Human care work and emotion: A call to re-examine theory

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Abstract

The shift to post-industrialism in western societies has been typified by an emphasis on worker knowledge as a commodity and growth in service work. Sociology provides a strong foundation to understand this growth as more than just a different type of physical or intellectual work, but also as a form of organisationally defined emotional labour. However, much of this consideration has centred on retail or personal service work, rather than the expanding field of human care service work. This form of service work requires expert knowledge, technical proficiency, emotional involvement and ability with information technology. Further, this work (especially when it involves inequality, poverty, trauma or grief) makes different emotional demands on service professionals. Together, these factors suggest the need for a re-consideration of emotion as it relates to human care service work.

Drawing on recent research into the professional aged care provided by Nurse Practitioner’s, as well as the unpaid care provided by family members to cancer patients, this paper explores the implications of these trends. On one hand, shifting demands in human care work produce new personal demands on service professionals. On the other hand, shifting boundaries in care work mean informal carers are required to increasingly take on the emotionally demanding task of balancing family and care-work relationships. The paper will argue that sociological considerations of emotion as it relates to human care service work could benefit from a renewed role for agency and advocate for interactive (in addition to structural) approaches to understanding human care work.

Key words: human service work, professional carers, family carers, emotional labour, affect.

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In this paper, we call for the re-examination of sociology of emotion theories to allow for the increasingly pluralistic, genuine/manipulated and interactive nature of emotions within human care work. We start by summarising changes to work, from industrialisation through to late modernity, then summarise changes to human care work. We review the largely structuralist
approaches that have been used and reworked to understand emotions at work. We then call for a sociology of emotions theory that can offer more flexibility in interrogating the broad range of implications for human care workers as the distinctions between public and private, work and home, genuine and manipulated become less relevant.

Industrialisation prompted a split of the public-work realm and private realm (Pocock 2009). Work became more mechanised and workers were expected to leave relationships and emotion at factory doors (Grandey 2000). Classes were politically pitted against each other, making structuralist Marxist perspectives highly relevant (Bonefeld & Holloway 1991). Emotions, however, were played down in such views, with structural change to bring about the end of capitalism seen as the ‘main game’.

Post-industrialism saw the nature and place of work change again. Middle-class work became more information and knowledge-based (Touraine 1971; Bell 1974; Gorz 1982). Production became more flexible and consumer-focused (Amin 1994). This resulted in a growing service economy, an emerging knowledge economy, and an increasing emphasis on autonomy and reflexive individuality.

Late modernity sees a further shift from these industrial divisions. More labour is occurring back in the home and theorists are increasingly identifying a blurring of work and life categories (Pocock 2008; 2009). More health and education services are supplied by private providers and the responsibility for managing these services increasingly falls to individuals and families (Dow & McDonald 2007). Furthermore, where such services had previously been supplied using Fordist rationales, increasingly there is an emphasis on flexible service delivery, community-based approaches and client choice.

In health specifically, we have witnessed substantial shifts. In place of paternalistic models of healthcare delivery, ‘patient autonomy’ is now a principle prioritised alongside beneficence and non-maleficence (Kerridge, Lowe & Stewart 2009). Cost-cutting imperatives have also motivated a shift in the location and providers of care work. Community-based care and ‘hospital in the home’ models allow for shorter in-patient stays with health care work provided by health professionals visiting patients in their homes (Olson 2012). These changes are having a significant impact on the relative boundaries, and hence responsibilities, in health care work.

This kind of work is now less personal and permanent, is highly stressful, and the need to maintain service quality is high. In urban fringe communities, where encounters with inequality, poverty, trauma and tragedy more frequently occur, this has contributed to growing attrition, fatigue and depression amongst human care service professionals (Dollard 2003). Increasingly, it has been recognised that emotion demands are a vital part of the work of these service professionals.

Over the past 25 years, Hochschild’s work has been predominant in considering this growth in the service economy and employees’ emotional efforts. Hochschild’s (1983) ‘emotional labour’ considers colonisation and commercialisation of emotions: the expectations of service workers to meet organisational standards or elicit responses from clients. However, there have been three broad criticisms of Hochschild’s work:
1) it dichotomises private and public, contributing to a one dimensional understanding of ownership of emotion by the organisation, rather than considering the worker’s agency;
2) it emphasises the negative aspects of emotion in workplaces, neglecting the potential for interactions to be empowering or satisfying; and
3) it is limited in its capacity to capture complexity and contradictory emotional labour processes (Bolton 2009; Brook 2009).

Many attempts have been made to refine Hochschild’s influential concepts. Zapf (2002), for example, argued for new distinctions in the terms emotional labour, emotional work and emotional management. Hochschild (1983) used these terms to distinguish between the processes of managing emotion in the private sphere (emotional work) versus the same process in the public sphere (emotional labour). In Zapf’s model, emotional labour became the feigned emotional response required from service workers in return for a wage. Emotion work became the natural emotional response to demands in the organisational environment. Zapf introduced ‘emotional management’ to refer to emotion manipulations within the private sphere. While dichotomies and limitations in capturing complexity persist, his key contributions were to emphasise agency and recognise that emotion could be natural and positive.

Others have stressed human care service work as distinct from other forms of service work and thus, suggested a need for other distinct emotional concepts that embrace the possibility of both positive and negative emotional labour, liberation and understanding through emotion (Isenbarger & Zembylas, 2006). While Hochschild acknowledges that the concept of ‘emotional labour’ can apply to workers in hospitals, welfare offices and schools, so far, the term has been applied primarily to those working in retail or personal service industries. While we concur that ‘emotional labour’ can highlight the inequalities in emotional exchange and can particularly apply to ‘nurses and teachers [as they] use their emotional work to paper over the cracks of failing public services’ (Bolton, 2009: 556), we also agree that there is more to the emotional investment required by human care workers than producing a smile to prompt a sale (Isenbarger & Zembylas, 2006). Hence, we are also looking for a conceptual category that can provide greater versatility in interrogating the broad range of implications for human care workers as they respond to affective demands in public and private spaces.

In a late modern context, where the nature of work, the structure of the economy, the distinction between public-private, and the boundaries of professional responsibilities are changing, we believe that structurally orientated perspectives alone are not enough to provide this rigour. Further, the neglect of changing personal, emotional and affect demands of work may potentially result in new forms of inequality. Thus, theoretical re-examination is called for.

In this paper, we select two distinct outworkings of the changes briefly outlined above. First, we look at the shifting boundaries of professional health care work and how the emerging role of the Nurse Practitioner not only exemplifies the late modern shift, but also requires new and complex affective responses on the part of these professionals. This example is based on the second author’s (BP) ongoing research involving interviews with Nurse Practitioners in aged care. Second, we look at the shifting responsibilities for health care work from public to private and how this is placing new and intense emotional demands on family carers. This example is based on the second author’s (RO) thematic analysis of longitudinal interviews with 32 carers of a
spouse with cancer (see Olson, 2011). In response to these cases, this paper will call for new approaches to theory that could better encapsulate micro-level meaning making, negative and positive emotions and affect, as well as the pluralistic, contradictory, genuine, manipulated and changing nature of human care work.

Shifting boundaries in health care work – Nurse Practitioners

Nurse Practitioners (NPs) are registered nurses with additional training, expertise and endorsement to provide health care services previously only provided by GPs. First trialled in Australia in 2000, numbers have expanded to approximately seven hundred endorsed NPs in 2012. The focus of the role is providing primary health care in homes and communities, with the intention of improving access to services. In Australia, NPs complete Masters level specialisation in particular scopes of practice. Recent funding changes have sought to make the role more economically viable in the community by allowing registered privately-practicing Australian NPs to access bulk-billed Medicare item codes and approved drugs within the Pharmaceutical Benefits Scheme.

The expanding NP role clearly embodies late modern trends. It is centred on an expanding, highly specialised and technical form of service work. The role relies on high levels of knowledge, sophisticated knowledge creation and efficient knowledge transmission. The role is designed to allow for greater individual autonomy and flexible service delivery. Furthermore, the role sees NPs taking up human care responsibilities outside of large institutional settings, producing new challenges and demanding more reflexivity. Finally, the role can result in raw and more frequent encounters with a range of inequalities, which can impose additional emotional and affect demands on NPs.

The NP role is still in the early stages of establishment. However, in preliminary interviews with NPs working in aged care, Prosser has identified interesting trends. One prominently expressed challenge is that they adopt a holistic primary health care model, while funding arrangements of the new role are built on a medical/clinical model of service. The interviewed NPs explain that while GPs are trained to focus on illness, diagnosis and treatment, NPs have been trained to be educative, preventative and care for the whole-person. While these claims of dominance of the medical model will clearly benefit from structural analysis, it is important to note that the new roles also makes additional relational demands, which, they explain, they meet at their own personal cost.

Another important aspect of NPs’ work with the elderly is the rigorous interaction with clients. These NPs report that because consultations occur outside of the hospital or clinic, and because they are not GPs, clients are much more assertive about their health choices, identities and roles as self-carers. This is a difference from the powerful doctor-patient roles that are extensively critiqued in the more structurally-focussed health sociology literature. Further, in their work with those in later stages of dementia or receiving palliative care, these NPs describe the importance of their relationships with unpaid or family carers. Without a nurse nearby, these carers are vital to monitoring clients in their homes. Additionally, the NPs in these interviews described the demands associated with being the primary point of health care provision for clients receiving
‘end of life’ care. These NPs reported forming closer bonds with their clients, but having to support these clients as they or their family faced (or refused to face) the prospect of imminent death. Their encounters with loss, grief and trauma may be no more frequent than those of health care professionals working with the elderly in other contexts. But, the emotional and affect demands were described as qualitatively different because of the nature of the NP role. Again, these preliminary reports of elements of this new role point to the benefits of using new theoretical approaches in addition to the solely structural to analyse this emerging role in Australian primary health care.

**Shifting responsibilities in health care work – family carers**

Medical systems have always been dependent on family carers overseeing patient care at home, but, as Olson (2012) explains elsewhere, this dependence has gradually increased over the last forty years. At home, carers now administer medications to patients, respond to adverse reactions to medications (such as chemotherapy), provide emotional support and assist with activities of daily living. In hospitals, carers now manage communication, appointments and care of their family member across multiple medical professionals and centres.

While more health care is being outsourced to families, families are simultaneously outsourcing private care work of children and the elderly to the market. The emotional labour associated with care work performed by professionals has been the focus of much sociological inquiry over the past two decades (see Hochschild 2012; James 1992). These studies describe the tension between medical professionalism ideals of distancing oneself from patients and the traditional care work ideals of selflessness and emotional connection. Much of this work focuses on the organisationally imposed aspects of emotional labour. Very little sociological research has focused on emotional experiences resulting from the re-privatisation of care work. To illustrate this point, we will summarise several findings to come out of a study conducted with carers of a spouse with cancer (Olson 2011) related to uncertain or automatic emotions and emotions as a means of resistance.

Carers often described uncertainty about their emotions. One carer wondered, ‘Am I weird?’ when she did not cry at her husband’s funeral. Another wanted to know what other carers were feeling so that he could judge if he was feeling the ‘right feelings’, in terms of intensity and regulation. Because Australians are less exposed to death and grief today, one carer surmised that the emotional norms surrounding these events are unclear and people are less prepared. Without this preparation, many expressed uncertainty about their emotions and feeling norms as carers.

The answers for how carers should feel came from many sources: patients, health professionals, culture, support groups and couples. One carer felt compelled to let his wife set the emotional norms for them. Health professionals were also central in setting and ‘correcting’ the emotional rules, while some carers cited their cultural upbringing as central to how they managed their emotions. Support groups were also said to promote a positive but realistic approach. Several carers explained their emotional approach as an agreed upon strategy between them and their patient. However, temporary deviations in thoughts and despair caused many to experience guilt and shame.
For some carers the feeling rules were clear and automatic. However, others resisted the emotional paradigm prescribed by health professionals, choosing instead to adhere to complementary and alternative medicine recommendations of believing they could beat the disease and being positive about their future together. Others vehemently opposed being told how they should feel. What this illustrates is the pluralistic, multi-directional and interactionist nature of the emotion work done by family carers and highlights the need for the re-examination of the theoretical bases of how we understand human care emotion work.

**Discussion**

The examples above illustrate aspects of the changing nature of human care work in late modern contexts and that post-industrial arrangements need post-industrial conceptual approaches. Neo-Marxist approaches emphasise emotions as a “primary site of social control” and exploitation (Boler 1999: x). Such approaches to NPs’ work might highlight the extent that these professionals use emotion to obscure structural inadequacies in service provision, viewing affective client connections as disincentives to resist inherent flaws in the health system. In the context of family carers, such an approach might highlight the false-consciousness of marriage, compelling spouses to care by exploiting the commitments set out in wedding vows (Glenn 2012). But this approach overlooks the influence of agency, meaning-making, identity negotiation and social bonding associated with changing patterns of caregiving in a post-industrial world.

Similarly, post-Fordist emotional labour literature emphasises the transactional nature of service work and the organisational constraints imposed on service workers. When applied to human care work, it produces an artificial private-public division and treats care as something that only operates to subdue or enhance emotional constraints. However, emotion is far more complex than such a dichotomous view would suggest. NPs are involved in health care work within clients’ homes, which alters the nature of private-public and professional-patient interactions, reducing the physical power and influence of institutional clinical health models on service provision. Furthermore, NPs report experiencing positive and negative emotions, as well as affective responses to elderly people in their care. Alternatively, informal carers are caught in a tension between professional expectations of emotional distance, familial feeling rules and their personal responses to emotional norms. This tension often prompts confusion, guilt and shame, pushing them to seek feeling rule clarification from others. Hence, previous post-Fordist approaches to emotional labour are also limited because they risk an oversimplification of the richness, complexity and diversity of emotion work, as well as its genuine, meaningful and influential place in human care work.

Finally, both the above approaches adhere to a primarily class-orientated approach to human care work. This view is largely dismissive of emotion and affect as distractions or illusions. For NPs, class-based approaches might focus on the funding arrangements developed from a medical or clinical model to argue that this new role is but an expansion of mechanisms to control the working class and blame the individual, with the influence of emotion and affect to ‘soften the blow’ of injustice and maintain the status quo. However, the influence of gender, ethnicity and
ageing was seen to be just as important in NPs’ consultations, while the role itself is worthy of consideration in terms of gender and social mobility. Clearly, for spouse carers of cancer patients, emotion regulation was not just a matter of adhering to prescribed feeling rules dictated by medical organisations or class-based cultural expectations. It also involved consideration and navigation of unclear norms, genuine affect and automatic regulation that led to meaningful emotional exchanges, improved closeness, and, for some, resistance against prescribed emotion regulation. Hence, we argue that class-based ways of understanding emotion regulation may have been more meaningful in early modern or industrial stages, but it can miss the diverse range of competing contemporary influences on human care work.

Towards a new approach

As we see the private becoming public and the public becoming private in post-industrial human care work we need to question the relevance of past distinctions between structuralist emotional labour concepts and more contemporary cultural emotional concepts. This is not to say that structural approaches are no longer insightful or relevant, rather that we also need a theory that allows us to appreciate emotion regulation as simultaneously exploitative and rewarding, that accommodates for genuine feelings of guilt for deviating from cultural norms, as well as grief when faced with the loss of an elderly client. What we need, and what sociology of emotions theorists should prioritise, is a concept that encapsulates the pluralistic, contradictory, genuine, interactive and manipulated nature of human care work in the post-industrial age.

Footnotes

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