The emotional labour of nursing 1: exploring the concept

This article discusses the concept of emotional labour in nursing in relation to stress and burnout

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This is the first in a two-part series on emotional labour, a trained and individualised response to help manage the emotions of patients. It reviews relevant literature to define and explore this concept in nursing, and considers examples of emotional labour and makes recommendations for future policy and research. Part 2 of this research, to be published in next week’s issue, examines routine aspects of emotional labour in nursing and the barriers to recognising this aspect of work.

**INTRODUCTION**

This literature review explores contemporary notions of care and examines the role of nurses’ emotional labour in health services. It assesses the significance, difficulties and therapeutic value of this issue. The article reviews examples of ‘good’ and ‘bad’ patients and children’s oncology to illustrate the therapeutic potential and challenges associated with emotional labour.

Reviewing these and other areas helps to evaluate the benefits and problems linked to close interpersonal contact in health services.

This is significant, particularly as emotional care and labour, and accompanying feelings of stress in nurses affect the retention of much-needed staff and influence the quality of nurse-patient relationships (Firth-Cozens and Payne, 1999).

This review is therefore helpful in an initial examination of the culture of care in health services and changing techniques of health and healing. In nursing, this helps in appreciating the everyday ethical and emotional dilemmas that staff face when supporting patients and families (Smith and Lorentzon, 2007; 2005; Smith, 2005).

**DEFINITIONS OF EMOTIONAL LABOUR**

Hochschild (1983) said that emotional labour involves the induction or suppression of feeling to sustain an outward appearance that produces in others a sense of being cared for in a convivial safe place. Emotional labour is typified by three characteristics (Smith and Lorentzon, 2007; 2005; Smith, 1992; Hochschild, 1983):

- It requires workers to produce an emotional state in another person;
- It allows employers to have a degree of control over workers’ emotional activities, through training and supervision.

Smith (1992) applied the notion of emotional labour to a study of student nursing, concluding that further research was needed, which she has since explored in much detail (Smith and Lorentzon, 2007; 2005; Hunter and Smith, 2007; Allan and Smith, 2005; Smith, 2005; 1999; 1992; Smith et al, 1998).

The term ‘emotional labour’ draws attention to the similarities as well as differences between emotional and physical labour. Emotional labour requires an individualised but trained response that helps to manage patients’ emotions in the everyday working life of health organisations (Smith and Lorentzon, 2007; 2005; Allan and Smith, 2005; James, 1993). James (1993) wrote: ‘The phrase “emotional labour” is intended to highlight the similarities as well as differences between emotional and physical labour, with both being hard, skilled work requiring experience, affected by immediate conditions, external controls and subject to divisions of labour… Emotional labour is an integral yet often unrecognised part of employment that involves contact with people.

‘It has been argued, and counter-argued, that emotional labour demands an individualised but trained response which exercises a degree of control over the emotional activities of the labour, and thereby commodifies their feelings.’

The health setting, in which emotional labour is an important part, needs to be examined in terms of its external controls and emotional divisions of labour between professions (Gray, 2009). James (1993) suggested: ‘Emotions can be regulated with varying sophistication and with various outcomes… Like other skills, emotional labour requires flexibility and adjustment. It involves anticipation, planning, pacing, timetabling and troubleshooting… At its most skilled, emotional labour includes managing negative feelings in a way that results in a neutral or positive outcome.’

Certainly, such definitions need discussion and clarification. The history, division and application of emotional labour to nursing still require us to ‘grapple with the conceptual complexity of defining care, especially in relation to its emotional components and demands’ (Smith, 1992). This means dealing with what is often an invisible skill.

**IMPLICATIONS FOR PRACTICE**

- Future research on emotional labour in health services should engage other professions, patients and relatives, as well as voluntary and advocacy groups.
- Gender, personal and professional barriers to recognising emotional labour should be studied and noted.
- The ways in which these barriers influence health practices should also be investigated (Gray, 2009; Gray and Smith, 2008).
- More research and in-depth mapping of emotion in organisations needs to be done.
HISTORY AND INVISIBILITY OF EMOTIONAL LABOUR

Historically, a pathway to understanding emotional care and nurses’ role in providing emotional support has been closed down by social and political factors in academic and clinical contexts (Ellis and Bochner, 1999). Emotional labour has traditionally been identified with ‘women’s work’ and the mother’s role in the family. This is especially significant, given that images of nursing still focus on the caring female, particularly with the prototype of Florence Nightingale (Gray, 2009; Smith, 1992). The portrayal of emotional care as an entirely natural activity for women is certainly related to the devaluation of emotional labour in cultural, gender and economic terms.

Even today, research and nursing practice tends to be concentrated on the more visible aspects of care and palpable outcomes of medicine, such as the acquisition of clinical skills and knowledge.

Science, viewed as a purely rational and objective enterprise, cannot tolerate the irrational and subjective components of human feeling (Gray, 2009).

Some might suggest that many are scared by emotions and unwilling to acknowledge the difficult and sometimes painful feelings that are often part of caring for patients.

Emotions are professionalised to present an impersonal approach of medicine to staff, colleagues, patients and wider society (Hochschild, 1983). This professionalisation is certainly one strategy to cope with: difficult medical experiences, particularly death and dying (Kelly et al, 2000; Barnes et al, 1998); the pressure of making mistakes (Barnes et al, 1998); and the uncertainties involved in exercising medical knowledge (Barnes et al, 1998; Lawler, 1991). However, emotional labour in this context is largely hidden behind a ‘cloak of competence’ in the case of medical students (Haas and Shaffir, 1977). Meanwhile, nurses’ efforts to provide interpersonal and emotional support are swept under the carpet, taken for granted and devalued.

This shows there are social and political components to emotional care that are transmitted from the past and crystallised in ideas of appropriate and inappropriate intimacies in nursing.

There is a hidden and largely unwritten history of emotions in society and emotional labour in nursing that is waiting to be rediscovered. James (1993) argued: ‘The British NHS is an intriguing indicator of western changes in negotiations over the expression of emotion.’

NEW MODELS OF EMOTIONAL LABOUR

The medical framework should be reinforced with social, psychological and sense-making accounts that draw on patients’ and nurses’ narratives (Gray and Smith, 2008; Ellis and Bochner, 1999; Smith, 1992).

Denial of emotional labour prevents the possibility of opening up new approaches of emotion and intimacy in nursing practice. Nurses are encouraged to do that by [a specialist cancer centre], I think that’s what all caring agencies promote, that’s normal and maintained as much as possible.

But I think towards the end of that little child’s life, it was taken to an extreme by health and social services and the parents. The little boy was apparently having nightmares and could see ghosts but, because the little boy’s parents had been told to maintain the norm, they didn’t know when to step away from the norm and show their emotions. The doctors and parents had in a sense stopped listening.

I said that it would be good to move the little boy in with the parents, into their bedroom in the last week, but nobody wanted to take on board the fact that the little boy was so poorly and needed to be closer to everyone.’

Source: Gray and Smith (2008)

REFERENCES


debate that may in turn influence more democratic alternatives of clinical practice. Ellis and Bochner (1999) argued: ‘To move in the direction of a narrative, evocative, medical sociology is to give more room to the sense-making struggles of people whose illusions of prediction and control have been interrupted by illness or death.

‘The move means giving up the notion that our work should protect us from the pain and difficulty of living. It requires our willingness to be uncomfortable and vulnerable along the way... In the end, all of us might feel better and know more.’

If, as Staden (1998) says, ‘a language to communicate care work does not exist’, then research must investigate the ways that emotions are dealt with in a variety of healthcare settings (Gray and Smith, 2008). Making emotional labour explicit and more visible in nursing practice gives nurses a better chance of coping adequately with the emotional pressures, stresses and strategies involved in patient care.

‘GOOD’ AND ‘BAD’ PATIENTS

As well as being at the heart of each individual nurse, emotional labour is also a social matter insofar as emotions are regulated in health services as part of managing closeness of staff and patient contact. It is also part of establishing
informal intimacies and showing patients that nurses care (Gray, 2009). In terms of managing closeness with patients, taboos of intimacy are often formed to deal with perceptions of appropriate and inappropriate contact (Gray, 2009; Savage, 1995). Emotions associated with nursing patients are central in this process.

For example, healthcare professionals often divide patients into ‘good’ and ‘bad’ categories. The division of ‘good’ and ‘bad’ patients is partly based on the social control elements of nursing, with ‘good’ patients viewed as more compliant than those categorised as ‘bad’ (see also Zapf and Holz, 2006; Lawler, 1991).

A ‘bad’ patient, according to one nurse, is someone who ‘brings an illness on themselves and can’t really be helped’. Those with mental health or alcohol problems and drug users are all often viewed as ‘bad patients’.

Obviously, dividing patients in such a way places severe limitations on interpersonal contact and makes all sorts of emotional demands on nurses.

The therapeutic ideal of equality in patient treatment sometimes conflicts with personal feelings about ‘bad patients’ (Gray, 2009). However, there is room for discussion, perhaps with a mentor, modern matron, ward sister/charge nurse, nurse manager or teacher, of how conflicts between nurses’ public role and private feelings about ‘bad patients’ may be resolved.

Reflecting on conflicting emotions about ‘bad patients’ or even patients in general and managing difficult events in clinical practice areas are essential to professional development and reflexive nursing practice (Zapf and Holz, 2006; Williams, 1999).

The task of looking at emotional labour in health settings involves assessing the strategies of emotional regulation available to healthcare professionals. This includes analysing how nurses manage their own and patients’ emotions and how nurses come to terms with the difficult processes that are often an unavoidable part of patient care.

Such research will have to explicitly deal with uncomfortable and sometimes conflicting emotions that nurses, healthcare professionals, patients and their families have to face.

**MANAGING DEATH AND DYING IN CHILDREN’S ONCOLOGY**

The length and uncertainty of some treatments, and the often-repressed feelings of patients and nurses may have about difficult medical experiences, mean that professionals inevitably adopt strategies to manage emotion and stressful clinical situations (Gray and Smith, 2008; Staden, 1998).

Sometimes nurses may try to deny the difficulties inherent in medical and nonmedical contexts, and avoid their emotional attachment to patients. Such denial of emotion, when not appropriately reflected on as a necessary strategy for dealing with uncomfortable events and ‘moving on’, avoids a context in which understanding and ways of coping may be developed.

In the children’s oncology setting, nurses have to deal with issues of dying, death, bereavement and managing a ‘good death’. Children’s oncology is an emotive and distressing clinical area in which there is often little hope of a cure and only the possibility of palliative care. Nurses in particular have to learn how to manage a ‘good death’. Emotional labour is a key component for doing this and for managing staff, patients’ and relatives’ feelings.

Although there is a growing shift towards the psychological and social aspects of patient care, an important gap in understanding is the centrality and therapeutic value of emotional labour in patients’ lives. For the perspective of a specialist cancer care nurse on emotions in the children’s oncology setting, which comes from my own research, see the case study in Box 1 (p27).

The nurse in this extract said she felt ‘anger’ and ‘despair’ in the situation, which mirrored the parents’ emotions and also related to the fact that the nurse had her own children. She said her feelings were not dealt with and supported. ‘You can’t show your frustration if you’re a nurse and you just have to sit on your anger,’ she said.

This dissonance between genuinely felt and displayed emotions is sometimes linked with the formation of the ‘hard nurse’ and with high rates of ‘burnout’.

Such an evocative narrative certainly adds to the argument that we need to extend an appreciation of emotional labour to allow a more explicit focus on systems of social and emotional support. James (1993) argued: ‘Cancer is a particularly apt disease to review in order to analyse the management, control and “labour” of emotions in health organisations.’

Children’s oncology is a protracted and painful event for all involved. As this nurse added: ‘People can go through years and years of hoping that someone close to them might live, but knowing in the end they are going to die. I don’t know how nurses and relatives can cope with that, really. They just get on with things and have to get on with things.’

Nurses, patients and relatives are all involved in emotional labour and engaged in reflecting on how to manage medical and emotional demands. All involved have to manage their feelings at some level.

In some cases, this means having to work at maintaining the belief that everything is normal in the patient’s life. In other cases, it means being faced with the uncomfortable task of disclosure or having to manage a ‘good death’ (Zapf and Holz, 2006; Kelly et al, 2000; James, 1993). James (1993) said: ‘The person with cancer and professionals have to regulate their feelings. Even the diagnosis… of cancer is surrounded by its own language – “disclosure”, “communication” and “insight” in health staff’s terms; “telling” and “knowing” in lay terms. At a personal level, cancer generates disbelief, fear, lies and chaos which

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**BOX 2. A NURSE’S VIEW ON BURNOUT**

This cancer care nurse said: ‘I think if you emotionally burn out, you don’t give anything emotionally and patients soon cotton on to that fact. There are lots of nurses who are burnt out and who don’t know how to cope and do erect a wall. ‘But then if you continually give and give and give and give, all the things I might be saying might be the right things, and I might have learnt to say all the right things, but they might not really mean anything to me anymore. ‘Although I was doing what I was supposed to be doing, medically at that point, my emotions weren’t engaged at that point and I had to get out.’

Source: Gray and Smith (2008)
are controlled through information, optimism, routine living and social expectation. ‘

The quotes above from a cancer care nurse support the case that research on emotional labour should involve an assessment of the strategies of emotional regulation that are available to healthcare professionals. This includes looking at:

- How nurses manage their own and patients’ emotions;
- How nurses come to terms with the difficult processes that are often an unavoidable part of care;
- Examples of successful support mechanisms and disclosure for patients, relatives and staff.

Systems of emotional support and ways to cope are essential, especially given staff burnout rates, the attrition of nurses who leave the profession, job stress and obvious emotional difficulties. For this cancer care nurse’s view on burnout, see the case study in Box 2.

Huy (1999) suggested: ‘Individuals obliged continually to enact a narrow range of prescribed emotions are likely to experience emotional dissonance. This reflects the internal conflict generated between genuinely felt emotions and those required to be displayed. This can result in emotional exhaustion and burnout.’

**DISCUSSION**

The task is to identify the relationships that sustain the emotional labour of nursing. In Smith’s (1992) seminal work, this was a prime role of sisters and charge nurses. These practitioners provided not just clinical knowledge – their interpersonal skills informed student nurses about how nurses care and what nursing is actually all about.

While there are pressures on resources and problems of recruitment and retention in UK nursing, this review suggests that nurses continue to provide emotional labour in a variety of difficult as well as everyday circumstances.

Despite the great internal and external pressures of working in health services, nurses use emotional labour to support relationships with patients, relatives and colleagues. By doing this, they keep healthcare organisations running through use of the different techniques of emotional labour that they use in daily practice.

Reflection and supervision of emotions are important methods of preventing burnout and emotional stresses, which are related to high rates of attrition and nurses leaving the profession (Firth-Cozens and Payne, 1999; Williams, 1999).

**CONCLUSION**

There is a need to identify successful policies and examples of good nursing practice that reinforce emotional labour and support patients and relatives.

There is certainly room to develop the role of emotional labour in policy as well as in nurse practice and training. Making this explicit is certainly in line with nursing philosophy, and pre-registration and post-registration nursing courses (Gray and Smith, 2008; Smith, 1992). ■

Part 2, to be published in next week’s issue, examines emotional labour in nursing practice and barriers to recognising this aspect of nursing practice.

**REFERENCES**


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**ESSENTIAL RESOURCES IN CLINICAL AND ARCHIVE ON nursingtimes.net**

**PAIN MANAGEMENT**

A solid understanding of pain and pain management is crucial to good nursing practice. In this three-part section on nursingtimes.net, pain expert Sharon Wood guides you through the key areas

**ANATOMY AND PHYSIOLOGY OF PAIN**

Many nurses have a poor understanding of pain and its management, which can result in failure to treat pain effectively. An insight into the anatomy and physiology of pain is essential to increase nurses’ understanding of what it is and how interventions can help to manage it. This section outlines the basic anatomy and physiology of pain.

**ASSESSMENT OF PAIN**

To provide optimal patient care, nurses need appropriate knowledge, skills and attitudes towards pain, pain assessment and its management. Systematic assessment of a patient’s experience of pain is a crucial component in providing effective pain management.

**INVESTIGATIONS AND GUIDELINES**

Healthcare professionals must be able to describe a patient’s symptoms, aided by the use of diagnostic tools and techniques (where appropriate or possible), with the aim of making an accurate diagnosis. A range of tools and techniques are available to support them in this.