequal status among nursing and medicine and patients and 'kin.'

Fraser goes on to explain that "[r]unaway needs are a species of *excess* with respect to the normative modern domestic and economic institutions" (p. 207, emphasis in original). Three types of needs discourses are used to control such problems. 'Oppositional' needs-talk brings issues into a shared political arena, 'reprivatization' discourses serve to contain problems within existing social, economic and domestic spheres, and 'expert' needs discourses consign concerns to institutions regulated by professionals. The goal of needs management is to bring problems into bureaucratically administerable services and convince recipients that their needs have been satisfied. This

analysis is highly applicable to health care services, which through alternate medicalization and reprivatization of social problems have become sites of overlapping and contradictory needs assessment.

Nurses are positioned simultaneously as patient advocates, clinical providers and bureaucratic managers. Conflicting assessments of patient needs can spark feelings among patients, family members, clinical personnel and financial gatekeepers. 'Emotional needs' are particularly 'subjective,' difficult to validate, and open to a range of interpretation that is culturally linked to age, gender, race and ethnicity, and social status. Emotional content of encounters between nurses and patients is somewhat serendipitous and arbitrary, and always takes place within larger regimes of authority and prioritization. The nurses interviewed took seriously the responsibility of appraising their patients' status from several perspectives at once. They emphasized that ascertaining emotional 'information' was often squeezed in around the doing of other more technical tasks.

A dialysis nurse commented,

> Usually I'm doing a lot of *my talking* while I'm initiating treatment. I'm doing the venipuncture, I'm getting everything in place, I'm administering the heparin [medication], getting started with the treatment. I find that to be the best. It's about a five minute initiation period and it doesn't sound like much. But it's amazing what you can get accomplished in five minutes (#18, p. 8, emphasis added).

On a busy oncology unit, the nurse explained,

> Basically, you *converse* with the patient while you're doing your [physical] assessment and ask them how they're doing. You pretty much can assess how they're doing, and anything else going on (#12, p. 9).

In addition to a clinical assessment of progress, a labor nurse emphasized the need to assess what support her patient could count on,

> Usually what I do right away when I first meet the people is I spend a certain amount, maybe fifteen or twenty minutes in the room, kind of looking at the relationships and looking at what kind of support the woman has, and what she's doing. Is she mostly staying in bed, is she scared? Is she handling the contractions well? ...You know, I really try to figure out how the woman's doing and what I can do to help basically (#13, p. 3).

Speaking of her work as a public health case manager for clients with AIDS, one nurse indicated indirectly that emotions were part of her work of guiding a patient through his illness:

> I think a lot of my job involves making assessments, all the time. Whenever I am interacting with a client, I think I am always assessing. There is one client in particular with whom I have been working *very intensely* and he is probably pretty close to dying right now. Yet he has got some unresolved stuff. ...We went over the benefits and risks of each [possible treatment] as briefly as possible, because he was pretty sick and didn't have a lot of energy. ...As much as possible, I really try to empower the people to make their own choices and just present them with their options. I had to also call the family and make sure that they felt like that [the treatment] was an OK thing to do and they were going to give him the support that he needed to be able to do that in the home environment (#7, p. 9, emphasis added).

Nurses are not positioned to make final clinical judgments about patient status or needs, but doctors, patients and families often rely on nursing assessments to make decisions. The nurse will notice a problem, then tell the doctor, "will you come and talk to so and so because they need you to" (#9, p. 5). Case managers have more autonomy than staff nurses. As one public health nurse explained, "it's problem-solving to whatever the situation is at the time. ...I'm the person who gets the whole picture and then refers out and keeps it all covered" (#5, p. 7). Sometimes that referral is for a social worker or psychologist. Specialization and emotional divisions of labor are discussed further in Chapter Five.

There are formal assessment tools that guide nursing process. A public health nurse explained,

> I do an intake, which is when a patient first comes to us. ...I do a complete history on them, which depending on their history can take anywhere from one to two hours. And then I do a psychosocial assessment on them, see where they are. ...[When] we first have them, they should have already filled out about a 16 page questionnaire ...it's very thorough (#15, p. 6).

In the hospital, the intake procedure is much briefer, but on oncology nurse mentioned that

> there is that part of the admission form, I can't remember how it's phrased, it's something about any stressful events or any recent stresses related to (pause), I

can't remember how it's phrased. But there is an opportunity for them to tell us (#12, p. 11).

Nursing process leads from assessment to planning and implementation. This implies a fair amount of decision making. For a supervisor, this can involve rapid decisions in a changing environment:

> So the priorities, and what you might think would always be the priorities can change, because it is so fluid. ...I've really learned not to make quick decisions. In some cases I have to make a quick decision, because I'm the ultimate one making the decision, ...[sometimes] I realized, no, I should have waited and talked to one [more] person. ...So even though I say *gut instincts*, I'm pulling in a lot of information before I will then process that (#14, p. 7-8, emphasis added).

This nurse is suggesting that a combination of instinct and information is used to assess a situation and determine what needs to be done. Reason and emotion cannot be separated. The 'embodied knowing' (Benner 1984) or 'getting a feel' for what is going on is an unspoken aspect of making assessments.

Empathy

In order to assess specifically the emotional status of a patient, nurses listen and watch for cues. An oncology nurse watches "the way they interact with you. Are they withdrawn, quiet, cheerful, angry?" (#9, p. 13). A public health nurse spoke of following the same clients with chronic illness for a long time: "It's a pretty close contact. It is a real bonding. You get to know a lot of aspects of the person, emotionally, psychologically, psychosocially, medically, physically" (#5, p. 4). Another informant explained, "I think a lot of the aspects of what we do are helping a patient cope. Listening, problem solving, patient advocacy, (pause) the way you interact with patients" (#9, p. 1). Sometimes the *listening* becomes an active process:

> I think you have to probe a little bit in order to care. To gain some insight, try to find out where they're coming from. I think a lot of it for me is just trying to understand, trying to fit in to that particular person's shoes. ...I just try to feel like, later on, perhaps not while I'm talking to them, perhaps later on. I try to get a feel for where would I be, how would I feel in a similar situation (#18. p. 16).

While this and other descriptions nurses gave of their work could be called empathy, only one nurse interviewed actually used the word empathy in response to my questions. She was speaking about her training in nursing school.

> The very first nursing class we had, I forget what it was called, nursing process, we looked at empathy, the difference between empathy and sympathy, I remember that really clearly (#4, p. 21).

In an important anthology on empathy, gender and medicine, historian Ellen S. More (1994:7) traces the 'cultural work' of the concept of empathy.

> The term 'empathy' first appeared in the psychology of aesthetics to signify an emotional connection between subject and object--a discursively feminine meaning that has persisted in popular definitions of empathy. It was introduced into medical theory and practice for quite different purposes. At a time when medical professionalism increasingly mimicked the values and behaviors of experimental science, physicians required an appropriate protocol by which to regulate the intimacies of the patient-physician relationship.

Previously, the term sympathy had been used in this way, but its Victorian connotations of sentimentality and femininity made it unsuitable for professional use. This was exacerbated by its association with anti-vivisectionists whose sympathy for experimental animals was labeled as irrational and pathologically emotional. Clinical medicine called for a 'detached concern' that was named empathy. It was found particularly useful to describe techniques in psychoanalysis for gaining knowledge about the subjective experience of the patient. Empathy, however, was never fully able to throw off its troublesome "unprofessional identification with the 'other'" (More and Milligan 1994:27).

Philosopher Lorraine Code (1994:77) "engage[d] critically with the epistemologies that foster this denigration of empathy," alerting readers to its pitfalls and its promise. She examined the bureaucratic impetus to eliminate uncertainty buttressed by epistemologies of empiricist social science "that make individuals into objects of study and seek to achieve impersonal control" (p. 79). By contrast, empathy, at its best, implies 'affiliative qualities' of intersubjectivity that defy instrumental rationality. However, its gendered association with natural, feminine qualities renders difficult the claim that empathetic knowing is a skilled achievement. Code is further bothered when this devalued female trait resurfaces,

"promoted to the status of scientificity and professional attainment when men 'discover' [it]" (p. 83). Her final concern, about 'therapeutic empathy,' is that in asymmetrical power relations, the claim to know how another feels could easily be as much coercive, intrusive and cooptive as it might be supportive.

In order to rethink empathy, Code introduces Annette Baier's concept of 'second person' relations in which conversation and engagement create the possibility of an intersubjective knowledge. She suggests that an interpretive epistemology, however rare and fragile, might allow the kind of open-ended dialogue needed for empathetic knowledges. Code concludes with a discussion of de Beauvoir's 'ethics of ambiguity,' emphasizing paradoxical qualities that impede the instrumentality of bureaucracy and locate values in the irreducible particularity of the concrete. She suggests that empathy 'at its best' respects the boundaries between self and other, seeking knowledges that can accept both the ambiguity and the freedom implicit in loving yet never fully knowing another. Empathy is one contemporary attempt to name aspects of the 'invisible work' of choosing to act based on intersubjective interpretations.

Nurses work *both* within medical models that make the patient an *object* of study, *and* outside of scientific medicine (both by exclusion and by gendered divisions of labor) in a nursing context that (at least theoretically) privileges the nurse-patient *relationship*. Part of the assessment done by nurses is in the service of medical practices of diagnosis and treatment, part of the assessment leads to nursing diagnosis, planning and interventions. This may include articulating psychosocial needs. A nurse's empathy contributes to the assessment because it engages her emotionally and influences what actions might or might not be taken. As I discussed earlier, some nurses have called for an 'ethic of care' that *expects* this engagement of self.

Emotion work is performed as part of operationalizing those aspects of nursing work that engage a nurse's empathy (or not). A nurse who 'can feel' the situation of a patient is more likely to take that person's perspective into consideration when interpreting her/his 'needs.' It is interesting to notice what conditions favor or disrupt the possibilities of engaging empathy 'at its best.' Whether or not to perform therapeutic

emotion work, and how, is highly variable, situational, and largely left to the discretion of the individual nurse.

In addition to structural and personal deterrents, this kind of receptivity to others is complicated by the highly stratified multi-ethnic demographics of who comes to health care facilities for care. The majority of American nurses are from white, lower middle class backgrounds seeking upward mobility through professionalization. This social location influences their encounters with patients and shapes the contours of their interactions.

The implicit challenges of engaging self to garner empathetic knowledges for a nursing assessment are made visible during encounters with 'difficult' patients (see also Liaschenko 1994). One nurse confessed, "there's times when a patient, there's something about them that I can't usually define, that just pisses me off. And I have a difficult time with that patient" (#15, p. 24). Another nurse expressed that her empathy was bounded by implicit 'display rules' about proper patient behavior:

> Even a lot of real difficult patients I can handle pretty well. I can handle it, it doesn't upset me too much. I know what they are going through. Unless their behavior is so totally *unacceptable*. I know some nurses throw up their hands and say 'forget it,' [but] I think my tolerance is good" (#9, p. 3, emphasis added).

For another nurse, assessment included figuring out what was 'normal.' Referring to a patient who was crying a lot, she said,

> I guess it depends on what they are crying about. If they just had a heart attack and needed heart surgery, ...that would be normal, and they probably need the time to cry. But I guess if they continued for the next two or three days, if they were still in the hospital, I would have somebody check up on them (#1, p. 11).

In other words, empathy was conditional and situational, and nurses were constantly juggling how to implicate themselves in a variety of relationships.

This longtime nurse expressed a realistic acceptance of a wide range of personalities among her patients,

> There are just some people that you just don't like, for some reason or another, but you've got to do your job. ...[even] the people that you don't like, you pick up on things too, ...how are they handling what's going on (#1, p. 15).

Another nurse explained that she did not expect to feel closeness all of the time,

> If you don't click, you're not going to have that really close talk, you're not going to have that open me up conversation, which I guess is good because you don't want to have that with everybody. I don't think you have the energy to be close with everyone (#8, p. 23).

An oncology nurse remarked,

> There are times when you think that you're not making an impact at all and you can go for weeks at a time taking care of them thinking, 'it wouldn't matter to him if I was taking care of him or if I wasn't taking care of him.' I mean he's being *taken care of*, but you don't think that you're making that much of an *emotional connection*. And then something will be said or done and you realize, 'my gosh, I really am' (#2, p. 6, emphasis added).

In any case, these nurses are providing a basic level of care regardless of the particular patient response.

As well as bringing in her own emotions, a nurse learns *not* to engage her feelings with some patients. An oncology nurse explained that

> you have some patients that are very manipulative and so I have learned skills to recognize when someone is being manipulative. We have patients that get--a lot of our leukemics get a lot of medications--they are on a lot of narcotics for pain and a lot of times they get addicted. It's very common that they get addicted to pain medicine for a period of time. ...We need to assess that they really need it. It's hard to say. The longer you work here, the more you can tell. The more you know the patients, if they really are in pain or not. ...And I would give it whenever they wanted it because that is how I learned. But the more you get to know that individual person, you get to learn their behaviors. ...You see it every day and you can start to realize...Now with experience I am learning to ask and research it more before I give it (#8, p. 5).

A labor nurse spoke of caring for a patient who didn't like her,

> every time I walked into the room, it was like daggers. It was like she didn't want me in there. And I thought, I'm just not going to take this personally. This doesn't have anything to do with me (#3, p. 10).

She spoke of another 'difficult' patient:

> She was incredibly demanding. She was using her labor as a time to just crack the whip. Her husband was fluffing those pillows as fast as he could fluff them. And she was just an incredibly angry, angry woman. She was using her labor as a time to vent. I was actually kind of glad my shift was over. I couldn't help but laugh. I could put up the reputation of 'oh, I can deal with anything,' and that's not true, I can't (#3, p. 10).

Another labor nurse spoke of

> a woman who was just screaming at the top of her lungs through the whole labor. It was almost like she wanted to punish her husband. There was something else going on there. She was not going to listen to a thing I had to say, she would not try in the least to even breathe. She was just screaming at the top of her lungs, so I just let her do it. What else could I do? (#4, p. 18).

In all of these cases, the nurse assessed the patient as 'difficult' and shifted her emotion work from reaching out to removing her own feelings from further engagement. Some dilemmas raised by such emotional dissonance are addressed at the end of this chapter.

Passing it On

Nurses rarely work in isolation. In the hospital setting, they share responsibilities for care with other nurses, doctors, specialists, ancillary staff and family members. I asked whether and how emotion knowledges were passed on. Certain kinds of information were important enough to be written and included in the permanent medical record.

> I think major depression, withdrawal behavior, major anger, those are pretty big categories. I guess I would have to say for documentation it would be a pretty major category or issue that would make the documentation. Mostly it's oral. If a patient has a lot of questions or problems, that's probably not going to be documented, it's probably going to be passed on orally. ...I think people take it as an everyday part of the patient and what's going. But still the documentation is focused on the physical aspects of what's happening. I think people pass on in report emotional issues (#9, p. 6).

For one nurse, "there are a lot of things you can't document, but I feel like passing the word along" (#18, p. 16). Another nurse commented,

> We put [things] down in the chart a lot of times, but we don't read each other's notes all the time. I don't have time to read the previous nurses notes, so what we think is important, we pass on in report (#4, p. 7).

In her ethnography of nursing work, Zane R. Wolf (1988) identified the change-of-shift report as one of the rituals that orders the complexity of tasks to be accomplished during a nursing shift. It is a way that nurses leaving the unit can suspend time and freeze facts while informing the oncoming shift of each patient's conditions and needs. While the primary focus is on lab results, treatments in process and other technical information, emotional concerns of both patients and staff are also discussed. Wolf (1988:237)

reported that nurses would share conclusions drawn about patients that included emotional assessments such as:

> [B]oth Sharon and Ann agreed that a patient has a 'weird affect'; ...a nurse stated that an 'ornery' patient did not like to eat and another had an 'attitude' problem--she did not think that the nurses were doing anything for her; another nurse advised to 'just be extra nice' to a cancer patient; a nurse commented that a patient who had a Texas [urinary] catheter 'gets a charge out of it and likes to look under the covers'; ...someone described a new admission, an elderly woman, as 'cute as a button.'

Wolf (1988:251) noted that hidden functions of change-of-shift report included "socializing new nurses into their role, upholding nursing standards, and maintaining nurses' responsibility for the care of patients." Complaining, expressing humor or worries, telling 'war' stories about patients, initiating new graduate nurses into their role, warning of errors, and monitoring nursing care were included in report. Each of these functions allows nurses to process aspects of emotion work with colleagues. In some ways, emotional tones and expectations are negotiated collectively by the nurses of a unit or a service. Standards are expressed and evaluated in an ongoing process of interaction.

For example, when asked how nurses determine what kind of support to give patients, one informant responded, "I think people's capacities are different, also their understanding of what the person needs. ...You know, nurses with different personalities" (#4, p. 11). Asked then how nurses know what's appropriate, she answered,

> Well, in the nurses lounge, how the patients' are talked about. Whether there's a certain kind of respect, or whether it's OK to kind of belittle the patients when the nurses are all together. Is that just accepted, how they're talked about? ...Sometimes all it takes is just one person to have that compassionate response and it awakens it in others who might be inclined to have a negative response. I think there's just enough people there like that [compassionate] so it creates a whole environment (#4, p. 11).

This interpersonal validation of emotional assessments may not meet scientific criteria of objectivity, but it does produce a shared reality that is dense enough to act upon consequentially.

Preparing the Patient: Overlays of Emotion and Information

In a sense, nurses are knowledge brokers. They accumulate useful knowledge about the patient and about doctors, diagnoses, treatments, bureaucratic procedures and a host of other great and small awarenesses of very complex and changing systems. Part of their job is to transmit these knowledges along various pathways and see that the right information gets to the right destinations. One aspect of these exchanges, known in the literature as 'patient teaching,' involves giving appropriate information to patients about their condition, progress, treatments and anything else that comes up.

In reality, teaching is about preparing the patient both cognitively and emotionally for whatever activities and experiences the illness and its treatments entail. As one oncology nurse said, referring to chemotherapy, "I also want to be able to explain it to a patient in a way that they could understand it and not be scared" (#8, p. 11). Disrupting cognitive/emotional dichotomies, the information and the emotion were neither separate nor separable.

Patients with new diagnoses are particularly vulnerable.

> When they come in, they know nothing. To support them--they are afraid, they're frightened, they're afraid they're going to die, they don't know what treatments to do. Just being there and answering questions, teaching them, is an emotional support system for them (#8, p. 2).

She added that,

> when someone knows about their disease and how to treat it and what they are taking and why, those people do a lot better than those people that are in denial. I usually say that 'the more you know, the better you are going to do' (#8, p. 19).

Patients need to process their feelings *about* new knowledges about diagnoses, treatments and possible outcomes. They also need to process their own feelings *as* knowledges that are informing them throughout the stressful course of illness and treatment. An oncology nurse explained that there is an art to doing this kind of teaching.

> I think it's very important that you *slow down* and take time to explain everything they ask of you. You try not to explain too much, because that can frighten them more. You have to kind of *feel your way* with them and how much they want to know. Just go slowly and evaluate as you are going along, how much they need to know and not just run in and out of the room (#6, p. 6, emphasis added).

The critical issue of time and how to fit emotion work into the nurses' day is addressed in Chapter Four. Nurses expressed concern that they don't have time to teach patients enough, wondering how to provide both emotional support and information.

> You almost have to break things down into real tangible things. I think education of the patient is something we can identify a little bit more and in that sense there is an emotional need component to that too. You almost have to lump your emotional support under a heading that people can relate to as something that they can say, 'OK, nurses do that and that's really a valuable contribution of what nurses do' (#9, p. 19).

In this way, emotional support gets classified as education. A nursing supervisor wondered how this aspect of nursing might be equitably rationed:

> So again, it's that perception of, would they [the nurses] always want more staff, so that potentially they could be more available? Or is it legitimate to feel that if a patient gets ten, fifteen minutes of teaching or support a day, is that OK? (#14, p. 26).

Several nurses expressed their personal satisfaction in being able to teach patients. One respondent exclaimed, "I thrive on being able to teach people things" (#2, p. 8). Another nurse wanted to "tell them what the routine is" (#12, p. 39) and let them know what to expect, "reinforcing the fact that we knew this would happen, that it is a part of the treatment that's normal" (#12, p. 25). For another nurse, it was also important to prepare the families by giving information and reassurance.

> There's always a lot of questions from family members. What does this [dialysis] machine do? Why does it look like so much blood on the bottom of it? Just in supplying answers to the questions, it helps ease their minds a bit. ...You can be honest with people without giving them gory details. ...I just try to find out where they're at. Find out whether they're just scared, whether they really want information or they're asking (pause), but they're really just scared to death for their moms, or whatever (#18, p. 13).

Labor nurses try to prepare patients for the challenges of birthing.

> I really believe people do better when they know it's not going to last very long and your body is not going to ask you to do anything you can't do. ...I say, 'you know, you're at five centimeters [dilatation] and you're not going to hurt too much more than this' (#16, p. 8).

Another aspect of preparation is getting patients ready for discharge and how to care for a new baby at home. This might include comments about emotional adjustments as well as physiological ones.

Some kinds of teaching can be awkward and uncomfortable. A public health nurse spoke about the emotions of giving pre- and post- HIV/AIDS test counseling.

> How to support a person when you have given them a positive [HIV diagnosis]. ...[Since] it's a communicable disease, I need to teach safe sex practices, the importance of telling medical providers, dentists, doctors, their diagnosis, for their own protections. They need to be honest and up front with those who might come in contact with their secretions. So I speak with them about sexual contacts and family members, for the support system. It's all their choice, who they tell. I feel like it is really important to counsel the benefits and drawbacks of telling who, when (#5, p. 4).

Giving sexual information often involves the emotion work of overcoming embarrassment, shame or guilt, and may require that the nurse process her own feelings about different values and kinds of sexuality in her patients. A dialysis nurse explained some of the issues confronted by his patients.

> Impotence comes into play, due to their renal failure, ...secondary to anemia and hormonal influences. ...Marital problems, with or without regard to sexual problems; it's hard living with someone who has a chronic illness. Sometimes they're hidden. You have to dig a little bit under the surface sometimes to try to gain access to what they're really thinking about (#18, p. 6).

Another challenge for dialysis patients is sticking to a strict diet. For many, this requires emotional support as much as information.

Teaching and providing emotional support can be demanding for nurses dealing with patients whose sociocultural origins are unfamiliar. One nurse said bluntly, "You know, a real challenge is to do all that in Spanish" (#16, p. 20). Several nurses mentioned coming up against people who seemed to operate under different cultural norms. One labor nurse commented,

> It's kind of interesting sometimes in the Hispanic relationships, because sometimes there doesn't seem to be much of a relationship between the men and the women on occasion. Like the man will be on the couch sleeping while the woman is in labor, or if he's not sleeping, he's watching TV. You know, he's not at her bedside helping her or encouraging her. ..So it might be their sister, or mother, or friend that's with the woman, and then the father is a little farther back (#13, p. 13).

Speaking of patients with HIV/AIDS, one nurse commented,

> I find that by and large, the Spanish speakers have a harder time dealing with the diagnosis. They don't deal with it a lot of times. What happens is you get them when they are really sick. Most of my Spanish speakers, except for one, have not been willing to disclose their diagnosis to their family (#7, p. 4).

Nurses did not always know how to respond to cultural variations and they were challenged to prepare patients for medical treatments and coping with illness when language and expectations were different. These hesitations were as likely to be felt and expressed or suppressed emotionally as cognitively.

Sometimes what nurses are preparing patients for is brutal. A labor nurse spoke of informing a patient who was complaining about contractions: "'You are having your labor,' and she goes, 'Oh!' So it was like a *reality check*" (#3, p.5, emphasis added). In a public health prenatal clinic, a nurse dealing with somewhat irresponsible clients spoke of the work involved in reflecting back their situation to them.

> I think a lot of my patients are making some poor choices for their lives, have been making poor choices in terms of taking care of themselves and taking care of their children. ...Sometimes it's just *speaking the truth to them*" (#15, p. 22, emphasis added).

With the elderly, the finality of aging is hard to accept. Speaking of a deteriorating client, a nurse remarked,

> You have to feel them out, it's really touchy, you have to see where they're at. But when they are ready for that, I tell them *straight out*. I say, 'The reality as I see it is, the human body wears out. You are 87 years old'" (#10, p. 17, emphasis added).

The challenge is to work with the emotional impact of 'the facts.'

In dealing with the complexities of illness, the 'emotional' content is so woven into the 'factual' that addressing the latter implicates the former. 'Patient teaching' subsumes the emotion work done by a nurse to process her own responses to the patient's situation *and* the emotion work of preparing patients to cope with the 'realities' of their condition. This work is largely taken for granted and invisible. It may be accomplished with sensitivity and compassion, with flat affect, or with rudeness. A seasoned nurse learns to recognize patterns in patient responses to typical situations and incorporates these knowledges into her practice.

Feelings, Stories and Identity Work

Nursing theory has developed the idea of 'self-concept' to express a set of attributes and beliefs important to processes of health and healing.

> A person's self-concept represents a complex integration of conscious and unconscious feelings, attitudes, and perceptions about the total self, the body, a sense of worth, and roles. It reflects interpretations of past experiences, social interactions, and sensations. Self-concept is what one believes about oneself as a separate and distinct entity. Self-concept is based in part on how we believe others to see us (Potter and Perry 1989:723).

A nurse is expected to develop reflexivity about her own self-concept and sensitivity to disturbances of self-concept in her clients. Patients need help adapting to changes in self-concept brought on by illness and other life events and transitions. "The nurse should plan for a therapeutic environment that supports the client through the stages of adaptation" (Potter and Perry 1989:740).

Examining the social organization of medical work, Strauss and colleagues (1985) break the accomplishment of these highly complex activities of therapeutic support down into smaller components for the purpose of analysis. Beginning with the concept of 'illness trajectories,' Strauss explains that organizing therapeutic action depends first on identifying the illness and mapping a trajectory scheme, then on determining clusters and sequences of tasks. These tasks include 'machine work,' 'safety work,' 'comfort work, 'sentimental work,' and 'articulation work.' While elements of emotion work contribute to performing all of these, the processes involved in sentimental work address more particularly the nursing activities related to 'disturbances of self-concept.'

As Strauss (1985:129) points out, sentimental work "is present as an ingredient in *any* kind of work where the object being worked on is alive, sentient, and reacting" (emphasis in original). Sentimental work is related to emotion work in that it involves felt and expressed emotions that are managed in interactions between nurses and patients, family members, and other care providers. Strauss lists 'interactional work and moral rules,' 'trust work,' 'composure work,' 'biographical work,' 'identity work,' 'awareness context work,' and 'rectification work' as different subtypes of sentimental work.

Two of these, biographical work and identity work, contribute to the ongoing process of self-definition that accompanies any 'illness trajectory.' 'Biographical work'

ranges from the ordinary diagnostic interview, which may or may not include 'sentimental' details, to in-depth inquiry into a patient's personal history. Strauss defines 'identity work' as more psychological or even spiritual, delving into deeper issues of an individual facing extended and difficult illness or life transitions. Biographical work is about more than facts and events.

> It is as if you were to tell the story of your life, epoch by epoch, making sense of each in terms of the end product. The subjective feeling of continuity turns not merely upon the number or degree of behavioral changes, but upon the framework of terms within which otherwise discordant events can be reconciled and related" (Strauss, 1959, cited in Strauss et al. 1985).

A number of studies have examined the importance of 'story work,' or 'illness narratives' to help patients make sense of experiences of illness.[5] Nurses' narratives (for example Astrom, Furaker, and Norberg 1994; Benner 1991) have also been explored as a repository of embodied practices and habits that contribute to the ethical care of patients. Furthermore, emotion work generally accompanies ethical work. Recent theoretical approaches to narrative studies (e.g. Mitchell 1980; Polkingame 1988; Stivers 1993) have explored connections between story and identity. More than a *representation* of social and historical knowledge, narrative is seen as an

> ontological condition of social life. ...[P]eople construct identities (however multiple and changing) by locating themselves or being located within a repertoire of emplotted stories (Somers and Gibson 1994:38).

Somers and Gibson (1994) suggest that conceptual narrativity is a process whereby meaning is constituted in constellations of relationships that are situated in time and space and connected through causal emplotment. Narrativity turns events into episodes by embedding occurrences into an intelligible plot. Public narratives are held by communities of people and metanarratives are those foundational stories "lodged in the theoretical core of social theory" (p. 63). In the absence of alternative public narratives, some identities are silenced. The lives of most contemporary individuals take place within a matrix of multiple and competing symbolic and material narratives. Identity work

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[5]See (Brody 1987; Epstein 1995; Frank 1995; Good 1994; Hawkins 1993; Kleinman 1988; Morris 1991; Weimer 1994).

involves selective appropriation of plot based on narrative themes that allow a social actor to arrange events in some order and evaluate their meanings according to some normative criteria.

Philosopher Martha Nussbaum (1990) takes her understanding of the importance of narrative one step further than these social scientists by suggesting that *emotions* are social constructs that are contained in and taught through stories. Narratives are intimately related to beliefs and judgments about what is valuable and important the world. They structure experiences of emotion in highly specific, culturally embedded ways. Plots have meaning within structures of desire that are socially formed.

> We internalize culturally narrated scenarios that give us the dimensions, pace and structure of the *emotion*. And these scenarios are then enacted in our own lives, as we cast ourselves and others in the roles created by them (Nussbaum 1994:508, emphasis added).

As for the excesses of passion, Nussbaum claims

> we must turn, with Seneca, to mercy and to narrative--trying to respond to what has taken place without strict punishment, asking the watchful eyes of wisdom to look with *narrative understanding* into the complexities of another's motivation and one's own" (Nussbaum 1994:510, emphasis added).

In other words, stories shape and portray the emotional meanings of human activities, therefore story work is emotion work.

Nurses participate interactively with patients at various points in their illness trajectory to create meaningful stories that can contain the complexities and transformations of their experience. Nurses also tell each other stories about patients that situate their own and their patients' identities within structures of meaning and feeling. Nurses recognize expected illness trajectories and their accompanying emotions of anger, fear, shame, loss, anxiety, loneliness and grief. Various expert, local and lay discourses narrate the acceptability of responses and actions occurring in particular clinical and personal situations. In the therapeutic settings where nurses work, events to be made sense of include bodily and emotional changes that are framed in reference to medical and cultural models.

Cheryl Mattingly (1994) uses the concept of 'therapeutic emplotment' to describe the intentional structuring of a patient's clinical trajectory within a narrative plot.

Following Ricoeur, she suggests that narrative time allows an actor to create a meaningful plot out of a succession of actions. Distinct from linear time, narrative time structures events into the form of beginning, middle and end. It represents human actions as causes for the outcome of events, and structures *desire* in a movement from one situation toward a desired outcome. In narrative time, there is conflict and drama, and the endings are uncertain. Mattingly examines the work of occupational therapists noting that they create a therapeutic plot with and for the client that embeds the details of clinical treatment in a future story of recovery and healing. Here, "[d]esire in the face of an uncertain future plays a central structuring role" (Mattingly 1994:818), stimulating the patient to take action and participate in therapy in spite of his/her suffering.

For Mattingly, narrative structures desire and moves the patient toward action. For Nussbaum, emotion is encoded through narrative accounts that contain social and cultural meanings of what is valuable and good. Complex forms of emplotment give meaning to events by configuring their unfolding in narrative time and situating their enactment within human communities that Somers and Gibson call a 'relational setting.' Patients seeking care during illness or other life transitions enter relational settings structured according to biomedical and nursing stories about health and healing. To these they bring stories of their own, framed according to the structures of feeling developed over a lifetime.

Health care practitioners are positioned to participate in the patient's often painful process of story work. As Howard Brody (1994) remarked, the patient might well be asking, "My story is broken; can you help me fix it?" He goes on to caution that "the narrative must be meaningful *from the patient's point of view*" (p. 86, emphasis in original). Reworking the stories restructures the emotions, which are *both* embodied *and* in narrative, linguistic form. The therapeutic potentials of story work are subject to the same cautions discussed earlier in relation to empathy and needs interpretation. Dominant assumptions about what is good and right may not reflect patient perspectives and patients may resist "expert, therapeutic constructions of their life stories and capacities for agency" by refusing, for example, "inducements to rewrite themselves as psychologized selves" (Fraser :218).

In any case, nurses routinely perform story work while guiding patients through illness trajectories and challenging life situations. They transmit expectations and teach coping strategies. One nurse put it directly, "I'll steer people in the direction that they need to go" (#7, p. 10). Speaking of greeting a new patient, another nurse explained, "A lot of the questions [I ask] are about her labor, so just letting her tell her story so far is also like emotional work in a way" (#4, p. 14). A public health nurse affirmed,

> I do think that we all need to tell our story, to be heard. ...I think listening to their stories, without judging them. I mean, when I say listening, really listening, so they feel that they are heard, no matter what their story is. And you're not judging them, and you're not criticizing, you're just there and acknowledging how that affects them (#15, p. 19).

For patients with chronic illness,

> it's just to talk about what they have been through. What this treatment means. Other things like finding out their life situation, about the kids, and family, and where they are from. What their life is like now (#9, p. 10).

With cancer patients, the illness forces them to confront their lives in new and often unwanted ways. One nurse explained, "They are scared and they freak out in the beginning, but they totally (pause) their whole life gets into perspective. They realize what's the most important in life" (#8, p. 5). She added that the identity transformation can be abrupt.

> They wonder 'What happened to me?' What can you expect? ...They have no clue what leukemia is half the time. These are people who yesterday were playing basketball and today they have leukemia. And they feel like they did playing basketball, they don't feel that bad. ...so you have quite a long way to go with them (#8, p. 20).

Nurses learn to expect particular emotional reactions at different stages of an illness trajectory. Referring to expert discourses on death and dying, she continued,

> I think it's just like a grieving cycle (pause) or whatever they call it. They do that and then, some get there quicker, to the acceptance, than others. I think they all go through it (#8, p. 21).

For some patients, their medical condition is one small aspect of a larger configuration of problems. A public health nurse exclaimed,

> I have yet to see a planned pregnancy come through my door. Generally speaking, ninety percent of my patients, it's probably not the best time for them to be

> pregnant. They're having major life crises, and they happen to get pregnant. ...Sometimes I see the pregnancy as the secondary thing that we're 'treating.' The pregnancy has gotten the women into care maybe for the first time in her life. So we're there to do as much as we can, because we don't have her for long, we have her for maybe six months (#15, p. 8).

In this setting, the overlay between physical and psychosocial problems is obvious.

Fear is one of the most common emotions that nurses are called to help patients deal with. One nurse listed some of the fears: "A lot of fear of going through the chemo, and fear of dying, you know, really realistic, fear of dying, and body image changes, being separated from their families..." (#12, p. 14). Nurses help patients integrate the realities of cancer into their own life story.

> It's a big combination of fear and anticipation of the unknown facing death, dealing with putting their life in order. ...They might have small children. It could be any personal aspect of their life that they are trying to cope with and then it comes out in strange ways with anyone's emotions (#6, p. 18).

A dialysis nurse spoke of doing reassurance work with clinic patients who had witnessed the cardiac arrest of another patient.

> If we have a [cardiac] code situation going on in the unit, I mean here are all the nineteen other patients watching us code one patient. There's a lot of fear surrounding that. Here's somebody who we're trying to resuscitate, and they have no heart beat whatsoever, they're not breathing. We're doing this code situation thing which can be very scary too. It's very dramatic. I always make it a point to go around and talk to each person. I find the time to do that, even after a code, things are still a little bit hectic and nervous. I go around to each person, I just ask them if they're OK. If they have any questions about what just happened. I try to alleviate some of the fears. ...I always refer back to the patient who has coded. I say, 'Well, this gentleman has a lot of other problems besides dialysis' (#18, p. 20).

This nurse recognizes that many patients will identify with the story of another patient with a similar diagnosis. Here he wants to individuate patients, demonstrating that each trajectory is different.

Patients dealing with HIV/AIDS work to assume a new identity.

> Initially, when a person is diagnosed as positive, [there is] a lot of fear and anger, pain, injustice, shock, confusion--it's just an emotional hodgepodge of 'what possibly am I going to do with this?' There's a lot of talking and experiencing and getting more information and sitting with it. I see people then kind of mellow out. There is some acceptance of some sort. Or denial. Deep denial that says I'm not

> dealing with that, I'm going on with my life and pretending it isn't. Different people go different ways with that, and for different lengths of time (#5, p. 10).

The nurse works with the patient within her perceptions and the patient's own interpretations of his own experience. The nurse sees

> lots of anger. The young who are facing mortality become angry. 'Just do something, I used to feel better.' ...The big turning point is having to stop work. When one can no longer keep a job and has to apply for SSI [Social Security Insurance], it's a major time for need of counseling. It's a big life change to become disabled (#5, p. 16).

Nurses work to get patients to accept their situation. An oncology nurse explains that early in the illness trajectory,

> people are angry. They haven't worked through their acceptance of the disease yet, so occasionally I see just angry people. Angry at everything just because they have cancer. There is not much you can do for that except be there (#1, p. 13).

Sometimes it gets unpleasant for the nurse.

> They have to direct it somewhere and you came through the door. So that's another part of it. The nurse receives the emotion as well as giving it, because there is no where else for it to go. ...It's hard sometimes not to take it personally (#6, p. 19).

On the other hand, another nurse spoke of the importance of expressing anger.

> One patient, recently...never expressed any anger or totally accepted everything. It was really pretty worrisome, and then she got depressed of course. Anyway, that's not the normal course. Usually for the most part, people are pretty verbal. ...[If they] come in and they're really happy, whatever, they're basically in denial, or it hasn't hit them yet (#12, p. 23).

These nurses usually have clear ideas of what might be a normal emotional trajectory for specific diagnoses and what would not.

Nurses try to frame the patient's experience in a positive way. A labor nurse said

> I use a lot of words of encouragement, and [tell them] this is normal, you're doing great, (even if they're screaming.) I really emphasize what they're doing, that it's OK. I just try to really encourage them, and to give them a sense of, a good feeling about themselves (#13, p. 6).

Another nurse described the words and gestures she uses to help shape the chaos of a woman's labor:

> I liken it to being in a altered state, ...and having this guide who is very close by you and saying, 'you're doing OK, you're going to make it through.' It's like standing in front of them and saying, 'come on, just keep one foot in front of the other' (#3, p. 9).

An oncology nurse spoke of encouraging her patients to go along with chemotherapy:

> We try to get them to understand that and get them in that 'pumped up' spirit, because people will fight and they will do well. We can't say how long they are going to be in remission, but most of them, we can get in remission for some time (#8, p. 18).

Even in the difficult instance of a stillbirth, a nurse took steps to shape the patient's experience:

> So I helped her, and we have a protocol that we follow for what we do. But that's kind of bizarre, handling this little dead fetus, and doing everything with blankets, and taking pictures, and I have to decide what kind of pictures does this person want with this little, not very good looking (pause) What I did is when the baby was born, I gave her the baby. The doctor left very quickly after the delivery, and I was just in there with her, and let her hold the baby until she was done (#13, p. 12).

Through her actions, the nurse created a birth and death story designed to help contain the mother's grief, (and possibly her own.)

A visiting nurse spoke of working with chronically ill elderly patients.

> They are all on the same level facing death closer, ...and they are facing a loss of function, of the freedom to have bunches of energy and run around. They have a hospitalization where suddenly now they can't do that, on some level. It can be from, they're a little tired for a little while, and they get over it, to, they are suddenly bed-bound or crippled. That's a real issue, I'd say that's the most overwhelming emotional issue (#10, p. 16).

Here the story work is about adjusting to a diminishment of activity. Many of these same clients deal with chronic loneliness. Given today's geographic dispersal of multi-generational 'kin,' as well as increased proportions of women in the paid workforce, this nurse added, "No one can stay home and take care of people any more" (#10, p. 18).

Nurses try to understand patients' situations within their family structures. An oncology nurse reflected on helping the patient make sense of his/her experience, saying

> you don't know at first what they are upset about. Is it their big job that they are not going to be able to do anymore? Or do they have any kids at home? Or are

> they planning a big trip? You don't know how exactly it is interrupting their life. So [I like] just sitting down with them and just listening (#1, p. 11).

Sometimes it helps to "connect with the family member. 'Tell me about Mary? How did you meet?' Then they do this whole life review for you" (#2, p. 9). In other instances, "they've had very horrible families of origin that they've come from, so they don't have that support" (#15, p. 12). One nurse expressed concern about some dying patients who "are very isolated. And they won't trust their family or their relationships; or their family rejects them and they are unloved and they are with only strangers to care for them" (#5, p. 8).

Sometimes a nurse must negotiate between multiple possible story lines. An oncology nurse said,

> Yesterday, I had [a patient] who was very 'end stage' but his family would not accept that, wanted him to be a full [resuscitation] code. ...they wanted everything done and we had to do everything (#12, p. 2).

Speaking of patients taking experimental oncology treatments, a nurse commented, "they are very frightened and they want to be hopeful, and yet at the same time they are skeptical" (#6, p. 5). Nurses help patients navigate between stories of 'will to live' and 'acceptance of death.' A nurse noted that,

> it takes emotional support to support the spirit. They are so intertwined that it's difficult to separate them entirely. ...I think that the more healthy emotionally, or spiritually, a person is, the more readily they can deal with the physical (#5, p. 18).

Speaking of work with death and dying, one nurse said:

> I think that to really be an effective hospice nurse, that there needs to be some acknowledgment of the spiritual component to our work. Healing doesn't always happen on a physical level, but I have seen incredible healing happen when people have to let go of their bodies and allow themselves to die. Or just come to terms with certain things about their illness. I try to really see the gift in it. I try to see it myself, and I don't always (#7, p. 20).

Witnessing the pain of another is one of the most difficult aspects of nursing work. For example, one nurse spoke of how hard it was to support a mother whose child was dying of AIDS. Watching nurses perform this kind of support work, a nursing supervisor commented, "I continue to be aware of how touched the nurses are by the sadness of the family stories" (#19, p. 2). An oncology nurse explained that for cancer patients,

> there is also a pretty good chance that they are not going to be cured. That's how I work. A person comes through the door, pretty good chance that they are not going to be here two years from now. ...so I *set myself* that way. ...I'm not surprised when the people I take care of pass away. ...You hope that you can give them some time and some good quality before that happens (#8, p. 4).

As another nurse put it, "in most cases, with our folks, by the time death comes, it is the time to die for them" (#2, p. 2).

Nurses calibrate their own expectations, channel personal emotions, and manage their responses to what they see. They guide patients in understanding and assimilating the transformations of identity that accompany illness experiences, as well as the emotions that are part of the journey. The nurse might 'set herself' to expect certain outcomes, and prepare the patient for likely scenarios. In this manner, illness trajectories are co-constructed as emotional/healing relationships between nurses and patients.

Nurses listen to the stories patients tell, and actively engage in 'therapeutic emplotment' based on both personal and clinical knowledges of what is 'normal' or not. They negotiate multiple interpretations, relying in part on *feeling* to identify intelligible narratives. They participate in the story work of patients who are making sense of life experiences in ways that may be helpful or detrimental, depending on a variety of considerations. This shaping of stories provides invaluable 'containers' for emotional experiences.

Emotional Dissonance

So far in this chapter I have discussed primarily nurses' accounts of what they do 'under the best circumstances' to provide care in ways that engage emotions of nurses and those of patients. I have attempted to make visible those uses of self and feelings that contribute to a 'therapeutic' outcome, according to criteria generated from within the practices and meanings of nursing. Within wide ranges of variation among practice settings, personalities, training and inclinations of individual nurses, as well as significant variations among their patients, I have focused on sketching the broad lines of 'ideal types' of therapeutic emotion work within nursing.

In this last section, I explore theoretical and situational elements of 'emotional dissonance' that also affect performances of emotionality among nurses. Alison Jaggar

(1989:153) notes that "emotions and values are closely related" and that emotions are implicated in the observation and interpretation of events. Dominant cultural norms and expectations are embedded in emotional responses and may mistakenly be taken as precultural or acultural. However, Jaggar suggests, people in marginal or subordinate social positions, notably women, may not experience the conventionally acceptable emotions.

Jaggar has called 'outlaw emotions' those feelings that might arise in contradiction with accepted or expected cultural 'feeling norms.' In these cases, people "perceive the world differently from its portrayal in conventional descriptions" (Jaggar 1989:163:161) and have feelings/ knowledges which may be subversive to dominant values and practices. In other words, dissonant emotions may reflect multiple or contradictory interpretations of situations and be indicators of irony, resistance or indignation. Such evaluations of social situations suggest that feelings and thoughts *together* produce important social knowledges. Suggesting that emotion and cognition cannot in any case be separated, Jaggar (1989:163) clarifies that "[a]ccepting that appropriate emotions are indispensable to reliable knowledge does not mean, or course, that uncritical feeling may be substituted for supposedly dispassionate investigation."

In a similar vein, Thoits (1990:181) examines 'emotional deviance' as "emotion that differs from that which is expected, conventional, or obligatory." She is particularly interested in the situation of people who hold "multiple roles that have mutually contradictory feeling expectations" (p. 188). 'Affective socialization' may differ in different social worlds, leaving people with conflicting feeling norms. She identifies a variety of coping strategies used by individuals to change components of subjective experience to bring feelings in line with normative requirements.

During periods of rapid social change, people sometimes experience 'emotional lag' (Olesen 1990), an emotional disjuncture that occurs when people confront new situations with emotion standards and expectations appropriate to previous conditions and circumstances. Mixed emotions and ambivalence (Weigart and Franks 1989; 1991) are feelings prevalent in such contexts of increased complexity and shifting demands. Current

transformations in health care systems have created conditions that foster experiences of emotional dissonance.

> Within nursing, multiple demands and perspectives coexist in any single job.
>
> The hospital nurse is expected, and typically expects herself, to be simultaneously (1) a caring individual, (2) a professional, and (3) a relatively subordinate member of the organization (Chambliss 1996:62).

Ambiguous clinical situations, conflicting moral and emotional evaluations, and contradictory knowledges and definitions of situations may give rise to 'outlaw emotions' in relation to medical or bureaucratic imperatives. Burfoot (1994) suggests that the 'sensual dynamics' of witnessing bodily pain, dying and death can engage a transformative power of compassion and provoke new definitions of the situation. On the other hand, nurses may find themselves aligned with the normalizing power of expert discourses and unwilling or unable to go along with perspectives of their patients. In other words, nurses can experience and express emotions that are both/either subversive of and/or representative of the institutional powers within which they operate.

Nurses are positioned to see multiple perspectives in clinical situations where (among others) doctor, nurse and patient play such distinct and separate roles. One labor nurse expressed the discrepancy between physician and patient perspectives when describing a particular obstetrician,

> his deliveries are like clockwork. ...They are very precise, it's by the book and it's precise. ...As far as the delivery, it's always safe, everything is, as I said, perfect. From the mother's point of view? Maybe not, no, not from the mother's point of view. You [the patient] have to get into our mold, rather than (pause) and I think the mother should be able to lead (#15, p. 2).

In this instance, the nurse takes the role of patient advocate, yet also identifies with the doctor, referring to '*our* mold.'

For another nurse, pain medication ordered by the doctor changed her participation in a woman's birth.

> I feel like epidurals [anesthesia] are my nemesis. ... It's like, 'don't take my work away from me.' ...I feel that largely when a woman has an epidural, then really my job is done. Then I become a technician, a recorder of blood pressures and fetal heart rates. There is really not much for me to do at that point (#3, p. 5).

She is frustrated not to be able to give the kind of support she is capable of providing and angry that the model of care being used disempowers her and the mother.

The use of pain medication is an issue with dying patients because it is prescribed for pain relief, but in larger doses, it can precipitate death.

> It gets to be a huge dilemma and we had a really hard time with one patient because some of the nurses would not go up [increase] on the morphine. ...One nurse says, 'I'm not going to be the one to give it. If you want to give it, you give it.' ...For some people, it's very difficult, they feel like they are murdering the person (#8, p. 18).

Without specifically mentioning the proximity of emotions and ethics, Chambliss (1996) points out that ethical dilemmas faced by doctors assume a lone individual determining what action to take. Nursing ethics, by contrast, occur in relation to problems over which nurses have no control. He proposes that

> nursing ethics ...is the ethics of powerless people; the ethics of witnesses, not decision makers; the ethics of implementers, not choosers; the ethics of those whose work goes unnoticed (p. 870).

The emotions of the dis-empowered are also different from those of decision-makers. In hospital, this often includes family as well. One nurse described a dying patient:

> He was having seizures and the family was there [saying], 'Do something.' They basically wanted us to give him potassium. They wanted us to practically kill him, and you can't do that. But the family is just in such turmoil because this guy is grunting and shaking. It's the hardest thing. It's so draining (#8, p. 17).

The nurse feels compassion, but is not in a position to take action.

Yet in many situations, the nurse represents professional authority. One labor nurse said it mattered a lot what she told the patients, "because I know I have a position of authority as a nurse there" (#13, p. 16). Another nurse is concerned that her affective assessments might be too authoritative and misconstrued by another nurse.

> Sometimes I might be more perceptive than the next person. I might pick up on some hostility between her and her husband. It's a delicate thing, because I don't want to give a preconceived notion about her. Say a patient is not bonding well with the baby, and she seems withdrawn. I don't want to color the other person's perceptions either, which can so easily happen. 'Oh, she's really demanding' (#4, p. 16).

On the one hand, this nurse is evaluating the patient negatively according to normative criteria, on the other, she doesn't want to impose an inaccurate definition on the situation.

A public health nurse explained that some patients resent her authority during prenatal visits: "I've had women walk in, the first thing that they say is 'OK, how long is this going to take?' So a lot of women don't really appreciate what they're getting" (#15, p. 7). From the patient's perspective, the public health nurse represents middle class values and assumptions that feel like surveillance more than assistance. For example,

> in situations of domestic violence, where the woman is still really trying to protect her partner, sometimes you need to intervene fairly strongly, and then, in my heart of hearts, I think I'm helping this woman and supporting her, and she thinks I have just torn up her life (#15, p. 21).

This nurse also spoke of her interactions with a drug addicted patient:

> 'I don't think you're a bad person. I think addiction is a disease and it hurts you, it hurts your baby. I'm here to help you, I'm not here to be the police. There are many reasons why people use drugs, and they may be valid, but it's not healthy for you' (#15, p. 23).

Clearly this nurse is feeling tensions between her feelings of compassion and her criteria of how a mother should be.

One nurse expressed sensitivity about the conditions of her own authority, commenting that,

> emotional support for clients is obviously very individual. ...There is also an issue of acceptance from the person, you know, do they want to accept some emotional support from someone that they've just met, or somebody who's part of the establishment, or whatever. I think it's fairly impossible to do without trust (#11, p. 5).

Another nurse mentioned visitation guidelines designed to build trust, "I don't drop in on people without an appointment. Some public health folks do. It feels more comfortable to me when they know that I'm coming" (5, p. 2). Another nurse felt tensions between the patient's right to privacy and the awkwardness of asking personal questions:

> On the form, you ask if they have sexually transmitted disease, if they've ever been sexually or emotionally abused, if they have a history of mental illness, but you know, people always say no. And I think about that, what's the possibility of someone [answering], with someone else in the room, [and] a total stranger asking you these questions? (#15, p. 6).

Nurses carry and transmit normative expectations of how patients should respond to various situations. One nurse spoke of the dying:

> I think that they need to clear things up. A lot of people have family dynamic problems and I think you should do your best to get your affairs in order, like they say. You should talk to who you want to talk to and get things (pause) I get frustrated for them because I think they're going to regret it (#8, p. 22).

In another setting, a labor nurse indicated her evaluation of a patient's tolerance for pain:

> I know that if someone is freaking out and not responding to my giving them encouragement and the things that I do, if they don't have, like, the *character development or the inclination* or anything, then I'm very liberal with the pain medicine (#13, p. 9, emphasis added).

In other words, the nurse is prepared to offer emotional support but if the patient doesn't meet her expectation, she compensates with a pharmaceutical solution.

With clearly deviant patients, the nurse must express her concerns directly. Speaking of a pregnant woman with a history of previous child neglect, a public health nurse said,

> I do question her parenting abilities very strongly. She's still homeless, she abuses drugs, and yet I'm also her advocate, so basically what happened is that I started telling her the steps she really needs to take. ..And what she believes is that the system is evil and they make the rules and she is the victim. ...She got very angry at me and I became the enemy. ...It made me feel very sad (#15, p. 13).

Liaschenko (1994:88) writes of the moral work that nurses do to connect with patients they dislike. She found that nurses make a conscious appeal to the 'moral concept of respect' in order to meet patient needs despite "serious, perhaps impossible, interpersonal difficulties." The moral tensions of caring for unpleasant patients are also a source of emotional dissonance.

An oncology nurse spoke of her own maturation in resolving some of these tensions:

> I'm pretty sensitive, and I used to want everybody to like me. You feel that when you come to work too. You want everyone you work with and all your patients (pause) to like you. But, it's just the way it is (#8, p. 24).

She realizes that she cannot always please everyone and that she may feel discomfort because of it. In a similar way, another nurse concluded, "It's part of the lifelong lesson for me of just accepting people for who they are. I can't control everything" (#4, p. 7).

These nurses expressed feelings of emotional dissonance and spoke of accepting it as part of the work. They were managing complex, overlapping and contradictory meanings in situations with multiple distinct perspectives. They also expressed deep frustrations about working conditions that exacerbated feelings of dissonance between their own emotion standards and what was possible on the job. I address these dilemmas in Chapter Five.

Summary

In this chapter I have drawn on interviews with eighteen practicing nurses to examine how nurses talk about emotions in their work, what they say they do and how it feels to them to care for patients in a variety of settings. I began by reviewing meanings of work as that which links the empirical/material with the theoretical/abstract, indicating that the emotion work of nurses takes place on levels of practice and symbol. I situated emotion work within the contemporary 'crisis in care' as one aspect of a cultural problematic about gendered divisions of labor and contested provisions for certain psychosocial needs.

I explored meanings of therapeutic emotion work as an ideal type of care provided to patients or clients experiencing illness and other life transitions. Nurses referred to giving emotional support as ways of being, doing and knowing. These practices were taken for granted and minimized with the ubiquitous 'just' in many of their accounts. They were learned by doing; embodied knowledges of practice. Sensing the emotional status of patients was part of knowing the patient and guided nurses 'intuitively' to take appropriate action according to the specific conditions of each situation.

Providing an environment for healing was psychological as much as material. Nurses often served as emotional buffer between patients and rougher elements of medical or bureaucratic treatment. The quality of empathy, like an ethics of care, was seen to contain dangers and possibilities for feeling the situation of another and taking action from

an involved intersubjective position. Nurses sometimes lack the institutional power to act from the empathetic knowledges they garner, yet strong collective nursing assessments of patients are passed on among staff, colleagues and family members. These knowledges can be *about* patient emotionality and informed *by* nurses' feelings.

People experiencing illness and other life transitions that bring them into contact with nursing services are also working to reframe meanings in their life. Illness narratives and other story work provide patients with updated identities that incorporate radical changes in experience and life possibilities. Nurses listen and provide therapeutic emplotments to guide patients along journeys of re-invention of self. Narratives structure emotions, offering stories that inform self-concept and motivate actions towards possible futures.

Biographies have meaning in narrative time, according to culturally available scenarios and expectations. Nurses are familiar with illness trajectories and their accompanying emotions. They help patients to 'set themselves' according to expected illness trajectories, and adjust their own feelings and expectations as well. Nurses carry and transmit evaluative criteria about social identities and can propose emotional standards for responses, in themselves and their patients, to acute and chronic situations.

The complexity of nursing work positions them to witness multiple, simultaneous and contradictory story lines regarding their own, patients' and colleagues' experiences. The divergence of interpretations and perspectives can lead to emotional dissonance, ambivalence and discomfort. Ethical dilemmas, social inequities, bureaucratic imperatives, economic priorities and medical requirements are all possible sources for emotional signals of distress. As managed care approaches to the delivery of health care services are being widely implemented in public and private institutions, nurses are caught in restructuring efforts that affect the dynamics of emotionality between themselves and their patients. Nurses respond with emotional lag to new situations, experiencing and expressing the emotionalities of older feeling rules. I turn next to a discussion of nursing in transition, the strategies nurses have developed for doing their work, and the impact of these changes on emotions of the participants.

Chapter IV Transitioning to Managed Care

> [In order to understand the crisis in health and medicine,] I shall focus on the needs created by the process of capital accumulation, a process characterized by economic concentration in which an increasingly smaller number of economic units account for most of the production of each commodity. A primary attribute of this concentration is that it determines *a process of production and consumption* aimed at serving the needs of that concentration.
>
> Navarro (1986:25, emphasis added)

> Milliman & Robertson is the most influential among scores of firms that write standards and provide consultants who teach increasingly cost-conscious [health] insurers to say no. By curbing practices they deem unnecessary and wasteful--like staying too long in a hospital, or seeing a costly specialist when a generalist would do--such firms have helped slow the growth of medical costs. Last year, for the first time in a decade, employers' total medical expenses fell, by more than 1 percent, even as health care prices rose nearly 5 percent.
>
> Myerson (1995:1)

> Customer service has become the most important base of competition in today's health care marketplace.
>
> Kelly (1995:115)

Nurses perform emotion work as one aspect of therapeutic measures undertaken on patients' behalf *and* as part of the interpersonal management of their own feelings, those of clients and family members, and those of colleagues, both superior and subordinate, in complex health care service organizations. In the United States throughout the 1990s, dramatic restructuring of the health care system is taking place that is changing processes of production and consumption of health care services and therefore changing the conceptualization and organization of nurses' work.

I begin this chapter with a review of managed care strategies being implemented as health care industries reorganize to increase profitability. Clinical technologies, medical informatics and redesigned utilizations of 'human services' have modified and notably

downsized nurse-patient interactions in significant ways. Tracking micro manifestations of macro changes, I examine nurses' responses to restructuring and their accounts of several significant consequences for emotion work. I then explore how under conditions of low prioritization and lack of time the nurses interviewed manage emotionalities. Implicit in the analysis are assumptions that emotions are performed in social contexts, and that each of these both frame and reflect the other. What strategies, resistances and silences weave through nurses' meanings and practices of emotion work at this historical moment?

Nursing In Transition

The transformation of health care services into for-profit commodities can be understood as a process of capital accumulation (Navarro 1986) in which small scale, entrepreneurial services are being transformed into a corporate type of medicine. Increased specialization and hierarchy accentuate divisions of labor within the industry and, when possible, the employment is concentrated in low paying jobs, often filled by women and minorities. Work processes are framed in terms of efficiency and productivity, and market competition determines the viability of the product. Professional autonomy diminishes as providers become managers of health care 'teams,' subject to the higher authority of rationalized policies and procedures.

New managerial strategies and cost containment measures being instituted in American health care organizations affect the practices of nursing in many ways. The complexity of these changes, and the diversity of nursing practices by specialty, geographical region, type of organization and level of skill make it difficult to generalize. Some of the trends noted are in contradiction with others; older models overlap and coexist with newer formats. Hospital managers have designed new work systems, but how they are actually implemented at the level of patient care is highly variable.

Nevertheless, it is possible to identify a number characteristics of managed care and integrated health care systems that are currently shaping the practices of nursing both in and out of the hospital. As an undervalued and partially invisible aspect of nursing work, emotional labor is particularly vulnerable to the kinds of structural changes implemented under logics of managed care. Paradoxically, attempts to reconfigure the

nurse-patient relationship into one of product and customer both diminish *and* accentuate the importance of emotion work. Implications of these dynamics of work and workers in service industries are taken up in Chapter Six.

Managed Care and Health Care Restructuring

The impetus to redesign the delivery of health care in the US began during the 1980s as both privatized and federally subsidized hospital and insurance systems grappled with escalating costs of providing care. While progressive politicians attempted to initiate government regulation and reform, conservative fiscal policy advocates and private investors succeeded in redesigning health care according to principles of market competition prevalent in other capitalist industries. For nearly two decades, large managed care conglomerates of insurance companies, hospital chains, pharmaceutical and medical equipment manufacturers, and physician associations have negotiated acquisitions and mergers, consolidated the health care industry, and redesigned the flow of work using corporate management strategies. These transactions have been among the most profitable on Wall Street.

U.S. health care is funded by private insurance, (often included as part of an employee compensation package for those working full-time permanent jobs), by personal spending, and by public sources such as Medicare and Medicaid. According to concepts of 'managed competition,'(Kotelchuck 1994) health care services are marketed as a commodity and purchased by insurers, individuals or government. Insurance, also a commodity, is purchased by employers, both corporate and small business, or individuals. The glaring absence of coverage for at least 38 million uninsured Americans and several million more who are underinsured (Navarro 1993), as well as the lack of coverage in many instances for long term and chronic care, raise serious doubts about the ability of this model to meet health needs of the poor or very ill.

In 1994, U.S. health care spending was 14.3 percent (!!) of the gross domestic product, and per capita expenditure was $3516.00 (O'Neill 1996). By contrast, during the same period spending in the United Kingdom was 6.9 percent of the GDP and per capita cost was $1211.00. Health care outcomes, however, have not been appreciably different. In 1991, infant mortality in the US was 8.9 deaths per thousand, and in the UK, 7.4 per

thousand. Female life expectancy at birth was almost identical in the two countries: 78.9 and 78.8 years, respectively (O'Neill 1996). Purchasers of insurance and health care in the US have been dismayed to watch costs rise, while many providers have profited from the robust economics of increasingly complex and technological health care services.

Capitalist rhetoric attributes consolidation and restructuring of the health care system to the need for cost-containment, but under market competition, the difference between cost and price also determines profit. As a *Forbes* report on the 'rising stars of American industry' announced: "Congress and the public decided not to entrust health care to the social engineers. A sensible decision: Market forces continue cutting medical costs in a big way" (Walsh 1995). However, cost-containment measures are unevenly distributed, directed primarily towards improving industry profitability. For example, a 1992 survey of the top ten health maintenance organizations in California showed a range of 19 to 31 percent of all revenue going to administrative costs and profits (1994). Administrative expenses represent *one fourth* of all health care expenses in the U.S., compared to 6% in the U.K. and 12% in Canada (Navarro 1993).

Under such favorable conditions, corporate providers of insurance and health care have sought to increase their market share in an unprecedented health care buying spree. Recent mergers and acquisitions (O'Neill 1996) feature such giants as:

> Columbia/HCA runs on Ohio Blue Cross/Blue Shield ($300Million), MedPartners/Mullikan buy CareMark ($2.3Billion), UCSF-Stanford five hospitals into new system, FHP acquires Takecare ($1.1B), FHP Pacificare announce merger plans (8/96), Foundation Health HSI ($3B 10/96), United Healthcare buys Metrahealth ($1.65B), Aetna buys US Healthcare ($8.8B), Anthem announces adds BCBSCT (10/96), Wellpoint (Bluecross California) buys John Hancock (11/96)

These new corporate entities are hybrid formations of insurance and provider organizations operating under the generic term *managed care.* Unlike traditional fee-for-service, or indemnity plans, managed care features "health insurance plans that offer prepaid or managed fee-for-service health care" (MacLaren 1994a). Health Maintenance Organizations (HMOs), in existence since the 1930s, were the first group plans that contracted with providers to meet health care needs of enrollees for a flat fee. Capitation plans such as these favor out-patient services over in-patient stays, have a stake in

preventive care, and are financially motivated to cut costs, ration care and reduce hospitalization.

In 1983, Medicare reimbursement practices shifted "from a cost-based retrospective system, in which a hospital is paid its costs, to a fixed-price prospective payment system (PPS) in order to create incentives for hospitals to be efficient" (DeLew and al. 1992:162). Under this system, a rate is set for each diagnosis related group (DRG) and the hospital receives a set amount, regardless of actual expenses. Another insurance model for cost management is Preferred Provider Organizations (PPO) that negotiate reduced fees with physician groups and promise increased numbers of clients in exchange for lower rates. A common feature of these models is to maintain 'competitive prices' among purchasers/insurers while prioritizing cost reduction, whereas previous reimbursement practices simply raised the prices of insurance and/or health care services to cover production costs.

In the absence of a comprehensive regulatory and payment system, 'market driven' designs are reshaping health care delivery in both private and public sectors. By 1995, 29% of insured Americans belonged to HMOs and another 22% received care through PPOs (O'Neill 1996). Many states are beginning to contract the administration of Medicare and Medicaid to managed care organizations as well. The shift from traditional indemnity payment to managed care has a number of important consequences. Under the former system, the financial risk and burden of patients needing more complex and expensive care was assumed by the insurance company (or government programs), whereas with capitation plans, the contractual service provider is responsible for meeting the full range of enrollees' health needs at a predetermined price (Himali 1995). This has led providers to institute gatekeeping functions and utilization review.

Most managed care plans require enrollees to choose a primary care physician who determines what care is needed and decides whether referral to a specialist is required. These standards are enforced in one California HMO by having physicians sign an agreement when they join that says: "Physician shall not market or offer to enrollees services beyond those authorized by primary care physician or referring participating provider" (Froneberger 1995). Some physicians have contested this disruption of the

'doctor-patient relationship,' but most are economically pressured into compliance with insurance payers.

With utilization review, insurance adjusters and case managers use standardized protocols to determine patients' access to benefits. Firms like Milliman & Robertson have developed guidelines that standardize "hospital admission and stays, doctor's office treatments, home health care and recovery times before returning to work" (Myerson 1995). For example, one HMO in Illinois using these guidelines was able to reduce hospitalization per thousand members from 363 days a year in 1991 to 227 in 1994 (Myerson 1995). These rationalized 'needs interpretations' (Fraser 1989) are capable of circumventing clinical evaluations of doctors and nurses by prioritizing depersonalized economic criteria. Power, authority and decision making have shifted from clinical and medical hierarchies to administrative and corporate ones.

Nurses are positioned to do their work within *both* medical *and* administrative hierarchies. Professionally trained to assess and advocate for patient needs, they are generally employed by hospitals or other health care organizations for whom they perform managerial tasks, *and* they work under the clinical authority of physicians. Nurses 'produce' 'point of service' health care. Given that doctors' costs are generally accounted for separately, nursing salaries typically represent the single highest item in the operating budgets of most hospitals. Managed care plans have directed considerable attention to redesigning the utilization of nursing staff. Based on the comments of the nurses interviewed, I contend that many of these measures have reduced the quantity and quality of nurse-patient interactions, and thereby are altering experiences and expressions of emotions between nurses, patients and other people encountered in the health care environment.

Structural Downsizing of Nurse-Patient Interactions

In 1994, over two thirds of the nearly 1.8 million registered nurses (RNs) working in the United States worked in hospitals; 40% of the 370,000 licensed practical nurses (LPNs), and 22% of the 1.5 million nurse aides/assistants were also employed in hospitals (Buerhaus and Staiger 1996). Financial realignments and organizational restructurings have been consequential for health care workers who provide the bulk of bedside care to

hospitalized patients. One change has been an absolute reduction in the number of hospitals and in-patient services offered. Typically, following mergers, hospitals downsize to avoid duplication of services and to consolidate those remaining, often eliminating nursing positions while increasing workloads of those now serving a larger pool of patients.

Shorter hospitalizations, made possible in part through increases in out-patient services and home health care, have served to reduce costs of insurees needing expensive hospital stays. Patients with chronic medical conditions requiring on-going care are sent home 'sicker and quicker,' often shifting the burden of care to lower cost unlicensed aides or unpaid family members (Glazer 1993). As a result of more stringent admissions requirements, only the sickest patients are hospitalized and nurses are caring for patients with much higher acuity and more complex medical problems (Himali 1995). People who are *very* sick often have multiple diagnoses with overlays of chronic and acute conditions. Their psychosocial needs reflect the strains of living with such illness over longer periods of time. When institutionalized, these sicker patients tend to have more acute emotional needs, yet overall, contacts between patients and nurses have been reduced.

In addition to increased workloads caused by shifts in the type of patient and the length of stay, nurses are adjusting to restructuring plans designed to reduce labor costs and streamline the delivery of health care. Hospital administrators have hired management consultants from expensive firms, such as American Practice Management, Anderson Consulting and Booz Allen Health Care (Nurse September, 1994) to plan and implement work redesign projects (Boston 1995; MacLaren 1994b; Riley 1994; Smeltzer 1993; Sovie 1995; Zimmerman 1995). Euphemistically called 'patient focused care,' these organizational models offer a package of deskilling and labor saving measures that attempt to rationalize and improve both efficiency and quality of care. However from the perspectives of patients and nurses, these innovations in human service technologies (Taft and Seitz 1994) portend both promise and peril.

The key logic behind patient centered care is to reconceptualize the patient as a customer and health care services as commodity. As one proponent of managed care wrote, "the essential initial step to substantive restructuring is an organizational

commitment to change the environment based on the needs and wants of the customers" (Kelly 1995:115). Departments and disciplines are broken down into multi-disciplinary care teams called 'partners' and organized to bring technical supplies, medications, linen, meals and treatments to the patient's bedside. "Some of the routine tasks traditionally done by nurses are now carried out by the multi-skilled worker, so the nurses must learn to delegate and 'let go' of some of the traditional tasks" (p. 121). Patient focused care has adopted customer satisfaction as an important outcome measure, so customer relations and hospitality skills have taken on new importance. The implications of this aspect of managed care will be addressed in a later section.

Many restructuring plans include a shift from primary care models, in which most care is provided by registered nurses, to task oriented and team approaches that replace high-cost professionals with low-cost and less-trained ancillary personnel (Fritz and Cheeseman 1994). This change in 'skill mix' positions nurses to train and oversee unlicensed assistive personnel (UAP) providing direct patient care (McLaughlin and al. 1995), while retaining the legal responsibility for documentation and patient outcome. The principle emotion work of nurses becomes that of managing other personnel more than interacting with patients.

In the name of cost containment, some state legislatures are beginning to reconsider the nursing practice regulations that define the scope of interventions to be performed only by licensed personnel, weakening the nursing monopoly on certain skills and knowledges. Where a decade ago there was much talk about nursing shortages, today hospital managers attempt to use fewer nurses more effectively (Zimmerman 1995). Other cost containment practices include: eliminating positions by cross-training nurses from one specialty area to cover another, changing or ignoring acuity ratings in order to reduce staffing ratios, and using a higher percentage of part-time or per diem staff that cost less in reduced benefits.

Nurses are expected to move flexibly from one specialty unit to another, or take 'call off' time, according to variations in census. New information systems, standardized care plans and labor-saving hospital equipment are used to reduce nursing hours. As working conditions for staff nurses deteriorate, better educated and more experienced

nurses are moving away from direct patient care into case manager, supervisory, or other advanced practice roles (Buerhaus 1994a).

The overall impact of managed care has been to decrease the number of nurses involved in direct patient care while increasing the levels of responsibility for patient outcome. In general, this has reduced the amount of time available for all aspects of work, including emotional labor. Nurses' responses to organizational restructuring have included feelings of uncertainty, impotence, anger, grief, frustration, resentment and insecurity (DeMoro 1996; Droppleman and Thomas 1996).

As patient advocates, nurses are keenly aware of the consequences of these changes for patient care. In a letter to the editor, one nurse wrote,

> The public must understand that under the guise of 'cutting costs,' what's really happening is that it is 'cutting care' and the 'savings' are not being returned to the patient. The difference is slipping into the pockets of the CEOs, the stockholders and the variety of shell corporations that are springing up to take their bite of the lucrative pie (Froneberger 1995).

Many nurses are concerned that restructuring endangers patient safety, health outcome, morbidity and mortality rates. While some elements of 'good care' are well established, such as technical skills and scientific knowledge, other dimensions of nursing care are less explicit. One vital aspect of care that often remains unspoken and untheorized is the emotional work performed by nurses while tending the ill.

Nurses Respond to Restructuring

All of the nurses interviewed mentioned changes in their work in recent years. Many referred to specific cutbacks, while others spoke more generally of how "times have changed" (#1, p. 9). Lower staffing and increased workload were issues in several of the work sites. One nurse explained,

> The most recent change that happened with regards to the staffing numbers is that we have less staff to take care of the same number of patients, and as you know, the patients are not getting any weller coming in. The acuity is much, much higher. Looking over the spectrum of 23 years, the acuity of people getting admitted to the hospital *in this day and age* is that they are sick, and they are getting sicker. Short of that, they are in the clinic or the ambulatory treatment center" (#2, p. 3, emphasis added).

Speaking of her patient load, another nurse commented, "I can have four to five in the evenings. Five is a lot. But because of the way everything is going around here, usually it's four, but recently, since the budget cuts, it's been steadily that I have five patients" (#8, p. 7). She continued,

> The way everything is going with the health care system, we are all getting a little burned out. We are working so hard we don't take lunch breaks, we don't sit down. We are working so hard that we get mean to each other. ...Right now, it's been *emotionally exhausting* and we're sort of bouncing off each other (#8, p. 26, emphasis added).

A public health nurse caring for chronically ill patients in their homes commented, "I used to have more time to get more intimate with people than I do now. I have a much bigger case load and people are a lot sicker" (#7, p. 10). A visiting nurse spoke of the number of patients she was expected to see in a day. "What they're trying to do at work now, ...they're changing our productivity. See, we used to see five patients, and now we're seeing six" (#10, p. 7). Another nurse spoke of her frustration at the latest budget cuts,

> we have been able to accommodate to it, where it's not fun but it's doable. ...all of the fun parts that were there are barely there anymore. By fun parts, I mean the teaching, the educating, the emotional care. That's *barely* doable in many instances. It takes little to nothing to tip you over into it being undoable, of being hit with an admission. Even a routine admission, you just can't predict for admissions as part of your acuity (#2, p. 12).

One nurse was concerned for the future of her unit, "[They] are really tightening up money, so we are denied new positions as well" (#6, p. 7). A longtime public health nurse discussed the changes in care resulting from decreased public funding. "Well, now you can only be in two categories, at least in [this] county. ...Those are the main pockets of money earmarked. ...Everything else is gone, there's just no money for it" (#11, p. 29). She continued to express her worries, "we don't want to close our doors, you know. ...right now, if we're not careful, that could happen. ...Nobody likes cutting back, but everybody knows it has to be done. So all the people up here are frantic" (#11, p. 36).

An oncology nurse spoke of covering for cutbacks in other parts of the hospital.

> The biggest thing is having more help, and not pouring back all of the duties onto nurses when they cut every department. It impacts nurses. Whether it's central

supply that they cut, or linen, or whomever; then you spend half an hour or longer on the phone on the weekend trying to locate a pair of pajama bottoms big enough to fit a patient. There are all those little things that are just the meat and potatoes of every day that fall back to the nurse. We'll cut back on the kitchen, so the nurse is going to serve the trays. ...So you are doing all of this at the same time that you are trying to do your actual nursing functions. (#6, p. 16).

Referring to similar 'consolidation' of work, a nursing supervisor spoke of taking on tasks previously done by another nurse: "There used to be an admit nurse, but that was done away with" (#14, p. 3). In another context, a public health nurse said, "in the last few months they've cut about 28 RN hours from pre-natal [services] alone in my clinic" (#15, p. 18).

While some nurses are prevented from giving patient care by taking on 'non-nurse' chores, other nurses are involved less in direct patient care as they increase their work coordinating others.

> Right now, I'm really getting that my job as a case manager involves the coordination of bringing in the troops, rallying the forces together and delegating. I'm not the one who goes out and does the stuff. Whereas with former clients, I went out and did a lot of things. (#7, P. 11).

It is not only the roles of *nurses* that are changing. A nurse noted how nurses aides in the hospital are doing more: "Now, they've expanded the role in a lot of cases, for what nursing assistants can do, and they have them drawing blood and doing EEGs or EKGs; they do lots of technical [things]" (#11, p. 17).

One nurse reflected on the shift in her work toward greater supervision of others,

> It went back to a kind of team situation and now they are getting more nursing assistants and LVNs. We have a lot of associates that we need to supervise and we do not have enough time to do that" (#1, p. 22).

Another nurse resented overseeing the work of the LVN,

> I'm supposed to sign all their charts, all the LVNs' charts. You know, and I haven't done anything to take care of any of those patients. I just don't do it. ...I don't talk about it, it's the night shift, and so I don't do it (#13, p. 28).

She went on to explain that "people on the mother/baby unit feel more threatened in their jobs, because of the LVNs and the RN thing. It just feels like people are feeling not so

secure in their jobs" (#13, p. 28). If a lower, less costly category of worker can assume specific tasks, the managed care model calls for substitution.

In another setting, a dialysis nurse explained that nurses are assuming work previously done by doctors.

> The nurse is the one that answered all these questions. You would think that it would be the physician. It used to be that the physician would call the family in. *I can recall the days* when some of the doctors would bring the whole family in and say, 'Here's what you mother's going to be doing, a dialysis treatment... (#18, p. 13, emphasis added).

Nurse managers, already somewhat removed from direct patient contact, are taking on greater fiscal responsibilities. As one nurse commented, "The managing role at [this hospital] is more paperwork and keeping budgets straight, which is very important" (#1, p. 9). Yet another nurse questioned the implicit superiority of management over patient care.

> How nursing values nurses I find fascinating. If you are a nurse and you are an excellent clinician, you provide excellent care to your patients, and you meet their physical and their emotional needs, but you choose to stay there and you don't choose to advance paperwise, you are not considered to be 'as good as' or 'as motivated as.' In some way, you're a more inferior nurse than someone who goes on and collects more pieces of paper and then delegates and organizes. To me that is just the opposite of what nursing is supposed to be. What if you choose to use that knowledge at the bedside with the patient? ...But that is not valued. (#6, p. 20).

Nurses expressed both resentment and comprehension in relation to the impact of managed care on the organizations where they work. One nurse said simply, "medicine is becoming more like a business" (#6, p. 9). Another commented,

> It's pretty sad the way healthcare (pause), well, it's more like there's the big fork in the road, the completely uninvolved HMO where you have a different doctor every time, a clinic situation. ...And then, the other aspect, of the general practitioner that encompasses more of our populist health view (#3, p. 13).

For one hospital nurse, the changes are necessary.

> Everyone has gripes about management. I've actually been trying to have more understanding about management. They have a very hard position. They have to make this place work financially (#4, p. 12).

Yet she spoke about their unwillingness to discuss staff layoffs and cutbacks, saying "it makes everybody feel like a pawn in the big thing" (#4, p. 13). Another nurse commented,

> I don't think it's fair to blame the institution, I think it's--is blame the word? I don't know. It's much bigger than [this] hospital. And [this] hospital is no different than any other institution, they are doing things to survive (#2, p. 8).

The theme of survival is relevant to this study of emotion work and of nursing. The expression 'this day and age' used by one of the nurses reflects a sense that the changes occurring are not 'business as usual,' but rather part of broader if unarticulated societal transformations taking place at this historical juncture with respect to care and caregiving. The question is not whether emotion work or nursing will survive, but in what forms, in what kinds of institutions, and with what implications for relationships of health and healing.

As I have noted earlier, many aspects of emotion work defy standardization, depending instead on unique and particular dynamics of complex situations and interactions. One managerial technology increasingly applied to nursing is a reliance on classificatory schemes and documentary practices to define, organize and verify the work. Both the presence of psychosocial categories *and* their absence in many written accounts of nursing work are significant indicators of ways that emotionality is *both* disciplined *and* left invisible. I continue my story of emotion work and nursing with a discussion of the power and limitations of documentary processes to shape health care services.

Documentary Processes and Management Practices

With the advent of computer-based data and information processing, management technologies in industry have shifted from Fordist factory models to cybernetic systems of control (Haraway 1991a; Jameson 1992). The sheer amount and wide range of information needed to manage caring for and curing the ill has led to the development of rationalized documentary and information support systems in hospitals and health care organizations. This has not always been the case in medicine or nursing.

Pickstone (1993:433) delineates "four 'ideal' socio-cognitive types--four knowledge structures which correspond to four sets of social relations" that have shaped the meanings and practices of medicine since the eighteenth century. He calls these

biographical medicine, analytical medicine, experimental medicine and techno-medicine and suggests, among other things, that each of these represents different types of *work*, social relations and ways of knowing. Tracing developments within science, technology and medicine (STM), Pickstone identifies and historicizes these typologies:

> *Savant STM*, which includes biographical medicine, was the predominant type of knowledge/practice in eighteenth-century Europe. *Analytical STM*, which includes Paris hospital medicine, came into prominence in the early nineteenth century; ...it can also be characterized as museological-diagnostic. *Experimental STM*, or perhaps experimental*ist* STM, was primarily created for the late nineteenth century, especially in universities; it can also be characterized by its disciplinary structures and by claims to command over nature. *Techno-science*, including techno-medicine, I take as first created at the end of the nineteenth century, when certain laboratory products (or processes) became commodities, so partially reconstructing the social relations of STM to include industrial research laboratories, linked to universities, to state laboratories and to other institutions (Pickstone 1993:434, emphasis in original).

In nursing, as in medicine, it is useful to conceptualize the interconnectedness of knowledge practices, organizational forms and bedside practices that have changed over time. Pickstone clarifies that while elements of each of these 'types' of medicine overlap, historical shifts can be traced that have favored medical knowledges and practices compatible with industrial research and technological products.

Practitioners themselves are often so identified with the tasks and limitations of their work that they may not be able to articulate awareness of implications of these changes (Kaufman 1993:316). Kaufman's study of the life histories of seven physicians trained during the 1920s and 1930s traces the transformations of medicine

> from a profession dominated by diagnosis and empathy and informed by a diffuse social responsibility to a profession dominated by cure and control and informed by values and methods of laboratory science.

She notes that the reliance on diagnostic technologies, the quest for 'hard' findings, and the press to save time have contributed to a devaluation of the "curative power of the doctor-patient dialogue" (p. 304) and changed the processes of medicine in significant ways. The emphasis here is that what is called medicine today operates within a cluster of assumptions, knowledges, decision pathways, and interventions that are different from what came before.

A prerequisite for accomplishing *techno-medicine* has been to control and contain the inherently contingent, heterogeneous nature of medical work. Early on, proponents of scientific medicine realized that by "standardizing nomenclatures and record-keeping procedures, medical practice could improve both the production of data needed for medical research and the application of the results of this research" (Berg 1995). Berg argues that 'rule-based expert systems' require enormous amounts of tinkering to be useful and that "the tool and the practice mutually transform one another to each other's image" (p. 112).

In an analogous manner, nursing meanings and practices have been substantively altered among other things by the adoption of 'textually mediated' (Campbell 1988c; Cheek and Rudge 1994; Smith 1990) forms of organization. Building on the work of sociologist Dorothy Smith, Canadian nurse Marie Campbell (1988a; 1988b; 1993; 1988c; 1992; 1992) has developed an analysis of documentary processes as ruling practices, and their consequences for the profession of nursing. She shows how nursing assessments and experiential (embodied) knowledges have been reconstructed into management-relevant terms. Contemporary nursing relies on documentary processes whereby "systematic information, abstracted from its workplace ground, and constructed on a framework of 'official' professional concepts, becomes the authoritative account; it constructs what nurses know, replacing their own ideas and judgment" (Campbell 1988a:34).

'Patient classification systems,' designed to quantify patients' need for care have been introduced to regulate nursing workloads and assign more efficient hospital staffing. Individual professional judgments of rapidly shifting, unstable patient situations are thereby translated, through progress worksheets and written treatment plans, into 'objective' indicators and standard expectations of productivity. Coupled with cost containment prerogatives, these compressed determinations of patient needs have served to displace nursing knowledge and authority. Computerized information systems have accelerated data collection for management needs and added to nursing tasks while displacing patient care.

Campbell suggests that nursing science has contributed inadvertently to the very management systems that undermine nursing practice by developing care plans according

to 'planning models of action' (see Suchman cited in Campbell and Jackson 1992). Nursing care plans are ostensibly designed to support the rational organization of nursing work. In fact they are structuring devices that produce an orderly *record* of action, often after 'repair work' involving considerable maneuvering of the 'actual stuff, the situated action' (p. 481) to turn the work accomplished into reportable instances of nursing. Campbell clarifies that "the routine or planned character of the work is not what *directs* it but what is *achieved* as its outcome" (p. 481, emphasis added). The resultant written records are *most* useful as instruments of accountability that serve management purposes of controlling production.

Internalized nursing knowledge bases (e.g. experiential practices and standards of care) have been reorganized by objective management practices to shift the attention of nurses away from professional nursing criteria into cost-based terms. Hospital and nurse managers control the production of texts which in turn define authoritative knowledge, patient classifications and definitions of needs. Quality control mechanisms, based on documentary standardization, have replaced clinical accountability so that evaluation of nurse work is based on paperwork rather than patient care. Among other things, these new managerial technologies represent an "intrusion of fiscal policy-making into a professional area" (Campbell 1988c:39) and shift nurses' attention away from direct interaction with patients.

> Expressed in Marxist language, Campbell concludes that
>
> [d]ocumentary management controls in nursing revolutionize the labor process in ways that result in intensification of the work, appropriation of the knowledge of the worker, and objectification and alienation of the product (Campbell 1988a).

This accentuates class divisions within nursing as some nurses experience de-skilling and proletarianization while others benefit from the upward mobility of managerial status. In both instances, nurses are likely to be distanced from previous forms of patient care and from emotion work, and these activities are subordinated to documentary practices of management.

Charting (Dis)contents

The nurses interviewed for this study commented on documentary practices in general and in relation to emotional dynamics of their work. A labor nurse spoke of her distaste for charting.

> [I'm] just denying that paperwork. It's just like shooing a fly out of your face. I don't see it as important. It's basically I have to do all that writing stuff just to get my paycheck. It's a task as opposed to work. The real work for me, the challenge, is working with a woman and helping her and the father and the baby" (#3, p. 6).

Another nurse confessed

> I kind of lag in the paperwork department. I could be spending a lot more time charting than I do. I just choose to do more with the patient. Some nurses do perfect charting. They chart every single thing that they did ...but they are overtime every night probably. ...I just do my quick charting and I just make sure the most important thing is to take care of the patient. I make sure I haven't slacked off on that. And if I slack off on the paperwork, I do that" (#8, p. 28).

From another perspective, however, charting was seen as necessary for both accountability and validation. One nurse summarized,

> I think we've gotten the message from on high over the years that if we didn't write it, it wasn't done. And that's the most *physical way* that people who are evaluating your work have of knowing you did it. Because they really aren't there watching the interactions you have with the patient (#11, p. 11, emphasis added).

It is ironic that the written *word* is taken to be the most *physical* evidence of the very embodied yet often invisible activities that constitute nursing practice. The displacement of emotion work, a particularly invisible aspect of nursing, into psychological jargon, in order to become part of the 'real work' is especially poignant.

Another nurse described her dilemmas of squeezing emotion into structurally constraining categories built into the paperwork.

> There's a psychology section in our flow sheet. I'll say, 'patient down today' or 'patient manipulative' or 'social worker notified.' ...Our notes don't have a lot of space so we are quick and to the point (#8, p. 7).

Missing the implicit double bind, she expressed gratitude for institutional efforts to streamline the paperwork: "We are always trying new types of flow sheets. I think it's getting a lot better" (#8, p. 27). However, another nurse was uncomfortable with reductionist information strategies, saying

> there needs to be a way to modify that [the care plan], in an individual way, and put information there. ...I'm really frightened that while we're into the speed of it all, reducing everything to a little box, that then we have a speed answer, you know? And the speed answer isn't very good either (#11, p. 13).

In these examples, emotion work might be included in the documentation (thereby gaining legitimacy) but the categories were so simplified and stylized that they no longer resembled the complex clinical encounter between nurse and patient. Several nurses referred to limitations of classification systems and acuity ratings. This was especially true regarding the intensity of emotional expressions and needs. A labor nurse explained that

> a lot of women will become extremely expressive in their labor. They are faced with their core emotion. ...One of the problems I have with the hospital is that there's no way to channel that expression particularly. The hospital seems to me to want to streamline everything and categorize and make everything fit into a box. Labor is just the opposite of that (#3, p. 3).

Emotional information about patients would not always be included in written documentation, unless something extreme or abnormal was taking place. One nurse specified that

> it gets passed on in report so that everyone can be aware of it. That's *orally*. I think our current system of documentation allows for that, there is a section on emotions. I think that if there is something significantly different that someone will chart on that (#9, p. 5, emphasis added).

On the other hand, an oncology nurse explained simply, "we don't have a place on our classification sheets that says emotional support" (#6, p. 14). She elaborated that

> sometimes you just have to feel your way and that's the trouble, what you are trying to decipher, it's so inexact. Nurses really put their feelers out. That's where you can't always put that on your classification form (#6, p.2, emphasis added).

The allocation of nursing time was tied to documentary categories, but the contingencies of the work were not included on the forms.

> This little list of things [that we fill out], there's nothing in there that accounts for [the fact that] they are scared to death and they take twice as long to try to say anything. If they have had a speech problem, your communication takes so much more time and energy, and that *isn't factored in*. But yet the ratio of patients to nurses is getting bigger (#6, p. 7, emphasis added).

Many hospitals use acuity ratings to determine how much care patients need and to allocate nursing staff accordingly. Typically there is a form completed on each shift that categorizes the complexity of each patient in such areas as mobility (do they get dressed alone? walk to the bathroom unassisted?), assessment (do they have wounds to examine? neurological deficits? continuous monitoring?), and special procedures (do they need pre-operative preparation? frequent suctioning? complicated dressing changes?). A high mark in each category gives more hours of nursing care. One nurse described how nurses would work this system to get enough staffing.

> One of the acuity symbols is 'mobility.' It's either minimal, moderate or major mobility. And 'assessment' is minimal, moderate or major. ...Some patients, like our leukemics, you can't mark them up enough. ...then sometimes we have to check 'pre-op[erative],' because pre-op gives you a certain number of hours. So we have to just check that, even though we aren't doing pre-op, *just to get the numbers. You have to kind of trick the machine, the computer*. But you have to be able to explain when your manager comes the next day and asks, 'Why did you do this?' You better have a good answer, because it's money (#8, p. 29, emphasis added).

Similarly, a public health nurse explained how the work of talking to somebody was categorized:

> I think that that is just counted as a 'direct contact' or an 'indirect contact.' Indirect is on the phone. ...and there are hours of 'case management.' And yes, it is counted. ...If I'm with you for an hour, *that's counted*. Whether I'm talking about your HIV specifically with this infection you have, or whether I'm talking about the emotional aspect of being fired because you are positive, that's all the same contact (#5, p. 7, emphasis added).

She is fitting in the emotion work, but in order to be reimbursed, she must document the services performed. She explained,

> Our program is funded by five different sources. We get federal money, state money, grant money and consortium money. That's a lot of different pots, and a lot of documentation. The paperwork is astounding...mostly it piles up. It's so much statistics of: who did you see? how many times? how many times did you talk to them? what kinds of needs? ...They want statistics for the funding for the work (#5, p. 6).

Fitting nursing into legitimate categories in order to get funding was a source of frustration. One nurse commented,

> There have been many times we have tried to get things that nurses do recognized to be reimbursed or whatever, and just can't quantify it. If we can't quantify it (pause), it's so intangible that people don't recognize it, at least economically (#9, p. 22).

Legal considerations were another imperative for documentary nursing. A public health nurse explained her preference for the out-patient setting:

> [An]other thing that bothered me about hospital work was just how highly regulated it was, that everything had to be done a specific way, and you felt like at any moment, if anything was off, there was going to be a lawsuit (#15, p. 3).

The possible threat of legal action reinforces compliance with documentary processes. Nurses are reminded regularly by management that the patient's chart is a legal document.

The nurses interviewed expressed a common ambivalence about the position of documentation in their work. Reflecting on the ubiquity of charting, a nurse explained that on the one hand, they all want to cut back on the paperwork, yet

> it's almost always the nurses who won't let go of it. ...When left to their own devices, nurses make paperwork. ...They don't realize that a lot of the things that they've developed in their programs, which they think make it easier, have actually doubled the paperwork (#11. p. 9).

In this way, nurses both resist and collaborate with management's substitution of objectified categories and documentary ordering for the messy, open-ended processes that inevitably constitute their work.

Documentary processes and management practices are powerful tools that are being implemented in health care systems to shape work organization according to the profitability requirements of market driven corporate medicine. Reduction of services provided by insurance to patients, distancing of nurses from patient interactions due to work redesigns, intensification of workloads, and other cost containment measures have all contributed to reconfiguring the meanings and practices of nursing. These transformations are affecting many aspects of nursing, including performances of emotion work. I turn now to take a closer look at some of the implications of these changes.

Micro Manifestations of Macro Changes

Rapid introduction of managed care processes of production and consumption of health care services has resulted in an overall reduction of nurse-patient interactions and a shift of focus from clinical accountability to documentary standardization. The already invisible work of relationship and emotional support is being displaced and transformed within new structural arrangements in managed care organizations. In addition, existing conceptual frameworks for tracking these transformations tend to reinforce ideological separations between 'the inside and the outside of persons' (Lutz 1990), making it difficult to articulate their interconnectedness.

Academic divisions of labor have generally designated psychology as the social science most suited to study emotions, and individuals are conceptualized as the primary 'bearers' of feelings. In contrast, sociologists of emotion reposition meanings and practices of emotionality in cultural and social domains, yet most discussions of health care restructuring do not address the accompanying shifts in emotionality. Nursing theories have framed the psychosocial needs of *patients* as synergies of person and social environment, but the implications of work redesigns in managed health care on felt and expressed emotions of *nurses* and their interactions with patients remain undertheorized.

Nurses are articulate about the consequences of cost containment measures and management strategies for their work, but tend to feel personally responsible for the emotional content, or lack thereof, of their relationships with patients. This conceptual separation of personal feelings from structural analysis contributes to a sense of powerlessness and inadequacy that this study intends to challenge. In this section I trace some of the linkages between structural conditions and performances of emotion work.

"I don't have time to spend like I used to"

Probably the biggest structural constraint to doing emotion work is the 'lack' of time. Since the beginning of industrialization, wage labor has been tied to linear, clock time. Early in this century, Frederick Taylor (1911/1947) proposed that time-and-motion studies be used to determine the most efficient ways to organize work, which was then subdivided into small tasks in the interest of greater productivity. It was assumed that 'the

one best way' to accomplish a particular process could be determined and implemented through standardization. Industrial manufacturing in particular prospered by structuring work (and time) in short, repetitious units of activity (Braverman 1974). Although care-work is different from the production of goods, in institutional settings such as hospitals patient care activities have long been organized into routines that manage the time of individuals, impose social order, and privilege linear, clock time (Davies 1994; Diamond 1992; Foner 1994).

By contrast, Davies (1994:280) describes 'process time' as a way of doing time that is 'enmeshed in social relations.' It is characterized by multiple, simultaneous activities, fluid boundaries, waiting, interruptions, and open-endedness. The everyday activities of 'women's' work, care work and emotion work all take place intermittently in process time and demand that workers remain available to respond to contingencies as they arise. In many work settings, "[p]rocess time and clock time compete for attention and result in inevitable clashes" (p. 282). Davies proposes that service providers acknowledge the tensions between these different temporal relationships and empower caregivers to determine how and when to switch between them.

Unfortunately, during the current round of rationalization of health care services, time management studies have again been used to determine what nurses do during a 'typical' shift in order to allocate tasks and staffing in efficient, standardized ways. One such study reported:

> Work sampling techniques were used to ascertain time allocation to various activities. Observations were taken every 15 minutes during an eight hour shift by six trained observers. ...[W]ithin a typical eight hour shift, nurses in the six services spend an average of 31% of their time, or two and a half hours, with patients. (Hendrickson, Doddato, and Kovner 1990:32)

Other activities were classified as indirect clinical, 45%, indirect non-clinical, 10% and 14% miscellaneous, indirect. The authors recommended a variety of management strategies and concluded that "[i]t is essential that hospital and nurse administrators find better ways to use scarce [read: expensive] nursing resources" (p. 35). The critical question remains: how to determine which activities to prioritize.

Under the current economic climate of downsizing and cost-containment, the stakes are particularly high for patients and nurses to have a say in the determination of what counts as nursing resources. In a qualitative study of patients and their care providers, Milne and McWilliams (1996:812) found that "the meaning of nursing as a resource was 'caring time,'" which was further determined to consist of 'being with' and 'doing to/doing for.' Their finding of 'being with' was similar to my finding of 'ways of being' described in Chapter Three and overlaps with the concepts of emotion work developed in this study. In their study, 'spending time' was seen to encompass *both* elements of caring, and was valued in totality by patients. However, institutional allocation of nursing resources focused on 'doing to/doing for' activities while 'being with' was provided "intuitively, unconsciously, and rarely intentionally" (p. 817).

Time spent doing 'invisible work' does not count in production models that treat time as a commodity. Most nurses earn an hourly wage, so they are not at liberty to 'spend' or 'give' time as they wish. Despite their claims to professional status, management continues to devise timetables and work requirements that structure nurses' time. Like teachers, nurses have experienced an 'intensification' (Larson in Hargreaves 1992) of work which increases demands, creates persistent overload, reduces time in the workday, and erodes the privileges of educated workers.

In biomedical practice, time is not only a basis of value, measured in nursing hours and productivity, but also a means of asserting control and power over patients (Frankenberg 1988; Gibson 1994). Intimate bodily functions such as eating, sleeping or bathing are scheduled according to institutional routines, and waiting for the doctor becomes a ritual of anxious significance. Status, importance and priority are enacted through allocations of time, made possible by and reinforcing dominant hierarchies. The low status of emotion work is felt by its virtual absence in time allocations for nursing (Hall 1993).

All of the above considerations about time and emotion work focus primarily on time as related to *work*, taking emotion work and nursing as a particular example of rationalized working considerations. There are also important linkages between temporality and emotion work that emphasize the element of time in *emotions*. Emotions

are constructed over time and are stored in memory (Crawford and al. 1992). Today's meanings are embedded in stories subsequently captured and constructed in narrative time (Nussbaum 1990; Somers and Gibson 1994) that make sense of illness trajectories and biographical transformations (Strauss et al. 1985; 1993). Cultural performances of sickness are shaped as temporal episodes (Frankenberg 1986) and learned emotion standards are played out in thematic reenactments that are modified over time (Stearns 1994).

Individual and collective expectations of what kinds of felt and expressed emotions are likely or possible depend on historical and contextual particularities that are situated in time and place. Emotional interactions between nurses and patients are *always* embedded in time/memory/personal and collective history, as well as being unique manifestations of a particular encounter in a particular time and place. At this historical moment of work intensification and time reduction in many sites of human caregiving, collective capacities for emotionality are being marked by 'lack' that is felt as 'not enough time.'

Not enough time

The nurses interviewed all expressed concerns about work speedups and time pressure. One nurse responded "we talk amongst ourselves, everybody is really feeling the squeeze" (#18, p. 11). He said, "you really have to be organized these days ...we're really pushed to the limit" (#18, p. 10). Another nurse commented, "everything is at a very quick rate, and you just don't get those easy patients anymore" (#14, p. 13). She continued,

> Many nurses walk out of work after a shift, just 'Thank you that I did not kill anybody today' ...there are those few times in a year when they'll say 'Thank you, I got to spend ten minutes talking with someone today about what they were going through, how it felt.' But I can count on one hand how many times that happened in a year. It's more ...a patient trying to have a conversation with you, and you are like backing out of the door because you know you've got meds to give to six other patients down the hallway and you can't at that time have this conversaton. (#14, p. 14).

An oncology nurse spoke of how busy she was caring for three patients with leukemia.

> They've got central [intravenous] lines and they all have chemotherapy and they all have blood products and dressing changes. ...You really shouldn't have more than one or two of those. ...You *don't have time* to sit with a patient and talk. A lot of

> that gets put to the side. Physical crisis comes first all the time. ...The emotional part of it is not the priority when you have an assignment like that (#8, p. 8, emphasis added).

Another oncology nurse summarized the conditions that caused her concern:

> Being understaffed, patients being sicker, new technology and there aren't ...enough people to take care of them; *needing overtime and not being granted.* So issues come up, because people don't take overtime but they are here doing things. ...They feel like they need to finish up or do something, but yet it's not recognized (#1, p. 21, emphasis added).

These nurses are concerned about meeting production levels that do not provide enough time to finish their work, let alone relate personally with patients. Their time is regulated and overtime is not allowed. One nurse summed up the problem of doing emotion work saying there's

> no substitute for taking time. Time is the key. You can learn how to do a technique fast, ...but no matter how you have it down with meeting the emotional needs of a patient, it's paced by the patient (#11, p. 18).

Emotion doesn't count

With the kind of work pace expected of these nurses, there is a *de facto* rationing of care. A nurse summarized,

> On busy days, ...you just don't have time to do anything but the technical things that you have to do. ...You have to convey your support in a very short--your interaction with a patient can be very short. ...You just have almost two minutes to give your emotional support (#9, p. 8).

A labor nurse explained,

> If someone seems to be doing OK on their own, I dash in, if I see their water cup is empty, I pour some water in the cup, ...then basically [I] read the monitor for my 30 minute check, and I'm out of there (#13, p. 11).

This nano-second emotionality has a different quality than interactions that take place in a different time frame.

Technical care was mandated but emotional care was at the discretion of the nurse. As one nurse remarked, "you just get the job done. We don't want overtime and we don't have the people for these *other niceties*" (#6, p. 12, emphasis added). For another nurse, "I don't do those *nice little special things* that I have done with some of my clients" (#7,

p. 12, emphasis added). In response to the difficult hospital work environment, one nurse moved to a public health setting.

> I was losing why I was there, I was becoming this *mechanical nurse*, hanging antibiotics, and hanging blood, and going from bed to bed, trying to get my assessments done by the end of the shift. And not having the time that I wanted to *be with* that patient (#15, p. 2, emphasis added).

What is lost

These nurses expressed dismay at not being able to provide better care. One nurse said,

> I think the patients are getting hurt the most. They are the ones that are getting short-ended because they have a right to have somebody. Every patient has a right to be able to unload on someone and not have to worry about their beeper going off. So many times I'm in the middle of something really good, a good conversation, and my beeper goes off and I have to leave and I don't get back for maybe an hour" (#8, p. 11).

Another nurse remained philosophical about making an emotional connection with her patients, "maybe you don't make the connection, but maybe the next time you will. You just hope" (#2, p. 6). If the patient is difficult, she continued,

> I have never *not* taken care of anybody; if it is taking much more energy to invest into them, especially in this day and age, I don't have that kind of time and energy to try to develop that. In days gone by, I might have tried, I might have been a little more patient (#2, p. 7).

One of the traditional nursing activities lost in the hurry is teaching to both patients and new staff or student nurses. Since emotional and cognitive contents cannot really be separated in teaching, loss of 'patient education' is also loss of opportunity to do important emotion work. A nurse explained that a patient going home with a high-technology Hickman catheter would have to be taught by the home health nurse.

> They're going to have to do the teaching, because I don't have time to do it. And yet, that time accomplishes not only the teaching, but accomplishes the rapport and everything else. So goes the teaching, so goes that kind of rapport, because they are linked very closely (#2, p. 8)

A nurse explained how opportunities for students to learn nursing have changed.

> ...[In] nursing education, the piece where you practice in the hospital is getting smaller and smaller and smaller. ...[Students] have time to do it [skills] once or

twice, which doesn't build confidence. But emotional things are harder, there's not much time for that at all (#11, p. 26).

For the hospital nurse, working with a student was both a help and an added burden.

> I had someone else's student yesterday. I didn't know I'd have her until I got there, and that was fine, but it also slowed me down a lot. ...I gave her a patient who...is pretty needy and needs a lot of attention. ...I think students have some time to spend. ...So anyway, I helped her get organized, ...then went in and saw my own two patients. ...It basically took all morning to get those things done. (#12, p. 7, emphasis added).

Since emotion work is learned through observation, participation and practice, the apprenticeship of these skills is an important invisible process being lost.

Trying to make time

Nurses recounted their efforts to fit everything in. One strategy, mentioned earlier, is to work the acuity system. A nurse explained,

> Just recently, they changed [the staffing] around so that there's less hours for certain situations. But the way that I deal with that is ...each nurse ...assigns the hours for the next shift. ...So if there's any inkling of a problem, ...I always put the hours more (#13, p. 29).

However, she mentioned how reluctant some nurses are to ask for help. "I see other people (Nurses) who just kind of, if they have an assignment that's too heavy, they'll go ahead and try to do it instead of trying to get help" (#13, p. 30).

One nurse spoke of the anxiety she feels with patients when it is too busy at work, saying

> [I feel] a kind of impatience, like 'Don't ask for too many things,' I keep saying 'Do you need anything else,' and I try to give it to them, but I have to get across this unconscious message, 'Don't ask for anything else' (#4, p. 3).

This nurse is managing her discomfort by getting the patient to ask for less.

Another nurse felt bad because she had not managed to fit in 'teaching mouth care' to a patient and the next day a different nurse "would only notice, hey, why hasn't she been started on the mouth care, and write me a nasty note, or put a nasty note in the communication book" (#12, p. 22). Here, peer surveillance reinforces structural time pressures and makes the individual more wrong than the system.

Time Management (and Emotion Management) as an Individual Responsibility

Acuity rating systems and staffing allocations that did not provide 'enough time' were enforced through policies governing overtime. It was considered the nurse's responsibility to finish her work on time and several of the nurses interviewed referred to the challenge of complying. One nurse said:

> When we're so understaffed and work so hard, it's really hard. I know I try really *hard to get out of there on time* every day. And I never want to go twelve hours without taking a break. In your evaluation [it might say], 'One of the things you need to improve on is getting breaks.' (#12, p. 45, emphasis added).

Another nurse referred to a recent evening at work, "I knew I had a million things to do. I knew I'd never get out till 12:30 [AM]. It's always like a little game to see if I can get out on time when I work" (#4, p. 3).

An oncology nurse told the story of an evening shift during which a patient had committed suicide and there had been no other nurses or doctors to help her deal with it.

> I was there until 3:00 in the morning, all of a sudden a nurse from psychiatry showed up. It was a nice gesture, but it was like 'I understand you had a suicide, and you must be feeling really bad right now.' And I just wanted to say something obscene. ...maybe it was the timing, maybe it was just a pathetic attempt at assistance because this had happened around 10 or 11 PM and nobody, including the supervisor, showed up to help. Then suddenly they are sending a psych nurse to listen to my woes" (#6, p. 11).

The transference of responsibility from the institution to the individual was expressed in other ways. One nurse spoke of being too busy to do all of her clinical care, feeling overwhelmed, and getting reprimanded,

> What happens is that someone might not like what you did and they don't speak directly with you, they speak to your supervisor. ...Well, you know, I'm human. ....Yes I do make mistakes, I'm human and I'm working on not very much sleep in the middle of the night and getting overwhelmed (#13, p. 10).

Another nurse was concerned for how her own mood affected her rapport with patients. She explained, "My own state definitely has an affect on how I can be with people. ...If it's too busy, that certainly affects my state. I can get cranky really fast" (#4, p. 10). Similarly, a public health nurse commented on the ways that time pressures

affected her at work: "Well, when you have to go faster, you aren't as open. I mean, if you're uptight because you're in a hurry" (#10, p. 8).

Under current working conditions and time constraints, emotion work is not the only nursing activity being squeezed. However, it is an aspect of the work that is less regulated. With less 'official' accountability, it is left to individual nurses to determine their own personal levels of involvement. Meanwhile, systems of patient classification and rationalized work processes tend to objectify patients more, treating them more as units of work than as complex individuals. Nurses, under pressure to accomplish more 'work,' end up choosing expediency and objectification over interpersonal dynamics. A nursing supervisor spoke of the difficulties of working at this pace and still finding time for providing emotional support:

> I also think that after doing it [working] this way for a while, you kind of get also a little bit hardened. Even if they have the time, would they go in the patient's room to talk, or would they sit at the nurses station and just take a breather. I think that's up to the individual nurse (#14, p. 15).

Prioritization as Reduction of Services

The common term used to describe the internalized management of time and activities by nurses is 'prioritize.' Like 'needs assessment,' discussed in Chapter Three, prioritization is an activity whereby values and expectations are determined and enacted. As one nurse said, "The fact is, people have to prioritize, and they prioritize well" (#12, p. 21). This process is taken for granted and is seen as one of the professional skills of nurses, as they must use various clinical, theoretical, organizational and interpersonal knowledges to accomplish it. Tensions between medical, bureaucratic, economic and nursing schema for prioritization are sometimes articulate and sometimes mute. Both factors *external* to nursing and considerations *within* nursing are part of the prioritizations that are managed by nurses.

For example, the lack of support for social problems reflects both the lower status of these clients, and the pervasive cutbacks in all aspects of health care. A nurse commented that some emotional support is provided by social workers, but "I know that our social worker is spread really thin right now, so she has to prioritize who needs it the

most right now too, which families need her the most" (#12, p. 26). A public health nurse spoke of organizing medical care for low income children with problems that were already identified during physical exams. She said,

> [I am screening] probably about 200 health records coming in a day, and looking at them and trying to prioritize what's going to need to be done. And mostly everybody who needs to have follow-up has no money" (#11, p. 3).

High Priority

Ultimately, priorities determine what does or does not get done at the patient's bedside. One nurse expressed her 'bottom line': "Basically, you kind of have to put the physical needs first. ...obviously that has to take priority" (#12, p. 4). Another nurse confirmed,

> You do what has to be done first. If you have a situation where someone needs emotional support, but you have somebody's IV running dry down the hall or somebody who has spiked a fever and you need to draw blood cultures, or somebody's medication is due ...all you can do is try as graciously and kindly as possible to say that you will come back (#6, p. 9).

Sometimes the prioritization is very painful for the nurse. An oncology nurse spoke of a very busy shift during which one of her patients was dying from cancer. The nurse only had time to go in and increase her morphine doses, but could not attend to the husband and family who were witnessing the dying. She explained, "I had to make that choice, [since] she's going to be dead, and I've got to take care of these people who I know are not going to be dead" (#2, p. 10). Another nurse explained that once a patient is ready to die, they require less care, so

> you just have your [patient] load, and you have that person. And usually when they are dying, and they are on morphine, and they are comatose, you aren't really busy, so you end up getting an extra patient probably (#8, p. 16).

In each of these cases, the living are prioritized over the dying and their families.

Low Priority

Although giving emotional care was seen as important, it was not seen as a priority. As one nurse said, "when you've got time just slashed from being able to [give emotional care], and you have to prioritize the time that you do have, and you're taking care of more people who are sicker, ...those are the things that get cut" (#2, p. 8). When

asked what happens to interpersonal work when the unit gets busy, a labor nurse replied, "that's what get sacrificed first" (#13, p. 31). Asked whether management considered emotion work when deciding about staffing, a nurse responded, "if they get letters of complaint, or verbal evaluations from patients, then they might kind of look at it. But no, I don't think they see it as that important" (#12, p. 45).

The priorities of administration are not necessarily those of the nurse, yet pressure is put on her to comply. An oncology nurse explained that a delay of a few hours in starting chemotherapy on certain patients could "increase somebody's length of stay a whole day, so ...[we] get them started as soon as we can. And *that* you have to prioritize, and again *what gets cut is the stuff that makes you feel good*" (#2, p. 14, emphasis added). She does not elaborate, but in the context of the interview, she means interpersonal contact with the patient. For another oncology nurse, the perspective of the administrators on emotion work was contradictory. She postulated,

> if you were to ask someone in charge [about emotional support], 'Oh, definitely this is important' and yet, 'don't do it though, if it's going to be overtime or if it's going to somehow impact the flow of things.' So you are getting this double message. [Actually] we're not getting a double message, usually. It's pretty clear that's not a priority (#6, p. 12).

Priorities in Tension

These nurses expressed frustration over the discrepancies among different sets of priorities. One nurse stopped choosing to act as 'primary care' nurse because "I didn't feel like I could really meet their needs the way I used to be able to" (#12, p. 19). Another nurse spoke of "my frustration level of not being able to do a lot of the things that I think I should be doing" (#2, p. 19). A labor nurse said, "I get very frustrated if my nursing task will not let me be with the mother. That's incredibly frustrating, whether it's to answer the telephone, or do charting (#3, p. 8). Another respondent said, "you do go away feeling guilty. ...I've gone home and just sat and cried. A lot of nurses have done that. You know you are not meeting their needs" (#6, p. 6).

An oncology nurse felt bad every time she had to interrupt her work with one patient to care for another. She reflected, "you certainly have to if you have drugs to give or whatever. You can only *fudge time and schedule* so much, there are things that you

have to get done" (#1, p. 10, emphasis added). A visiting nurse spoke of juggling the different priorities of her patients, "for me to spend the time that one person needs, I often have to shortchange someone else. ...Since I know my patients, ...[I] can get away with a shorter visit on some" (#10, p. 8).

Working with and carrying these tensions requires emotion work as the nurse finds ways to manage her own feelings of discomfort. She may adopt a minimalist, task oriented approach, saying

> 'Well I'm a nurse and I'm supposed to give you your med[ication]s and check you pulse and do this and do that,' and that's what I'm going to do. Like going to the store with a shopping list. Maybe not seeing that other things are there, that *other things* need to be taken care of (#1, p. 24, emphasis added).

Another nurse explained that there are different approaches to doing the work and not all nurses prioritize spending time with patients:

> I don't spend a lot of time at the nurses' desk, because I'm in the patients' room, generally speaking. ...[T]hat's not always the case. A lot of times they're [other nurses] not. A lot of times they'll go in and do the checks, and go in and out. ...maybe they don't understand the importance of the things that I feel are important (#13, p. 21).

On the whole, prioritization meant that some things would get done, others would not. These nurses felt individually responsible to prioritize 'correctly' while juggling between a variety of claims on their time and attention. Emotion work easily became low priority when workloads intensified. A nursing supervisor explained, "the sicker the patient, the more priorities we're going to have. ...[yet] what you might think would always be the priorities can change, because it is so fluid" (#14, p. 7).

Emotion Work Seen as Extra

Knowing how to prioritize is akin to knowing how to act. They both depend on relations of power, distribution of resources , meanings and values, and the contingent particularities of a specific situation. Nurses working within systems of cost containment priorities in managed health care organizations are juggling in the midst of intrinsic and extrinsic fluidities in order to determine, at any given moment, which activities to undertake next. As they ponder the relative merit of various courses of action, dimensions of time and money implicitly intersect with less metered territories of offering and gift.

Emotional support and other forms of emotion work are often seen as nice but not essential to accomplishing the 'real' work.

Historically, offering health care services was linked in Christianity to gifts of charity. To offer a 'gift' is a deeply embedded cultural practice in which social relations, gender assumptions and standards for reciprocity are enacted (Douglas 1990; Mauss 1950/1990; Strathern 1988). Despite the commodification of health care services, many nurses operate according to a 'use' value of emotions and caring, sustained by their private, personal selves, as well as a 'market' exchange framework of service-as-product and wage labor in the public, economic sphere.

Forced to prioritize according to multiple criteria not of their own making, these nurses offer emotion-as-gift *and* they perform emotion-as-commodity. Boundaries between these different ways of doing and feeling emotion are fluid, interwoven and poorly defined. An interactive stance may begin as a formalized courtesy, then spark into a personal connection; or it may start with informal bantering, then shift into directive management to meet a clinical goal, such as calming patient anxiety before initiating a medical procedure. Nurses' uses of self contribute to patient care, *and* working conditions of caregiving shape nurses' selves.

In nursing, it is difficult to separate providing care from selling caregiving labor. Over ninety five percent of nurses are women, and the profession has sought since inception to position itself favorably in relation to gendered assumptions about women's 'special gifts.' Nurses themselves, their employers, medical staff and patients often take for granted that they will provide a supportive style of emotion work, yet there is almost no recognition, economic compensation, structural support, training or accountability to insure the viability of these skills and knowledges. Most of what is 'given' takes place informally, on nurses 'own time,' which is becoming increasingly scarce.

Speaking of providing emotional support to patients, one nurse commented succinctly, "it's part of 'if you have time.' And that's just a p.r.n. [as needed]" (#2, p. 20). She gave the example of a busy shift during which a patient she had cared for previously returned very sick to the cancer ward.

> I should not have taken her. I was 'resource' [a charge position]; I had my own people. But when I saw her, there was no question in my mind that I would be the

> one to take care of [her], because she knew me so well. My emotion, I came out and I was near tears just to see her in that state. ...Was I overtime? Yes, I was overtime. Does it matter to me? No ...it didn't matter at all because I knew [her] and loved [her] (#2, p. 15).

Another nurse spoke of finding time to give emotional support:

> Very often, that's on your own time. Or you put off the things that you can, like all your paperwork. So then, it's the end of the shift and you go to do your charting. Then that's not looked upon kindly by your supervisor" (#6, p. 9).

The nurse is allowed to 'give' of herself only after accomplishing the assigned tasks. She added, "you get caught in the dilemma of having to explain a lot of times, 'Why weren't you done? What were you doing? They didn't have anything done, they didn't get any weird drugs, they didn't react to anything, what took you so long?'" (#6, p. 12).

A visiting nurse explained that "the emotional need is not what Medicare is paying for" (#10, p. 19). Speaking of her co-workers, she said

> People [Nurses] definitely visit people on their own time. ...Because you get to be friends with somebody, you want to go see them. ...I don't do it as much as some people. ...I have certain people, they have the same interest as me, I'll go visit them. Like I've brought Easter eggs to people" (#10, p. 13).

Here, the rapport has bridged from client to friend. In another instance, a public health nurse regretted the loss of opportunity to spend time 'socially' with clients like she had before her case load increased.

> I miss [that], I had clients who I went out to a couple times a week and just did a lot of things with. I miss *having the luxury* to do that. It wouldn't be everybody that I would to do that with, but there are certain clients who are really special to me (#7, p. 11, emphasis added).

For these nurses, making a personal connection with patients was important, even if they had to do it on their own time. A nurse pondered,

> Who values the emotional support of nurses? The patient might and probably does at the time that it's happening, but ...in our society, what's *the difference between medicine and nursing*, too, is what's valued. ...what I mean by value [is] that in that sense an *economic value* is not put on it. ...I think it is valued in the schools. I think that's where nurses get the frustration, because they come out thinking this is valued and then get into a situation where it is valued in theory, but they don't have the time to do it (#9, p. 19, emphasis added).

Attending to the psychosocial needs of patients is done differently in nursing than in medicine. One nurse commented on the doctors, "they don't even really acknowledge the work we do, above and beyond *just the medical part*" (#15, p. 11, emphasis added).

Nurses have long sought recognition for the interpersonal work of caring, including therapeutic emotion work. Traditionally, medical monopoly and professional dominance in health care positioned nurses and their supportive patient care as subordinate to clinical and therapeutic priorities defined by medicine. More recently, rationalized efficiency models of managed care have reprioritized nurses' work according to economic criteria. As mid-level practitioners, nurses have partially internalized the value systems of medical and bureaucratic prioritization, *and* they resent the displacement of nursing values that recognize the importance of nurse-patient interactions for health and healing.

In her study comparing the work styles of nurse practitioners and doctors, Sue Fisher (1995) discusses the qualities, dilemmas and limitations faced by these advanced practice nurses who assert that nurses can give *better* primary care than doctors by attending better to social psychological and medical complaints of patients. During extensive observation of medical and nursing consultations, Fisher noted that the nurse practitioners guided their interactions with patients in ways that allowed far greater knowledge of the patient and "mov[ed] between positions that reinscribe and dismantle the asymmetry usually associated with the provider-patient relationship" (p. 193). The nurses in this study, whether in hospital or public health settings, are similarly positioned to both reinforce and undermine expected nurse-patient roles within medico-bureaucratic institutions.

Fisher's critique of the nurse practitioners' "liberal, reformist discourse" (p. 201) is relevant to this discussion of the value of nurses' emotion work. She is concerned that nurses add caring to curing

> while leaving intact the notion of an objective medical science. In addition, by basing their claim for professional status and their identities as providers on a system of *care*, they leave unchallenged the bifurcation of the medical and the social. Medicine remains the real stuff of clinical practice unsullied by social concerns. Nurse practitioners just add the gendered activity of caring (p. 202, emphasis added).

It is not enough to rehabilitate the devalued knowledges and practices of emotion work while leaving intact the separations of emotion from thought, body from society. Under existing conceptualizations, emphasizing the importance of emotions and caring reinforces the very gendered divisions of labor that reenact its subordination. Without the work of reconceptualization, emotion work will continue to be seen as 'extra.'

Requisite Emotion Work

While some *therapeutic* emotion work may be considered optional, other aspects of emotion management are integral to nursing work. In addition to nursing interventions regarding psycho-social problems that assist and facilitate patients' processes of health and healing, nurses are also acting as representatives of social institutions with various interests in controlling patient processes and outcomes. The nurses interviewed spoke of needing to control patients, of ways that organizational systems and expectations controlled *their own* attitudes and behavior, and of the use of customer feedback to evaluate their work.

One nurse spoke of mediating between the hospital system, her patient and his wife's emotions in a story about a patient who was waiting for a radiology procedure. The patient's wife grew impatient and

> every ten to fifteen minutes she came out, wanted me to call CT [contrast technique] again, and find out if they were ready, you know? And I kind of had to *set a limit* with her, and tell her, reiterate with her, 'Remember, I told you that...and no, I'm not going to call them again, they'll call you when they're ready.' (#12, p. 4, emphasis added).

In a more direct way, a nurse spoke of managing a patient in labor. "I hate to be so controlling, but I believe that I give them control because they have not brought control with them. ...[I]f they're out of control, the delivery's a mess, isn't it?" (#16, p. 10).

A nursing supervisor spoke of working with the mother of an injured adolescent who wanted to see him before he went into surgery.

> I had to ask her if she could be a little more calm, because it would be in the hallway and other people were going to be around and she was just upset. And she said yes, and got pretty quiet. ..[W]e brought her into the hallway and of course, she saw him and just kind of lost control again, her legs buckled and we caught her fortunately (#14, p. 11).

In each of these instances, the nurse is working to control emotions of patients and family in the interest of smooth systems operations.

The nursing supervisor is responsible for overseeing nurses' work as well as patient and family relations. She spoke of 'setting a tone' to encourage the nurses under her supervision.

> We have a supervisor that has kind of set a very poor tone, and the staff again come to me about one of their supervisors. I've had some times when they've been in tears. ...And it's about them feeling non-support, not supported ...it's very important for them to know that they can depend on me. ...So it's my intention to have a dialogue among all of us and to agree on the highest level of performance, and that we would be accountable to one another" (#14 p. 19).

Here she is counteracting the negative influence of her colleague and attempting to engage the nurses in 'high performance.'

Another nurse spoke of how the nurses of a hospital division 'set a tone' and expected other nurses to join in.

> [T]here were times in my old unit where we would get new hires who just didn't seem to fit in to ...what was going on at the time, and they didn't last very long. They figured that out for themselves. It's not like anybody was nasty to them. They just didn't want to offer their time or their energy, or be concerned about other people, [which was] what the unit was about" (#1, p. 8).

In her study of emotion work in Britain, Pam Smith (1993) found that it was the 'ward sister' (head nurse) who set the 'emotional agenda' of the ward.

> When the nurses felt appreciated and supported emotionally by the ward sisters, they not only had a role model for emotionally explicit patient care, but they also felt able to care for patients in this way" (p. 68).

In other words, the manner in which emotional matters were addressed was highly variable, and subject to the intentions and directions of 'local' and institutional leadership who could set emotion standards in both implicit and explicit ways.

Disciplining Emotion under Managed Care

If on one level, caring for the emotional well being of patients is subordinate and auxiliary to the 'main' work of clinical medicine, on another level, within the new customer-focused managed care models, producing congeniality, compliance, cooperation and patient satisfaction are outcome measures of success. This success can be understood

in terms of what Foucault (1979) calls 'the disciplinary society,' where 'docile bodies' and emotions are produced through subtle, 'flexible methods of control' (p. 211). Managed care and health maintenance organizations are designed to keep populations functionally healthy based on statistical models of disease frequency, risk management and interventions. Employers purchase health services in exchange for the promise of healthy, productive workers. Emotion management of workers is often called 'mental health,' and when workers provide emotion work in service jobs, it is called 'hospitality' or 'customer relations.'

As professional health care providers and as workers in health management organizations, nurses are involved in multiple kinds of emotion work. On the one hand, nurses manage and discipline the emotions of patients, to produce among other things compliance with medical regimens of care. On the other hand, emotions of nurses are disciplined by structural contingencies in their work, producing feelings ranging from collaboration to ambivalence to dissonance. Administrators of managed care organizations have, in both explicit and implicit ways, delegated to/imposed on nursing the emotion work of 'seeing to the patient's comfort' in a hospitality sense as well as any therapeutic advantages conferred. One mechanism for assuring this has been the widespread introduction of Total Quality Management (TQM) systems into health care.

The (TQM) philosophy, also called continuous quality improvement (CQI), was developed by W. Edward Deming and others in during the 1950s. In 1987, the quality movement was applied to health care in a demonstration project by the Harvard Community Health Plan and was later incorporated into the accreditation policies of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). "A recent national survey of 3,303 hospitals indicates that 69 percent have actively begun to implement the basic components of CQI/TQM" (Barsness, cited in Shortell and al. 1995:379). Key CQI/TQM principles include: 1) a focus on organizational processes and systems, 2) structured problem-solving based on statistical analysis, 3) cross-functional employee teams, 4) employee 'empowerment' to identify problems and take actions, and 5) focus on internal and external customers (Shortell and al. 1995).

Quality improvement is a managerial rationalization strategy in which work processes are monitored and evaluated according to specific outcome criteria. The patient is conceptualized as a client and indicators of customer satisfaction are used to determine quality. Data is collected on an ongoing basis and multidisciplinary teams are rewarded for devising and implementing 'action plans' to improve service delivery through efficiency, cost-containment and hospitality models of customer relations (Flarey 1995; Kelly 1995). Proponents of TQM envision "a cultural transformation of the entire organization with changing beliefs, attitudes and behaviors" (Zonsius, 1995:1).Changes in feeling and expressions of emotionality are part of that transformation.

In an article written for employees and clients of a large Northern California hospital, the Public Relations Department (1995:4,5) described the latest 'Continuous Process Improvement' training for managers and supervisors.

> [This hospital] benchmarks customer relations with world-class hospitality organizations, such as Ritz-Carlton and Disney. Frequently, lessons from one industry can be effectively transferred to another.

The hospital representative goes on to describe the Disney approach to customer relations that is now recommended for employees in this hospital:

> People who work at Disney are expected to:
> - •Display pride and professionalism,
> - •Think of themselves as uncommon, extraordinary,
> - •Have empathy,
> - •Be positive and patient,
> - •Promote team work,
> - •Smile, be sincere, make good eye contact,
> - •Display good posture/body language,
> - •Excel in appearance and grooming.

Micro-instructions such as these recommendations for Quality Improvement are characteristic of customer relations standards used in other service industries. Sociologists Fuller and Smith (1991) examine the corporate ideology of quality that links service workers' performance to customer evaluations. They suggest that, unlike manufacturing, different controls are needed by management to assure that employees deliver the intangible product of customer satisfaction. In order to function effectively, workers must have the discretion to engage a variety of affective and interpersonal skills that are difficult

to standardize or predict given the fluctuations inherent in service work. Yet managers want to retain control over the work process.

'Customer control mechanisms' collect customer feedback through surveys and monitor worker attitudes and behaviors. This 'panopticism' (Foucault 1979) shifts the *appearance* of power from managers to clients, but in fact

> customers' reports broaden *managerial* power, augmenting it with *customer* power; conflicts between employers and employees may thus be reconstituted as conflicts between employees and customers (Fuller and Smith 1991:11, emphasis in original).

The authors conclude that these continuous, unobtrusive control systems are an effective way for management "to insure the delivery of quality service by enlarging the arena of employee self-direction" (p. 14).

There is ample evidence that managers within the health care industry are adopting continuous quality improvement strategies to rationalize and control the delivery of services. Nurses, accustomed to the notion of 'patient advocacy' have somewhat balked at the substitution of 'customer service,' but are gradually replacing the term 'patient' with the designation 'client.' Increased awareness of 'client satisfaction' implies increased 'self-monitoring,' which in one study of emotional labor (Wharton 1993) was associated positively with both job performance and satisfaction. 'High self monitors' were workers who were sensitive to what was expected of them in social interactions and in some instances derived satisfaction from performing this work.

In a recent editorial targeting nursing managers, one nursing leader (Kerfoot 1996) addresses "The Emotional Side of Leadership: The Nurse Manager's Challenge." She cites Goleman's (1995) bestseller *Emotional Intelligence* that has popularized the importance of this 'other kind' of intelligence for success and leadership. Key skills include

> the ability to read and respond appropriately to the moods and emotions of others, the ability to *monitor one's own feelings*, and the ability to discriminate about those feelings and the appropriate responses to these emotions" (Kerfoot 1996:59, emphasis added).

She suggests that emotional skills are needed to help staff deal with the emotions of rapid organizational change, to respond to the high levels of customer demand for quality services, and to perform effectively in the new interdisciplinary provider teams of complex

managed care organizations. Describing the ideal employee, she concludes that "[e]mpathy, emotional literacy, and self-discipline all support the character and moral development desired from health care workers" (p. 61). It is alarming to watch the potential co-optation of these important skills for production goals that may bypass or subvert previous meanings of emotional care in nursing.

Under TQM models, the profit making potential of customer loyalty and satisfaction is defined as quality and the worker is enlisted through emotional colonization to manage self and others according to enforced standards of 'excellence.' The power of management is obscured by customer control and team building strategies that make employee groups responsible for meeting production requirements. Emotion skills are important tools in highly interpersonal work settings, and the emphasis is on knowing how best to 'control' and 'handle' self and others in complex situations.

Catherine Lutz (1990) explores the metaphor of control used to describe the emotions as something, like sexuality (Foucault 1978), that would otherwise be wild, unruly, a threat to order. "To speak about controlling emotions is to replicate the view of emotions as natural, dangerous, irrational, and physical" (p. 72). Women, as the 'more emotional' gender are implicitly *both* more qualified to do emotion work *and* more dangerous and in need of control. Lutz explains that in Western psychological discourse, emotions are defined as something inside the individual and the rhetoric of emotional control replicates hierarchized gender control in *society* within the *individual*.

> When women speak of control, they play the roles of both super- and subordinate, of controller and controllee. ...[This] includes a process by which women come to control themselves and so obviate the necessity for more coercive outside control (p. 74).

In service industries, the emotions of clients and workers alike are potential disrupters of the smooth operations needed to process highly interpersonal encounters successfully. Soothing emotions of anger, frustration, fear and loss are important mechanisms of social control and personnel management. Stearns (1994) traces the development of 'anti-intensity emotionology' among middle class Americans in the twentieth century citing, among other things, TQM movement trainings that have made 'niceness' the watchword for casual contact. Acting 'cool' involves "a genuine effort to be

agreeably disposed but not deeply emotionally involved while expecting pleasant predictability from others" (Stearns 1994:293).

The emphasis on patient relations creates an interesting paradox of emotion work in nursing under managed care. While organizational restructuring has reduced the amount of time available for nurse-patient interactions, workers are enjoined to meet new production standards in 'gracious hospitality' that link embodied performances of emotionality to profitability. Nurses find themselves caught between competing models with contradictory demands. Prioritization of cost-containment and efficiency has reduced structural support for the 'psycho-social' dimensions of care, yet increased consumer demand, along with medicalization of various social problems, have made emotional knowledges and skills increasingly important 'tools for the job.'

A growing body of advice literature, inservices and continuing education options for nurses indicate renewed interest in gaining emotional skills for handling the complexity of patient care in the redesigned settings of today's health care system. Topics include conflict resolution, empathic relationships, caring for the dying, dealing with grief and loss, handling difficult people, reassuring anxious patients and creating a sense of security and trust (Baker 1995; Davidhizar 1992; Davidhizar and Bowen 1993; Ellis 1993; Raudonis 1993; Schaefer and Peterson 1992; Teasdale 1995). These articles indicate a considerable attention within the profession of nursing designed to develop emotional assessments and interventions for clinical situations. Whether institutional support for performing this work is forthcoming remains problematic.

Increased medicalization of psychosocial problems *and* the new 'customer focus' in health care have *both* increased the demand for emotion skills and work, but in many cases the economics of managed care have decreased the supply. The administrative recognition and support needed to provide emotional and interpersonal care has paradoxical dimensions. As one nurse manager explained,

> The pace is quicker and shorter; patients are sicker. Families are more stressed, yet people are feeling more entitled to quality service. The shift to customer focus and the service business aspects of nursing have put stress on personnel. ...We are using new words to speak of the interpersonal work of caregivers. The customer focus talks about teamwork, and this requires interpersonal skills (#19, p. 1).

With Quality Improvement plans, hospital employees are often organized into care teams of multi-disciplinary providers, all working together to produce 'customer satisfaction.' A care team might include nurses, respiratory therapists, dietary workers, supply providers, secretarial help, a social work, perhaps even medical providers, though doctors usually function separately from other hospital employees. Interpersonal skills needed to function in teams are complex and require increased self-monitoring and self control on the part of staff. This emotion work is separate from, and in addition to, attention given to psychosocial dimensions in patients.

Being accountable to emotion work may mean compliance with new standards and forms of surveillance. One supervisor affirmed the importance of these skills, noting that they are included in employee evaluations.

> I guess I see part of emotional skills as good communication skills. ..How do I evaluate it? I mean, I think it has high importance, and it actually is evaluated on their [annual] evaluations as 'interpersonal skills' (#14, p. 28).

An oncology nurse spoke of the conflict between what patients want and the kind of support nurses need to provide it.

> I think patients value a pleasant stay, a smooth operation, things that go well. They appreciate someone to talk to about what's going on with them. They value it. The only way (pause), there are times patients write letters and give feedback. I think that's one mechanism for recognition of what happens. [As for administrators], they value it, and again, they value [that] patients have a smooth stay, get their needs met, have a nice situation. Except for *the bottom line*, when it comes to [that], certainly we're not going to have more nurses so this [kind of support] can happen (#9, p. 20, emphasis added).

In a sense, nurses confront a double standard in which performance expectations are high, but skill and appreciation for what it takes to meet them may be missing. For example, a public health nurse spoke of resenting her supervisor who gave lip service to emotional care, but offered no real support:

> I think the boss that I had felt that she was giving emotional support. She was saying the right things, but the *feeling piece* wasn't there. ...[T]he ways that she was being were getting across just the opposite message, like the micro-managing (pause) looking at every little thing that you do, telling you how to do everything, every little thing (#11, p. 37, emphasis added).

This nurse could feel the difference between languages of emotional support and 'real' support. She did not want someone else's template of how to act interfering in her relationships with patients, but she would have liked a different kind of attention and recognition from her manager.

> Another nurse described her resentment of pseudo-support.
>
> I think it makes us mad, nurses. ...[The administrators] have a lot of these little awards all over the place now. They have the nursing award things each year. And they have these forms that they tack in all the patients' room to write up if somebody does something you think is worth acknowledging. ...We have employee of the month and employee of the week. You almost feel like you are treated like a child, like it's condescending, and you have to give a people a little pat on the head or they are not going to be good and do their jobs. It's almost insulting for adults (#6, p. 11).

Here managers are using carrot and stick to control employee attitudes and behavior. 'Gold star' reward systems substitute hollow praise for concrete institutional support. Soliciting patient feedback gathers information about workers incorporating recognition into forms of customer control.

Contemporary nurses face multiple demands in which well-developed emotional skills and flexibility are needed to handle increased work loads, high levels of patient acuity, medicalized social problems, increased customer expectations, and labor speed ups. Nursing 'needs interpretations' do intersect with management concerns for patient satisfaction, but the resources needed to accomplish this are not necessarily furnished. Emotionalities of patients and nurses are disciplined by strategies that elicit sophisticated control and ultimately contribute to the transformation of complex interpersonal processes of production and consumption.

Summary

This chapter began with a discussion of recent transformations of health care services into for-profit, corporate medicine. Processes of capital accumulation have influenced the organization of production and consumption in medicine, and contributed to commodification of emotion work by nurses within new managed health care models. HMOs and other health plans have shifted insurance reimbursement to capitation plans

that reflect economic incentives to reduce services. Nursing labor costs have been targeted by cost containment measures in a variety of ways leading to structural downsizing of nurse/patient interactions.

Managed care strategies have included: implementing utilization review to monitor service delivery, reducing hospital stays, re-routing patients with less acute illness into outpatient settings, and changing skill mix whereby registered nurses have increased supervisory responsibilities but provide less direct patient care. Documentary processes and management practices have distanced nurses from bedside care, diminishing the context for therapeutic emotion work. Shifts in nursing toward textually mediated classification systems for staffing assignments, and accountability by documentary criteria instead of clinical judgments are displacing bedside skills and knowledges such as those involved in providing emotional care.

The nurses studied expressed ambivalence about managerial prioritization of documentation over clinical care and its impact on nurse/patient relationships. On the one hand, paperwork was seen as detracting from patient involvement, on the other hand, being able to include emotional concerns in the nursing record legitimized these assessments. If emotion work was not included, it did not exist; however, rationalized 'check off' charting reduced complex interpersonal interactions to minimalist soundbytes. As for the bottom line, documentation was linked to funding as well as legal protection and accepted as necessary.

A closer look at the micro manifestations of these macro changes focused on implications of work redesigns and overall reductions of nurse/patient interactions. Felt and expressed emotions of nurses and patients were squeezed by time constraints of labor speedups. When time is a commodity, caring time is a scarce nursing resource. Nurses juggled overlapping dynamics of clock time and process time and expressed feelings of frustration over the lack of time. Emotion work was part of what was lost in the hurry of meeting new production standards. Nurses attempted various strategies to make time, but often it meant getting the patient to ask for less or setting boundaries on emotion work.

Time management and emotion management were seen as the nurse's individual responsibility and she was expected to prioritize according to managerial criteria more

than nursing judgment. Prioritization, like needs assessment, is ultimately a political question: who sets priorities, according to what criteria, which work counts, what gets done first? In the context of efficiency and cost containment, it means a reduction of services. Physical needs are seen as high priority; emotions and interpersonal considerations are 'sacrificed' first. Emotion is seen as 'an optional extra,' if the nurse has time and is so inclined. For example, nurses' reluctance to take the option of being a primary nurse, or having the same patient over time, indicated how far the organization of care has shifted.

The paradox of emotion's increased visibility under managed care was examined. TQM/CQI (Total Quality Management/Continuous Quality Improvement) approaches to engaging worker compliance and participation have been aggressively introduced into service industries such as health care. Reconceptualization of patients as customers, and health care as product, has fostered the development of organizational processes that discipline emotions of workers and clients in the name of customer satisfaction. Customer evaluations have become outcome measures for quality control, shifting the appearance of worker control away from management and onto the client.

Under managed care, nurses are likely to be enjoined to produce patient satisfaction through self-monitoring of feelings, hospitality work, and other sophisticated emotional skills. Yet time constraints and cost containment measures have reduced available resources for producing this emotional labor. In the next chapter, I examine some of the strategies nurses use to make it all work, and some of the frustrations they express about these changes.

Chapter V Accommodations and Frustrations

> If you're feeling stressed, your lack of effective coping skills will drain your emotional strength, eventually leaving you feeling empty. ...If you've got too little time to accomplish everything, you need to change the way you're using your time. ...Changing a situation may be impossible, but changing your attitude about it puts you in control.
>
> Laura K. Wilson (1986)

> [I]ndividuals with high initial job involvement, professional commitment, idealism, and empathy for others are most susceptible to burnout, presumably because they invest more emotion in the enactment of their helping role.
>
> C. Maslach, cited in Ashforth (1993:106)

An important premise for this investigation of emotion work and nursing has been to conceptualize emotionalities as emotion standards, expectations and performances that vary according to historical and cultural contexts as well as particular situations and sites. Emotion work involves management of emotions in self and others according to a rich complex of conditions, possibilities, dispositions, motivations and perspectives. These configurations of attitudes and behaviors involve meanings and practices, and link the discursive with the embodied. In the instance of nursing care, embodied refers both to the material conditions of doing the work and to the corporeal aspects of tending to the ill. As I have discussed earlier, emotions are at once socially mediated and physiologically felt.

From the perspective of nurses providing patient care under changing structural conditions of managed health care, two distinct components of emotion work emerge. On the one hand, there is the emotion work of interacting with patients, family members and other care providers that is a 'doing' of emotion. Such efforts, discussed extensively in Chapter Three, are important and hopefully therapeutic aspects of professional services provided. On the other hand, there are emotions *about* the transformations and how they affect the nurses. A different kind of emotion work involves modifications and adjustments of attitudes and activities in order to continue to function under altered conditions.

The nurses interviewed described *both* ways that they were changing how they 'did' emotion work, *and* ways that they were adapting their own emotional behaviors and expectations to accommodate to new organizations of work. While they spoke of institutional strategies used to make their work more efficient, they indicated that much of the emotion work, both in caring for patient needs and in keeping control of their own feelings, was considered to be an individual responsibility. In this chapter, I address first some of the strategies these nurses used to 'make it work.' I then focus on frustrations and hurt feelings that express how these nurses are also *not* comfortable with the impacts and consequences of recent restructurings.

Making it Work

Faced with multiple, overlapping and often contradictory demands on their time and effort, the nurses in this study described a variety of strategies and approaches that they have implemented to facilitate their work. They spoke of organizational and individual strategies to reduce or deflect emotion work using various 'shortcuts' that streamline work processes. They discussed the importance of setting limits on their involvement in relationships with patients or clients while still taking into account, and being accountable for their own and their patients' emotionalities. The agency of these nurses to both influence and accommodate to rapidly changing work environments and expectations reflects emotion work across boundaries of inner and outer, self and other. Yet coping with the strains and challenges of meeting so many demands was seen primarily as an individual matter for nurses as workers.

Shortcuts

Work Processes and Standardization

When asked how they managed to care for patients given labor speed ups and work intensification, these nurses mentioned several strategies. One nurse explained

> We ended up, because of budgets (pause); certain things like tubing changes we used to do every 24 hours ...we have changed to every 48 to save some time. *We've changed when bottles expire*, when you need to draw the new bottle. ...[W]e've found ways to shortcut our work. Instead of changing a dressing everyday, you can change it every two days. So those kind of things we've done so we can cut corners (#8, p. 27, emphasis added).

The somewhat arbitrary yet authoritative process for creating the clinical 'fact' of expiration shown here is an example of the power of protocols and expectations to shape the doing of clinical 'reality.' As a result of time and efficiency studies, clinical tasks and documentation practices were modified to meet the intensified pace. She described their streamlined charting system:

> We have a new flow sheet that's about five or six months old now and that takes off tons of time. It's so easy, it's just check-off charting now. We don't have to do a lot of narrative. Unless it's a psycho-social issue, we will. And even for psycho-social issues, there's one box that says 'patient verbalizes feelings,' and you check it; and you might put 'see note' if you need to say a little bit about it; or if a patient's withdrawn, check it; seems depressed, check it. So far as legally, we're OK. And then that takes a lot less time (#8, p. 27).

The emotional assessment is boxed up neatly and quickly, so theoretically the nurse might have more time for interactions and other interventions.

A nursing supervisor spoke of creating uniform standards for emotion work as well as for clinical tasks.

> We have manuals of policies and procedures that are the ways you're supposed to do things, but I also discover there are lots of holes; and OK, if this happens, then [do] this. Yet six different supervisors are doing six different ways. And it was something that should always be done the same way [like] complaints about harassment. You have to handle that the same way. ...[I] try to find what those areas are, bring us all up to the same expectation level, and make sure everybody knows what that is (#14, p. 9).

Standardization is helpful, yet another nurse explained how impossible it is to rationalize such contingent work. She remarked,

> You cannot plan when somebody's going to throw up all over, or their IVs are going to come out, or the drug's going to be on the floor inserted of in the patient. You just can't control those things (#6, p. 13).

This nurse used examples of 'physical' indeterminacy; emotional imperatives are similarly unpredictable.

Technology and pharmacology

Technology and pharmacology were seen as ways to make the work faster and more efficient. However, they paradoxically were also seen to contribute to the intensified work process. For example, a dialysis nurse described the new machines used in his unit.

> You really have to be organized these days; it's just like other departments in any given hospital. We're really pushed to the limit. Also, the dialysis times have been shortened. What they're doing now, it's called rapid dialysis, high flux dialysis as it's known as. So they're able to speed up the process with more efficient dialyzers. The patients aren't there as long. Instead of 3-4 hours, they may be there 2 1/2-3 hours. ...[Y]ou have a turnover of 15 minutes between patients, so it's a bit of a juggle" (#18, p. 10).

A labor nurse spoke of her ambivalence about the vacuum extractor, a tool that obstetricians attach to the head of a fetus while the mother is pushing out her baby.

> [T]hey used to do a lot of vacuum extractions to help, basically shorten second stage [of labor], I'd get real frustrated about that. Because I'd get, you know, 'hey this lady is a primip[ara], she just needs to push more.' What's the point in pulling the baby out and stressing the baby and making the woman have a big cut on her bottom? (#13, p. 18).

Technology speeds up the birth process, but changes the woman's experience and reduces the need/possibility for emotion work to support natural birth. Another labor nurse described her distaste for central fetal monitoring, a technical capability that allows a nurse at a central station to watch the electronic tracings of several fetal hearts at once, without engaging with the mothers.

> The new charge nurse was talking about central monitoring and she is planning a proposal for central monitoring. And I said that I worked with [it] in Miami, and I hated it. She looked quite shocked and she said 'Oh, I just love it.' And I said, 'well, as far as I'm concerned, it just puts you *farther away from the patient.*' (#3, p. 13, emphasis added).

Technologies have been used to restructure the organization of nursing work according to criteria of efficiency that may shorten some tasks, but disrupt other aspects of the work.

Discursive oppositions between emotional and technical, or mechanical and human were common to these nurses' framing of my questions. In the following exchange with an oncology nurse, technical is conflated with cold.

> D.B.: How would you characterize a nurse that you didn't think was very skilled in [giving] emotional support
> Respondent #9: Technical.
> D.B.: What kind of bedside manner?
> #9: Not very warm, hurried. I've seen nurses that are downright abrupt (#9, p. 22).

In another conversation a nurse juxtaposed the impacts of technology with the challenges of working with human beings.

> Respondent #6: The situation around you changes by *technology* [and] the increase in knowledge, but the problems are the same. You are dealing with ***human beings***, and somehow that element gets lost.
> D.B.: Do you think any of the technologies have changed the emotional work in some way? ...How has that impacted the work at the bedside with patients?
> #6: The work itself, there is more to monitor. You may have a machine that is doing it, but ***you still have to look at the machine*** and react to what's going on. ...[W]hat you are doing as a nurse today is far more involved than what you were doing as a nurse 20 years ago because of the technology, because of all that has been learned. ...[Y]ou've got it right in your face, and if you don't respond to something (pause), you have to even be more on your toes, there's so much more information coming at you. In that respect, I think it is harder. It's less forgiving if you screw up (#6, p. 9).

In a sense, the nurse retains and enacts the emotional parts of the nurse/machine complex that are in fact conjoined in the caregiving project. She must respond both to the patient and to the information communicated by various monitors. Ultimately, her gestures and comportment incorporate the exigencies of the machine. For example, a labor nurse described the intricacy of making contact with a new patient while accomplishing routine clinical tasks.

> There's always the delicate balance between getting those 'initial things' done right away, and letting her know she can labor how she wants to. 'Put on this gown, pee in the cup, get on the monitor, let me get your blood pressure and temperature,' and somehow meeting someone with all those technical things and not make ***them*** feel like ***some kind of machine*** (#4, p. 14, emphasis added).

Like technical equipment, pharmaceuticals intervene and facilitate various physiological and psychological processes. If standard care wasn't helping a patient, one nurse advised, "you have to call the pain service to come in, because they know all about drugs and what will help them" (#8, p. 17). Pain medication given in labor helps women cope with the discomforts of giving birth. It can also diminish the need for nursing knowledge and teaching about positions and activities that support the birthing process. One nurse explained,

> Well, I think they hurt more [lying] on the left side. So people give them Demerol, when they're on their left side. Then they get them all floppy and fagged out. But if they're standing up, they don't hurt as much (#16, p. 8).

However, a patient standing up in labor needs someone there to encourage her; this is not always available. This nurse continued to say that by giving good support, she can get most women to handle labor.

> Sometimes they come around when they're ready to deliver. Sometimes they scream the whole time. I don't know. I think 98% of the people deliver fine ...and there's that 2% that are off the curve, you know. And maybe people that are off the curve get the epidural [anesthesia] just to shut them up (#16, p. 27).

'The curve' is a mutable standard that reflects normal expectations for the handling of pain. If nurses and doctors have less time to assist in other ways, epidural anesthesia can be given to supersede costly forms of emotional support. Pharmacological solutions to problems of pain management are only one example of contemporary development of designer drugs to control, among other things, emotional problems. In some ways, pharmaceuticals and medical equipment are labor-saving technologies, but in other ways they displace human attentions that offer valuable contributions to health and healing.

Delegating

Organizational streamlining, technical devices, and pharmacological interventions are among the shortcuts designed to make it possible for nurses to accomplish their work. Another strategy implemented both formally and informally has been to shift aspects of nursing work onto other care providers. One model has been to create specialized people who handle particular types of problems. An oncology nurse wished for someone to provide teaching and emotional support.

> That would be the ideal thing, if someone gets leukemia, a separate nurse should come in with only the intention of sitting there teaching and not having to do anything [else]. ...[Someone] could come in every day and sit with every patient that needs to learn, needs teaching and emotional support. But realistically it won't happen. That's why we need to do as much as we can when we are in the room (#8, p. 9).

Another nurse spoke of the difficulty nurses have providing emotional support when

> they're changing the IV, ...they're changing dressings, or whatever, they don't have time, it's not programmed into their day to just go and sit. So we need to figure a way to integrate that into what else is happening. ...[W]e talked about giving small pieces, doing small things, and then making *referrals,* feeling comfortable at the part that [we] *were* doing" (#11, p. 25, emphasis added).

Several of the nurses interviewed spoke with both relief and regret about delegating some aspects of their work to others. Specifically, when they did not have time to work on psycho-social issues, they would refer patients to social workers, chaplains, and agencies, or hope that their families would meet patient needs. An oncology nurse, speaking of new roles said,

> We just started the case manager role and we had a social worker who was very involved. They knew every patient, they stopped in to introduce themselves and followed through with things and followed up with problems or issues that came up. ...But sometimes I think they [the nurses] rely too much (pause) I mean you can't say 'Well, I can't finish this up, the social worker is coming in, you'll have to wait until she comes' (#1, p. 10).

In another unit, there was a 'crisis nurse' available to assist if a patient required acute interventions. An oncology nurse spoke of calling in 'the patient relations representative' to spend time with a patient who was unhappy with her care. A number of the nurses interviewed mentioned the importance of the social workers who "meet the patient and their whole focus is on the patient not [just] the physical part of it" (#8, p. 10).

Patient care is broken down into component parts and nurses do part of the work. A nurse expressed her gratitude about sharing the work, "No, I don't ever wish to be doing everything, do you know what I mean? I mean, it needs to be a team, and that's what social workers are for! That's how I feel" (#12, p. 27). For another nurse, the responsibility for meeting emotional needs was shared by several people, though it ultimately 'belonged' to no one.

> I guess you hope that it gets handled by somebody someplace down the line. Maybe you aren't there, but maybe the LVN picks up on it and she can sort it out. If they have home care nurses, they sort it out. If the priest at their church knows that's going on (pause)...there are a lot of different resources ...if somebody doesn't have time, hopefully the next person gets it. For instance, the chaplain, that's their major role, so maybe they'll have the time to pick it up (#1, p. 22).

Another nurse explained,

> I just do what I can do with understanding the way the hospital is right now, you can't do everything. You have to pass on to the next nurses and say 'he's really upset, and I haven't had time to talk to him, could you try?' When staffing is good, a lot of patients will stay up at night and talk. That's the time they can really let a lot of things out, and the best I can do is to refer to a social worker or psychiatrist. They will come in (#8, p. 10).

Although grateful for the help, one nurse expressed regret in passing work on to nursing assistants:

> You are taking care of far, far sicker people, and you have to take care of more of them, and you have less nurses, and have to delegate much more. Some of which is very valid. I don't need to be the one to give a person a bed bath. [Yet] I can remember, again in days gone by, that was one of the best times to get to know somebody (#2, p. 11).

A nursing supervisor commented on the reluctance of some nurses to reduce the range of their work:

> I think because nursing is evolving right now, nurses, RNs are needing to learn how to delegate more and more tasks. And they're having a hard time learning to do that. They're not wanting to let go of some of that (#14, p. 15).

A public health nurse explained how she came to accept the need to pass some emotion work on to others, reflecting philosophically,

> I do believe that as a nurse, I felt like I had to fix it. And somewhere along the line, I *let go* of that. And then, that releases you from the fear of not having the time to deal with it. ...I believe very strongly that it helps the person, even if they just get to share a little bit, open it up, and it's fine to refer it to someone else ...it's OK to just be there, hear it, and then turn it to somebody else (#11, p. 20, emphasis added).

Another public health nurse spoke of trying to delegate care to other providers, but many of her clients were poor so that gaining access to services was sometimes problematic.

> There's lots of hired-out counseling. There are a lot of volunteer counselors in the community at low or no-cost. And there are [AIDS project] social workers. ...There are a few psychologists now who will take Medi-cal; I know of only one psychiatrist. ...It's not an easy situation when you don't have money (#5, p. 5).

She mentioned a variety of support groups available to her clients, people with HIV/AIDS. This patient population could receive care from attendants, skilled nurses and hospice nurses, all of whom would provide some emotional support, as well as other levels of care. "I don't think anything's quite as intact and complete as the HIV support systems. ...It's paid off to make a lot of support available, to really fight for it politically" (#5, p. 18). However, another public health nurse explained that even with agencies and referrals, "If somebody's having a crisis right then and there, and there is no time to refer, [and] there's nobody else available, I'll deal with it myself if I am able to" (#7, p. 17).

These nurses appreciated working with a team of professionals to provide comprehensive care, but in the absence of 'specialists,' nurses 'picked up the slack.' One nurse visiting a large Bay Area hospital noticed that

> there was no longer a social worker assigned to the maternal/child division. If you needed a social worker, you had to beep somebody. I just couldn't believe that ...in this area ...having such a high percentage of high risk clients, most of whom don't speak English; and they don't speak Spanish either, by the way; some of them are Asian, and some of them are from the Middle East and from Iran, Iraq, and Russia, Egypt, all over the place, that there's not a regularly assigned social worker there. That really kind of got me (#11, p. 14).

In another hospital, a nurse explained, "We have social workers during the week that can assist us, but on the off hours we don't. So a lot of times we're dealing with that" (#14, p. 9).

The other source of support and help are the patients' families and communities. An oncology nurse explained "we get the family involved. ...A lot of the family members are willing to learn to take care of the [IV] lines and help" (#8, p. 14). For another nurse, families helped do the work, "I mean, not in the sense of doing the physical work, but doing support work" (#12, p. 43).

The move to bring husband and family support into labor and delivery settings has provided personal support to birthing women and also unpaid labor for many of the 'little things' that offer comfort and encouragement. One labor nurse said "I ask, 'is there anyone who can come and be with you?'... [Then] by me doing with the woman what I do when I'm there, they'll model me; that's basically how I teach them" (#13, p. 11). On a busy day, these minimally trained helpers provide most or all of the emotional support these new mothers get, in whatever forms friends and relatives are capable of providing.

A home care nurse relies on family involvement to assist elderly clients living alone. "[O]ften we are calling someone else, their daughter, and saying 'Hello, this is the nurse, I'm with your mom, and this is what she needs'" (#10, p. 21). However,

> a lot of these people don't have much support, because they've outlived their whole families. ...A lot of times it's social crises, just like, you know something happened and they need more care all of a sudden and you have to call their family and say, 'look, she can't be alone today because of [whatever]' (#10, p. 10).

A nurse expressed the view that families should be doing more: "I think family is taking more responsibility ...families need to meet some of those needs, and I think it's OK to put that back on the family and involve them more in the care" (#14, p. 25). However, reliance on families to provide health care represents an added burden primarily for female family members who may not be available to offer this work. The political question remains, who is responsible for meeting physical and emotional needs of transiently or chronically ill and/or dependent adults and children? What provisions account for the emotional complexities of this work? How are expectations, feelings and displays of emotion altered in adaptation to constricting resources?

A larger, unspoken issue that needs to be addressed is what happens to the emotions of people undergoing the challenges of illness when key carriers of knowledges and skills about these experiences, nurses, are re-positioned in their performing of this work. As one nurse reflected, describing the web of connections and support needed during serious illness, "It takes a lot of people to support one person facing their mortality" (#5, p. 12). Neither nurses nor emotions disappear. They adapt, find shortcuts, delegate, set limits and work as best they can with others. And it is difficult to track changes in something as fluid and invisible as emotion work.

Pleasures and Dangers of Feeling: Setting Limits

The emotion work of caring for people experiencing illness or life transitions such as birthing and dying engages emotions of both providers and recipients of care. Personal involvement and caring are sources of deep satisfaction and can also cause discomfort and pain. For a nurse, making it work involves managing her own feelings and those of her patients while accomplishing clinical, organizational, documentary and interpersonal tasks. One important skill is the ability to set limits on the uses of self in nurse/patient relationships. The fluidity of boundary making and maintaining, their ongoing negotiation, and the partiality of any norms or expectations of what distance is 'appropriate' at any given moment, make the work of 'setting limits' a most contingent aspect of nursing work.

This ability is not new and it is not easily rationalized or standardized. Under current conditions emphasizing efficiency and cost containment, nurses are pressured to

set new limits on their involvement with patients. Expectations of what kinds of feelings are allowable and possible may need to be modified.

Pleasures

In various ways these nurses suggested that becoming emotionally involved with their patients could be a source of pleasure. One oncology nurse who provided chemo-therapy to patients spoke of seeing patients later in remission. "That is what makes it all worth it, when you see someone come in looking good, their hair is growing back and they are strong looking. You can't recognize them sometimes. It's nice" (#8, p. 15). Explaining how nurses learn to do emotion work, one nurse responded

> I think some of it is just training and some of it is just your individual personality and how you relate to people and life anyway. Some of it, sometimes it's just expected, so you work at it. ...Nursing is a role and you are protected. You can *get closer* to people where you would not maybe in ordinary life because you just have this protection. So you can be more *involved emotionally*, and it's OK and *it's safe, sort of*. You can walk away and it isn't like you are going to live with that situation every day (#6, p. 3).

Such permission to connect and to have distance are built in windows of intimacy without long-term expectations. Another nurse said,

> I think that I'm drawn to work with people that have their barriers down, and usually birth and death does that. I worked a year in oncology ...and to be honest I loved working with my patients ...I think I learned more than any of my patients learned from me. They taught me" (#15, p. 2).

Another oncology nurse appreciated the immediacy of the personal connection that is possible when a patient is very ill. She explained,

> You get to that gut-intimate level very quickly ...there's no pretense. They are there and they come out with their feelings, they come out with their emotions and a bond is established very quickly. They come back a month later and you don't have to reestablish that ...it just gets more intense with each visit and each admission. Because there is more information, there's more shared, there's more trust" (#2, p. 5).

Dangers

The temporary intimacies made possible through illness situations are not without dangers. As one nurse pointed out,

> It's almost like there's a fine line between letting yourself care, then realizing that you're going to have to let go. And you know you're going to have to let go right

> from the very beginning, so you don't *ever* take everything in (#12, p. 33, emphasis added).

Another nurse spoke of the grieving she experiences when patients die

> I can remember very early on ...you got to know everybody very well, closely ...I can remember being devastated when these people would die. I would be going home in tears. That's not to say that doesn't [happen] anymore, because it does. Does it happen with everybody I take care of? No. I couldn't and be able to survive (#2, p. 7).

It is very hard for nurses to continue to witness pain over and over. One nurse spoke of learning this in nursing school,

> In fact, the hardest part of nursing school was [that] I was suddenly exposed to everyone's worst nightmare. The worst thing that happened in their whole life and you'd see ten of them in a day, or thirty of them a day. And that was very hard for me, at first. And then you start realizing, you know, these things are going on whether you see them or not. And you can't *physically be affected* by every single thing that happens. It would kill you (#10, p. 11).

Here part of the danger of her emotional responses is their embodied nature, she must set limits in order to protect her own health.

Given nurses' relative lack of control over the prioritization of their work, their agency in the nurse/patient relationship centers around keeping feelings manageable and keeping the management in their own hands. Boundaries between personal and professional feelings are porous and it is often a challenge to negotiate how much to let in and when to close off. In fact, to do this well has long been an invisible skill in nursing. Under managed care, with dubious resources and support to respond according to 'nursing judgment,' it is all the more painful to feel the pain of another. Often, it seems 'better' to set limits and remain detached.

Control Talk

It is impossible to separate which of the comments from the nurses interviewed represent limit-setting challenges 'inherent' to nursing, and which are exacerbations incurred under recent working conditions. Catherine Lutz (1990:88) suggests that

> emotions may involve the identification of problems in women's lives and are therefore political. ...By extension, talk about the control of emotions would be, in

this feminist discourse, talk about the suppression of public acknowledgment of problems.

These nurses expressed high levels of self-monitoring and self-sanctioning as they spoke of avoiding 'too much attachment.' If they 'become emotional' about the conditions faced by patients, it is considered 'their problem.' 'Making it work,' making the job of nursing work for themselves and their patients under changing conditions, means mastering emotion standards of 'detached involvement.' For professionals trained in assessing and attempting to meet 'needs' of people in their care, it is challenging to produce such a stance.

Nurses routinely confront problems of 'compassion fatigue' and burnout (Schaufeli, Maslach, and Marek 1993) that arise when service workers must continuously contain their own emotional responses to situations beyond their control witnessed during the course of their work. In the popular imagination, some of these situations, such as dealing with old age or death, are classified as 'natural' but others, like automobile accidents or child abuse are seen as preventable and 'man made.' In *either* case, *emotional* responses (both on the part of providers and patients) to illness and disease are attributed to the individual and framed in apolitical ways. Control talk is language used to express and reinforce the need to contain these 'individual' responses and often serves to deflect private or public anger about unjust conditions.

Accepting the limitations of her advocacy, a public health nurse said,

> I try to separate myself and tell myself that it's their life. They are making their own choices. It's not my life. ...I try to [keep distant] because for *self-preservation* purposes. It's not healthy for me to get *sucked in above and beyond.* I have to really *create boundaries* so that I can survive and do my job, otherwise I get too entangled, too *emotionally entangled* (#7, p. 10, emphasis added).

In an oncology unit, nurses could regulate their level of involvement with patients by choosing, or not, to operate according to the role of 'primary nurse.' Primary nursing is a model of care in which each patient is assigned one main nurse who provides as much of that person's care as possible during an entire hospitalization. Ideally, this allows a comprehensiveness and a continuity of care less possible with the staffing rotations and work organizations of team models. In fact, primary nursing has served contradictory

functions of unifying nursing tasks while reducing availability of auxiliary help and intensifying nursing work (Brannon 1994). For one nurse, emotionally, this model was sometimes too demanding.

> We do primary nursing where if you take a particular interest in a patient or you really click with a patient, you sign up to be primary nurse with the intention that every time you come to work, you'll be assigned that patient. You don't have to do that. A lot of nurses choose not to take primaries because, I think, it is sometimes very hard to be that person's nurse all the time. You get a little *burnt out* and also you might get a little *too attached* (#8, p. 3, emphasis added).

She spoke of needing to set limits with a very demanding patient.

> Sometimes you just have to sit back and say, 'I'm your nurse, I'm here to take care of you and help you get out of here. I'm not your waitress.' This is not my role to get *sucked into* it (#8, p. 6, emphasis added).

Other nurses also used the metaphor of getting 'sucked in' where the patient was seen as a dangerous 'black hole.' Here the risk is getting lost in a void of unmet needs.

Nurses control their own feelings, and they sanction the emotional expressions of colleagues as well as patients. Reflecting on another nurse who was crying after the death of a favorite patient, this nurse commented,

> You want to be there for that person and you want to help her get through it, at the same time, you want to [know] 'Where did you cross the line where you couldn't *keep yourself separated* from the situation?' (#8, p. 24, emphasis added).

Another nurse warned, "you can't take every patient to your heart, like they were a family member. ...It has its emotional toll" (#9, p. 4). A nursing supervisor said, "it's almost necessary to hold back on our emotions. ...I don't think ...I would be as effective if we were both crying" (#14, p. 29). A labor nurse spoke of being reprimanded by a physician for aligning with her patient, "he thinks I'm a terrible nurse, that I *overidentify* with my patients, and he doesn't want me to take care of any of his patients" (#13, p. 24, emphasis added). Here the emotion work is to keep separate, avoid identification with the patient, and instead in some instances to identify with physicians.

A public health nurse talked about caring for people with problems beyond the scope of her work. "Sometimes it's problems you can help them with and sometimes they aren't, ...like, 'Oh, my boyfriend and I just had a horrible fight,' so it's nothing you can fix" (#15, p. 21). She added, "for me [it] is a continual learning process, to be able to let

go. Or at least [learn] where my limit is, *how much heart and soul* you're gonna put into this person. ...I get *too attached* to the outcome" (#15, p. 26, emphasis added).

A labor nurse spoke of her concern to prevent child abuse which she would explore with her patients:

> I used to ask the father and the mother, 'When you were children, how were you reprimanded?' Because I got *too many bad answers*, and I was not able to deal with that, I let it go. ...[I]t just got to be too much, so I ...stick with breastfeeding (#16, p. 13, emphasis added).

This nurse was too uncomfortable to routinely take on social problems beyond the scope of her nursing work and consciously limited her concern to areas where she felt she could have an impact without herself becoming emotionally overwhelmed. Later in the interview she said, "I don't get that attached to most of them, do you?" (#16, p. 25).

A labor nurse spoke of recognizing her limits:

> There's a lot of things that are beyond ...what I can do in the moment, you know. If they are having a bad relationship, what can I do about stuff like that? Homeless? Abused their last child?...Sometimes that's just the way it is, I'm not going to reach everybody (#4, p. 18, 19).

She acknowledged that her emotional involvement would be different if someone was receptive to her or not. In the case of someone she wasn't drawn to, "I give them what I feel is necessary, but not the whipped cream and cherries" (#4, p. 9).

Asked about distance and involvement, a visiting nurse replied,

> I'm not sure, sometimes it's how much I like the person. ...[Y]ou know, you get involved, what works. This is a weird word to use, but if they're *too sticky*, I mean, some of these people have really, really bizarre social histories and *entanglements*, some of them are like that. You just figure out what works for you. ...Actually, I have pretty good limits, boundaries, I think (#10, p. 12, emphasis added).

Here the metaphor used to describe a patient who makes the nurse risk emotional over-involvement is 'sticky,' as if the problems will stick to the nurse.

Yet these boundaries are porous, variable and subject to negotiation. A public health nurse expressed the range of variation regarding boundary-making among her colleagues,

> If you spoke with every other care team nurse, you would get different ways of being a case manager. ...[T]he amount of self invested or time invested in any

> particular client or issue [would be different]. ...The boundary of how far you go with assisting, versus giving the information to say 'Here are your resources.' ...It's all the dance of where it hits for the person and for yourself. I find that for me it changes with each individual (#5, p. 11).

These nurses are constantly negotiating their emotional responses and interactions in order to do this work; standardization seems like a fantasy from their perspective. One oncology nurse, for example, did not expect to resolve the tensions between feelings of connection, loss and detachment.

> Getting used to it is probably not the right word. The day I get used to it is the day that I shouldn't be doing it. Getting the sense of the *life cycle* I guess is more of it (#2, p. 2, emphasis added).

Her use of the term 'life cycle' naturalizes her feelings of connection and loss and naturalizes boundary-making as well.

Another nurse spoke of the tensions within nursing to determine norms of 'appropriate boundaries.'

> [A]s long as I've been a nurse, since 1969, there's a little bit of a negative connotation about being too caring and about being too available and being too connected to patients. ...And it's like, OK now, you can care a little bit, but you gotta cut it off. You've gotta terminate those relationships. ...Maybe because people in nursing always felt that if you didn't put some boundaries on it, it would consume you (#11, p. 41).

In fact, the amount of unmet human need that nurses are simultaneously positioned to witness and carefully trained to assess is staggering. Using languages of self vigilance, these nurses set boundaries reinforced through 'control talk' as ways of coming to terms with their inabilities to fully meet those perceived needs.

Keeping Multiple Selves Divided

Since the nursing role was seen as bounded and defined, these nurses spoke of separate personal selves that had outside lives and unrelated feelings. As one nurse put it,

> When I leave at 11:00 o'clock at night, I'm good at leaving it behind. That's one good thing about me. That's why I don't think I'm going to burn out too quick, because I'm really good at *keeping it separate*. ..[T]his is work and I'm going to give my all at work. Then this is outside of work and I can leave (#8, p. 4, emphasis added).

Another nurse expressed similar feelings, " basically, you have to be able to leave and have a separate life outside of work" (#12, p. 37). For an oncology nurse, "it's kind of just straight forward, here's room 112B and I need to do these things, but then I'm making dinner for twelve people, so I don't have time to worry" (#1, p. 23). In other words, her energy is divided between serving on the job and serving at home; she rations carefully.

The potential for overlay between private and work selves went both ways. A labor nurse was concerned to be available to her patients, "like, how much is my personal world interfering with my work world. You know, how present can I still be with this person, even if I just had a fight with [my partner]" (#4, p. 9). For another nurse, personal curiosity intruded inappropriately into discussions between nurses.

> [T]here's a lot of word of mouth. I find a lot of times, as is typical in hospitals, sometimes information tends to become *rumor*. And things get around about someone. I've had incidents before where I've talked to my co-workers about a particular something, and the next thing you know, the patient's coming to me 'You know, I didn't really appreciate that at all, that you spread this around' (#18, p. 17, emphasis added).

What counts as personal, what is of professional, or official interest? Where does nursing end and gossip begin? The boundaries are fluid, negotiated, situational. For example, a home care nurse pondered,

> How much do I take it home with me? I definitely think about my patients, I will think about my patients at night, like something will be going on with somebody, and I'll think about them. ...but...if my kid gets hurt, it affects me a lot more than what goes on in my day with my patients (#10, p. 10).

The work of maintaining these separate identities and the work of keeping their feelings separate is harder when the feelings are uncomfortable or painful. The nurses spoke of various strategies used to discharge intense feelings and recharge emotionally.

Discharge/Recharge

The nurses mentioned formal and informal activities available to them to discharge difficult feelings and recharge or reenergize themselves in order to keep on performing this work. As one nurse put it, "[sometimes] you are just totally drained, you may just not have anything left. ...And nothing you could do [for the patient] would be helpful anyway because there is just nothing more that you can put out right then" (#6, p. 10

I wanted to know what resources were available for renewal and carrying on. Organizations are well aware that nursing is demanding work. An oncology nurse spoke of 'staff retreats' held every year to share perspectives on work in her ward. Another nurse referred to 'stress rounds' or 'stress conferences' in which a special psychiatric nurse would come to the ward. She explained, "Most of them are called on patient issues. Somebody that's been a long-term patient that died, ...or ten people die in two weeks, something patient [related] always" (#1, p. 17). One nurse expressed cynicism about the retreats, "it's always the same thing. We spend so much time discussing our frustrations about this unit and I don't think it's going to change" (#8, p. 8).

A nurse spoke of the support program for nurses in her public health agency,

> Every three weeks we have a two-hour session with a counselor. We call it 'group grief.' When we all get to debrief. We check in in a circle and he facilitates. And it's 'how are you feeling, what's up for you now? Who's died and who's real sick? And how does it feel to you? What's the thing that's *hooking you in* here? How may you *unhook* and allow the person's process to be not *entangled* with your personal desire or process?' It's a wonderful support. It's really helped (#5, p. 17, emphasis added).

Such sessions provided guidelines and training in emotion management that helped the nurses to do the work. Another nurse described her early emotion training in which she was given permission to cry:

> I can remember one of the very first patients that I just got so attached to, and was just dying. And I could not get myself to go into the room, because every time I went into the room, I would cry. [A nurse I worked with] finally said, 'you are not going into [his] room.' I said, 'I'm afraid I'm going to cry every time I go in.' She said, 'so what?' She said, 'it's OK to go in there and cry, you just get a good cry out with them and then they'll be fine. But if you're trying to avoid them because you are afraid you are going to cry, isn't going to accomplish anything.' ...She gave me permission. I was a fledgling new nurse. You aren't supposed to show that kind of stuff to the patient (#2, p. 18).

A public health nurse used the ritual of reporting off to another nurse for emotional expression,

> It's also our debriefing time. Kind of 'Oh, my God," and it helps enormously. If I had to *hold it all in*, I couldn't. And when things get *really extreme*, I do go to my supervisor. She's also fairly supportive, she's very busy, and it's not like she can avail herself very often, but when it's really something big and I really need it a lot,

> *more than the norm*, then I go to her and she's very supportive (#15, p. 19, emphasis added).

This nurse passed on emotional stress as well as patient care information in giving report. She considered her supervisor as additional site for discharge, but only under exceptional conditions. One supervisor indicated that sometimes the best help was to recommend taking a 'time out,' "I have to tell people, 'take a fifteen minute break, go for a walk, get some fresh air'" (#14, p. 31).

More informally, nurses saw other nurses as sources of help and support. Emphasizing the importance of these connections, one nurse said,

> I always found that your relationships with your colleagues (pause), I found to be my best support. Just being in good working relationships with your colleagues and socializing outside of work. That was my main coping mechanism (#9, p.12).

Another nurse commented, "[It] helps that we have a pretty good support group of nurses. We're all mostly just very good friends" (#8, p. 10). She also took time to recharge on her own: "Outside the hospital, I exercise a lot, and I have a dog. When I'm with him, and I'm on my own,...[I] go running, go swimming, or take my dog with me" (#8, p. 10).

An oncology nurse spoke of having friends and support away from work. She valued sports and exercise, saying

> I run, go out and play basketball, go to the beach, do fun things, go hiking, go camping, things that I like to do. ...I mean, you have to *take responsibility for your self*, what you're doing with yourself outside of work (#12, p. 38, emphasis added).

A public health nurse spoke of needing to take care of herself,

> I have this book, ...it's called 'The Woman's Comfort Book.' It's a great book. There's an index where it lists about maybe a hundred different feelings, *like feeling depressed*, and then you go across and there's a graph of all these little exercises and things you can do on page 265, or, you know (pause) and they're all just nurturing, comforting, wonderful things to do just for yourself, from yourself to yourself. And they're simple, some very simple things that we just don't take the time to do. Like lighting a bunch of candles and putting flowers and taking a hot bath. Just wonderful, sweet things (315, p. 17, emphasis added).

In the absence of other forms of support, emotional and otherwise, this woman is learning how to be emotionally self-sufficient.

The theme of self-care was mentioned several times. One nurse said "I do yoga, I meditate, I pray, I try and exercise... I try to *take care of myself*" (#7, p. 18, emphasis added). Another nurse referred to her spirituality. "The older I get, the more I believe that you have to have a *spiritual belief* to help cope with everything that you see, as well as stress and pain" (#9, p. 13, emphasis added). She added, "I think that *sense of humor* is a tremendous coping mechanism for the nurse" (#9, p. 17, emphasis added). Another nurse recommended, "every time you answer the phone, before you say hello, *take a deep breath and relax*, and then say hello" (#16, p. 31, emphasis added). One nurse said,

> I am more of an introvert, or introspective, ...but I kind of go off and talk to the trees and myself. I've done that ever since I was a child. ...I kind of tend to *keep things to myself*" (#6, p. 4, emphasis added).

Individual strategies are cited as means to expressing emotional discharge and experiencing recharge. Missing from these nurses' accounts of how they make it work are collective strategies for change. Modifying their own expectations and setting limits to their involvement, these nurses have developed a wide array of personal accommodations to the challenges of doing emotion work. Interestingly, most of them framed their own 'personal' situations as workable due to various 'exceptions' in their particular work settings.

"I'm lucky because..."

After furnishing me with many examples of the difficulties of performing emotion work according to their own therapeutic standards, and after describing some of the strategies and compromises adopted in order to make it work, almost every nurse I interviewed explained that in some way things were 'different' in her unit in ways which made the work possible. These nurses, committed to providing 'good' emotional support, displayed impressive determination to give quality care to their patients and found ways to describe their personal situations positively.

One oncology nurse commented, "I know that we are very fortunate here as far as funding and our staffing, which may not exist forever. So I'll enjoy it while I can" (#9, p. 24). Another nurse said, "for the most part, as a whole, I feel like the unit's really supportive" (#12, p. 18). A nurse expressed gratitude for her colleagues,

> Everybody is very good. So that is the other way you survive this is through each other. The tough part of it is that everybody is so stretched to the limit that we don't have as much time to support each other (#2, p. 18).

One nurse praised her supervisor, "we actually are very fortunate here, because [our manager] ...likes people to try to problem-solve, and she trusts our decisions a great deal of the time" (#6, p. 15). A public health nurse distinguished between management and the staff. Asked if her employer was supportive of her efforts, she said, "The organization itself is not. *Luckily*, I work with some great individuals, and we do it for ourselves, basically" (#15, p. 18, emphasis added).

Beneficial conditions were seen as exceptional and situational. A dialysis nurse explained,

> I think it's very unique to dialysis. We do get to see the same patients over and over. We get to know them. A lot of patients really open up to us. It's *not like a typical floor setting* in a hospital where patients come in and they're sick and they don't feel like talking. (#18, p. 5, emphasis added).

Another nurse said,

> I think that just because of my personality and the relationships that I have with other people, I generally can get the help that I need to give the kind of care that I need to give, that I assess is needed to give. So, *for me personally* (pause), but I see other people [have difficulties] (#13, p. 30, emphasis added).

For some nurses, the exception was the particular unit they worked on, or the time of day that they worked. Speaking of the different norms and expectations in different nursing specialties, one nurse explained, "I would never work on a surgical unit. Because I think there's a difference in the nurses that work in ICU, versus the medical unit, versus the surgical unit, versus pediatrics. I could never be a ped[iatric] nurse" (#1, p. 20).

A supervisor talked about how the night shift allowed greater contact with patients,

> I talked to [a nurse] this morning ...and she just asked to go back to nights because she said... 'I kept on trying to talk with the patients, believe it or not, in the middle of the night ...they would wake up and [I] could be available to talk to them.' But on PM shift, no, it was just too busy (#14, p. 14).

A night nurse explained,

> People who work the night shift are just kind of the *odd ducks*. They are either wanting to get off the night shift, or they work it for a specific reason. My reason has been primarily that I can do my work uninterrupted. I'm not interrupted by the telephone, I'm not interrupted by management wanting to give in-services, or teaching about particular things. It's uninterrupted (#3, p. 7, emphasis added).

Often, these nurses were describing structural properties of situations yet they were perceived as individual solutions. They framed their continued adaptation to and coping with the consequences of restructuring in terms of personal savvy and luck. They learned to streamline tasks and delegate to other providers or family members. Exhibiting ingenious ways to preserve personal agency amidst organizational change, they negotiated boundaries between self and patient, and between personal and professional selves. They learned to release work strains and renew themselves, and they optimistically considered themselves lucky.

Nursing(s') Hurt Feelings

Although many of these nurses developed ways to 'make it work' by finding shortcuts, setting limits and creating personal outlets for discharge and recharge, their conflicted feelings about their new working conditions were far from resolved. They often found it painful to be constrained by new cost containment priorities. They resented and grieved for losses of time and support that have altered their customary interactive routines with patients. Emotional responses, expectations, and scenarios of how to handle clinical situations were deeply ingrained in the professional selves of the nurses I studied.

Virginia Olesen (1990:21) speaks of 'emotional lag' as "a subjective response to a new structural situation in which established emotional responses are not allowed or new ones are expected but have not yet developed." At this historical moment of rapid transformation, long-term nurses are both accommodating to change and feeling frustrations and loss about aspects of their work that are disappearing or no longer possible. The generational cohort that currently comprises the majority of hospital nurses have witnessed numerous organizational restructurings. Some of the nurses interviewed expressed acute awarenesses and concerns about changing standards and styles of practice. The adaptations and accommodations to change discussed above have been

tempered by considerable experiences of discomfort. One common expression used to describe a condition of distress among service workers is 'burnout.'

Burned Out, Glazed Over and Shut Down

The concept of burnout was introduced in the mid-1970s to describe a cluster of work-related symptoms including "emotional exhaustion, depersonalization and reduced personal accomplishment that can occur among individuals who do 'people work' of some kind" (Maslach cited in Schaufeli 1993:14). Like the concept of 'stress,' burnout gave human services professionals a vocabulary for talking about frustrations and disillusionment in bureaucratized quasi- and governmental agencies. Since the word was first used, a combination of increased social problems with decreased resources to address them has intensified work in many human service occupations, including nursing. Burnout theory targets individual worker discomfort and poses job satisfaction as the remedy. It is a popular term that sums up many different frustrations.

One nurse contrasted her pleasure in caring for sick people with the challenges of doing it:

> I did not mind dealing with terminal illness, it made me feel good, like my job was worthwhile ...I did not mind that. But I think I really *burned out* afterwards. I needed a change" (#9, p. 12, emphasis added).

Another nurse reported, "in this day and age there is not a lot that's making you happy about your job because you are so overworked" (#2, p. 17).

Being able to include emotional criteria in caregiving work was considered important for job satisfaction. A nurse explained her frustration that physical care took precedence over emotional care.

> If the person gets septic [infection] or sick, it doesn't really matter what the emotional thing was. That's where we *get upset* on the unit because we aren't able to do the *bonding* that we like to (#8, p. 8, emphasis added).

Another nurse said, "the job wouldn't be very satisfying ...if you could never feel like you are giving your patients any support" (#9, p. 8). She spoke of the work intensification of recent years, saying

> I went through a stressful time, because I had to make an adjustment personally that I could not expect to do the same things that I did in the past. And I had to let

> go of doing nursing the way I did. I had to become more technical than I ever had been, and I had ...to do things faster. That bothered me a lot. I know that I went through a real depression almost, and then finally I had to let go of it. I couldn't do things as thoroughly as I liked. I changed my standards and my expectation. That was very difficult (#9, p. 23, emphasis added).

For this nurse, the emphasis in her caring had shifted from quality to safety.

> I didn't think I was giving nursing care the quality that I had [before.] I thought you were very compromised because you had so much to accomplish in 'x' period of time. So, safety became your major concern ...if it is being done safely and you are getting as much done as you can, then you have accomplished your goal (#9, p. 24).

Several of the nurses indicated that they have lowered their expectations about quality care to match the circumstances of their work. One nurse reported

> I know that we are all frustrated. It's not just me. ...You can't do everything, that's what you learn. You have to leave things for the next shift. You can't get everything done in eight hours anymore. I am learning that that's OK (#8, p. 10).

She spoke of limiting her *personal* interactions with a patient, saying "I know not to make a patient so dependent on me, or to think that I'm the only nurse who can do anything" (#8, p. 26)

One nurse indicated that there is a range of variation among nurses as to what are considered acceptable behaviors and expectations.

> DB: Do you feel that there is a certain amount of emotional support that is considered routine, that would be expected as part of your job? Or do you feel that it's always at your own discretion?
>
> #18: Within the context of the unit that I work, I don't think that there's any; I think that there's an implied expectation, but I don't think that there's anything that would be considered necessary for the job. I mean, we do have some nurses that come in and they're *just all business*. Just, do this, do that, next patient. Nurses who provide, from my point of view little or no emotional support. And that's OK, I mean, there's enough there. It's not that they don't care, it's just that some people are so fixed on what they need to do workwise. They don't feel like that's a necessary component, or at least they don't exhibit that (#18, p. 15, emphasis added).

Observing other nurses working in a busy hospital, another nurse said,

> In the last couple of years, more and more, the nurses looked glazed to me, they're kind of *glazed over*. They're running around like chickens, trying to do everything

as quickly as they can. ...They look ...like they're *insulating themselves*; they know they can't meet everybody's needs. They know they can't even come close. They don't even think about it, they *just do their work*. They just get the med[ication]s out, do the treatments, try to *be as civil as possible*.

I think I see more nurses being less open to patients than I have seen in the past, and I think the reason for that is *protection*. I think the nurses are doing that because *the pain of someone reaching out to them and them not being able to stop and respond is more than they can tolerate*.

And I think how they deal with it is just, they don't give someone the opportunity to do that. I think it's what doctors have done for years. They run in and out of a room really fast, and you hear from patients, 'I couldn't talk to him, he was in such a hurry.' Or, 'He didn't sit down', 'He didn't look up at me, make eye contact with me..' You know, when you ask someone, 'Well, why didn't you tell the doctor?', "Well, you know, *he didn't look like he had the time*.'

...[Some nurses] learn how to operate that way ...they just look at nursing as a job. It's a job, like going and being a checker at Safeway. The pay is pretty good, and you just kind of keep yourself separate from the pain ...you bottle it up, or you work it out in the gym. (#11, p. 15-16, 40, emphasis added).

This nurse is describing conditions under which it is dangerous to feel deeply. There is not enough time or continuity to support the social construction of depth. In her study of flight attendants, Hochschild (1983:129) called the refusal to perform emotional labor 'going into robot.' "They withhold deep acting and retreat to surface acting....Half-heartedness has gone public." For some nurses, it was very disconcerting to no longer be the kind of nurse they wanted to be. Others are adapting by glazing over, shutting down emotionally, and focusing on 'just doing a job.'

Feelings Being Lost, Feelings of Loss: Salvage Ethnography

Throughout the process of conducting and analyzing these interviews, I have been repeatedly struck by feelings of *loss* and an awareness of *feelings* being lost. I move between my own positions of double vision as cultural commentator and engaged participant, intermittently seeing/feeling from outside and from within. At times I am deeply touched by the losses I am witnessing, grieving profoundly the ways of being/doing/knowing that seem to be gravely endangered if not already gone. Other times, my perception shifts. I release my own humanistic longings long enough to grasp at possible 'third spaces' that do not bind me to dualisms of thought/feeling,

unity/fragmentation, and good-old-days/apocalypse. I do not yet have all the vocabularies I need to explain this, especially to my dear colleague nurses, who frame their pain in modernist terms and are perhaps quite wary of the 'promises of monsters' (Haraway 1991a).

In some ways this work is a 'salvage ethnography,' informed by the anthropological tradition of "rescuing in writing the knowledge of old people" (Clifford 1986:112) and recording their 'authentic' culture before it vanishes into global Westernization (Marcus and Fischer 1986). However, I am concerned that the narrative structure of 'disappearance' might serve to compound the 'invisibility' of emotion work and contribute once again to silencing or invalidating ways of being/doing/knowing that already have a long history of being overlooked.

It is painful to tell this story of grieving the loss of something already invisible; to render it more visible at the historical moment its of possible disappearance. It is not enough to seek the redemptive pleasure of 'being seen at last.' For I hope that beyond shedding light on complex transformations that *do* involve invisibility and loss, these substantive and conceptual efforts will contribute to struggles for the recognition of emotion work in health and healing.

'Modern' nurses are not an endangered species in quite the same ways of pre-colonial or indigenous peoples. Nor is the 'tribe' in question, that of nursing and nurses, separated in time and place from the multi-national capitalist culture that threatens to engulf it. Indeed, perhaps it is primarily *gender* that makes the culture of nursing so 'foreign,' so 'other' with its insistence on values of nurturing, caring and emotional support. Attentive to Clifford's (1986:113) warnings about the 'allegory of salvage,' I recognize the temptation to construct emotion work in nursing as an 'ethnographic disappearing object,' and I acknowledge the pastoral longing to lament "the loss of a 'good' country, a place where authentic social and natural contacts were once possible," though never routine.

The notion of salvage implies losses associated with the passage of time. Earlier in this project, I have attempted to historicize emotion work in nursing. Contemporary dilemmas take place within a long history of participations *and* devaluations of women's

contributions to the work of health and healing. Tracking temporalities of transformation in nursing, there is another theme besides salvage that seems useful. The stories of these nurses reflect a mood of nostalgia that merits analysis.

Yiannis Gabriel (1993) explores nostalgia as a collective emotional 'tool' (my term) that performs several important functions in groups of people with shared histories of rapid organizational change. Gabriel notes a Western cultural predilection to yearn for a 'golden past' and juxtapose an impoverished present with an idealized, mythologized yesterday. Unlike grief, nostalgic feelings offer a bitter-sweet pleasure that carries at once a tender yearning for something different and a "resigned acceptance of the impossibility of bringing the past back" (Gabriel 1993:123).

Gabriel suggests that nostalgia is more about coming to terms with the present than about actually working through something from the past. It enriches today's identity through memories of past associations and accomplishments, asserts a fictitious alternative to today's impersonal realities, and provides "a symbolic way out of the rigours of bureaucracy, seeking to re-enchant a long disenchanted world" (p. 137). While its usefulness is primarily palliative, Gabriel found that nostalgia was particularly beneficial among older employees struggling to survive the temporal dislocations of organizational change. At its best, nostalgia is an *experience* of the tensions between a longing for something else and the acceptance of an imperfect, partial present.

These nurses spoke nostalgically of 'days gone by' while adapting as best they could to present conditions. Longing for the past is apparent in one nurse's comment saying, "I think there were times when I was able to spend a decent amount of time with a patient and [I] was able to go the extra mile" (#8, p. 12). Another nurse recalled that "in days gone by I would have had more patience because I would have had more time to be more patient with it. And those days are gone" (#2, p. 7). Another nurse remembered,

> When I first started in this hospital in 1979, we used to be able to spend a lot of time. We really would sit down and talk and get in depth; get to know them on a more personal level. But with things in health care the way they are, it's all we can do now to just initiate the treatment and make sure that everything is going OK (#18, p. 7).

Another nurse said simply, "I remember ...having the time to get to know the people and be there if they needed me" (#1, p. 22).

The issue of age and generation came up in several ways. For one nurse, age might determine what type of work a nurse would choose to do. From her perspective, "as nurses get older, they certainly can't be in the ICU [intensive care unit] with the stress and the physical part of their job" (#1, p. 23). A mid-life nurse compared her experience of nursing to that of newer, younger nurses, saying

> I'm 45 years old, and the average age of a hospital nurse is my age. ...[T]he thing that I see [as] vastly different is the kids who are coming out of school now. [They] know this as reality, they don't know anything different. This to them is reality, and they haven't lost a lot in the process of these cutbacks in terms of knowing what it was like before. (#2, p. 16).

The unspoken forgiveness of 'they can't help it, they don't know any better' is an awkward expression of tolerance and might serve to smooth relations between these two differently positioned generations of nurses.

In fact, the population of practicing nurses is aging. In California, "half of working nurses in the state are over the age of 45" (Sponselli 1996:6) and it is predicted that in the United States, "by 2000, two thirds of the nurse population will be over 40" (Aiken and Salmon 1994:320). This demographic reality suggests at least two implications. First, dynamics discussed in this study regarding the awkward adjustments of older configurations of selves and emotionalities to new working conditions promise to be widespread. Second, tensions between approaches to work favored by older versus younger groups of nurses may lead to rivalries, resentments and power struggles.

Generational differences in workers have been observed in other service industries. In her study of workers in a telecommunication company, Margaret Heide (1997) found that younger employees had an attitude of 'entitlement' towards sick leave that created resentment in older workers. The older workers retained allegiance to the 'parent' company and maintained pride in a work ethic that was not shared by younger employees. Older workers saw younger workers as having a bad attitude and resented covering for work lost to sick leaves they perceived as illegitimate. In turn, the younger workers, alienated by nearly unbearable working conditions and lack of institutional support or

recognition, resented being targeted as troublemakers for organizational problems they didn't cause. The older nurses interviewed for this study expressed similar sentiments.

For example, when asked how the next generation of nurses was responding to the heavy work load, one long-time nurse replied,

> They don't have any work ethic. [They manage] by not caring as much, just doing the minimal amount of work. Hurrying up to get out, caring about themselves more than what happens and what they need to do in the hospital. (#1, p. 23).

Reflecting on lowered expectations about nursing care, one nurse commented,

> It [giving emotional support] is not a shared value. ...It doesn't mean that it's not a right value, it just means it's not a shared value. Whatever works, for whoever, is what's important. ...other people could not care less about that. *Before* that was absolutely a shared value with everybody, and that's no longer a shared value. I see part of that as the difference in ages (#2, p. 17, emphasis added).

Faced with so many changes in nursing, one nurse reflected, "Many nurses, if they don't have to, they don't stay in nursing" (#6, p. 8). When asked how she envisions the future, one nurse responded "I don't know, retire" (#9, p. 24). As for the younger nurses, she replied,

> In a way, I think it will be all right because they have never known it any differently. So they are coming into what is now, and they have the energy and the enthusiasm to try to make changes for the better. And, maybe they can't (#9, p. 24).

These nurses expressed feelings of sadness, nostalgia, resentment and acceptance. A group of 'seasoned' women, their/our lives have spanned decades of massive social and economic change. Their emotions of loss and grief at the passing of 'a way of life' can justifiably be framed in narrative structures of nostalgia, pastoral or salvage ethnography. Indeed, their/our stories do contain many elements of each of these. Yet this is not all that is going on, nor are the dubious comforts of these forms enough. Not because I am not gravely concerned by what I have seen, but because witnessing the work of nurses continues to inspire my deep respect and awe for their/our tenacity and inventiveness.

My story is part modernist and part post(-) in that it seeks both to explain and to unsettle. Existent conceptual frameworks reinforce some prioritizations and devalue others. I search for non-dualistic vocabularies and practices of feeling that blur boundaries without necessarily seeking synthesis. I conjure conceptualizations of feeling/thought that

situate these processes in bodies *and* in culture, understanding that impoverishment of one is diminution of the other. I seek frameworks that recognize multiple identities and multiple ways of knowing, advocating for awarenesses *both* psychically *and* politically, and building on models of coalition rather than unity (Ferguson 1993). As collectively we (re)configure ourselves to survive transitions into the New World (Dis)order, what concepts and conditions might produce emotionalities enacted with authenticity but without essentialism?

As social critic, I am comfortable with paradoxes, but as healer, I require meanings and values compatible with the deepest longings of life. And so I end with a discussion of contested definitions of nursing, highlighting through the comments of these nurses some dilemmas of emotion work in contemporary health care systems.

Competing Definitions of Nursing

The nurses interviewed for this study have witnessed many transitions in the way health care in the United States is delivered. They expressed concerns about what they framed as 'new values' in nursing. Almost all of the respondents contrasted what is happening now with what came before, implicitly if not explicitly comparing sets of values, priorities, practices and meanings. One nurse articulated these differences, saying,

> I think it's different. I think there was more emphasis years ago on some of the *personal comfort* of patients. I can only say this from some experiences I've had with newer graduates. [Now] there is more of a sense of: the nurse sits back and *organizes and delegates* and that that's a good nurse. I blame the nursing profession itself. ...When you first go into nursing school, what is stressed over and over is 'the patient comes first,' ...that's the first thing you hear. Then you get out into the real world and you find out, no, the *dollar comes first*, and the doctor (#6, p. 20, emphasis added).

Another nurse explained how differences in nurses' training and types of hospitals have changed the profession, recalling

> When I went to school, you could go to a hospital program and ...it was different than going to one of the colleges now. The hospitals you worked in were run by nuns or small community hospitals. [Now] it's different, it's *more business-like* than it used to be (#1, p. 24, emphasis added).

An oncology nurse spoke of her concern that some aspects of nursing, such as providing emotional support would not get passed on to the newer nurses.

> You can help other people to learn, but my fear is that the time frame is not going to be there to allow that kind of nurturing to the younger nurses. It takes time to nurture. Specifically each other. ...We support each other (#2, p. 18).

Another respondent explained how she might be more uncomfortable than patients about cutbacks, indicating how she has internalized implicit, older nursing values.

> I don't think it bothers them [patients] as much as it bothers me because I don't think a lot of them know if they are getting enough information. ...We know *what we're capable of* helping them with, I think that it's more of *a nursing thing*. ...I think expectations aren't what they used to be. I think that if you can get in there and get your shift done and keep things flowing from a physical point of view ...then that's a pretty good thing (#8, p. 12, emphasis added).

A birthing nurse indicated that for her, the rewards of nursing included intangibles such as being able to help women.

> I could go and maybe get a different kind of job. But I enjoy [nursing], I enjoy being able to help someone. ...I enjoy figuring out what someone needs and trying to provide it on that [emotional] level. ...I know I can make a difference; and I know it made a difference to me who was around me when I was in labor. That's why I do it instead of something else. ...I just feel like my reward is helping the women (#13, p. 17, 27).

Another nurse remarked, "What makes it more satisfying personally is when I'm with somebody who's receptive" (#4, p. 8).

Speaking of the intangible rewards of nursing, an oncology nurse said,

> It's just seeing people do better ...if you can help them, if they have been having trouble feeding themselves, you can help them do that. It makes you feel like you have done something to make their life better.
>
> Or you can see if you listened enough or if you do something ...that makes their existence a little better, that's *the reward*. Because, the rest of it doesn't really matter. I think that's the biggest thing, it's just feeling like you've done something to make [it] a little nicer for them, even if its momentary (#6, p. 19).

A public health nurse spoke of her personal growth from working as a nurse.

> I've grown incredibly. It's amazing how much I've uncovered about my mortality, ...my death and dying issues.
> The face of being human has so many aspects. ...And the importance of *relationship*. I've really got clearly that *that's all you take with you*. You don't get to take all of the toys that we accumulate, and the stuff. Really all you get to go with is the relationships that you have made. ...I don't want to go out mad; and I don't want to go out empty (#5, p. 8, emphasis added).

Witnessing dying and death taught her to prioritize relationships over material gains. For another nurse, emotional and spiritual support were close. She explained that "emotional support deals with feelings, [and] spiritual support just deals with knowing that there is something greater than ourselves. ...It gives some purpose to their suffering" (#7, p. 19). These values and perspectives were part of the experiential learning acquired over many years of practice.

The comments of these nurses reflected awareness of competing definitions of nursing, old and new sets of values, affirmations of non-monetary rewards, and frustrations about changed expectations in their work. Speaking of the relative invisibility of emotional support, one nurse said,

> You almost have to lump your emotional support under a heading that people can relate to as something that they can say, 'OK, nurses do that and that's really a valuable contribution of what nurses do.' But I don't know if we call it support, or something else.
>
> ...I just can't imagine any nurse, if they were to talk to you like this, to not say that emotional support is a big part of what they do (#9, p. 21).

Although she was unsure about the nomenclature, she affirmed the perspective that nursing includes providing emotional support. Another nurse explained how the language of nursing is changing:

> We are *using new words* to speak of the interpersonal work of caregivers. The *customer focus* talks about teamwork, and this requires interpersonal skills (#19, p. 3, emphasis added).

As new managerial strategies incorporate older conceptualizations of nursing into work redesign, some practices will survive, while others are condemned to the cutting block of the bottom line. As this nurse added, "These emotional issues are important, but it's hard to compete with the tangible, visible and economic issues in health care" (#19, p. 4).

Many of these nurses held high ideals about nursing, but they also expressed anger and frustration about it. Responding to changes in work organization, one nurse said, "I don't want to work unconsciously. I don't want to *just do tasks*" (#3, p. 15, emphasis added). Another nurse spoke of how a hiring freeze in her current job as public health nurse affected her and her colleagues.

> Right now one of our nurses is leaving. When somebody leaves, we all carry the caseload of the absent nurse until there is a replacement and there is a training. That imposes extra workload. ...That's *what's happening with nursing*, and we're just having to 'eat it' is what I'm seeing. Not just in my job, in a lot of nursing jobs (#7, p. 12, emphasis added).

One of the nurses interviewed spoke extensively about changes in nursing roles and identities.

> In nursing, *we've let so much of the stuff that we do be taken by others*. ...You know, we've let, pretty much, health education go. We've let lots of pieces go, they're being done by other people, other disciplines. They've been taken over. So we have this really pretty narrow way that other people define us. And there's a lot of thought among nurses ...that emotional work, that's the work of social workers, that's the work of marriage and family counselors, that's the work of a psychologist. If they have a problem, go see those people (#11, p. 22, emphasis added).

> We're going to have to find new ways of showing how we care, or demonstrating that caring. Because the ways of the past, that long-term involvement with people and the large chunks of time, isn't there right now. ...We have to find some way of holding on to that piece. Because from my perspective, that is one of the major components of nursing. And if we lose that, then we're a *technician*. And if we're a technician, anybody can replace that. It's the broad knowledge we have, and helping patients, clients, modify their life, or their treatment, in a personal, individual way, that is what nursing is all about. ...We *can't allow ourselves as nurses to be diminished to the place of a technician*. (#11, p. 23, emphasis added).

> ...It's part of that 'use it or lose it' thing, too. If we don't participate in giving emotional support for patients, people won't see that as an important role for nurses. That will be something that will be out the window (#11, p. 25).

> I think that caring is a piece of emotional support. But I think *you can monkey around with the words and the process* and institutionally say we deal with the emotional needs of our clients by saying on our nursing assessment, as part of our intake interview, we will ask these particular questions of patients and identify emotional needs that they have, and see that they get dealt with in some way. Which you can do in a way that shows caring, or you don't have to. You can *just mechanize it*, like 'OK, now here's the questions' and *go through it in a rote kind of way* (#11, p. 34, emphasis added).

During recent rapid transformations of health care delivery systems, these nurses have observed the appearance of competing definitions of nursing, expressed in new languages, while older forms persist in many ways. Both new and old forms utilize

vocabularies of emotion to reflect *and* shape experiences, activities and expressions. In the following chapter, I discuss dilemmas of crafting auspicious vocabularies of emotion, and highlight challenges of situating both emotion and work within frameworks of nursing.

Summary

I began this chapter by examining nurses' strategies for making it work. Nurses spoke about shortcuts such as streamlined work processes, standardization, technology, pharmacology and delegation to others that enabled them to function under strained working conditions. These nurses negotiated amongst pleasures and dangers of feeling by setting limits to their involvement. Control talk referred to self-management efforts to avoid getting 'too attached.' Multiple personal and professional selves were kept separate through ongoing vigilance and emotion work that allocated different feelings to different parts of self.

These nurses talked about formal and informal mechanisms and activities utilized for discharge of emotions and personal recharging. Organized support systems, personal friendships and individual undertakings such as exercise, sports, meditation, and prayer were named as sources of revitalization. If other sources of support, emotional or otherwise, were inadequate, it was assumed that each care provider would take care of herself. The resilience and determination of these respondents was evident in their overall affirmation that, in their personal situations, they were lucky. Despite organizational challenges, individuals and exceptions offered contexts for emotionality and for agency.

However, during recent transformations of nursing practices under managed health care, the nurses interviewed expressed feelings of loss, and remembered feelings no longer possible under current working conditions. I examined this grieving, as well as the ironic capacity of nostalgia to enable employees to better endure todays' new realities. I explored the pleasures and dangers of 'salvage ethnography' (1986; Clifford and Marcus 1986; Marcus and Fischer 1986) as I attempt to record aspects of nursing that are in danger of vanishing. Without reinforcing narratives of disappearance, my project seeks to express in textual form the complexities of nurses' 'invisible' emotion work. Tracking historical

transformations, I link interpersonal practices with structural conditions and discursive framings.

Articulating a range of responses to structural change, these nurses reported a general sense of lowered expectations and new (reduced) emotion standards. Their comments reflected the existence of competing definitions of nursing and the selective survival of some emotion skills and knowledges, as some things were passed on while others were being lost. The nurses interviewed represent a generational cohort of practitioners whose emotion standards reflect meanings and practices largely established before the advent of managed care. It will be interesting to watch how newer generations of nurses adapt to these changes.

Both strategies of accommodation and dynamics of nostalgia represent efforts by nurses to preserve identities under conditions of rapid organizational change. Senses of self and feelings/expressions of emotion are related. In the next chapter, I explore relationships between organizational change, personal and professional identities, and emotionalities as indicators of deep societal changes in being/doing selves.

Feeling Squeezed: Dilemmas of Emotion Work in Nursing Under Managed Care

Chapter VI Feeling(s) Fit for the Job: Emotion Work @Second_ Millennium[6]

> ...[W]hat is most interesting about the current situation is the way in which capitalism is becoming ever more tightly organized *through* dispersal, geographical mobility, and flexible responses in labour markets, labour processes, and consumer markets, all accompanied by hefty doses of institutional, product, and technological innovation.
>
> David Harvey (1989:159, emphasis in original)

> I simply wanted to raise the question: What new images and forms of the body and kinds of powers that regulate it are coming into existence contemporaneously with the dramatic shift in political economic organization that is being brought about by flexible specialization?
>
> Emily Martin (1994:245)

> In discourses about subjectivity the term 'the self' will be superseded by discussions of 'subjects.' The term 'subject(s)' more adequately expresses the simultaneously determined, multiple, and agentic qualities of subjectivity. ... Psychic 'structures' are constituted by the interweaving of many heterogeneous experiences and capacities. These include complex clusters of capabilities, modes of processing, altering and retaining experience, and foci of affect, somatic effects, and transformation of process into various kinds of language, fantasy, delusion, defenses, thought, and modes of relating to self and others.
>
> Jane Flax (1993:94)

This story/quest to dis/un-cover meanings and practices of emotion work in nursing is situated in the "time zone of the end of the Second (Christian) Millennium" that Donna Haraway (1997:10) links to histories of both progress and apocalypse, and to the material-semiotic practices of technoscience. Nurses are located along dense nodules of capitalist accumulation strategies, bioscientific management of bodies and populations, and gendered divisions of caregiving labor. Their interpersonal relations are enacted in sites and temporalities infused with the "cultural logic[s] of late capitalism" (Jameson 1992)

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[6] With gratitude to Adele Clarke (1992), *The Right Tools for the Job: At Work in Twentieth-Century Life Sciences*, and Donna Haraway (1997), *Modest_Witness@SecondMillenium FemaleMan(c)_Meets_OncomouseTM*.

where corporate biomedicine has found ways to "pursue profit (or other forms of advantage) by altering the ways time and space are used and defined" (Harvey 1989:229).

Implications of these extensive economic and cultural changes for the organization of work and workers have been theorized and historicized from a variety of perspectives, some of which I review below. In this chapter I situate dilemmas of emotion work in nursing within broader frameworks that are tracking transformations from 'modernist' relationships between self and society, to global, post-industrial, de-centered inhabitants and world. I address theoretical implications of this study, and discuss the need for new vocabularies of emotion both in nursing and in the social sciences.

The health care industry is changing so rapidly that residual modernist modes of organization and ways of being/feeling currently coexist with newer service industry strategies and their emerging emotionalities. The massive redesign of managed care models is changing what kinds of workers/persons/subject positions are available and possible. I reframe nurses' expressions of concern about their work as one example of these kinds of changes.

Both the gendered composition of nursing workforces and the gendered subtexts of emotionality invite feminist inquiry into meanings of emotions, identities and selves at this particular historical moment. Conceptual interventions to reframe emotion as 'embodied sociality' (Lyon and Barbalet 1994) might shed light on processes of doing 'self' at a time when incursions of the 'New World Order, Inc.' (Haraway 1997) into contemporary 'structures of feeling' (Williams 1973) are contributing to active redesign of what it means/feels like to be human. Widespread uses of designer pharmaceuticals (e.g. Prozac), professional and self-help psychologies, and workplace trainings for flexibility (Martin 1994) have contributed to agendas of 'personal reinvention' (Sinetar, cited in Martin 1994:217) for survival into the next century.

Interventions at the level of individuals typically frame emotions as properties of separate, solitary selves and overlook sociocultural enmeshments of feelings within contexts of groups, communities, economies and media images. Emergent critical models of emotionality that recognize the inseparability of thought, feeling, body, society and identity are requisite. What nondualistic vocabularies of emotion might be used to address

"the sickness of binary epistemology" (J. Martin 1996), to resist corporate colonization of emotion/body/thought, and to validate skills and knowledges of emotion/thought needed for the work of health and healing?

Personal and Work Identities

My premise in the following discussion is that kinds of societies produce kinds of selves that in turn (re)produce kinds of societies, and so on, in historically specific and complex ways. Academic divisions of labor over the last one hundred fifty years have tended to give the analysis of social forms to sociology and the investigation of individual and interpersonal dynamics to psychology. Symbolic interactionist social psychology has investigated spaces of intersection for several decades. Contemporary theorists are also working to develop fresh vocabularies that reflect the interdependence and interdisciplinarity needed to adequately understand selves in societies and societies in selves. Building on concepts of emotion work that address connections between felt and displayed emotions in socioeconomic contexts of employment, and on theoretical recognition of discursive as well as material practices that shape human (and non-human) meanings and activities, I offer these remarks about emotion work in nursing as example of self/society interwoveness.

In some dominant twentieth century discourses, emotions are conceptualized as interior, subjective feelings, situated in and emerging from individuals. They are taken to be 'authentic' expressions of the singular 'true self' and, especially in women, evidence of over-sensitivity and weakness. Psychologized elaborations of emotional states and therapeutic efforts to cure them have been a mainstay of modernist social organization. This includes most significantly the knowledges and interventions of industrial psychology and the development of human relations approaches to job satisfaction and motivation (Hollway 1991). As modernist forms of social organization give way to what some have called postmodern, or postindustrial forms, both discursive meanings and material practices (and they are not really separate) of emotionality are also changing. Nurses are feeling these changes, though they probably wouldn't identify them as such.

Contemporary analysts have named current societal transformations 'postmodernity' (Harvey 1989), 'late capitalism' (Jameson 1992), and 'post traditional' (Giddens 1991a) and refer to new economic strategies of 'flexible accumulation' (Harvey 1989), 'globalization' and 'knowledge work' (Aronowitz and DiFazio 1994). Focusing on changes to the 'self,' theorists have discussed 'identity processes' (Giddens 1991a; 1991b; Lash and Friedman 1992), 'decentered selves' (Flax 1993; Foucault 1978; 1979), 'narrative selves' (Gergen 1991; Kondo 1990; Linden 1993; Plummer 1995), and 'embodied selves' (Burroughs and Ehrenreich 1993; Featherstone, Hepworth, and Turner 1991; Grosz 1994; Strathern 1996; Turner 1992; 1984). I situate this analysis of emotion work in nursing along rich intersections of these considerations of socio-economic relations of production and psycho-cultural productions of selves.

Among other things, nurses are coming to terms with the profound discursive and material interventions of changing 'patient' into 'customer' and the ensuing reframing of psychosocial interactions. Industry-wide reorganization of health care work parallels the consolidations, downsizing, outsourcing, and de- and re-skilling seen in other corporate settings. Like other industries, service, product and image are joined, demanding sophisticated levels of emotion work from most employees. Within nursing, emotion work takes on multiple guises that mirror stratified occupational rankings of this sometime 'profession,' ranging from 'flexible' managerial and professional autonomy to the controlled front-line service work of an 'emotional proletariat' typical of today's 'service society' (Macdonald and Sirianni 1996).

Since Hochschild's (1969; 1975; 1989; 1983) writings on feeling rules and emotion work appeared over two decades ago, there has been proliferation of both service work and analyses of it. Hochschild's concept of 'feeling rules' locates emotions in the social, and her study of 'emotion work' performed in the context of employment examines commodification of feelings when workers' interpersonal skills and knowledges become part of the service product sold to customers. She is concerned that this process affects workers not only as they shape surface feelings and presentations of self, but also as they tailor deeper feelings and self to meet production criteria of service work.

Hochschild's efforts bring *emotion* into more general discussions of work and workers that have been central to sociological analysis ever since Marx, Durkheim and Weber examined the effects of industrialization on selves and society. Catherine Casey (1995), whose insightful *Work, Self and Society After Industrialism* reviews classical perspectives on work and self in sociological and psychological literatures, then explores contemporary transformations of work, productions of selves, and what she calls new interim forms of social solidarity.

> [For Marx] [h]uman character is an ideological construction that reflects the particular mode of production and social organization dominant in specific historical epochs. For Durkheim, the rise of industrial society had produced a new person, one who was progressively freed from the constraints of traditional society and whose interests were increasingly centered around the pursuit of a higher and moral self interest. Industrialization and the dramatic expansion and sophistication of the division of labor produced the phenomenon of individualism, and fundamentally altered the forms of social solidarity and cohesion in society. ...Weber in turn analyzed the psychological conditions which made possible the developments of industrial capitalist society. He postulated a Protestant religious foundation of the character of the industrial capitalist self (Casey 1995:24).

Catherine Casey (1995:13) chides poststructural theorists of subjectivity for distancing their analyses of postmodern 'selves' from material conditions of work. Suggesting more than a post-Marxist perspective, she proposes a closer analysis of *discursive* as well as material practices now embedded in the doing of work. Under industrial conditions, workers bodies were disciplined by mechanical needs of the production line, but their 'self' was not implicated in the work. Indeed, Marx's concept of alienation emphasized estrangement between worker and product of labor, separating man from self, others, nature and his 'species being' (Marx in Tucker 1978). In todays' transforming postindustrial and service economies, driven by flexible accumulation strategies, 'products' are linked to and embedded in interpersonal relationships enacted between service 'representatives' and customers. Discursive interventions mobilize employee collaboration through the shaping of designer selves. In such contexts, workers' selves are resources colonized for extraction of wealth in forms of emotional performance.

The consequences of this 'fact' of the necessary complicity of selves in postindustrial economies are far more complex than simple 'horrified modernist' responses

suggest. Concepts of emotionality and self are among many assumptions underlying modernist 'world views' currently being pried apart as no longer tenable. As I do this work I find myself constantly examining my attachments to residual concepts and configurations, and wary of (also justifiably perturbed by) barely recognizable, emergent forms. My (modernist?) hope is that conscious conceptual interventions might alert collective reshapers of meanings/practices of emotionalities to dangers and possibilities implicit in these transformations. I am particularly attached to reconceptualizing and increasing awareness of linkages between society, emotion, body, and health and healing, yet the very meanings of these terms are under radical revision.

Work Worlds

Interest in the relationships between workers and their conditions of work is not new. Nineteenth century sociology is grounded in discussions by Marx, Weber and Durkheim about the rise of industrial society and its modes of production, social organization, bureaucracy and divisions of labor. Earlier analyses of alienation, Protestant ethic and anomie suggested that changes from 'traditional' to 'modern' (European/ American) society produced 'individuals' shaped by the dynamics of industrial capitalism. Although contemporary concepts of emotion and emotion work were not used to evaluate laborers and labor processes until the late twentieth century, pragmatist thinkers such as Cooley, Dewey, Thomas and Mead (Meltzer, Petras, and Reynolds 1975) addressed issues of self in society, and laid foundations for interactionist writers such as Blumer (1969), Hughes (1958) and Goffman (1959; 1967) to explore human agency within social environments. Critical theorists, such as Horkheimer and Adorno (1944), C.W. Mills (1959; 1963) and Marcuse (1964) also examined interrelations and tensions among individuals and social and economic forms in advanced industrial society.

Anselm Strauss' (1993) social worlds/arenas theory "aims at capturing, describing, and thus rendering susceptible to analysis the multiple simultaneous organized actions of individuals, groups of various sorts, and formal organizations" (Clarke 1991:131). He suggests that identities are shaped through commitments to various reference groups and enacted through shared activities with particular histories, geographies, temporalities and dynamics. Emphasizing the centrality of work, defined most broadly as forms of

interaction, Strauss sees actors and activities as inextricably linked. His study of the social organization of medical work (Strauss et al. 1985) highlights work processes, including 'sentimental work' performed by providers in health care environments before the advent of managed care.

More recently, Casey (1995) traces historical transformations from industrial labor, with its efficient, mechanical, standardized processes and its specialized, stratified workforce, to post-Fordist labor processes "effected by the widespread deployment of advanced automation and information technologies in the production of material goods and services" (p. 42). Aronowitz (1994) enumerates characteristics of these same transformations, such as downsizing, deskilling, and replacement of permanent work with part-time labor, indicating that "the 'meaning' (in the survival, psychological, and cultural senses) of work --occupations and professions--as forms of life is in crisis" (p. 16). Production jobs of a manufacturing-based economy have diminished, replaced by jobs with different skills and often lower pay in the growing service industries.

Macdonald and Siriani (1996) report that 79 percent of nonagricultural jobs in the United States are now in the service sector. "By definition, a service is intangible; it is produced and consumed simultaneously, and the customer generally participates in its production" (p. 3). Service workers are required to 'inhabit' their jobs differently from industrial workers. Managerial strategies to train for, supervise, and control production quality involve a combination of standardized procedures and employee empowerment techniques, such as Total Quality Improvement.

From the perspective of management, the best employees are those who most thoroughly internalize and reproduce desired feeling states and inhibit undesirable ones. The authors note that service work is polarized between large numbers of low-end, 'peripheral' jobs, and a small number of high-skill, high-income jobs at the 'core.' "This distinction not only refers to the level of responsibility and autonomy expected of workers, but also to wages, benefits, job security, and potential for advancement" (Macdonald and Sirianni 1996:12). In the segmented health care labor market, nursing aides and assistants often fall into the former category while registered nurses continue to pursue professionalization strategies to position themselves in the latter category.

Transformations in the organization of work have affected mid-level professionals and managers, as well as front-line service providers. Casey explains how information networks have democratized and dispersed many knowledge functions, replacing 'occupational distinctiveness' with 'teamwork.' Internal hierarchies are flattened and mid-level professionals, now generic 'employees,' are expected to adapt, retrain and flexibly learn to do whatever rapidly changing needs of production require. These trends are evident in the health care industry where job descriptions are becoming blurred. In medicine and nursing, hands-on 'craft' knowledges are being superseded by standardized 'clinical pathways' and 'expert systems' designed to render the work more efficient. Investment strategies of consolidation and downsizing have created job insecurity among professionals who are then persuaded to enlist in retraining projects that redesign workflow and alter levels of autonomy and responsibility. As I examine below, emotions are prominent both as feelings *about* these changes and as increased components of the work itself.

New managerial strategies in many industries are changing middle-class working conditions from professional and occupational 'sovereignty' to dispersed conditions of postindustrial knowledge work, made possible through widespread adoption of information technologies (Aronowitz and DiFazio 1994; Casey 1995). Despite unique and long-standing traditions in health care work, managed care models have begun to dis-assemble *professional* practices and expectations regarding, among other things, interpersonal relationships between healer and patient. Although physicians and nurses, with their legally sanctioned gatekeeping and state 'practice acts' are among the most clearly delineated professions, corporate restructuring is shaking the very foundations of these (modernist) professional identities.

I contend that some forms of emotionality, such as those associated with performances of selves and identities in transition, or perhaps in some contexts no longer possible, are being eliminated, transformed or replaced. I have reported earlier how nurses described skills and knowledges of particular forms of emotional support common to a passing historical time-frame (Chapter Three), and their concerns about what is being lost under managed care (Chapter Five). It is both easier and nostalgic to look back at what is

being lost, but there are also some indicators of what might be emerging in the future. Notably, organizational psychologists and management experts are developing techniques and trainings designed to shape and improve the 'selves' of health care and other workers, rendering them more fit for the job.

In order to accomplish collaboration of service workers with management goals of production and sale of customer focused services, employee emotions are one of the 'work objects' (Casper 1994), those material/semiotic entities at the center of deliberate efforts and activities, needing to be refined. Service workers develop skills for handling and managing customer emotions as well as for disciplining their own. As part of this 'pro-active' approach, a significant discursive intervention has been the gradual reconceptualization of emotions as learned (and therefore mutable) rather than innate. Techniques for emotional reprogramming, marketed under names like 'healing toxic emotions' (Northrup 1994) and 'emotional clearing' (Ruskan 1993) suggest both dangers and possibilities for this mutable yet embodied aspect of human selves.

Postmodern Subjects

Recent theoretical works on the nature of the 'self' have contested Cartesian assumptions of an autonomous, rational subject and Humean views of self as a site of verifiable empirical experience (Barrett and Phillips 1992; Flax 1993; Nicholson 1990). Masculinist and heterosexual 'norms' have been contested and post-colonial identities explored (Butler 1990; Collins 1990; Mohanty, Russo, and Torres 1991). Contemporary considerations about emotionality must be situated in relation to new understandings of subjectivities and identities as multiple, contradictory, flexible and embedded in sociocultural communities of similarly constituted entities.

Henrietta Moore (1994) traces changing concepts of 'subjectivity,' noting how considerations of gender, ethnic and cultural differences reshape theories of person and self. She writes that although "the dominant model of the person/self in western Europe could be said to be one which characterizes the individual as rational, autonomous and unitary," (p. 35) many people do not experience themselves in this way. She then examines crucial connections between language and identity, and links "the constitution of subjectivity to social discourses and discursive practices" (p. 48) that make particular

subject positions possible. In addition to discursive formations, people enact and produce practical and unconscious 'knowledges' as they appropriate social identities. Moore points out the complex ways in which "identity is guaranteed by a matrix of social relationships rather than by anything which might be deemed an essential attribute of the individual" (p. 39).

Moore explains the post-structuralist concept of the 'subject' in which "individuals take up a variety of subject positions within different discourses" (p. 55) which may be conflicting or contradictory. Within these disparate formations, subjectivities are held together by "the subjective experience of identity, the physical fact of being an embodied subject and the historical continuity of the subject where past subject positions tend to overdetermine present subject positions" (p. 55). In light of these more fluid understandings of 'selves,' it follows that emotions are felt and displayed according to meanings and expectations affiliated with particular identities or subject positions. The contemporary prevalence of ambivalent emotionalities (1989; Weigert 1991) is one consequence of living with multiple identities.

Moore adds that "not all subject positions are equal" (p. 65) and suggests that people negotiate between competing and possibly contradictory discourses according to rewards, sanctions, emotional investments, and fantasies about "the kind of person [they] would like to be" (p. 66). If 'self' is no longer (conceptualized as) a unified, essential way of being, possibilities of *self modification* take on new meaning. Likewise, dispositions, and even manipulations of emotionality contribute to preferences and possibilities for particular 'senses of self.' In other words, how people *feel* shapes/is shaped by desires, preferences, values and moral positions that vary according to the subject positions they are inhabiting at the time. As symbolic interactionists have long noted, presentation, representation and misrepresentation of self are all negotiated in social interactions and in social worlds (Goffman 1959; Strauss 1993). Felt and displayed emotions are part of these negotiations.

Responses to material and discursive assaults on modernist selfhood range from fundamentalist assertions of traditional forms to postmodern celebrations of fragmentation. Articulating new possibilities for a decentered subject, Jane Flax (1993:xii)

warns that "[t]he unitary self and the fragmented one are simply mirror images; neither represents an alternative to the subjects Enlightenment discourses construct." She explores the possibilities of fluid, multiple subjectivities that can nevertheless "achieve coherence or long-term stability without claiming or constructing a (false or true) solid core self" (p. 102). Kathy Ferguson (1993) brings irony and kitsch into her discussion of 'mobile subjectivities' in order to undermine longings for unity while aspiring to solidarity.

Flax identifies two types of 'troubled subjectivity' found in persons unable to negotiate the simultaneous 'distinctiveness *and* mutuality' of differences embedded in multiple identities. Schizoid persons are rigid and compartmentalized, splitting reason from feeling. They "can adapt behavior to achieve predetermined ends while appearing to be an authentic person who is also genuinely concerned for the welfare of others" (p. 102). She notes that this configuration has proven quite suitable in a variety of contemporary occupational settings.

By contrast, borderline persons fluctuate from one isolated affective experience to another, caught in an "unpredictable whirl of fragments" (p. 105). They lack experiences of constancy or continuity and have difficulty negotiating transitions between one fragment and another. I think of homeless people, or children living in conditions of advanced societal disintegration, where the disappearance of economic and social support has brought excessive fluidity. These exaggerated 'types' are cautionary tales about how people (mal)adapt in the flux of postmodernity. Speaking from her position as a therapist, Flax intimates that we must learn to navigate along this paradoxical continuum: "[w]hile I must be multiple, I cannot fragment" (p. 106).

Metaphors of therapy and healing have contributed unevenly to notions that a person's 'self' can be modified, improved, and 'made whole.' Seemingly contradictory ideologies currently abound in popular culture that propose simultaneously *programs* of self-improvement that can restore *natural* (or authentic, or real) health (or self, or well being). These beliefs juxtapose people's responses to inherent social and economic instabilities, and the obvious collective need to change and adapt, with memories and longings for previous and future experiences of stability.

Emerging corporate conglomerations, that are becoming (somewhat by default) the most stable social entities during this era of rapid transformation, are making ingenious use of these contradictory beliefs. Building on sophisticated social science knowledges and techniques, they have designed programs to guide and support workers, ostensibly filling social, cultural and emotional voids created by the collapse of previous economic and communal forms. Positioned both as workers in health care organizations, and as providers of and educators about health care, nurses are potentially both consumers and producers of these new emotionalities. Exhorted by Total Quality Management strategies to feel and perform in certain ways, they in turn guide therapeutic processes that shape emotional experiences and expressions of patients/clients.

New Zealand sociologist Catherine Casey (1995:86-87) is systematic in her analysis of programs used by corporations to modify 'personal' attitudes and behaviors of workers, shaping 'designer employees' who are adaptable, flexible team-players. Pointing out that socialization and learning at work are not new, Casey shows how the discursive practices of post-industrial work require "additional skills of 'personality,' congeniality, good humor and interactive skills" and asserts that "the new forms of self-discipline are mediated through the rhetoric of self-actualization, flexibility and hyper-adaptability."

Even more than advanced industrial and information technologies, Casey claims that the new 'social technologies' such as Total Quality Management are crucial to post-industrial production. In the absence of earlier forms of 'organic solidarity,' sustained for example by strong occupational identification, trade unionism and other intact social and political organizations in industrial societies, companies are intentionally creating interpersonal connections and networks using a new rhetoric of teamwork. Casey (1995:109) explains that "[t]o be effective, the team requires the deliberate creation of a substitute, discursive social cohesion that is necessary for production to occur."

This production of cohesion relies on corporate 'image' inside the firm in ways that are analogous to establishing 'brand name loyalty' with consumers outside the company. In this manner, simulated social solidarity is accomplished through cultivation of 'designer employees' and replaces older forms of organic solidarity now weakened under post-industrial conditions. Building on Casey's analysis, I contend that designer

emotionality is a critical element in these processes. For example, hospital employees are expected to dispense hospitality and good cheer in exchange for customer satisfaction as part of an economic arrangement. Rewarding employees for providing such 'team spirit' may reflect configurations of *affective* solidarity that are beginning to overshadow earlier, more substantive employee arrangements such as job security or collective bargaining rights.

In her recent study of 'flexible bodies,' anthropologist Emily Martin (1994) examines how ideologies of flexibility reflect the disappearance of 'substantive arrangements' such as long-term employment, career advancement, health care benefits, and pension plans. She explores metaphorical connections between the biology of immune responses and the types of workers deemed most suitable in a competitive, multinational marketplace. She explains that

> [t]he preeminent model of industrial organization of the decades before 1970, which has been called 'Fordist,' has undergone *radical* revision. Gone is the linear work sequence of the moving assembly line, its machinery dedicated to mass production and mass marketing. Instead, the organization is a fleeting, fluid network of alliances, a highly decoupled and dynamic form with great organizational flexibility (p. 209, emphasis in original).

An ethos of 'personal reinvention,' coupled with extensive opportunities for 'retraining' highlight new expectations of a flexible workforce dedicated to 'continuous learning' that can do for the company what macrophages and T-cells are said to do to protect the body from infectious diseases.

Martin suggests that "a new incarnation of social Darwinism" (p. 229) in both biological and socioeconomic spheres hints "that *some* people with the right kind of immune systems will survive" (p. 231, emphasis in original). She tracks an interesting twist in current beliefs about 'natural selection' when applied to corporate contexts. On the one hand, the strongest get ahead, on the other hand, the "concept of earnable competence, hinging on a core notion of trainability and educability, powerfully reflects the peculiarly American cultural attachment to individual growth and development" (p. 243). This ideology is used to mobilize personal training, private self-help programs and other individual strategies for 'making it,' while attributing success to natural superiority.

This same paradox is apparent in a recent popular book about the importance of an 'emotional intelligence' (Goleman 1995) that is deemed *as* necessary for economic and social success as the more classic IQ (intelligence quotient.) Emotional abilities and skills are described as a hybrid cluster of innate and learned responses that facilitate interpersonal relations. For example, detailed neurological accounts of connections between the brain's limbic system and the neocortex are loosely juxtaposed with report of an 'emotional literacy program' designed to help children in a New York City school. Inborn or achieved, these new aptitudes are deemed critical for survival. According to Goleman, 'self awareness' is the most important ability/skill, facilitating (self)-control of emotions and enabling a better 'read' of emotional cues in others. Training for emotional self awareness both *notices* and *constitutes* these phenomena in new ways.

Recent attention to and shaping of 'designer' emotionalities may serve to redress imbalances created by long-standing emphases on reason and rationality. In settings operating according to 'modernist' dualisms separating emotion from thought, tools and techniques that reassert valuable awareness of feelings can be extremely helpful. But these new discursive and psychic practices also contribute to contemporary strategies of capital accumulation by bringing intra- and interpersonal surveillance and management to new levels of refinement.

As health care organizations seek to implement managed care strategies, one approach is to enlist emotion work systematically as part of the health care product offered. Yet the very nature of emotionality is to be contingent and situational. There are opportunities for control, agency, resistance and creativity. Emotional behavior and discourses are emergent and dynamic, shaped by both organizational demands and individual variations. Professional nursing cultures, particular ward configurations, and personal dispositions all contribute to enactments of emotionalities among nurses and patients.

During this time of rapid change in health care systems, emotionality is simultaneously/alternately overlooked, rehabilitated, reconfigured, and consciously enlisted as collaborative, competing and/or conflicting needs/desires of interested parties are negotiated. I return now to the nurses interviewed for this study and their responses to

transformations experienced and felt in their work and in their 'selves' as nurses. I make no direct claims about the 'selves' of these nurses, neither about *who* they *are*, nor what/how they *feel*. Rather, I explore the discourses they used to *talk about* their identities as people (women) and as nurses in the context of these discussions about emotion work in particular and nursing work more generally. I am interested both in what they might say about their experiences and in what is left out, glossed over or ignored. I identify assumptions and contradictions that coexist uneasily during this time of transition, and I speculate, in relation to the previous discussion, about what meanings and practices of emotion work might be emerging.

Innate Qualities: "I'm just that kind of person"

To assume the identity 'nurse' a woman (or man) takes on, in individually and situationally varied ways, a collection of culturally and historically overdetermined roles, expectations, skills, dispositions, images, opportunities, and liabilities. Gendered female, 'nurse' is marked by association with the category 'woman.' From nursing standpoints, claims of 'professional' and 'scientific' provide additional overlays, as do more recent associations with 'management' in complex health care organizations. Racial, ethnic and class markers serve to particularize individual nurses, as do designations of clinical specialty, age, and geographical location. Defined externally, role-identities are "sets of behavioral expectations (or 'scripts') which are attached to positions in the social structure; identities based on positional roles should provide the individual with a sense of who he or she is" (Thoits 1991:104).

From the perspective of the individual, self-identity is maintained, repaired and altered through 'biographical work' (Strauss 1993:100).

> Each person's account of his life, as he writes or thinks about it, is a symbolic ordering of events. The sense that you make of your own life rests upon what concepts, what interpretations, you bring to bear upon the multitudinous and disorderly crowd of past acts. If your interpretations are convincing to yourself, if you trust your terminology, then there is some kind of continuous meaning assigned to your life as-a-whole.

Incorporating new identity configurations, during the professional socialization of student nurses for example, sets in motion a constellation of activities, interactions and

interpretations whereby new identity can be recognized, simulated and finally internalized (Davis 1972; Olesen and Whittaker 1968). To learn and live out an identity is to engage with the 'feeling' and 'display' rules (Hochschild 1983) deemed necessary and appropriate to the identity.

Hochschild (1983) found that workers feel discomfort when there are discrepancies between privately felt emotions and public displays of feeling required on the job. Other investigators of emotion work in service occupations found responses to doing emotion work ranging from psychologically negative to rewarding. For instance, workers with more developed skills in 'self-monitoring,' defined as the ability to "observe and control the self they present in social interaction" (Wharton 1993:211), were found to have higher levels of job satisfaction while doing emotion work. Wharton suggests that "jobs involving emotional labor attract workers whose personal qualities are especially suited to working with the public (e.g., friendliness, empathy, patience, etc.)" (p. 219). Similarly, Ashforth and Humphrey (1993) found that service workers who identified with the values and norms of the job role often enjoyed their performances of emotional labor. However this identification with their work made them susceptible to burnout if they were unable to meet emotional expectations (see also Schaufeli, Maslach, and Marek 1993).

The nurses in this study were longtime practitioners (from five to over twenty five years of service) who spoke reflexively about their self-identities and indicated personal identification with being nurses. Their expectations, knowledges and skills about therapeutic emotion work have been discussed in Chapter Three, and their feelings of frustration with reorganizations that narrow the range of emotional expressions possible in nurse-patient encounters were elaborated in Chapters Four and Five. In these conversations, connections between feelings and identity were understated, but a number of comments implied that emotion skills were among the inborn qualities that allowed them to be nurses in the first place. There was little separation between 'who I am' and 'who I am as a nurse.'

For one oncology nurse, her identity as a person blended with her sense of self as a nurse:

> #1: A lot of this caring, I just don't do it as a nurse. I try to do it all the time with school or friends or neighbors. So that's kind of *just me*. There's people I work

> with who could not care less, you run into those at school, I think it is just *personal make-up*.
> DB: Then what is it that makes some of us feel that [giving emotional support] really is an important part of the work and then some of us not?
> #1: *Born that way* (#1, p. 7, emphasis added).

A dialysis nurse commented, "I could not separate myself from some sort of emotional bonding that I have with my patients. It's just *part of who I am*" (#18, p. 15).

For another nurse, her private self and her work self were quite distinct. She explained,

> Well, how are my emotions affected by work? I'm very calm when I'm in the grocery store, and I have assurance about the things that I do. When I get to work, that same calmness, I don't have. When I'm in the midst of a labor, or in the midst of an immanent delivery, there's a heightened anxiety level (#16, p. 34).

Speaking of the interconnectedness of her personal and work selves, an oncology nurse mentioned a time when she was grieving a personal loss saying "those are situations where my own personal feelings probably prevented me from being a real support, objective support" (#9, p. 14). Made visible here by her personal pain, the ongoing efforts that this nurse makes to keep her private self separate from her work self, in order to give 'real' (i.e. professional) support, are unspoken and taken for granted.

A public health nurse indicated that her choice of career involved her desire to find a context for emotional expression, saying "I needed to be where I could *use my compassion* for people, to be able to work. So I started talking to nurses and decided that's probably what I needed to do" (#15, p. 1). A nursing supervisor also saw her job as a way to 'make a difference':

> My own style of doing my job is to be very supportive of my peers. I feel like going into supervision was about being in a position (pause) ...I had an opportunity to get myself in a place where I could *have an impact*, maybe not so much on the patients at this point but at least an impact on the staff" (#14, p. 4, emphasis added).

A nurse who cares for people with AIDS spoke of her self-identity as someone who participated in addressing social problems, commenting "[w]hen I'm an old woman and I look back on my life, and there was an epidemic in my lifetime, I have to say, I did what I could do" (#5, p. 22).

A labor nurse also expressed her desire for a self-identity as someone able to give of herself, saying,

> [If assigned to] somebody who's demanding, I think I actually like to take those patients because they're like, 'I can satisfy them, they really need me.' ...I like people to have a really good experience. This is something to remember for the rest of their life. If I feel like I can be there for them, I take them (#4, p. 17).

A public health manager spoke of her prioritization of providing emotional care, saying that she felt unusual among her nursing peers,

> I often feel when I'm working that *I'm kind of rare*. There are few people in the organization that have similar feelings to me, we tend to talk privately with each other. Even when our work is very effective and our people are very effective and everything gets done, and everyone thinks you're very efficient, there's some kind of value judgment on the part of maybe other managers or other nurses or whatever, that maybe you're *too soft*. (#11, p. 37).

A labor nurse spoke ironically of the kind of person she felt that a demanding doctor wanted her to be, " (laughter) 'I am the helpless nurse, I know nothing, you know everything. Tell me what to do!'" (#13, p. 27). Another labor nurse referred to a demeaning side of nursing identity, saying

> The thing that was always incredibly hard for me was that I always felt that, as a nurse, I was not looked upon as being very bright. That was something that you did, sort of a glorified maid, glorified waitress. It took me a long time to develop a kind of *esteem* about nursing--that it was valuable work (#3, p. 2, emphasis added).

For some of these nurses, feelings about self-as-nurse were ethically driven. One nurse commented about a time when she needed to prioritize care among too many patients:

> What it came down to was, I had to take care of the three people who were the sickest and who, quite frankly, I knew would be there tomorrow. And the other two, who were dying, it was like, 'I'm sorry.' Me, *ethically*, I went home and I could barely live with myself that night. (#2, p. 9, emphasis added).

She emphasized her dismay, adding "there is no way I could have *physically come in* and worked this place the next day. Because of feeling so awful about the kind of care I gave the day before" (#2, p. 11). Referring to her high standards, she temporalized her identity, stating "I'm an old school person and that is just how I operate" (#2, p. 19).

Another nurse spoke of her self-identity in moral terms:

> That is one of the frustrations of nursing, you can not walk away. You can't have a *conscience* and walk away from a human being who is laying there in your face in agony, whether it be pain physically or emotionally (#6, p. 13, emphasis added).

She felt inadequate *as a person* if she could not give the kind of care she felt the patients deserve.

> It's terrible when a patient makes you *feel awful*, when you are running around but you are still there to take care of them. You find out they've been suffering with something, or they wanted something, and they didn't want to bother you. And you feel about this big [gestures with thumb and index finger]. ...The patients are the blessing, they are the one thing that makes your job *worthwhile*, and yet when you feel that you can't meet their needs, you just feel awful (#6, p. 16, 17, emphasis added).

The rhetoric of 'feeling bad' positions the nurse to internalize the inadequate staffing, personalize the problem and blame herself for not meeting her own high standard of care. A nursing supervisor spoke of a similar tendency in the new graduate nurses she was overseeing.

> I've seen them make mistakes, and I have them calling at six in the morning, in tears on the phone, wondering if they should really be a nurse. This is a really good nurse, actually. ...Well, she made a mistake with a patient ...and just questioned her ability to take care of patients. 'How can I be this *perfect nurse*?' (#14, p. 30).

I suspect that by selecting for nurses who valued emotional support, my sample was biased in favor of nurses whose identities were tied to their feelings. I noticed that some nurses framed their capacity for feeling as being somewhere between pre-existing and learned aspects of self. For instance, one nurse explained,

> I think I came into the medical field with a high degree of sensitivity, probably more than what was healthy. Sometimes I carry a lot of it around with me, other people's problem situations. But now I'm trying to be positive about everything and be good to myself as well. But [I don't want to] lose sight of that *innate sensitivity* that I have. More like, that's half of it. The other half has just been *learned* (#18, p. 22, emphasis added).

Expressing her views about emotional skills, a nurse said

> I think a lot of it is *just* your personality. ...A lot of it is training from the people that you had in [nursing school]. Some instructors focus a lot more on the *intangibles* with people (#6, p. 3, emphasis added).

Another oncology nurse expressed pride in the *kind of people* she worked with,

> we have a lot of really *strong personalities* on our unit. There are a lot of us who are very (pause), we'll tell you exactly what we think (#12, p. 31, emphasis added).

These comments reflect cultural views that certain qualities exist within individuals and reflect the 'inner self.' Some of these attributes are also learned, suggesting a discursive weakening of implicit connections between 'true' self and emotion. Upon further elaboration, we will find attributes such as feelings and emotions situated along a continuum ranging from depth to surface. Emotions are also implicated in discussions of deception (intentional or not) and authenticity.

Depth and Surface

Hochschild (1983) analyzes types of theatrical acting to explain the difference between surface and deep acting. In the former, an actor reproduces physical gestures, intonations and facial expressions in order to convey recognizable characterization to the audience. With the latter, the actor uses his imagination to reactivate 'emotion memories' until the 'illusions' are experienced as 'real' by both actor and audience. In everyday life, these techniques can be consciously used to convey impressions and present a desired identity or feeling (Goffman 1959; 1967). They may also be adopted to align inner feelings with formal and informal emotion rules and standards. It is this capacity of individuals to alter inner, deeper feelings that corporate improvement programs have harnessed for the design of 'self-managed' employees.

Hochschild suggests that cultural preoccupation with 'authenticity' has replaced an historically earlier longing for 'sincerity.' Building on an analysis by Lionel Trilling, she explains that sincerity emerged as a concern in Europe after the sixteenth century when "guile became an important tool for class advancement" (Hochschild 1983:191). This first move represented a detachment of the surface self from its more solid and permanent 'true' self. Contemporary fascination with authenticity, continues Hochschild, represents a preoccupation with the many guises of *self* deception, especially those created by commercialization of feeling. She suggests that celebrations of spontaneity, self-help therapies, and quests for the lost inner child are therapeutic attempts to recover the 'true'

self amidst economic proliferation of 'false' selves needed for the mass production of moods, feelings and relationships.

While Hochschild's perspective seems to hold out for the possibility of a 'true' self potentially capable of resisting the onslaught of new emotion management technologies, I suspect that it is more accurate to examine 'depth' and 'authenticity' as socially constructed formations that are currently undergoing radical historical transformation. The very premise of deep acting, use of the imagination to activate emotion memories and culturally embedded scenarios, suggests the possibility that feelings, as floating 'signifiers,' can be effectively *experienced* in forms that are disembedded from their socially recognizable and initially 'signified' contexts. In other words, feelings can be decontextualized, enacted and felt *even though the rules and scenarios are imported or prefabricated from previous cultural repertoires of meaning.* If *feelings* are defined (and perhaps experienced) as authentic, terms like fabrication and simulation lose oppositional vigor, and boundaries between the virtual and the real are irreparably blurred.

In another context, Mestrovic (1996) has proposed the concept of 'postemotionalism' to help explain global manipulations of collective emotions about the Balkan War. Building on Durkheim's notion of 'collective effervescence,' he suggests that Western politicians and the culture industry manipulate public opinion and current events by transferring "'dead emotions' from the past into the living present" (p. 15) and infusing current 'reality' with emotionally charged 'fictions.' This same fluidity of feelings is used in film, television and advertising to engage emotions by appropriating and reworking pre-existent cultural repertoires and scenarios for a variety of purposes. As modernist sources of context and identity are de-stabilized, experiences of depth become problematic. Multiple emotionalities accompany multiple identities; ambivalence and inability to 'know how to feel' are indicative of sociocultural complexity without 'deeper' reliable guideposts.

Until recent de-stabilizations brought on by industry-wide restructuring, a number of modernist characteristics could be identified as prevalent within nursing and among nurses. Nurses are fairly grounded in the mundane daily activities of giving care. Through

witnessing experiences of illness, they routinely encounter the immediacies of embodiment and pain. The 'profession' of nursing has been historically predictable for at least half a century. Systematic efforts, reinforced in schools, hospitals and professional associations, have been made to standardize socialization into nursing and regulate identity formation among its practitioners. Given their generally well-formed senses of 'how to be a nurse,' the nurses interviewed for this study expressed shock and dismay at new 'production standards' that expect them to downscale and control emotional 'depth' yet continue to provide 'competent' emotional care. They are not happy to relinquish modernist configurations of emotionality and self.

These nurses used the rhetoric of depth and genuine feeling to describe relationships with patients. One nurse explained,

> If we use the word caring to mean the emotional piece [of the work] ...as in a feeling kind of thing, like 'I care for you;' my feeling is that it needs to be a *genuine emotion*. In other words, I *cannot fake* caring for you. Either I care for you or I don't. So the patients I take care of, I can express to them my caring and *they feel it*. I think it's something that is a two way communication. I give something, they receive it, and I know that they received it. ...In fact, ...even if everything went well in their [hospital] course, if they didn't make a connection or feel like someone cared about what happened to them, their experience was not a positive experience" (#11, p. 33-35, emphasis added).

Another nurse expressed the 'ideal type' of what held her unit together, referring to "the *genuine* sharing and trust of all the nurses and patients and family and physicians" (#1, p. 8, emphasis added). For these nurses, trust is as an important quality, fostered in 'authentic' relationships. As one nurse commented, "I have a very good *rapport* with patients; patients have a lot of *trust* in me" (#12, p. 46).

An oncology nurse spoke in appreciation about caring for patients with life-threatening illness, "there's no *pretense*. They are there, they come out with their feelings, they come out with their emotions and a bond is established very quickly" (#2, p. 5, emphasis added). She explained that

> in oncology, you either love it or you don't. If you don't, you are out of there pretty darn quick. If you love it, you love it for these very reasons that I'm talking about. ...With experience [I got] more comfortable with ...talking to people about life-threatening and *genuine gut-level stuff*. I was privileged enough to have started twenty years ago and being in the setting where you had the time to do

> that, because a lot of that is time related. *That time is not going to be there*. (#2, p. 17, emphasis added).

She anticipates the arrival of an historical moment when the social conditions for creating this kind of depth and rapport will no longer exist.

The role of memory in bringing up feelings was acknowledged. An oncology nurse explained how memories from her own personal history triggered emotions with patients.

> I found that situations that reminded me of my own personal losses were situations where my *emotions were strong*. Situations where you get closer to some people than others for whatever reason. You identify with them or you just happen to hit it off personally. (#9, p. 14, emphasis added).

A dialysis nurse spoke of the effort needed to achieve in-depth knowledge of a patient's feelings saying, "you have to dig a little bit *under the surface* sometimes, to try to gain access to what they are really thinking about" (#18, p. 6, emphasis added). He elaborated, "I think you have to *probe* a little bit in order to care, to gain some insight, try to find where they're coming from" (#18, p. 16, emphasis added). In other words, depth could be achieved through certain kinds of effort and emotion work.

Another nurse noted that there were different degrees of involvement and depth between nurses and patients:

> I think that nurses that haven't worked oncology don't particularly want to deal with the oncology patients as much, in the emotional sense. They'll still take care of them, but they won't deal with the emotions as *deep*. (#9, p. 18).

Sometimes it was uncomfortable to know so much about another and could even be construed as inappropriate professionally. A public health nurse spoke of having a disagreement with a client.

> I went home that night thinking, I don't know, maybe I'm not cut out for this. This is too much ...do I really want to be this *involved* in this kind of *depth* in people's lives? ...I'm not a therapist, ...I don't want to get, (pause) I can't really get too *deep* (#15, p. 16, 19, emphasis added).

Another nurse commented, "I don't think you have the energy *to be close* with everyone" (#8, p. 23, emphasis added). Speaking of practitioners with disengaged attitudes in a variety of caring professions, one nurse said, "it's comfortable for them and they *go*

through the motions. And that can happen with any kind of [work], and I think that happens with nurses too" (#1, p. 25, emphasis added).

An oncology nurse spoke of nurses who had different expectations than she did, "[t]hey don't care whether they know the patient or not" (#2, p. 16). They are not seeking to develop depth in their relationships. Another nurse described the lack of depth in her superior and how that set a tone at her work,

> I think the boss that I had felt that she was giving emotional support. She was saying the right things, but the feeling piece wasn't there. And it didn't feel good ...it affected how available I could be to others, because I didn't feel good (#11, p. 36).

For a nursing supervisor, emotional processing was a condition of doing nursing. Speaking of nurses, she stated,

> No matter how busy she is, if she sees or hears something, she will have to process it. She may block it, and 'hypertrophy the shell' [thicken her skin] in response to the barrage of input. [Yet] it's there, so she will process it somehow. The question is, *how and at what cost to the self and to others* (#19, p. 2, emphasis added).

This nurse believed that nurses' emotions could range from shallow and shut down to deep and engaged, but regardless, they would have to respond emotionally in some way to the circumstances of their work. Part of her job was to motivate nurses to perform according to the 'quality excellence' mission of her managed care employer.

Emotions/selves as Learned

While deep feelings and an inner sense of self were implicitly assumed to exist at the core of individuals, nurses also spoke of ways that these were learned, either in childhood, or in relation to the trained adult, professional self. Here the assumption was that self is indeed flexible. New (better) ways of recognizing and expressing feelings can be adopted, particularly following therapeutic models of psychological improvement and healing. There is also a sense that cultures of emotion are situated, learned in association with other people, in social groups or community settings (see also Strauss 1959b).

> Asked how she learned to give emotional support, one nurse explained,
>
> I guess from my family and growing up ...I think it was just the caring that came through from my family situation." As for school, "I don't think that emotional support was ever hit upon too much. I think after I got out of school, the first job I

had ...that's the second thing that kind of helped is the *group of people* that I worked with when I first came out of school (#1, p. 2, emphasis added).

Another nurse responded to the same question, saying

> Where did I learn how to do it? Probably from observing other nurses, probably from raising children, understanding it from reading books, just from general life. You know, if you want to teach someone something, if you want to get their behavior to change, then you really appreciate and reinforce the thing that you're trying to get them to do (#13, p. 15).

A labor nurse spoke of a specific technique she knew that could be used to modify the self, in this case to promote calmness.

> It's the think, feel, do cycle. You think you're calm, then you'll feel calm, and then you'll act calm. And if you act calm, maybe you'll feel calm. ...Maintaining and keeping and *training yourself* to be calm is a skill, and it might look like you're calm, [but] maybe you're not (#16, p. 32, 35).

Another nurse felt he developed pre-existing emotional qualities by using them at work.

> I originally got started in nursing when I was sixteen; I worked as an orderly in a hospital for two years. ...[A]t that time I *developed* my sense of empathy to a much greater degree. I always had that sense of empathy (#18, p. 1, emphasis added).

A public health nurse spoke of learning by doing.

> You can *become proficient* in interviewing, or in your presence, how you make yourself available. ...I have developed the ability because I've worked as a teacher for such a long time and I'm really open for people to tell me very heavy emotional things. ...I think you can develop that. (#11, p. 18, 19).

For some nurses, these skills of providing emotional support were learned over time, as part of a personal maturation process. An oncology nurse said,

> I'm more comfortable and confident now in my own description of myself as a nurse in general. And that goes totally, not only my clinical skills, but my way to approach people with life-threatening illnesses. ...I've thrived on being able to establish relationships with these people and really helping them (#2, p. 6).

Another oncology nurse explained, there has to be a *desire* to learn these skills.

> Every single nurse that's on this unit is here because they want to do oncology and leukemia. They didn't get thrown here. They have chosen to be this kind of a nurse. ...You have to want it; you can't wing it (#8, p. 31).

A labor nurse described how her *will to serve* guides her uses of self with patients.

> If they are rude to me ...there's still some way that I have to be bigger than my own stuff with people and recognize that I'm there for them, and put aside my hurts and whatever. ...I guess everybody deserves all of it, but it really seems to be dictated by how much they're open to, [that] is how much I give (#4, p. 9).

Most of the learning described here is 'by doing.' These nurses spoke of remaining open in situations, watching others, and becoming more skilled in interpersonal relations. One nurse expressed concern that the contexts for learning are shifting and opportunities for passing these knowledges to new nurses are diminishing. As therapeutic emotion work is done less and less, it will no longer be learned, and the skills will disappear. A public health nurse explained that

> the places for people to practice, the places where people do their internships, are drying up. Think about how many hospitals in America are closing. Think about how many fewer patients are in the hospital. Think about how the length of stay is so much shorter. So the opportunities for students to do that are changed (#11, p. 27).

As informal, taken-for-granted situations and contexts for passing on and learning emotionality are shrinking, managers have designed training programs and contracted continuing education providers to give formal instruction in a wide array of skills and techniques for better 'handling' people, but this is not the same thing as 'caring for.'

Deskilling/Reskilling for the Service Society

The health care labor market has long been segmented both within and outside of 'nursing.' In 1994 (Buerhaus and Staiger 1996), registered nurses, the highest grade of nursing workers, represented 49% of all working nurses; 11% of these workers were licensed practical nurses, and 40% of the total workforce were nurse aides/assistants, orderlies and attendants. This job stratification is divided along racial lines as well.

> In 1980, whites were 86.7 percent of RNs even though they were only 76.7 percent of the population. ...Racial-ethnic workers constituted 23.4 percent of LPNs, with Blacks, who were 11.7 percent of the population, making up fully 17.9 percent. ...Among nurse's aides, 34.6 percent were minorities, with Blacks making up 27.0 percent of all aides (Glenn 1996).

Nona Glazer (1991) outlines strategies used historically by women from the higher stratum of nursing to protect class-based and racial/ethnic privileges. These include gatekeeping practices regarding admission into training programs, job descriptions

delimiting legally permissible clinical activities, and emphasis on baccalaureate and graduate education for elite professionals. Glazer notes that exclusionary practices are justified by invoking a principle of merit. "Merit-based awards assume that rewards flow from differences in training and individual performance and that some fundamental differences among workers prevent the lower-grade worker from *learning* the content of upper-grade jobs" (Glazer 1991:369, emphasis in original). Emotion work, seen as relatively low status work, can be easily transferred from the registered nurse to less costly workers.

Recent managerial emphasis on cost containment in health care organizations has included measures to shift 'non-professional tasks' to lower-grade women workers. While some nurses lament the replacement of nurses with unlicensed assistive personnel (Zimmerman 1995), some also collaborate to design new training programs. In one hospital,

> The clinical nurse specialist in critical care was charged with developing, educating, and implementing the Patient Care Specialty Technician role. This included the development of qualification and selection criteria, performance standards, and curriculum design. ...
>
> Each skill was broken down into small steps as outlined in various basic nursing skills books. ...Emphasis was placed on the rationale for performing the skill and the key information to be reported to the responsible nurse. ...
>
> To decrease role confusion, a report sheet was developed for the RN to communicate to the PCST the skills to be delegated for a shift and the expectation of time management. ...
>
> Registered nurse 'buy in' was accomplished by involving staff RNs in the initial stages of planning and development during staff meetings and on an individual basis. (Fritz and Cheeseman 1994:329-330).

Marie Campbell (1992) examines nurse complicity in transformations of the nursing labor process as textually mediated management practices replace situated, clinical decision-making. Craft skills and apprenticeship models for experiential learning are decreased, leading to deskilling in interpersonal activities. At the same time technical training in computerized information systems requires nurses to reskill as patient information managers. Despite the "intense subjectivity of bedside care-giving, ...[i]t becomes part of [the nurses'] job to translate their thinking about patients into management-relevant categories" (Campbell 1992:761). Campbell is concerned that a

'new managerial professionalism,' in direct contradiction with the (professional) nursing heritage of 'clinical expertise,' is displacing important skills, knowledges and practices. As the focus of attention shifts from patient to management, I contend that aspects of therapeutic emotion work are among the practices being lost. For example, skills and practices of supporting patients through the trials of a difficult labor, a long course of chemotherapy, or dying of AIDS, are commonly being curtailed. Given current criteria for work 'prioritization' in most managed care settings, emotion work performed by nurses is focused more on coping with frustrations and meeting management information demands than on providing therapeutic interventions.

Ironically enough, new managerial strategies take worker frustrations seriously. In 1995, I attended a seminar offered to workers at a large West Coast medical center undergoing organizational restructuring. The program, given by a psychologist, was designed to ease employees through this period of downsizing and 'Operations Improvement.' A course in what I might call emotional literacy for the disempowered, the session offered skills for coping with the consequences of a de-stabilized workplace. Handouts entitled "Overall Impact of Reorganizing," "Challenges to Work Relationships During Times of Change," "Work Related Stress," and "Damage Control for Work Relationships During Organizational Change" were distributed to employees.

> Emotions and problems associated with change were listed as:
>
> -anger, sense of betrayal; -helplessness, vulnerability; -uncertainty and ambiguity eating on people's nerves; -lower concentration skills, distractible; - active rumor mill; -survivor discomfort, guilt; -desire to punish the organization, get even; -heavier workloads; -low morale; -half-hearted effort (Rasch 1995).

The discussion focused on first acknowledging the loss then adapting to the changes. Challenges that were named included,

> -More time needed to discuss the process of change and our emotional reactions, but less time to do it; ...-increase in time spent on training/orienting self or others to new tasks or technology, when workload is already high; ...-increased competitiveness due to job insecurity; ...-disruption in the sense of belonging to a team.

Solutions were framed in psychological terms. Employees were encouraged to 'learn to take care of yourself' and address stress actively, 'don't be victimized.' The following 'work stress coping strategies' were recommended:

> -Respond to stress warning signs; -healthy life style habits; -daily/weekly work plans; -protect and use rest periods; -separate work and home; -maintain a sense of humor; -keep up outside interests; -limit setting/saying 'NO;' -ask for what you want [!!!!!] ; -develop supportive relationships; -slow, deep breathing.

In the context of major organizational change, employee responses were framed as 'emotional reactions' to be soothed by psychological intervention. Nurses were invited to this seminar as employees of a large medical complex undergoing change. Needless to say, union organizing was not mentioned in this management sponsored event. However, this program is indicative of the kinds of emotional instruction offered to facilitate nurses becoming *better* employees, therefore *better producers* of the commodity of health care.

Nurses are also required to take continuing education courses to meet bi-annual state registration requirements. A number of these are designed to improve nurses' competence in interpersonal management. In some of these courses, the emotional skills and knowledges developed are part of the *commodity* offered to consumers of health care.

The following are sample titles and contents advertised in brochures sent to my home because of my status as registered nurse.

- "Personality, Health and Motivation" looks at personality types and health. For example, a section on 'The healing process' covers: "Imagery, Affirmations, Confiding, Effective Communication, Forgiveness, Social Support, Mastery, Humor, and Hope, Faith and the Healing Process." Presumably the nurse would use these to assist her patients.

- "Listening to the Body: Understanding the Language of Stress-Related Symptoms" offers a section on "Managing Emotions: Anxiety and Panic, Post-traumatic Stress, Anger, and Depression." This course could be addressed to the nurse herself, or taught in her professional capacity to patients.

- "How to Manage Conflict and Maintain Emotional Control" is "A special workshop for women only." In this seminar, "You can learn to handle any situation no matter how emotionally charged it becomes--without giving in or stepping on others." Here, the nurse could be managing patients, doctors, administrators, nursing assistants or irate family members.

- "Interpersonal Communication Skills" are needed because "Experts agree that your professional success depends primarily on human relation skills." One of the topics

covered is "'Reading' People: Tailoring Your Approach to Individuals," this includes learning "The 'unwritten' behavior rules in your workplace: how to determine what's acceptable and what's not within your particular organization." The flexible employee must be able to assess quickly and adapt to changing 'rules.'

- "How to Handle Difficult People at Work"
- "Living with Loss"
- "How to Promote Patient Satisfaction"
- "For Nurses Only: Express Yourself, Enhancing Communication with Doctors, Patients, and Co-Workers"
- "Self-discipline and Emotional Control: How to stay calm and productive under pressure"
- "Professional Telephone Skills"
- "Humor Skills for the Health Professional"
- "How to Overcome Negativity in the Workplace"
- "Conflict Resolution and Confrontation Skills: How to keep your cool, stand your ground and reach a positive solution"
- "The Essentials of Credibility, Composure and Confidence, A Seminar for Working Women"
- "Managing Anger in Healthy Ways"

An analysis of the topics covered by these seminar offerings illuminates how nurses are reskilling first as workers and managers requiring human relations skills, and second as professional health providers and educators, to better assist clients with emotional skills and knowledges. They are invited to learn scripted techniques for effective management of their own and other people's emotions. Emotions become another set of tasks, one more thing to do, and subject to evaluation, quality control and possible reprimand.

Often the effectiveness of these approaches depends on the willingness of workers to *replicate* emotional scenarios and *simulate* desired affective states in the absence of contextual conditions that originally made those feelings possible. This type of emotional training builds on beliefs in meritocracy and frames emotional competence as something that can be learned. These courses are offered so that employees can gain confidence by 'knowing how to behave,' learning to individualize their responses correctly in highly contingent work situations, and becoming competent in 'acting appropriately' under complex and changing organizational rules.

Other considerations unspoken and implicit in these management trainings in emotion work for nurses are indicators of class differences in types of emotion work

performed, depending on where a worker is situated in the stratified labor market of nursing work. Some of the skills are needed for high level, supervisory roles, while others resemble the behavioral micro-management common to other 'front-line' service workers. Nor is there any overt reference to the types of emotional services available to customers, clients and patients, depending on *their* class position, access to services and social status. For instance, the managerial incentive to inculcate hospitality skills may not be the same in a public health clinic as in an upscale insurance or private-paid medical center.

The selective deskilling and reskilling currently taking place in health care organizations affects arenas of workers and consumers alike. Dynamics of nurses as emotion workers are situated in larger contexts of service work organizations. They also take place within cultural transformations of popular and professional discourses about emotions, identities and selves. I now explore briefly some alarming and intriguing possibilities of where collective understandings of emotionalities might be headed.

Alarming and Intriguing Possibilities

Nurses appropriate knowledges from formal and informal sources that offer perspectives on relationships between emotions, health and healing. Textbook explanations of emotions and the nervous system reflect neurological understandings about the 'wiring' of emotions and psychological frameworks about attitudes, behaviors and feelings. Pharmacological texts feature information about psychotropic drugs designed to modify mood and affect through chemical interventions. Popular self-help manuals address issues of emotional distress and physical illness, offering an array of advice and techniques for self-improvement. Alternative and complementary medicines propose a variety of pathways toward 'optimum wellness,' many of which explicitly engage with emotions as part of the process. Stories, images and plots played out in popular cultural arenas of film, television and advertising enact familiar scenarios that offer/reinforce/ instruct views and standards about emotions.

As social, economic and cultural configurations of selves, identities and subjectivities shift, so too are emotionalities undergoing alterations. With increased dis-embeddedness of feelings from selves, and feelings and selves from contexts, free-floating and virtual emotionalities are more easily appropriated for *both* projects of healing

and of social control. Rigid separations of mind from body and of reason from emotion are coming to be seen as inaccurate and ineffectual in new socio-economic worlds. It remains to be seen what new conceptualizations will emerge and be sustained, if any. However, by virtue of their critical position in health care enterprises, nurses will be among the players negotiating meanings among complementary and conflicting definitions/practices of emotionalities.

From amongst many studies and truth claims about emotions, I have selected three worth citing that are indicative of upcoming trends. The first is a book about emotions on the job called *Working Up a Storm* written by psychologists Jeanne M. Plas and Kathleen V. Hoover-Dempsey (1988: 10,12). They lay out their premises and approach in the introduction:

> Emotions are as important for successful work as they are for successful marriage or successful parenting. The work setting requires that emotions be expressed and received from others in different ways from the manners in which they typically are in personal lives. But deal with emotions people must. Whether individuals are conscious of them and *channeling them* or unaware of them yet *controlled by them*, feelings make a big difference in what gets done and how it gets done at work.
>
> ...As we talked with people about their work-related experiences with emotions, we heard countless stories of the various problems that people have found to be associated with the styles they employ for dealing with emotions at work. We have responded to these issues by developing *step-by-step strategies that can be used to create style changes*. Throughout, however, it is important to recognize that no single style or set of change strategies can possibly be appropriate or useful for everyone. Each person is unique. ...In fact, the most effective and satisfied people at work usually have developed styles for feeling, expressing, and receiving emotions that are compatible extensions of personal values.
>
> ...[W]ork performance for most of us has the potential for moving into the excellent range when we, as individuals, have significant room for exercising personal style, abilities, skills, and interests. When we exercise these at work we usually develop high levels of *commitment--an emotional concern for the job* and our job performance that usually underlies workplace success (p. 284, all emphases added).

Emotions are 'things' to be managed individually in work and life contexts. This book stresses the possibilities for modification and control of emotional styles and the importance of this for job success. It offers 'how to' techniques for self modification.

A second set of studies and practices about emotion has been developed by Deborah Rozman and associates (1995:207) of the Institute of HeartMath in Boulder Creek, California. This contemporary research and seminar facility develops and teaches techniques for physiological control of emotion states to corporate employees and others who can afford the somewhat exorbitant weekend prices. Freeze-Frame (Childre 1995) is a 'scientifically proven technique' advertised on the cover of its Audio-Cassette to:

- Boost Cardiovascular and Immune System Health
- Activate Creativity
- Accelerate Learning
- Stop Procrastination
- Enhance Personal and Professional Relationships
- Reduce burnout from overload, anxiety and indecision
- Balance hormones for free energy
- Increase personal effectiveness
- Achieve what you usually can't...

Rozman and associates (1995:208) describe how this stress-reduction technique has been used for "self-management of mental and emotional states:"

> Participants were taught how to intuitively identify and understand the impact that thoughts, feelings and actions have on their psychological and physiological well-being, including the effects of *mental and emotional stressors on the balance between the sympathetic and the parasympathetic nervous systems and the immune system.* Participants were taught techniques for consciously disengaging from unpleasant mental and emotional reactions and transforming stressful feelings of anger, frustration, despair, etc., into more coherent feelings of love, compassion, forgiveness, and appreciation *at will.* ...
>
> Freeze-Frame is an example of one of these techniques. The first step of Freeze-Frame is to recognize the stressful feeling. The second is to intentionally shift one's attention to the area around the heart, where most people subjectively feel positive emotions. The third step is to direct one's feelings toward experiencing *sincere appreciation* for someone. Appreciation is defined as the state where the subject has clear perception of the feelings of gratitude and recognitions for someone or something. The last step in the technique is to decide on an appropriate course of action using intuition and common sense. The technique focuses on *genuinely experiencing* the feeling of appreciation, in contrast to other self-management techniques which elicit an emotional response by mentally visualizing or recalling an emotion (p. 208, emphasis added).

This technique, like Hochschild's 'deep acting' calls on participants to 'relive' emotional experiences at will in order to change physiological parameters. These 'experiences' are disassociated from their original context, but used to modify neurological and cardiac functioning with a goal of highly refined self-management and emotional control.

A third indicator of current approaches to emotions and health is in an info-tisement by Christine Northrup called *MD, Modern Doctor* (1997). In it, Dr. Northrup critiques physicians and medicine for inadequate treatment of women's medical conditions and recommends a combination of mental, physical and emotional approaches to wellness. She links emotions to physiology and implies 'essential' differences between men and women.

> For the past 5,000 years, Western civilization has been ruled by the rational mind. Masculine pursuits, intellectual values, and control have been top priorities. More *feminine values (such as intuition, nurturing, and emotions)* are seen as abnormal and inferior (p. 4, emphasis added).
>
> Modern medicine believes: 'what works for men works for women, too.' But this is simply not true. *Women have unique medical needs from a biological and an emotional point of view.* We have been dominated by the patriarchal model for so long that we've forgotten what is known about female physiology. We must return to women's body wisdom, female intuition, and feminine insight.
>
> How much sense does it make to surgically remove the fibroids in your uterus -- without acknowledging the futility of pouring your energy into dead-end relationships or ones that *don't serve you emotionally*? (p. 14, emphasis added).

In this model, emotions are situated in the body, and gender differences are reified as physiological. Women are encouraged to improve their health by taking control emotionally in uniquely feminine ways.

I cite these three publications because they are all indicative of ways that emotions, taken as changeable and/or 'natural,' can be enlisted innocently to accomplish powerful social effects. Since they are closely linked to identities, changing emotions is a potent means of altering selves. Decontextualized feeling can easily be manipulated to meet job requirements and to modify bodily functioning. Through deeply ingrained gender definitions and associations, privileging emotions can also be a way to reinforce asymmetrical power relations and divisions of labor. These approaches to emotion are

alarming in that they affect individuals without appreciation for consequences of social uses or meanings embedded in these concepts. By contrast, I continue to question what vocabularies of emotion might reflect *non*-dualistic positioning of emotions as socially constructed, enacted and experienced.

For this I refer to theories of emotion as 'embodied sociality' (Lyon and Barbalet 1994) that transgresses boundaries between particular bodies and socially meaningful expectations, standards and scenarios. Here emotions are cross pollinations of personal and political responses and incentives to action. Reason and emotion are integrated, grounded in the physical 'is-ness' of the body, as well as in interdependent relationship with the world. Emotionality is simultaneously material, physiologically and energetically, and semiotic, carrying social meanings of relationships among ongoing living processes.

In another context, Nina Lykke (1996:27-28) speaks of analogous tensions among material and semiotic worlds when she juxtaposes images of goddess and cyborg. Creating dialogue between cultural feminist invocations of the divine feminine (e.g. Bolen 1984 Anderson 1991) and techno-feminist evocations of cyborg (Haraway 1991c) hybridity, Lykke proposes the possibilities of a 'monstrous' (Haraway 1991a) sisterhood:

> There seems, however, to be a difference in the way goddesses and cyborgs act as material-semiotic subjects. They blur the boundaries between human and non-human, between the material world and the semiotic world of signs and meanings, in different ways. The cyborg of virtual reality tends to absorb the material into the semiotic. The material is constructed as potentially changeable by semiotic, sign-producing acts, by programming and reprogramming. The goddess is different. When she represents a mythical reality to her adherents, we might say that she, in contrast to her cyborg counterpart, tends to absorb the semiotic into the material. For her adherents, the goddess is not just a name, a semiotic device; she IS.
>
> ...These differences between cyborgs and goddesses may collapse into a split along the lines of the modern divide between 'the artefactual' and 'the natural'. But to me this collapse looks like a misplaced act of purification that represses their kinship as feminist monsters, who/which in important ways contribute to the deconstruction of the great divide between human and non-human. In my opinion, feminist science studies should reject neither the goddess metaphor nor the cyborg metaphor. Why not instead talk about their monstrous sisterhood?

In the instance of emotion, the divides being transgressed are those of mind and body, the social and the innate. Feelings contain social meanings *and* they are more than discursive

productions. They are shaped by social conditions *and* they reflect the unique embodied experience of a particular individual. New vocabularies of emotion must emerge in/from an 'elsewhere' (Haraway 1991a) that is neither/both 'produced' and/or 'natural.'

What conceptualization can express the inseparability, like a Moebius strip, of feeling and context, and embrace the interconnectedness of inner and outer? Shifting intellectual terrain most speculatively, I ponder the insights of Buddhist teachings in which "some form of meditation practice is assumed to be the basis for developing an experiential awareness of non-dualism and interdependence" (J. Martin 1996:111).

Perhaps in such experiential practices, neither thought nor feeling is privileged, and another way of being in the world is possible. Perhaps there are embodied practices of non-dualism, almost impossible to conceptualize from our Western perspectives, that offer different configurations of being human. American Buddhist nun Pema Chodron (1994) suggests that in walking the paradoxical pathways of practice and no-mind, compassion is born. What recognitions of non-separation might be incentive to re-allocate resources and reconceptualize emotion work of nursing? What new vocabularies of emotion might re-situate this occupational turf and sidestep dilemmas caused by epistemological separations of emotion and reason?

Vocabularies of Emotion in Nursing: Situating this Turf

Languages of emotion are scattered throughout the culture as advertisers, consultants, healers, self-help advocates, scientists, and all sorts of folks vie for the feelings of selves in some way attached to dollars. In the instance of health care, nurses have long been guardians of knowledges and practices about illness and emotion that have been both valued and taken for granted. With increased commodification of nursing work, previous configurations of self/emotions/relationships are being undermined. Prioritization of cost-containment over patient care has restricted the conditions under which nurses encounter patients and therefore diminished the possibilities for therapeutic emotion work.

The convergence of several factors, including reduction of community and domestic availability of women with 'free' time, and increased expectations on the part of 'consumers' of health services, have led to increased demands for the emotion work of

caring (see Hochschild 1995). However, impoverishment of state supported social services, financial conversion to for-profit service models, and overall lack of recognition of 'women's work,' have diminished support for the conditions of its production. Within this larger societal context, gendered subtexts continue to inform separations of technology from feeling. Despite attempts to theorize nursing as science *and* art, unequal distributions of resources and status have left proponents of emotion work and caring in a classic double bind. To assert the importance of these aspects of nursing is to reinforce their categorization as 'essentially' feminine and implicitly 'not quite' real knowledge or skill.

Under current trends, some nursing ways of being/doing/knowing passed on as craft through apprenticeship are endangered. Replacement efforts at systematizing these knowledges and practices risk falling into reductionist 'expert systems' models compatible with informatics, but missing the particularities and variations needed to create deeper empathy and understanding between one human being and another. Managed care may learn to design rationalized micro-management of interpersonal relationships as part of overall fitness plans to keep insured populations healthy. Stylized renderings of hospitality and customer service may be implemented that garner rewards and recognition for employees of the month. But this depersonalized 'one size fits all' niceness cannot provide the same solace as an individualized relationship. Under these regimes, social conditions for constructing depth are displaced and 'heartfelt' surface interactions become societal norms for emotionality.

These alterations in social conditions for enacting and reproducing 'modernist' emotionalities in nursing have occurred in conjunction with changes in the organization of health care work. Emotion work, as the least 'visible' and least 'accounted for' dimension of nursing has been disproportionately displaced by restructuring and cost containment measures. Leigh Star (1997; 1991) has argued that visibility and invisibility are themselves negotiated aspects of all work, and that critical elements of work inevitably do remain invisible. For example, articulation and arrangements (Strauss 1993) are activities of coordination and carrying out that involve communication and setting things up, often accomplished 'behind the scenes' and very hard to quantify. Tending to emotionalities of

clients and coworkers is a kind of articulation work that tends to remain invisible in most settings, yet it facilitates and often *is* the work in human service contexts.

Timmermans and colleagues (1994) describe the predicament of nurses struggling for visibility and acknowledgment of their work. Educators have worked to identify nursing tasks and devise classification systems. Yet this specification thereby risks the loss of certain ambiguities and kinds of discretion necessary for skilled work. Emotion work is particularly vulnerable to this tradeoff because it is difficult to standardize and is necessarily performed at the discretion of the nurse. Her assessments, abilities, willingness and availability will determine how she inhabits the nurse/patient relationship at any given moment and what performances of emotionality will transpire.

'Given moment' is the operative term (all puns intended.) Nurses need *time* more than any other single resource to utilize emotion skills and knowledges effectively for health and healing. In a service economy, commodification of time *is* commodification of emotion. In an exclusively market economy, a moment cannot be *given*; it is managed, packaged and sold according to financial criteria that are different from clinical priorities, and different again from emotional ones. Nurses have worked for wages for a long time, but both discursive and material practices of their work allowed for meaningful interactions with patients. Gendered socialization, liberal humanist and Christian values of 'helping,' and solid internalization of 'nursing' identities all contributed to common if invisible practices of giving time and emotion. Recent intensification of nursing work has made this kind of time less available, if not unavailable. New 'programmed' emotionalities of service workers introduced to replace/compensate for missing forms of interpersonal feeling are enacted according to dynamics different from earlier performances.

Emotional imagery and scenarios enacted for commercial purposes may resemble exchanges of feeling that occur within gift economies of relationship and obligation, but they are not the same. Gendered divisions of labor developed during industrialization, and reinforced by demarcations of separate spheres of public as commercial and private as emotional reflected this fundamental distinction between market and gift exchange. Woman's work, given and taken for granted has long provided this non-quantifiable, ir-rational(izable) component of human relations. However, late capitalist expansion into

previously noncommodified areas of human activity are destabilizing the 'use value' of human feeling. Dilemmas of emotion work in nursing mirror dilemmas of emotion work in many sectors of society/economy as interpersonal relations are valued for extraction of profit while other configurations of meaning are displaced as too costly, inefficient and (economically) irrelevant.

Theoretical and pragmatic implications of this study concern the need to reconceptualize vocabularies of emotion in nursing and investigate the possibilities of reconfiguring/reclaiming this turf. What nondualistic epistemologies might recognize emotion skills and knowledges and revalue therapeutic emotion work? What implications for healing relationships and mind/body interdependence might emerge if nurses in particular, and emotion workers in general reframe understandings of these activities? What demands for institutional support and what individual and collective strategies for repositioning and recognition might be possible?

In my conversations with nurses, I found that assumptions about 'the nature' of emotions were largely implicit, coming into conscious awareness primarily under circumstances of dysfunction, pain, frustration and interference. In other words, smooth interactions were largely taken for granted, unremarkable and *just* 'given.' Everyday gestures and words of encouragement, support, understanding and guidance were barely acknowledged. Even the importance of providing emotional support in more dramatic instances of illness or dying, and to patients undergoing life transitions such as birth or surgery, was self-evident, needing little comment. Explicit references to connections between emotional states and bodily healing or well-being did not surface, although the nursing texts reviewed contained assertions to that effect. In fact, vocabularies of emotion were not particularly well developed among these nurses to describe what they 'just' did to assist patients.

Efforts to translate lived, extra-linguistic processes, through which intersubjective experiences of nurses and patients are enacted, confront challenges of mediating sensory perceptions via language and culture. Jane Flax (1993:100) warns us of

> the hegemony in postmodernism of a singular category--discourse (or textuality). No singular category can do justice to the vast and highly differentiated variety of processes in and through which subjectivity can be constituted and expressed. An

> implicit privileging of language, speech, and writing circulates through this one. Many aspects of subjectivity and its practices are denied, obscured, or marginalized. Discourse is a particularly inapt synonym for practices (for example, ballet or breastfeeding) which are predominantly affective, sensuous, visual, tactile, or kinetic. These qualities are important in the constitution and expression of subjectivities.

In addition to inherent challenges of translation, my longing to articulate practices of emotion work as powerful therapeutic tools has been tempered by concerns that the visibility of recognition and validation that nurses seek could easily become the visibility useful for surveillance and control. I do not advocate standardized 'cheerfulness' treatments for employees or patients. I want a visibility that can hold a place for the invisible without attempting to colonize it. However, given the capacity of current medical systems to appropriate emotion knowledges for purposes of social control, I have felt hesitant to contribute knowledges that might further efforts of rationalization and efficiency in this way.

Despite a personal inclination to explore embodied practices of emotional healing, this study has focused on the changing dynamics of emotionalities in discursive and material conditions of production and consumption under late capitalism. From a place of grief and concern, it has emphasized practices of surveillance, inscription and incorporation. I have examined how techniques of emotional performance and control are being used in dangerous ways. Culturally available knowledges about humans, developed in a variety of social and biological scientific disciplines provide discursive formations that shape understandings and contribute to the design of interventions. It is my hope that this investigation might trouble assumptions about emotions and contribute to revaluing meanings and practices of emotion work in nursing.

Summary

I began this chapter with a discussion of social and economic transformations associated with transitions from industrial to post-industrial forms of economic production and consumption. The impact of multiple subjectivities and the interface between service workers and emotional expectations in institutional contexts were explored. I examined

negotiations of personal and work identities and investigated beliefs and practices about 'innate' emotions contrasted with professional, developed selves. Nurses are learning to adapt them-*selves* to new commodifications of emotion work following the fundamental re-conceptualization of patient as customer.

I investigated ways that the material-semiotic entities/experiences known as emotionality are shifting as workers uses of self are modified to meet job specifications under managed care. Ideologies of individualism and unitary-self as seat-of-emotions position workers to manage and control their own and customers' feelings as *personal* problems, while organizational strategies guide and enforce narrow ranges of possible/allowable feelings and expressions to meet corporate earning criteria.

Returning to the interviews conducted for this study, I analyzed respondents' talk about personal and professional identities amidst conditions of rapid organizational change. I suggest that cultural shifts from concepts and experiences of 'unitary self' to flexible subjectivities are disrupting traditional assumptions about self. I explored ways that new dynamics promote self modification and the creation of designer employees with emotionalities fit for the job.

I have examined connections between identities and emotions, and looked at beliefs about emotions as both innate qualities and subject to learning and training. I discussed perceived feelings and cultural discourses about depth and surface, and explored transformations of emotion work and workers in today's service society. I investigated conceptual changes and ranges of variation as theorists give alarming and intriguing new meanings to emotionalities, changing the kinds of interpersonal relations that are recommended and possible.

Content analysis of seminars and instructional materials available to nurses highlighted retraining and reskilling processes being used to develop 'emotional intelligence' for psychosocial interventions. Class differences can be seen both in emotion work performed and emotion services available. During this era of profit maximization, there is diminished resource allocation to the care of marginalized populations coupled with a proliferation of services marketed to profitable clients. Under these conditions, emotion skills are distributed differentially among both producers and consumers.

I concluded the chapter with a discussion of vocabularies of emotion in nursing. As nursing adapts to cost containment and efficiency measures of a leaner health care system, there are tensions about devising classification systems and means of standardization that render emotion work more visible, yet risk reducing its range and particularity. Commodified feelings often rely on meanings from economies of gift, yet practices taking place under altered conditions produce different experiences. New vocabularies of emotion are needed first to destabilize previous assumptions, then to suggest different pathways for understanding and accounting for these aspects of human interaction.

Chapter VII: Conclusions

This inquiry into the meanings and practices of emotion work began as a quest for vocabularies to speak about what in 1937 Martha Smith called 'invisible' nursing. The meanings of emotion and 'what counts as work' are both contested sites. Both are central to activities of health and healing performed by nurses. Both are embedded in gendered assumptions and divisions of labor that take for granted certain things that women *do*. These 'doings' (emotion and work) now take place in the context of a post-industrial medical service complex currently being restructured according to managed care models to meet the latest requirements of capital accumulation. Emotions and work are changing in ways that portend both perils and possibilities. I begin these conclusions with a review of the findings and then address the significance of the study, posing questions about implications for emotion work in general, and nursing in particular. In both instances, I suggest that reconfiguring vocabularies and enactments of emotion might contribute to better understanding and valuing this work.

Summary of Findings

The dissertation consists of five main chapters in which the conceptual and substantive findings of this qualitative study have been presented. After a brief introduction, Chapter Two examined what nurses have done as emotion work, and what it has been called. Foregrounding the importance of discourse, I began by reviewing theories about body, mind and emotion that frame cultural understandings of emotion in general and those of nursing in particular. I situated 'research agendas in the sociology of emotions' (Kemper 1990b) historically, and discussed new hybrid conceptualizations that destabilize classical mind/body separations.

The concept of emotion has served as 'other' to reason since it replaced the more classical term 'passion' a century or two ago. Modern meanings of 'emotions' emerged

after James and Freud situated them in the body, connected to drives and instinct. 'Emotions' were elaborated in the modern discipline of psychology to explain those parts of human capacity and experience not compatible with the criteria of rationality, and paradoxically as evidence of the 'true' self. Who defined rationality and in accordance with whose interests were questions of power not discussed by the experts who (not-coincidentally) asserted correlations between the 'irrational' emotions and the feminine. In addition, expressing and nurturing emotions fell to women in domestic divisions of labor that were 'naturally' reproduced in nursing. These dualistic configurations have served the development of science, technologies and industrialization in multiple ways.

In recent theoretical dialogues, classic dualisms are being ruptured and reconfigured. These conceptual reformulations are taking place synchronously with a variety of economic, social and cultural transformations. Contemporary social scientists have proposed that emotions are best framed as a 'somatization of social relations' (Lyon and Barbalet 1994), suggesting terrains of 'embodied thought' (Rosaldo 1984) and 'expressive body' (Freund 1990). Some new understandings of relations between embodiment and sociality are informed by phenomenological approaches to the experience of the lived body. Others have investigated aspects of social control by which body/mind/emotions are managed through techniques of surveillance, inscription and incorporation.

Introspective investigations (Ellis 1991b) of emotionality rely on language, narrative and story telling as sites and processes that shape and express feelings. Notions of *habitus* (Bourdieu 1977) connect emotions to bodily memories below conscious awareness that resist intellection. In the medical sciences, neurobiological mappings of neural pathways, endocrine systems and immunology have contributed physiological perspectives on the 'nature' of emotions. Nurses' uses and understandings of emotionality are situated within these multiple, overlapping and contradictory discourses.

In the second section of Chapter Two, I examined the history of nursing, focusing on conceptualizations of those elements of practice that in contemporary language might be called emotion. Early nursing texts referred to the importance of etiquette, ethics and character, qualities compatible with Victorian ideologies of womanhood and domesticity.

By the 1930s, psychological vocabularies were introduced into nursing, and Freudian theories replaced older moral and aesthetic frameworks.

As nursing shifted from home to hospital in the 1930s, scientific management techniques displaced 'woman's intuition' and became a dominant approach to the organization of care. During the 1950s and 1960s, the first theoretical accounts of nursing since Florence Nightingale were developed. They articulated the importance of emotions and defined psychosocial support as a critical component of meeting patient needs. Emotion was also seen as a secular and more scientific way to refer to spiritual dimensions of illness. Yet feeling and thought have remained dichotomized, and claims to reason and scientific authority have dominated nursing struggles for legitimacy.

In Chapter Three, I began my analysis of the narrative accounts of nursing work as told by eighteen practicing nurses. I situated emotion work in relation to concepts of caring, and highlighted what Hochschild (1995) has called a contemporary 'care deficit' in both public and private life. Nurses are among a number of 'helping professionals' for whom allocation of resources and support is increasingly problematic. According to the nurses I interviewed, certain kinds of 'therapeutic emotion work' that provide emotional support to patients in times of illness and life transition are currently in jeopardy.

Many of these aspects of nursing have been invisible within medical and bureaucratic frameworks, although what is visible to whom is contested terrain. In some ways, 'work' (Star 1991; Strauss et al. 1985) is precisely the link between visible and invisible activities, many of which include management of emotions. I did not attempt to determine what emotion *is*, but to discover what these nurses *do* and how they name and describe it. New conceptualizations of emotionality were proposed that take into consideration the complex skills and knowledges nurses use to weave together understandings, feelings and explanations for themselves and their patients. I have attempted to address levels of symbol and practice simultaneously in order to account for both discursive and embodied aspects of this work.

I focused the remainder of Chapter Three on accounts of those ways of being, doing and knowing utilized by these nurses in the course of their work. Such activities of emotional sensitivity and support are hard to validate and resist standardization. The

nurses themselves tended to take many of them for granted, mentioning, for example, physiological benefits as a way to legitimize emotion work, yet acknowledging it was difficult to distinguish between 'providing emotional support' and 'just chatting.' Gestures of welcoming patients, making them comfortable, establishing trust, and offering reassurance were seen as commonplace, barely worth mentioning. More complex, the work of patient assessment was shown to defy separations of emotion and reason, and to take place along intersections of multiple interpretations of patient needs (Fraser 1989).

'Patient teaching' was examined as an umbrella term which encompasses a variety of nursing activities including exchanges of emotion knowledges about illness trajectories, treatments and outcomes. In preparing patients for illness and healing experiences, passing on information and tending to emotions could not be separated. These nurses offered emotional interpretation and facilitated patients' biographical, identity and story work as ways to help them make sense of feelings during life-altering episodes. During these kinds of interpretive activities, nurses assist patient healing by acknowledging the uniqueness of each illness trajectory and by weaving together considerations of body, mind and emotions.

I ended the chapter with a discussion of emotional dissonance, the experience of tensions between multiple, contradictory feeling expectations. Emotion standards appropriate to one situation or actor may not be the same in a different context. For example, nurses who are expected to arrange their feelings one way in relation to their employers may experience different responses in relation to patients. The nurses interviewed expressed the importance of providing emotional support to patients. They felt frustrated and angry at being caught amongst competing work models of productivity, efficiency and caring.

Chapter Four focused on transitions to managed care and examined nurses' explicit responses to health care restructuring. Situating current dilemmas of emotion work in nursing within corporate strategies for capital accumulation, I explored how health care has been reorganized as a commodity, and patients reconceptualized as customers. I noted that shifts in financing from non-profit and fee-for-service models to capitation plans have led to cost containment measures and have downsized nurse-patient

interactions in a number of important ways. Weaving considerations of structural reorganizations with attention to interpersonal dynamics, I explored macro/micro linkages between occupational contexts and emotional performances.

For the nurses interviewed, the most critical change has been a continual lack of time to provide levels of care according to nursing prioritizations. Lower status, contingency, and unpredictability have all contributed to the nearly complete absence of emotion work in official time allocations and staffing criteria. In this instance, invisibility has contributed to the disappearance of previously assumed, if unofficial practices. These nurses spoke of what was being lost, and of both individual and organizational efforts being made to improve time management. Although this time squeeze is industry-wide, overtime policies made it clear that 'doing the work' (according to whose definitions?), and finishing on time remained an individual responsibility. Under such intensified working conditions, I questioned what might be the consequences for both nurses and patients as nano-second emotionalities replace more traditional nurse-patient relationships.

In the stories of these nurses, emotion work was not alone in being squeezed, but it was subject to regimes of accountability less formalized than other tasks and therefore more easily omitted. In nursing, 'prioritization' is a term that refers to the process of determining what gets done when. The ability to prioritize well is considered a professional skill, and it reflects the constant juggling nurses do to accomplish such shifting, contingent work. Under current conditions, prioritization is sometimes a euphemism for reduction of services. Implicit and explicit priorities dictated that physical needs be met first and, even in their frustration, these nurses did not really question the bifurcation (and hierarchical ordering) of the medical and the social (Fisher 1995). In many instances, providing emotional care was considered 'extra,' an individual responsibility left to the discretion of the nurse.

One relatively new priority has been meeting the needs of computer information systems. These nurses had ambivalent feelings about documentary processes that offer ways to legitimize their work yet are displacing clinical activities and former practices of accountability. Expert systems attempt to standardize nurse-patient relationships by introducing formal pathways alongside informal connections. In fact, nurses provide both

emotions-as-gift and emotions-as-commodity, and the boundaries between these are fluid and changeable. I examined how new production standards of 'gracious hospitality' are being instituted by some healthcare service providers as a systematic effort to link performances of emotionality to profitability. These strategies, inspired by Total Quality Management philosophies, have served to discipline emotions of workers and to engage customers in employee surveillance along with management.

In Chapter Five, I explored ways that nurses have accommodated to organizational changes, and their expressions of frustration about transformations and loss. I noted that emotion work encompasses both the 'doing' of interpersonal relations and the management of their own feelings *about* these massive changes. Despite references to new institutional expectations and practices in the workplace, these nurses framed both kinds of emotional work as primarily an individual responsibility.

The nurses interviewed spoke of various tactics that helped to 'make it work' in the midst of changes brought on by managed care. They described shortcuts and streamlined work processes that facilitated patient care. They noted how technological and pharmaceutical interventions, as well as practices of delegation to other care providers were ways to reduce or contain their emotional workload. They discussed personal accommodations, setting limits, and various forms of self-sanctioning used to manage their own feelings and those of their patients.

The emotional burdens of feeling too much and not being able to respond enough were seen as individual problems to be managed through efforts of personal discharge and renewal. They learned to keep their private selves separate from their professional identities, and were vigilant not to let it 'get to them.' Among the nurses interviewed, collective strategies for confronting these difficulties were generally missing or not mentioned. If anything, several of these nurses expressed gratitude that in their *personal* situations, they could make it work.

However, these nurses were also frustrated and sad. They spoke of nurses who are burned out, glazed over and shut down in response to work intensification and lowered standards of care. Reflecting on competing definitions of nursing, feelings of nostalgia were expressed. They compared an imperfect present to an idealized past, and

remembered a time when providing emotional support had different meanings and practices. Most of the nurses interviewed came from a generational cohort whose knowledges and skills were formed under earlier material and discursive regimes. It remains to be seen what non-dualistic vocabularies and practices of emotionality might emerge in response to, and perhaps subversion of, current economic and cultural conditions.

Chapter Six situated dilemmas of emotion work in nursing within broader contexts of late capitalism and the service economy. Various breakdowns of traditional social forms have contributed to the emergence of mobile subjectivities, multiple identities, flexible workers and designer employees. In the new service society, a type of commodity has emerged that is as much a discursive production as a set of material relations. Packaged and sold, such services are produced in interactions between workers and customers, and utilize emotional labor in the interest of corporate profit.

Taking nursing as a kind of case study, I traced shifts in the organization of work and workers from modernist to post-industrial forms. I explored how commodification of interpersonal relationships is placing new demands on emotion work and changing the conditions under which depth and surface are produced. I suggested that in nursing, like in other service occupations, skills of emotional competency, from scripted scenarios to sophisticated management techniques, are being used to make workers into self-managed employees with feelings that fit the job. Might the changes of managed care redesign and the resultant new subject positions represent the formation of historically different emotionalities?

For the nurses studied here, transformations in working conditions, selves and identities had significant impact on performances of emotion work. They experienced the constraints of cost containment priorities as painful losses of identity and impediments to being 'the kind of person' they expected to be. Without framing it as such, these nurses were resistant to work reorganizations that implied relinquishing modernist configurations of emotionality and self. One direction for future research would be to investigate meanings and practices of emotion work among a younger, more recently trained cohort of nurses, and compare their responses to those of the group studied here. What kinds of

evidence might indicate the emergence of new forms of emotionality among a next generation of practitioners?

Other future research in managed care settings might investigate the impact on patient outcomes of integrating emotion work in new ways. Non-dualistic conceptual frameworks could be used to link feelings with thoughts and individuals with contexts, more effectively bridging between micro and macro dimensions of analysis. Out of such perspectives, systems that acknowledge, support and reward therapeutic emotion work might be developed.

Transformations of cultural and economic conditions of production present both opportunities and dangers. Within nursing, it will be important to track the emergence of new vocabularies and practices of emotionality. It is not a question of whether or not nurses will do emotion work, but rather, under what conditions, constituting what meanings, and through which practices will this work be accomplished.

Significance of the Study

In order to weave together this tale of transformations in meanings and practices of emotion work among nurses under managed health care, I have highlighted several distinct threads and pointed out some of the patterns connecting them. Integrating micro and macro perspectives, I have conceptualized emotions as sets of feelings and expressions that mediate inner and outer, and self and context, in profound and inextricable ways. Key threads have been to trace discursive framings of emotion and emotion work, and to situate them within sets of practices that are historically bound. This move to historicize emotionality enabled me to examine transformations in nurse-patient interactions in the context of the current moment of crisis in U.S. health care.

Examined discursively, I tracked conceptualizations of emotion in relation to ideas about body, thought, person, society and work. I foregrounded languages and conceptual framings of nurses as a way to explore links between semiotic and material dimensions of understanding and enactment. I traced how nurses interact with available discourses to frame their own and other people's interpretations and activities.

Drawing in part on symbolic interactionist perspectives, I situated performances of emotion within socially constructed and negotiated sets of meanings, rather than as individual or psychological attributes. Notably, I explored how nurse-patient interactions shape and are shaped by emotionalities in the often highly charged situations of illness, recovery or demise. There are also dimensions of routine and taken-for-granted interventions involving emotionalities that pass almost unnoticed.

Examined historically, I began my analysis with explorations of the history of nursing, noting how vocabularies of emotion changed over time, along with structural changes in the organization of work. Bedside practices, gendered divisions of labor, and definitions of what counts as work have all been modified over time. I turned my focus to discourses about the place of the emotions in health and healing utilized in the recent past, as well as clinical and interpersonal practices taken as (often unspoken) standards of care during these same decades. Relying on both the words of my informants and content analyses of selected nursing texts and continuing education materials, I elaborated the kinds of practices and assumptions that comprise what I have called therapeutic emotional support.

I then turned to the current moment of massive transformations in health care as for-profit and managed care models are being implemented on an unprecedented scale. The first impulse was to offer a kind of salvage ethnography, making visible under-recognized skills and knowledges, and attempting to rescue from possible oblivion sets of assumptions and practices held by a generation of nurses who are witnessing these changes. However, the notion of salvage emphasizes fragility and disappearance, whereas the more accurate story is one of perseverance and transformation. I have given voice to experiences of loss and grief expressed by nurses who are both adapting to change and reconfiguring vocabularies of emotion to meet current expectations. As the conditions of enactment change, old identities no longer have sites of production, yet new forms are only beginning to emerge.

The critical discursive shift has been the reconceptualization of patient as customer. This recoding corresponds to massive changes in material practices as well, and is reformulating both providers and recipients of care in profound ways. Managed care

models draw on formulations from other industries to conceptualize service as product. For example, employee trainings in hospitality skills promote the formation of designer selves with emotionalities that are compatible with the needs of production. While modernist socialization emphasized the control of emotions, postmodernist trends suggest transformation and reconfiguration of selves and emotions.

Within modernist organizations, stable models of unitary selves with specific occupational and professional specializations were likely. In postmodern economies of flexible capital accumulation, employees are encouraged to develop flexible selves (Martin 1994) and work in teams that are breaking down professional divisions of labor (Casey 1995). Nurses in new managed health care systems are learning to adapt quickly to organizational change and to be effective in multiple roles, according to criteria of profitability and efficiency. The conditions under which constructions of emotional depth are possible are shifting, suggesting surface emotionalities more compatible with multiple roles and flexible selves.

Nurses are involved in managerial functions, both within service organizations and as health care practitioners participating in medicalized management of contemporary populations. Older vocabularies of emotion are recoded to accommodate to new situations and older meaning structures are coopted for use in destabilized material contexts. Patients may have little or no economic or social support during illness, but they will be greeted kindly on their rare encounters with medical services. I am concerned that we are being switched to 'emotionality lite' with reduced calorie appeal (less heat, very cool.) Designer emotions may offer lots of fluff but little flavor as Hallmark hospitals provide Disney hospitality and 'have a nice day' surgery, but don't expect funding for longterm care, chronic illness or other high touch/low tech needs.

Under current conditions of capitalist incursions into every aspect of 'private' life, service for profit is here to stay, as well as tailored emotionalities to produce those services. In health care, the key question becomes not whether there will be designer emotions, but according to whose design? Will health care providers collaborate to market emotion work for profitability, or will other wellness criteria prevail? There are already designer drugs (Prozac and friends), management seminars and self-help psychologies

available to reskill all kinds of workers for new socio-economic realities. In addition, an increasingly well established 'alternative health' industry has pioneered technologies of self that propose pathways to authenticity by design. Perhaps new meanings of depth will emerge as self-help psychologies blend with spiritual practices to reconfigure human experiences and values according to insights of expanded consciousness.

Ultimately, political and economic decisions will be made that determine allocations of resources and prioritizations of spending. Conceptual framings about emotions and how they are to be understood and lived will emerge according to what is possible socio-culturally. Like other contemporary populations, nurses will be both subjected to changes and agents within it. I now address briefly why nurses have been a good group in which to study some of these dynamics.

Nurses, by sheer numbers, represent an important group of women in society and in health care systems. Over two million practice actively in the United States and there are comparable groups throughout the world. Encompassing activities of tending the weak, dependent, ill and dying, nurses provide emotion work as part of the highly interpersonal services they offer. Historically, nurses have been a kind of 'everywoman,' performing in public settings according to gendered divisions of labor common to domestic arrangements in the 'private sphere.'

Currently, nurses are situated centrally in a medical industrial complex that consumes nearly fourteen percent of the GNP in the United States. They are located in the middle of multiple hierarchies of power that include bureaucratic management, economic administration, and medical authority. Their activities are governed partially by others, and they also oversee work of other para-professional and occupational groups. This positions nurses as both disempowered workers and as powerful agents, both in relation to the institutions in which they work and with the clients they serve.

Nurses are often frontline service providers, offering education, training, assistance and care in many capacities, all of which involve emotion work of some kind. Their attitudes and interventions in situations of health and healing transmit models of how to feel, what to expect and how to work with feelings in meaningful ways. During recent

transformations of managed care, they are actively involved in reshaping their own meanings and practices, as well as guiding patients through these changes.

The limitations of this study were marked by the small size of the sample. It was only partially possible to examine ranges of variation, as geographical, racial, ethnic and age differences were not adequately represented. In this particular historical moment, it was hard to capture emergent patterns. In general, my informants were operating under assumptions about emotions embedded in residual forms still firmly in place from previous experiences. I was therefore cautious that it was not enough to capture and give voice to the experiences of these nurses, without also examining the terms that have framed their experiences, as well as the material conditions and organizations of work that enabled their enactment.

I looked at emotions in the doing of the work, and emotions expressed by these nurses *about* changes in practice. I explored discourses that nurses produce about *emotions* when describing their work, and examined feelings about the changes associated with managed care. I noted how they adapted to and grieved about transformations, while seeking to preserve identities amidst disruptions and disappointments. Things that didn't come up were connections between emotions and body as part of the healing process. Nor did these nurses explicitly situate emotional needs or responses within networks of psychosocial interactions, and not just within individuals.

I found that this generation of 'seasoned' nurses had well developed patterns of emotionality, established through long years of practice. They found it hard to relinquish certain standards of care no longer valued or supported. I suspect that they will continue to react, adapt, feel frustrations or accommodate. Those who can't or won't perform according to new expectations may have to quit. An interesting future investigation would be to question and observe a younger, newer cohort and compare as new emotionalities emerge in a next generation of practitioners.

In conclusion, I propose the value of two interventions, one discursive and one material. First, I suggest that emotions be seen as historically contingent and socially mediated aspects of human response to and actions about situations, including those associated with illness. Whereas previous concepts of emotion as embodied were linked to

conceptualizations about the natural and the immutable, more workable concepts today might understand emotions as embedded in bodily functions, and therefore critical to health and healing, but also inextricably linked to social structures of meaning.

Second I suggest that the organization of practices and priorities in health care generally, and in nursing in particular, be designed to provide the structural support necessary for therapeutic emotion work. This work has long hovered along fringes of invisibility, but its benefits to processes of health and healing remain paramount.

Appendix A: Interview Guide

Interview Guide: General Areas of Inquiry and Probes

1. Biographical information: age, sex, educational background, current and past work in nursing.

2. Tell me what your day was like, start to finish.

3. Describe a typical day at work. Daily routines, tasks, etc.
What is the spatial configuration of the work site?
How many different people use the work space?
How many clients or patients are you *responsible for*? How many others might you encounter in a more casual way?
How much do you interact with family members or friends of patients/clients?

4. As nurses, we wear many hats. Over the last week or two, what hats have you worn?

5. In the course of your work day, what kinds of feelings did you keep to yourself? What kinds of feelings did you express to patients? To other nurses? To doctors?

6. What makes nursing meaningful to you? What is rewarding? frustrating? Joys? Challenges?

7. Can you give me an example of how you might use the term "emotional support"? Are there different types? What are they?

8. What kinds of things would you call emotional needs? Would other caregivers have the same list? The doctor?

9. Give an example of a story a patient told you recently that gave you insight into their emotions.

10. What emotional cues or indicators might you observe in patients when trying to understand their emotional states? Are there some emotional responses to illness that are typical, that you expect to see? Give example.

11. What kinds of emotional processes do you see most often in your patients? How do you identify them? Give an example.

12. Give an example of a time when you consciously intervened in an emotional way to assist a patient.

13. Give an example of a satisfactory interaction with a patient? An unsatisfactory one?

14. Are there some forms of emotional support that you use over and over? What are they?

15. What kinds of emotional support are expected as routine care? What's extra? Give examples. How do we learn what's expected?

16. Can you describe a situation at work when you felt emotionally unavailable? What conditions make you feel emotionally available, or not?

17. What might trigger you to turn off or on your feelings during the day?

18. What kinds of work load and time constraints determine how much time you can spend with your patients?

19. Think of a new patient you had in the last few days. What did you do when you first meet him/her? What did your patient expect?
How might you re-establish contact with a patient that you've met before?
What might you do differently if you like a patient or don't like them?

20. Give an example of a time when you got attached to a patient. What happens when you get attached? When you don't?

21. What do you call on in yourself to determine what to do next in response to a patient's situation? How did you learn that?

22. When you report off duty, what terms might you use to pass on emotional knowledge about a patient?

23. How might your own feelings help you do your job? How might they get in the way of your job? Is emotional control part of being a nurse?

24. Have your working conditions changed in the last few years? In what ways? Do you interact differently with patients because of these changes?

25. What technological devices are part of your daily work environment? How do they make the work easier? Harder?

26. If you had the power to change anything in your workplace, what would you do or suggest be done?

27. In addition to caring for patients, does part of your work involve managing the feelings of other workers? Give an example.

28. Give me an example of a situation in which you needed help. How did you ask for it? What help did you get? How did you feel?

29. Has the move to redesign health care changed your work? How has it affected 'bedside nursing?'

30. What are your beliefs about the connections between emotions and health? Where do they come from?

31. Is there a difference between emotional support and caring? Emotional support and spiritual support?

32. How important are emotional skills in being a good nurse? How would you evaluate that in a colleague? How is this aspect of the work considered in job performance evaluations?

33. Have you ever attended any inservices or presentations on the emotional or psychosocial aspects of your job? What were they?

Appendix B: Some Notes on Methods

> [A]ll human experiences, whether of the external world or of the internal world, are mediated by theoretical presuppositions embedded in language and culture.
>
> Mary E. Hawkesworth (1989:338)

> '[I]ndividuals' do not exist except as socially located beings; thus social structures and categories can be 'recovered' by analyzing the accounts of particular people in particular material circumstances.
>
> Liz Stanley and Sue Wise (1990:43)

> The research process becomes a dialogue between the researcher and researched, an effort to explore and clarify the topic under discussion, to clarify and expand understanding; both are assumed to be individuals who reflect upon their experience and who can communicate those reflections. ...[N]either the subjectivity of the researcher nor the subjectivity of the researched can be eliminated in the process. ... The question becomes how to produce an analysis which goes beyond the experience of the researched while still granting them full subjectivity.
>
> Joan Acker and colleagues (1991:140, 142)

Liz Stanley and Sue Wise (1990:26) distinguish between method, methodology and epistemology, suggesting that method refers to specific sets of research practices, methodology is a theoretically informed framework used to explain and justify methods, and epistemology is a theory of knowledge that addresses "who can be a 'knower', what can be known, what constitutes and validates knowledge, and what the relationship is or should be between knowing and being (that is, between epistemology and ontology)." In order to examine meanings and practices of emotion work in nursing under managed care, I have had to consider how best to approach each aspect of my inquiry in relation to these three dimensions of knowledge-making.

In this Appendix on Methods, I address first some theoretical issues that have guided my research design. I discuss some intrinsic challenges of conducting social science research on emotions and explain how I have dealt with them. In a second section, I provide a detailed account of the steps taken to conduct the study, situating this work within qualitative research traditions.

Theoretical Issues

I have structured this dissertation to be both a conceptual intervention and an accounting of meanings and practices, emphasizing the inter-relatedness of discursive and material conditions in productions of emotionalities and work. I have consciously resisted social scientific approaches to the emotions that attempt to identify pre-existing entities, affirming instead that emotionalities are defined and experienced within social contexts, according to cultural norms and expectations. I have not attempted to provide objective typologies, foregrounding instead subjective accounts by nurses of their activities and experiences, and how they call them. I have emphasized the interplay between embodied feelings and social locations, hoping to show how, in the doing of emotionalities, "praxis is itself a moment of interpretation" (Moore 1994:77), highly subject to contextual constraints and possibilities.

A key premise of this investigation has been the invisibility of certain aspects of nursing work. I have suggested that 'making visible' or 'giving voice' to emotion work is ineffective without addressing important questions of to whom these activities are invisible, and what power relations are reinforced by this invisibility. I have examined core assumptions about the nature of emotions, what counts as knowledge, and who does this work, as integral to explorations of these nursing practices. The project of both rendering these activities visible and situating them socio-economically presented the methodological challenges of linking micro to macro to discursive.

An important epistemological subtext has been the highlighting of Hochchild's (1983:29) claim that "emotion, like seeing and hearing, is a way of knowing about the world." Nurses rely on tacit, experiential knowledges that include emotional skills easily taken for granted and undervalued in medical and bureaucratic systems. In order to reposition and revalue emotion work within the wide range of nursing activities, I have questioned separations between emotion and thought, and sought to demonstrate their interdependence. I have also gnawed at the problematics of how best to include my own emotional knowing within the text.

I have discussed in Chapter Two some dilemmas of studying 'experience.' The challenge is to find methods that can *both* capture 'lived' and 'felt' experiences of

participants, *and* go beyond accepted cultural interpretive frameworks. In order to access the full implications of meanings and practices, it has been necessary to analyze dynamics embedded in these experiences that are beyond the common understandings of participants. Focusing on emotionalities, I relied *both* on interpretations given to me by informants, *and* on my interpretations of their vocabularies of emotion, informed by theoretical considerations outside of common usage. My goal was both to elicit appreciation for the importance of emotionality in health and healing, and to challenge conceptual separations of emotion from thought and reason.

Investigations of emotion are particularly fraught with difficulties of translation. Verbal displays are but one component of complex languages of feeling; touch and other nonverbal contact, especially vision, are commonly used to communicate emotional tones, intensities and meanings. Phenomenological and ethnographic methods utilize 'thick descriptive texts' (Ellis 1991a) to convey inner feelings in an almost literary manner. For instance, autoethnographies, memoirs and narratives are formats that allow investigators to tell the selves of protagonists using some of the writing conventions of fiction. In such approaches, emotional 'logics' are expressed through developments of plot and character, linking events to feelings along culturally recognizable scenarios, and inviting readers to re-'live' the emotionalities of the participants.

These reflexive and descriptive approaches foreground the immediacy of felt experiences. They are often expressed through textual practices that intentionally seek to evoke particular feelings in the reader. By contrast, more analytic languages tend to describe emotions cognitively. In designing this project, I was torn between a desire to *evoke* and a commitment to *explain.* In the end, I chose to base my investigation on interviews and to forego 'direct observations' of interactions between nurses and patients that might have yielded descriptions of the rich non-verbal cues, facial expressions, body languages and intonations that, in addition to language, shape emotionalities. I used the words of nurses to describe their feelings *about* their work, and to convey both their own and their patients' and families' felt/expressed emotions involved in the *doing* of their work. I did not attempt to learn from observation, nor to recreate through language how all of these might feel.

This choice was based on several considerations. While there is in any case no such thing as a 'pure' context for observing social life, in the instance of emotions, I felt that interactions between patient and nurse would be significantly altered in the presence of an outside observer. I understood that 'direct observation' would neither circumvent the challenges of translation nor address the inevitably mediated nature of emotionality that I sought to investigate. I decided to rely on the nurses to tell me about their activities in their own words, and to focus the analysis on intersections between macro and micro elements that are currently altering the conditions of nurse/patient interactions.

This reliance on linguistic expression allowed me to focus attention on historical and contemporary *vocabularies* of emotion as shifting configurations and processes rather than as universal or 'essential' descriptors. Privileging discourse analysis, I supplemented nurses' accounts of their work with examples of descriptions and recommendations found in nursing texts and continuing education course materials. This also enabled an examination of the standardization of nursing languages, documentary practices and information systems that have contributed to disruptions of previously taken for granted practices.

During the course of the analysis, I came to understand an element of wariness I felt toward creating typologies of activities of therapeutic emotion work: that they might be taken somehow as 'standards.' I grew concerned that some kinds of visibility, particularly among the relatively disempowered, are akin to exposure and vulnerability. Ironically, I came to appreciate that some 'taken for granted' activities are better left protected by invisibility, and that nursing judgment and discretion might better respond to the contingent nature of emotional need than certain required or imposed responses. The danger here is that bureaucratic impulses to rationalize and standardize emotion work might subject nurses and patients alike to new means of surveillance, disciplinary practices and co-optation rather than therapeutic care. In professional contexts where discretionary power, not micro management, is indicative of higher status, I was reluctant to contribute social science knowledges that might be used to assure tighter social control.

Eschewing both behaviorist classifications of emotion and quasi-literary efforts to express feelings 'on their own terms,' I have sought instead to explore how vocabularies

of emotion both reflect and shape socio-cultural norms and expectations. I have examined emotion work as part of the gendered divisions of labor in productions of 'health care.' I have explored how particular conceptualizations of emotion might contribute to the prioritization of certain aspects of nursing work and the devaluation of others.

Pursuing micro/macro linkages (Clarke 1991), I developed a hybrid set of methods, drawing on grounded theory (Strauss and Corbin 1990), content analysis, discourse analysis (for example Fairclough 1992), and historiography. These methodological approaches were informed by symbolic interactionist, (neo)Marxist and feminist frameworks. I explored performances of emotion work as 'ideal types' and then situated these within changing contexts of managed care. Triangulating between local and profession-wide expressions, I juxtaposed accounts told by eighteen practicing nurses with historical and recent nursing texts, as well as policy analyses of recent structural transformations in health care.

Throughout the analysis of patterns and commonalities, I sought to maintain a sense of the complexities, multiplicities, contradictions and paradoxes inherent in discussions of the emotions in social life. As a nurse, I became aware of interesting disciplinary constraints, understanding that an academic production such as this one could not be the site of an instructional 'passing on' of emotion knowledges and skills which, in another context, merits a very different exploration. For that project, I would want other methods, including perhaps dance, sculpture, or poetry, and devise different strategies for translation, evocation and transmission... Meanwhile, let me describe the steps taken to conduct this study.

Conducting the Study

Overview

The core of this qualitative inquiry was designed as an interview study, using a grounded theory approach to ask nurses about those aspects of their work I have called emotion work. Additional perspectives were gathered from content analyses of selected nursing texts and continuing education materials. Theoretical reviews of literatures about the emotions and about nursing history and health policies were also utilized. I discuss first the procedures developed for conducting and analyzing the interviews. I then explain how

the content analyses were undertaken. The theoretical reviews, guided by scholarly tradition, are found in the main body of the dissertation.

Sample Selection

Once the general design of the study was established, determining who to interview and how to contact them became an issue of critical importance. Given a potential pool of nearly two million practicing nurses in the United States, I knew that the size and scope of a manageable sample would never be representative of the multiple diversities of age, geography, ethnicity, race, gender, sexual orientation, sites of practice, religious background, levels of education, class origin, marital status, or years of experience that mark both the commonalities and the differences among this disparate group of people who are, by virtue of state licensure, legally permitted to call themselves registered nurses.

I began by limiting myself geographically to nurses practicing in Northern California and narrowed my recruitment to people and settings that were logistically accessible to me, notably current and former colleagues, recommended contacts, familiar clinical sites. I determined that 'purposeful sampling' (Morse 1991:129), seeking "informants with a broad, general knowledge of the topic or those who have undergone the experience and whose experience is considered typical" was an approach compatible with my goal of contacting 'expert' (Benner 1984) nurses. Further, I wanted to speak with nurses who avowedly valued emotional aspects of their work and were considered by their peers to have developed knowledges and skills for these activities.

I decided to contact nurses who worked in several different areas of clinical specialty and organizational affiliation. With one exception, I interviewed nurses who had been actively practicing for at least five years, and many for over twenty. This gave me access to nurses with considerable experience in managing their own and patients' emotions, and allowed me to inquire about historical changes that are occurring as institutions implement managed care strategies. I relied on a 'snowball' approach to contact and enlist the collaboration of eighteen nurses working in the clinical areas of oncology, maternal/child health, public health/home care, supervision, and renal dialysis. All of the connections were made through personal and professional contacts.

This particular selection of nurses offered both benefits and limitations. While these nurses were able to give valuable perspectives on changes in the delivery of health care, I acknowledge certain shortcomings inherent in this sample. Most importantly, I did not seek informants marked by racial or ethnic categories; all of the respondents were 'white.' In the segmented nursing labor market, registered nurses have been disproportionately white. For instance, in 1980, 87% of RNs were white, while only 77% of the population was white (Glenn, 1996). Nor could the one male informant be considered 'representative' of his gender. Emotion standards, both in 'public' institutional contexts and in more 'private' settings, are lived out according to multiple socio-cultural variations that merit further inquiry beyond the scope of this study. However, I believe that commonalities in the themes addressed herein, notably the impact of managed care on interpersonal relations among nurses, colleagues and patients, are relevant across distinctions of diverse and multiple identities among those working as nurses.

I did not seek to describe or identify localized meanings and practices of emotion work in particular ward sites. If it were possible to name and generalize effectively about these, it would surely be interesting to compare meanings and practices of emotion work in different clinical contexts. However, this would be a different project and, moreover, current conditions of rapid change would make such an endeavor problematic at best. I did intentionally select nurses working in specialty areas known to require high levels of emotional care, hoping to find 'good informants' about these aspects of nursing work. As Janice Morse (1991:132) explained,

> a good informant is one who is able to reflect and provide detailed experiential information about the phenomenon. ...[She] must be willing and able to critically examine the experience and [her] response to the situation, and ...to share the experience with the interviewer.

The nurses interviewed were invited to speak about emotional dimensions of their work, and they spoke with enthusiasm and conviction. A different sample might not have reflected such emphatic concern. There is a wide range of emotion styles and standards available to nurses, including many who operate within technical, bureaucratic and perfunctory parameters that differ from those expressed by the nurses I interviewed.

Nevertheless, I am convinced that the nurses selected for this study were able to articulate concerns shared by many in the profession.

Informant Profiles

Six of the nurses interviewed worked in oncology, including a research wing dedicated to experimental cancer treatments. Of these, one had been a nurse for five years, working in oncology for just under three years. One had been a nurse for nine years, working with cancer patients for eight. The other four nurses had been practicing for twenty to twenty six years, all for more than ten years in oncology.

Four of the interviewees were working in maternal/child settings. One had been a nurse for nineteen years, but had stopped for six years to raise small children; she had spent nine years providing obstetrical care. The others had been in nursing from twenty to twenty nine years, each in their specialty area for about fifteen years.

I interviewed four public health nurses and one home health provider. Their years of nursing experience ranged from six to twenty seven years, with three to twelve years spent in their current jobs. I spoke with two nursing supervisors, one had been in nursing for thirteen years, with three years in supervision, the other had been in management for sixteen years. The one dialysis nurse had received an RN license only two years previously, but had practiced in the same setting as a clinical technician for many years.

I conducted one interview with a woman involved in cancer research who was not a nurse. However the conditions of her work were so different from those of these nurses that I did not use her comments for the study.

Doing the Interviews

I met with each nurse for one to two hours in a variety of quiet locations convenient to their homes or work. I presented myself as a nurse and a doctoral candidate in sociology, interested in the ways that their work involved their own and their patients' emotions. I found it easy to develop trust and rapport, in part through the shared identity of nursing, in part through the personal and professional connections that had enabled me to contact them. I remained vigilant not to exploit this ease of rapport (Finch 1984), carefully working with the nuances of my own multiple identities. I explained that all comments would be treated with confidentiality and anonymity, and obtained written

informed consent from the participants. All of the interviews were tape-recorded and later transcribed by two professional transcriptionists.

I conceptualized the interview process as a context for guided conversations (Burgess 1984; Lofland and Lofland 1984; Mishler 1986) in which my respondents and I could co-construct the topic, the languages for talking about it, and its salient dimensions. My own experiences as a clinical nurse were invaluable in this process. I developed an interview guide with general areas of inquiry and probes (see Appendix A) suggesting broad and inclusive parameters to investigate. I encouraged the nurses to articulate for/with me what often resides in unspoken, taken for granted arenas of feeling and wordless practice. They prefaced many of their remarks with a 'just' that seemed to indicate reflections of self-evidence and/or insignificance.

Following a semi-structured format, I posed questions inviting descriptions of their activities, reflections on how they think about emotions, and comparisons between their responses to different situations and events (Burgess 1984). I was equally interested to learn what they said they *did*, and how they *framed* it. I also paid close attention to reflections of temporality, noting how often these nurses contrasted 'days gone by' with 'this day and age.' These comparisons enabled me to link descriptions of daily activities with concerns about structural change.

The interviews were conducted between November 1995 and June 1996. Throughout these months, I maintained a research journal in which I noted my thoughts before and after holding the interviews. I reflected on the tone of the interviews as well as the contents, and pondered theoretical questions stimulated by these interactions. I was attentive to the languages they used to describe what I was calling emotion work, and searching for ways to talk about these ubiquitous yet understated activities. While I did not want to put my words into their mouths, and attempted to avoid doing so, I was aware of the *mutual* creation of the data through intersubjective dialogue. Building on approaches of theoretical sampling, I found myself asking questions differently in later interviews, seeking to extend and clarify issues brought up in earlier encounters.

One theme I began to note concerned the nurses' reactions to my choice of emotions as theme of inquiry. At first, most of the nurses seemed surprised that I had

chosen to do research about emotions. In various ways, they questioned whether my topic would be taken seriously (by doctors or administrators?), and expressed gratitude that *I* was taking these aspects of their work seriously. After my conversations with them, several of the nurses expressed hope that I might be able to draw attention to problems they felt were not being adequately addressed, such as greater recognition of emotional aspects of nursing work, different allocations of time, and better staffing. These remarks were spoken typically as wishes for 'good luck' and stood out as the rudiments of a collective perspective on issues that were primarily framed in terms of personal and individual attitudes or styles of doing the work. It seemed that conducting these interviews and framing conversations about the importance of emotional care might themselves be a kind of intervention.

Coding and Developing Category Systems

Although I began formulating categories and grouping issues throughout the course of conducting the interviews, I focused on coding in earnest after assembling a full set of transcriptions into a large notebook. I separated the interviews according to specialty areas and began line-by-line coding according to procedures recommended by grounded theory methods (Charmaz 1990; Glaser and Strauss 1967; Strauss 1987; Strauss and Corbin, 1990). I still have a list tacked to my bulletin board with the words "conditions, tactics/strategies, dimensions, interactions, consequences" that was used to guide my initial sorting of nurses' accounts of emotions and work expressed in the interviews.

I was struck early on by two contrasting sets of comments that helped me to structure my analysis. I distinguished between accounts of activities these nurses considered to be part of providing 'good' emotional support, and those expressing frustration about not being able to give the kind of care they felt should be given. These concerns were explicitly or implicitly linked to comments about recent changes in the organization of their work, what was valued, and how things were prioritized. Sorting through the data, I began coding for 'ideal types' of practices and expectations about what I came to call 'therapeutic emotion work.' In a separate section, I assembled reflections

about impediments and adaptations to changing situations. In both instances, I sought to clarify meanings and practices in the terms of the respondents.

John and Lyn H. Lofland (1984) identify meanings and practices as building blocks for understanding socially negotiated interpretations and activities. They explain that

> **meanings** ...are the linguistic categories that make up the participants' view of reality and with which they define their own and others' actions. Meanings are also referred to by social analysts as culture, norms, understandings, social reality, definitions of the situation, typifications, ideology, beliefs, world view, perspective, or stereotypes (p. 71).

They provide further definition, writing:

> The smallest behavioral unit of a social setting may be envisioned as a social **practice**, a recurrent category of talk and/or action which the observer focuses on as having analytic significance. The category so isolated is, by definition, an activity the participants regard as unremarkable, as a normal and undramatic feature of ongoing life. It is only the analyst who, by collecting instances of it and dwelling on it, singles it out as something remarkable (p. 75).

I looked for the range of variation of processes, actions and assumptions that characterized 'types' of emotion work performed. For example, in Chapter Three I delineated a number of strategies used by these nurses to provide a therapeutic environment in which healing could take place. These included welcoming and orienting new patients to the unit, establishing trust, and covering for the shortcomings of other nurses, doctors or the institution. I compared data and categories across all interviews, seeking commonalities, contrasting evidence and noting negative cases. In Chapter Four, these same nurses spoke of conditions in which emotional needs of patients were not prioritized, and there was not enough time to interact therapeutically.

Descriptive clusters of activities and conceptual frameworks began to emerge. As the coding grew more complex, I began work more theoretically with the interviews, linking data to concepts and connecting micro manifestations with macro considerations. At times, I drew on my own 'ethnographic memories' of situations and experiences witnessed during my years as a practicing nurse to help shape the categories. I was particularly interested to demonstrate how nurses modified their bedside practices to meet cost containment and efficiency directives. In order to broaden the analysis, I turned to

selected nursing texts as a way of triangulating between local informants and profession-wide expressions.

Content Analysis

In addition to interpreting the interviews, I began a content analysis of selected nursing texts and continuing education materials to see how the comments of the nurses interviewed articulated with discussions of interpersonal work in nursing literature. I also wanted to historicize my analysis, suggesting that meanings and practices of emotion varied in different contexts and time periods. I went into the collections of the UCSF library, examined the holdings, and chose from two to five standard nursing textbooks from each decade between 1900 and 1990.

My criteria for selection was primarily to select texts designed to teach general nursing to registered nurses. In the early decades, there were not many texts available, so I examined what was there. After 1940, there were many more texts, so I focused on those addressing basic nursing, also called medical-surgical nursing, and avoided texts in specialty areas. In recent texts, I concentrated on theories about psycho-social aspects of nursing. I searched the indexes and tables of contents for relevant categories, and photocopied portions of each text. I also found some helpful articles in editions of the American Journal of Nursing between 1900 and 1910. I examined two texts on nursing ethics from the 1920s (Brogan 1924, Garische 1929).

In order to gain insight into contemporary nursing practices, I searched recent nursing literature for articles giving instructions about psychosocial dimensions of care. I also collected brochures and advertisements about continuing education courses offered to nurses on a variety of topics relating to the management of emotions. I looked systematically through historical texts for references to comportment, etiquette, bedside manner, and emotions. In later decades, I found discussions of interpersonal relations and articulations of the 'nurse-patient relationship.' In Chapter Two, I traced various languages that have been used to advise and teach nurses about these dimensions of patient care, and situated different perspectives within broader contexts of nursing history. This use of written materials allowed me to compare languages and perspectives as

identified more broadly in the profession with comments from the sample of nurses interviewed.

A note of caution about these investigations is in order. Although I was able to trace conceptualizations of emotions and work in nursing texts across historical time periods, it is impossible to know how those experiences were lived, or even talked about, by nurses and patients no longer able to speak of their interactions. Contemporary vocabularies cannot fully shape or translate experiences during which different feeling rules and expectations, both written and unspoken, were in effect. Nor are recommended procedures the same as actually enacted ones. Nevertheless, it has been helpful to note how advice and guidelines were modified over time, such as shifts in emphasis from etiquette to psycho-social dimensions of care, in part in response to changing conditions.

Analysis, Interpretation and Theory Building

As I began to develop my interpretations of emotion work in nursing and transformations under managed care, I wove together the words and stories of these nurses, the explanations of texts and course materials, some reflections from my own unspoken memories and observations of many years of working as a nurse, and a multiplicity of other sources of relevant information. I was very aware of my own active role in steering, selecting, weaving and juxtaposing multi-levels of inference and evidence as I orchestrated analyses and interpretations. My own experiential knowledges of nursing contexts and practices were especially helpful in ordering and making sense of the comments of these nurses.

Proceeding fairly systematically from codes to concepts to theory building, I was guided both by a commitment to tell an accurate story, and by an agenda to better conceptualize these aspects of nursing work. Focusing both on languages used by nurses to talk about emotions, and on their descriptions of what they *did*, I sought to link meanings with practices, and to connect macro perspectives with micro dynamics. In the early chapters, I reviewed discourses on emotions within the social sciences, and traced how nurses have defined and talked about these aspects of their work historically. I attempted to identify first a set of meanings and practices commonly held by this group of

nurses, then to explore how structural changes have led to modifications of behaviors and conceptualizations.

As the inquiry progressed, I kept ongoing memos about my processes in the form of a research journal in which I collected hunches, queries and inspirations. I turned to analysts and theorists from a variety of disciplines for insight and guidance in understanding the dynamics of these complex processes of emotion and work. I sought to integrate descriptions of embodied practices with articulations of conceptual frameworks. I investigated socio-economic arrangements, gendered divisions of labor, and managerial organizations of work in recognition of the inseparability of these structural conditions from performances of emotion in interpersonal relationships.

As I assessed my findings, I was careful to 'stick to the data,' holding tight to the reflections of these informants and interspersing their words throughout my interpretations. I developed an elaborate system of color coded 'post-its' and cross-reference markers to navigate throughout the transcriptions and establish correlations as I shaped the analysis. Exploring paradox as well as consistency, I juxtaposed instances of 'both/and' as well as expressions of patterns and commonalities. I found many indications of complexities and contradictions as part of emotionalities generally, and particularly prominent under current conditions of rapid transformation.

Sticking to the data also meant shaping the analysis around topics and perspectives articulated consciously by the nurses interviewed. Some aspects of emotionality embedded beneath conscious awareness were not accessed by these methods. Difficult and unpleasant emotions were less likely to be addressed. Shameful feelings, such as patients' embarrassment or nurses' disgust were not easily accounted for. Nor were feelings associated with, say, racism, ageism, or responses to ethnic or class differences. I am not sure what kinds of methods might bring the emotions connected with these considerations better into view. I remember the day when I realized that I would be limited by the silences in the interviews, for I did not find some concerns of mine reflected in their stories. Yet there was ample material to generate and illustrate an array of valuable insights.

I did not attempt to delineate the specifics of different types of emotionality, nor to develop typologies of behaviors, expressions or feelings. There are probably too many variations and contingencies for such rationalizing approaches. I sought instead to explore the broad lines of what conditions make possible what enactments of selves and emotionalities. Specifically, I attempted to show how changes in the organization of nursing work affected emotionalities and interactions between nurses and patients. The kinds of theories I propose involved questioning implicit assumptions about emotions in nursing work and rendering them explicit. I sought to disrupt conventional categories of emotion/reason, inner/outer, personal/public, in order to reconceptualize meanings and practices of emotion work as historically situated, culturally constituted and subject to economic as well as interpersonal dynamics.

Validity, Adequacy and Credibility

Rejecting positivist criteria for making truth claims, qualitative researchers have addressed issues of plausibility, validity and credibility in a variety of ways (Altheide and Johnson 1994; Denzin and Lincoln 1994; Denzin 1989; Emerson 1983; Fielding 1986; Lather 1995; Olesen 1994). Of common concern is the desire to develop interpretive methodologies flexible enough to account for emergent and contingent qualities of social life, yet robust enough to produce knowledges useful for understanding patterns of human interaction.

Even before the 'crisis of representation' (Lather 1995), emotions have been problematic for social scientists to investigate. They are often less visible to observation than many other activities or expressions, and defy attempts at objectification, seemingly affiliated with subjective responses and displays. Debates among experts on emotions in various disciplines continue unresolved as to whether, and which aspects of emotion are 'physiological' and which are 'socially constructed.' Answers to these questions suggest very disparate methodologies and methods.

Following Catherine Lutz and Lila Abu-Lughod (1990:1), I have chosen to "examine discourses on emotion and emotional discourses as social practices." This approach attempts to de-essentialize emotions, examining how emotional processes shape and are shaped by socio-cultural dynamics. Proposing to investigate "the genealogy of

'emotion' itself," Lutz and Abu-Lughod suggest that "emotion discourse might represent a privileged site of the production of the modern self" (p. 6). I would take this line of thinking a bit farther, and suggest that emotionalities are embodied responses that, like languages, are the result of collective 'definitions of situations.' I have tried to show how these 'languages,' in forms of emotional enactments, are contextual. And that changes in the organization of nursing work, over time, alter the conditions of interactions, and therefore contribute to shaping what kinds of emotionalities and selves are possible.

The plausibility of my findings rests in part on these theoretical perspectives about the nature of emotions, languages, interactions, and the collective construction of meanings. In other words, suggesting that emotionalities are altered as the contexts for enacting them change depends on accepting that emotion is in part a discursive category whose meanings are situated historically. Epistemologies, methodologies and methods are deeply linked and co-constitutive (Clarke 1997). Making a case for plausibilities in one of these dimensions is nested in entertaining the validities of the others.

It is not possible to take the terms and perspectives of these nurses about their own emotion work at face value. In the primary perspective expressed by the nurses interviewed, emotions are natural, personal, internal responses to situations. They are also tacit knowledges often understood without articulation. As Henrietta Moore (1994:76) explains,

> [F]or an actor to strategically invoke or revoke certain meanings, it is not necessary for the actor to be involved in conscious, intellectual reasoning about alternative interpretations and strategies, though there will be occasions when this is the case. The ability to pursue alternative strategies within symbolically structured space requires no more than the practical knowledge of how to proceed within that space, of what you should and should not do.

These practical knowledges of tending and managing emotions are taken for granted, invisible, undervalued and very important in processes of health and healing. It would not be sufficient to 'give voice' to these workers, although that has been important. As Sherry Gorelick (1991:465) has pointed out, "the structure of oppression is often hidden." These nurses were quite aware of the limitations of their power within medical and bureaucratic systems, yet I would claim that their conceptual frameworks about emotions serve to reinforce some of those limitations.

In discussing her analyses of stories told by women with HIV/AIDS, Patti Lather (1995:50) noted that "there is both frequent use of ready-made cultural discourses and some sense of the inadequacies of available language." From the perspective of nurses working with healing, there is also a dearth of vocabularies to convey the full meanings and actions engaged. Throughout this analysis, I have chosen to remain close to paradox, seeking vocabularies of emotion yet knowing that some aspects of my subject must remain beyond language. In an essay on validity after poststructuralism, Lather (1995:54) refers to the possibilities of

> feminist efforts toward a double science that endorses neither the collapse of the referent nor its transparency. Paradoxically, in the postmodern moment, the mystical, then, is 'a material turn,' a gesture toward bodies that exceed social constructions.

In the current moment of deconstruction, fragmentation, transformation and reconceptualization, I remain humble about the credibility of these interpretations of meanings and practices of emotion work. I have attempted to highlight vocabularies of emotion within contemporary contexts of nursing work as an assertion of articulation and reflexivity about processes and disappearances clouded by layers of invisibility. If I have been more successful at making visible *languages* than *processes*, it is in part to respect certain untranslatabilities. It is also in recognition of the limitations of even the best social science research to capture all of the complexities and nuances of human interactions.

Writing the Narrative Report

The last task of this project has been to write up the 'findings.' Recent critiques (for example Behar and Gordon 1995; Clifford and Marcus 1986; 1996; Ellis and Flaherty 1992; Marcus and Fischer 1986; Van Maanen 1988; 1990) have rendered problematic previous assumptions about the transparency of language, and drawn attention to the importance of textual practices in the creation of knowledges. Standard literary formats of academic writing that guide how experience is defined, organized, selected and presented, have been questioned for implicit content and claims of authority. 'Facts' have been sundered from the means of their production, and it is necessary to create texts that explicate how we know what we know (Altheide and Johnson 1994).

I chose to frame my story in a style of writing that would convey a 'realist tale.' (Van Maanen, 1988). I remained primarily 'outside' of the text, speaking as one who has gathered all of this material and is now presenting it. It is a classic, 'factual' style, much like the Times New Roman font bouncing along this computer screen. It is designed to keep distractions minimal and focus attention on the logical unfolding of the arguments and the stories. I used the voices of the respondents liberally, but remained clearly in control as I cut and juxtaposed to meet my research agendas. I also included quotations from nursing texts and other written sources to illustrate my arguments. I attempted to maintain a linear flow throughout the telling of the tale.

I found this style of representation to be familiar and comfortable. It allowed me to raise theoretical questions and develop substantive analyses. A different approach to conveying emotionality might have involved a more ethnographic style, using thick descriptions to evoke emotional understandings in my readers. As I explained earlier, this approach would have resulted in foregrounding different aspects of emotions and work. I have been astonished to realize, as this story unfolded in some ways according to logics of its own, how other possible stories remained unwritten. Each word and each paragraph is a choice that leaves other options behind.

I have prioritized directions of inquiry that have dealt meaningfully with issues raised by the profound grief and concern that led me to embark on this investigation. At times, I have felt these cognitive languages too stark and too dry to convey the full range of knowledges, skills, losses and possibilities embedded in practices of emotion work. But meanings are interpretations mediated through languages, even if some of those are extra-linguistic. And for whatever reason, I have been given the gift of language...

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