Benjamin Gray

Face to Face with Emotions in Health and Social Care

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Dedicated to the carers.

Preface

This book, as the title suggests, draws from the everyday experiences as well as the harsh realities facing people on the frontline. The book recounts the stories and sometimes disturbing emotions of people whose lives have undergone sudden change or even drastic trauma and people whose feelings of comfort and safety have been shattered by exposure to illness, abuse, death, and bereavement. The perspectives and experiences of nurses, social care staff, patients, children, and families are at the core of understanding the importance, challenges, and therapeutic vitality of emotions. The people on the frontline who took part in interviews, on which study is based, are thus owed a huge debt of gratitude for their frankness and honesty. The participants discuss difficult emotions associated with care in mental health, children's oncology, and AIDS/HIV, as well as child protection and abuse, racism, refugee exile, poverty, and social exclusion. Their bravery, openness, and ability to communicate and share their emotions made this book possible. This book explores in further and richer detail the emotional issues raised in health and social care by previous research (Smith 1992, 2005; Smith and Gray 2001a, b; Smith and Lorentzon 2005; Gray and Smith 2009; Gray 2009a, b, 2010); as well as offers a new and innovative synthesis of Hochschild's (1983) concept of emotional labor and Bourdieu's (1977, 1984, 1992, 1993) ideas of cultural/economic capital, habitus, field, cultural reproduction, distinction, and symbolic violence.

There are several colleagues and people who persevered to shape my appreciation of emotional labor and care in the National Health Service and Social Work. Chief among them is Professor Pam Smith, whose introduction to the subject of emotional labor stimulated this book. Our close collaboration helped me to understand, challenge, and redefine emotional labor as originally set out by Hochschild. There has also been great mentoring, assistance, and recommendations for study while I was a student by Professor David Silverman and Professor Charles Watters. I would like to thank Dr. Kenneth Wilson for his mentorship and gentle encouragement. Thanks are also to many advisers through the years, particularly, Jenny Perry, Dr. Carla Reeves, Dr. Stephen Smith, Dr. Catherine Robinson, Dr. Robert Harding, Professor James Arthur, Angela Roberts, Shirley Bowen, Dr. Ray Godfrey, Geraldine Cunningham, Mark Stogdon, and Honor Rhodes.

Finally, this book would not have been possible without the constant help and emotional labor of my family and friends. Monica and Sofia have constantly helped me to rethink and better understand the best qualities of emotion. In this respect also my family—Catharine, Ricky, Richard, Sheona, Mark and Joyce—has shown constant support as well as intellectual and emotional encouragement. Jessica, Jack, Sam, and Zac have helped to keep these pages full of endeavor and honesty through their examples of kindness, vigor, fun, and warmth.

Essex, UK Benjamin Gray

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Chapter 1
Introduction

Emotional Labor in Health and Social Care

Emotions are vital to our lives and at the heart of nursing and social care. Despite their centrality emotions remain largely tacit and invisible in public health and social care organizations, such as the United Kingdom's National Health Service (NHS) and social work services (James 1993a; Smith 1992, 2005; Gray 2002a, b, 2009a, b, 2010; Bendelow and Williams 1998). Emotions go unexplored and undeveloped in public services that are under great economic pressures and sociopolitical upheaval (Fabricius 1999; Bradshaw 1999). Emotions are sometimes avoided as socially and psychologically awkward or even skirted around, often seen as the remit of mothers and daughters in the family or stereotyped as a "weakness" or "women's work" (Oakley 1974, 1984; James 1989). This means that the way public service staff and the people that they interact with feel, very often in difficult and highly threatening circumstances that involve death, bereavement and loss, requires clarification in social science theory and unpicking in terms of health policy and practice. The United Kingdom's health and social work services remain an intriguing and fertile indicator of Western negotiations in the expression of emotion (James 1989, 1993a). Emotions are pivotal to understanding, both about ourselves and the caring relationships made in the social world with others, so have particular relevance for health and social carers who are required to engage with the feelings of patients and families as a matter of routine.

The management of emotions ensures the smooth running of organizations (Saks 1990; Hochschild 1983). Patients and families are increasingly critical of the quality of care and support provided by doctors and nurses in the National Health Service and by social work teams in the community. If health and social care staff do not manage their own feelings satisfactorily then this may undermine their performance as professionals (Hochschild 1983; James 1993a). Emotions affect how staff treat patients, children, and families. If emotions are not managed appropriately it may result in feelings of hostility, lack of trust, and nondisclosure with a subsequent

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vacuum in care. Emotional management is vital to helping people and is valuable therapeutically.

There are therefore many questions that this book will begin to answer in the course of applied qualitative research on emotions in health and social care. It will attempt to answer some difficult and pressing questions that are of relevance to social scientists and health and social care professionals such as nurses and social work teams, as well as managers of services and public policy makers. At the crux of understanding emotion in the public health and social services are the perspectives of professionals, patients, and families. Largely ignored and unheard stories are elicited during in-depth interviews with nurses, doctors, family support workers, managers, supervisors, families, and children.

There are many questions that professionals and people interviewed touch upon which this book makes explicit and throws open for further discussion. What is emotional labor? Why is it of therapeutic and organizational value? Is it easy and natural for health and social care professionals to "switch" their emotions "on" and "off"? Is it easy for those who have to engage people's emotions every day to step back from their feelings? Can professionals gain a quiet space for reflection that helps them understand difficult situations and so work more effectively with people's problems? Or do health and social care professionals bear the burden of their emotional work and carry related problems home with them? Why is emotional labor in the public services predominantly undertaken by women? Why is the expression of emotions seen as feminine? Why does emotional labor go unrecognized and unpaid, giving it low status and little prestige? What are the mechanisms that are used to reduce stress and prevent emotional burn out? How do professionals make people feel better and engage emotions to improve health and social care? How do nurses, doctors, and social work professionals learn to care and continue in the strenuous activity of caring for people on the frontline?

To begin recognizing and assessing emotions, Hochschild (1983) defines emotional labor as the management of feeling that sustains in others a sense of being cared for in a convivial safe place. James (1989) defines emotional labor as the work involved in dealing with other people's feelings, which regulates the expression of emotion in the public domain. James writes:

> I define emotional labour as the labour involved in dealing with other people's feelings, a core component of which is the regulation of emotions… Emotional labour facilitates and regulates the expression of emotion in the public domain (James 1989, 15).

The health and social care settings, in which emotional labor is a vital activity, are subject to external controls and emotional divisions of labor between professions. In the domain of health and social care, emotional labor involves everyday interactions of professionals with patients, children, and families in both the community and the hospital. Most importantly, emotional labor involves feelings of care and support that nurses and social care professionals are constantly called upon to instill.

The concept of emotional labor may be used to define and understand both the content and process of care in clinical and community contexts. Emotional labor is

of relevance to nurses, social workers, family support workers, and other professionals who work with distressed people on the frontline. Emotional labor impacts upon the quality of patient care and family support. Emotional labor provides a model that helps to describe and investigate what are often seen as the tacit and uncodified skills associated with care. The emotional labor of professionals therefore informs interpersonal relations in the health and social care settings. The study of contemporary emotional labor explicates the care relationship. A key question is hence to inquire about the extent that nursing and social care have dealt with emotions and emotional management in the past and how this has changed today, if indeed at all.

Emotional labor is addressed in this study in diverse areas and situations which are pertinent to the nursing and social work professions, such as oncology, education, mental health, sexuality and HIV/AIDS, nurse leadership, family support, ethnicity, social exclusion, child protection, staff and student retention, stress and burn out, and extremely difficult and emotive processes of dying and bereavement. In all of these contexts, emotional labor is a central part of working with people on the frontline. Emotional labor in all these situations is an undercurrent that sustains the smooth running of health and social services. Emotional labor increases the quality of care that is provided to people and helps maintain interpersonal relationships in day-to-day work.

Similar suggestions have been made by a number of studies in relation to the work of secretaries and administrators, who combine local knowledge and expertise to ensure the smooth running of a range of individuals and departments within complex organizations (Davies and Rosser 1986a, b; Rosser and Davies 1987; Saks 1990). Davies (1995a, 56), citing Saks, observes that clerical staff are the key people who "direct traffic," moving consumers through the system. Their job is similar to that of nurses, family support workers, and other social work staff because it requires a wide range of coordinating skills to fill the frontline of a "bureaucratic void," behind which works a variety of specialist practitioners, who are usually male, who are dedicated to specific tasks. This type of frontline work, which combines local knowledge with coordination skills, bears the hallmarks of emotional labor in a number of respects. It is predominantly undertaken by women, it largely goes unrecognized and unrewarded, yet requires a variety of 'people' skills to keep complex organizations on the move.

Given recent changes in health and social care policy and organization, a comparative review of emotional labor in the health and social work professions will help illuminate transforming patterns of care. Comparison will, so to speak, measure the pulse of emotional labor at the heart of health and social services. A review of current forms of emotional labor will be helpful in building an empirically tested knowledge base that is rooted in the practice of nurses and social carers (Phillips 1996; Smith 1992, 2005; Davies 1995b). Emotional labor is better understood if empirically documented and made visible as part of the package of care that is provided by nurses and social workers. From such an evidence base, the contribution of emotional labor to nursing and social work practice, education, and policy is clearer. This means that recommendations for the development of emotional labor can be

made in the light of recent initiatives to improve nurse and social work education and practice (UKCC 1986, 1999a, b; DoH 1999a, 2000a, 2004, 2006, 2008).

Aims

The focus is the negotiation, shaping, and management of emotions in health and social care. Emotional labor is discussed among students and qualified nurses and their lecturers. The views and experiences of family support workers (FSWs), the family support service (FSS), social work professionals, and families in Tower Hamlets are another source of evoking the centrality of emotions to people engaged with the health and social services. Emotional labor is compared in different situations, East London and Essex localities, and when employed by different professionals and semiprofessionals involved in health and social care.

Table 1.1 shows that there are a host of principal elements and aims that are associated with this study of emotional labor in the health and social services.

There are consequently many findings that are relevant to health and social care professionals as well as to researchers and social scientists. There are at least ten outcomes of this applied research on emotions, as listed in Table 1.2.

An innovation of study is to test the horizons as well as the limitations of social and political theory in Hochschild's work. Hochschild's North American social theory on emotional labor is largely a conservative politics of emotion that maintains the status quo (Smith 1999b; Craib 1995; Duncombe and Marsden 1998; Gray 2010). It does not challenge the structural relationships of emotion in the workplace, such as in more radical feminist and critical theory (James 1989). The study will thus assess the contemporary pertinence of Hochschild's view of the managed heart by drawing from the challenging perspectives and politics of emotion reported by professionals and people involved in modern health and social care. Views from the frontline will enable analysis of tensions in ways of expressing, understanding, and dealing with emotions. A consensus or conservative perspective, which is largely the broad strokes of Hochschild's social politics, does not allow study to examine conflicts or emotional divisions in the workplace.

A critical focus of study is the reproduction of emotions in systems of health and social care, which may be explicit and expressed in formal methods of education or implicit in processes of invisible inculcation that occur in the routine of work, during child rearing by the family and in everyday techniques of supervision and emotional management (Bourdieu 1992, 1993; Elias 1991; Smith 1992; James 1989). Instead of preserving the status quo with a conservative politics of emotions this study will assess differences and conflicts between the professions, in their orientation toward emotion work and as expressed in divisions of emotional labor. In this respect, Hochschild's largely conservationist notion of emotional labor will be challenged, synthesized, and reconceptualized by the more critical European social thought of Bourdieu (1977, 1984, 1993). Study will not only assess the horizons and limitations of Hochschild's notion of emotional labor but also outline a new model

Table 1.1 Aims of studying emotional labour in the health and social services

Aims of study
Defining emotional labor and what emotional labor means for families, children, patients, health and social care staff and relatives
Assessing why frontline work in health and social care bears the hallmarks of emotional labor. This will help to understand why emotional labor is predominantly undertaken by women, largely goes unrecognized and unrewarded, yet requires the skill and regulation of feeling as a social and organizational glue (Saks 1990; Gray and Smith 2000c; Smith 1992)
Investigating perspectives of nursing and social care. Nursing and images of nursing develop during the 3 years of nurse education. To examine the ways that family support workers and social workers learn to labor emotionally
Exploring the invisible links between emotions, the body, social and psychological boundaries and sexuality
To look at views of emotional labor, interpersonal contact and mechanisms of social support
The comparison of learning needs and expectations within current educational and mentoring provision
The delineation of the contexts of emotional labor in the health and social services. The study will explore the clinical and non-clinical contexts of emotional labor, drawing from a wealth of participants' experiences in diverse places, including: general practice nursing; mental health; HIV and AIDS; children's oncology and bone marrow transplant; student nurse education; clinical and social support and mentoring; family support; child protection; social work; and local voluntary schemes. This will assist in the comparison of the emotional labor of health and social care staff
Exploring what these different contexts of emotional labor mean for those in them
Investigating interprofessional differences of emotional labor of nurses, doctors in general practice and social care professionals. This will attend to the different ways that the professions learn to labor emotionally. The study documents the different ways nurses and general practitioners deal with emotional labor in the primary care setting. By investigating nurses' and General Practitioners' opinions, the study will touch on issues of sending emotional labor down the line and methods of patient and family consultation
To focus on policies, as well as the health and education practices, that sustain the emotional labor of professionals. This requires an assessment of responses to changes and new methods in health and social services
Assessing the impact of emotional labor in dealing with issues of social exclusion, poverty, health and social care
Describing the psychosocial aspects of emotional labor and what people feel when dealing with difficult health and social care issues
To make suggestions for future research, social theory and development in health and social care

of emotions, which is relevant to health and social care work as well as generic emotional labor in modern capitalist societies.

The experiences of people on the frontline of health and social services will remain at the crux of a sensitively conducted examination on the psychosocial impact of emotions. Quotations and extracts from interviews are lengthy so as not to attenuate people's views and detract from their sometimes difficult experiences. It is vital to include the fullness of people's first-hand accounts in a participatory and experiential way that does not damage or limit people's voices or the rich expression of their emotions. Thus, a narrative, experiential, and qualitative approach

Table 1.2 Outcomes of studying emotional labor in the health and social services

Ten outcomes of research on emotions
The provision of primary evidence as to how emotional labor impacts on the quality of care of families and patients as well as the working environment and performance of clinical level health staff and social care teams
Comparison of strategies of emotional management, which help the smooth running of organizations, in the health and social services
Analysis of gender, the body and emotions, particularly in difficult and emotionally strenuous situations such as cancer and oncology, HIV and AIDS, child abuse and protection, and mental health
Assessment of the educational significance of emotional labor to professionals to inform curriculum development
Recommendations as to how theories, policies and learning tools can be developed to support meaningful change
Presentation of the first-hand experiences of families and patients. The presentation of people's emotions and reflection upon their emotions in their own words
Perspicacious unpicking of the narratives of families, patients and staff. A qualitative approach will examine difficult emotions in health and social care
The comprehensive and scholarly review of sociological, psychological and healthcare studies literature on emotional labor
Comparison of sociological and psychological models of emotions and their relevance to professionals, patients and families
Clarification of social theory and methodology. Recommendations for theory as well as health and social care policy and practice that are grounded in the experiences of patients and professionals

opens up people's voices and emotions in health and social care, allowing them to express emotions in their own words, with their own values and in their own terms. The study focuses on the views of professionals and people on the frontline, drawing from a robust basis of original empirical research on emotions in the public sector. The project aims to propose a new perspective on emotional labor relevant to people's views and contribute to policy and practice in modern health and social care (James 1993b; Gray 2002a, b, 2001; Smith and Gray 2001a, b; Gray and Smith 2009).

The structure of this book tries to reflect the fact that emotions are multifaceted and that emotional labor is employed in a multitude of ways by health and social carers. The stories of participants are quoted at length and discussion in each chapter casts light on the complexity of emotions on the frontline. The book starts with a survey of the literature, which explores different definitions and conceptualizations of emotional labor by a variety of sociologists, psychologists, researchers in health and nursing studies. The unequal history and gender divisions of emotional labor are noted in many of these studies. The review of literature makes a case for focusing more fully on systems of emotional regulation and the way people feel in difficult circumstances in health and social care. Bourdieu's and Hochschild's theories are considered and contrasted to begin to lay the foundations for a new model of emotional labor. Beginning with a review of the literature on emotions in health and social care the study turns to contemporary debates in public policy and practice.

Growing emotional labor in the health and social services is mirrored by a decline in public sector funding. There is an accompanying increase in small and economical services which aim at coping, rather than curing pressing issues of poverty, inequalities in health, and social exclusion (Shaw et al. 2001; Davey Smith et al. 2000; Gray 2009a). Services on the frontline, which cope with increasing demands while having limited funds, are outlined in a description of the East London and Essex areas. This presents demographics and the characteristics of nursing and social services. Study then turns to the sample, methods, and methodology employed in qualitative study to elicit the views of people on the frontline.

The findings are subsequently divided into two parts, which present emotional labor in health care in part one and emotional labor in child and family social care in part two. Part one is composed of three chapters, beginning with an outline of emotions in nursing and then following the pathway of student nurses as they learn to care. Four clinical contexts are then analyzed to study the different aspects and therapeutic affects of emotional labor. Primary care, mental health, AIDS/HIV, and children's oncology show the multifaceted nature of emotion work and the different ways that nurses manage emotions to make a difference in people's lives. Part two begins with defining the macroproblems and emotional dilemmas facing families and workers on the frontline in Tower Hamlets. Ethnicity, racism, and child protection exemplify the struggle of people's emotions in highly difficult circumstances of poverty, stigma, and social exclusion. The management of emotions is an equally strenuous and emotionally draining activity that supervisors talk through with semi-professional workers. Finally, the conclusion will draw together the central findings of the research and describe points of theoretical interest, as well as detailing issues that relate to practice and current policy. The concepts of Hochschild (1983) and Bourdieu (1977, 1984, 1993) will be compared to outline a new model of emotional labor in the health and social work services in modern British society.

Chapter 2
Introduction to Literature and Key Concepts

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

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

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

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

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

Defining Emotions in Public Health and Social Care

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

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

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

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

Gender, Race, and Emotions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Emotions Are Hard Work

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

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

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

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

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

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

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

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

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

Immersing in Emotions Through the Befriending Relationship?

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

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

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

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

Building a Language and a Picture of Emotions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Chapter 3
Health and Social Care Policy and Practice

Nursing Policy and Practice Relevant to Emotional Labor

Project 2000 (UKCC 1986) is based on the principle that nurses must have a flexible and conceptually driven education. This is seen to allow nurses to work in a variety of clinical and nonclinical settings in a rapidly changing National Health Service, during a time of constant change in nursing. Nurses are educated so as to be able to monitor, reflect upon, and assess their practice. This leads some to argue—in quite different ways—that nursing is becoming more academic and research based and the target of harsh ministerial and media criticism (Phillips 1999; Aldridge 1994; Smith 1992, 2005).

The Fitness for Practice (UKCC 1999a), Nursing Competencies (UKCC 1999b), Making a Difference (DoH 1999a), and other more recent initiatives (DoH 2004, 2006, 2008) have attempted to modernize the nursing profession and in the case of nurse education address some of these criticisms. These documents call for a more evidence-based approach to practice, together with the continued expansion and development of the nursing role (DoH 1999a, 5, 2004, 2006, 2008).

The modernization of nursing is related to changes in health service provision and restructuring in the National Health Service. For example, the shift from institutional to community orientated practice and the formation of primary care groups (PCGs) as forerunners of primary care trusts (PCTs) who commission and purchase future health care are indicative of the change in the role and scope of nursing.

The move from the institution to the community influences the types of emotional labor that nurses may provide and shapes the interpersonal relationships involved in the delivery of health care. A prime example is the transition from the psychiatric institution to community mental health. A similar pattern is reflected in learning disability and other areas. Changes in interpersonal contact and emotional labor are necessary within the community location be it in the patient's own residence, health center, or general practice (doctor's) surgery. These alterations may have been impossible or perceived as inappropriate in the institutional setting. It is in this sense that the study will examine primary care and nurses' and General

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Practitioners' (GPs') perceptions of emotional labor. General Practitioners' and nurses' perceptions of emotional labor influence staff–patient contact and forms of consultation in community health care as visualized by the formation of primary care groups.

Central and local organizations including the media (Lawson 1999) acknowledge the current crisis in nursing, focusing mainly on difficulties of nurse recruitment and retention among nurses and student nurses (UKCC 1999a, 22; DoH 1999a, 18–30, 2004, 2006, 2008; Feldman et al. 1999). According to the UKCC:

> Further consideration should be given to how service providers can better support students whilst on pre-registration programmes and as newly qualified nurses and midwives (UKCC 1999a, 23).

Emotional labor is a support for student nurses, qualified nurses, patients, relatives, and other healthcare staff. The review of emotional labor therefore responds to points of local and national priority. The UKCC write:

> The role of lecturers in the teaching and assessment of practice skills needs to be defined… In the immediate future, innovative approaches to practice education are needed (UKCC 1999a: 48).

It is in this sense that the study of emotional labor examines the role of a variety of nursing and non-nursing groups. Lecturers, mentors, students, and others informants are asked to define and reflect upon the extent and application of emotional labor in nursing. The study clarifies the often unrecognized technique of emotional labor and the staff who develop the emotional labor of student nurses.

Emotional labor and learning to care remain largely implicit within local services and national groups. This invisibility is possibly due to perceptions of emotions as privatized and natural phenomena that are inculcated from an early age in the family (Elias 1991; Bourdieu 1992, 1993; Aldridge 1994; Smith 1992; Gray 2010). Often, emotional labor is not fully recognized and summarized with other "essential" categories of nursing. Nurses must "demonstrate a range of essential nursing skills," such as "maintaining dignity", "effective observational and communication skills, including listening," and "emotional, physical, and personal care" (UKCC 1999b, 9). By brushing over the emotional labor of nurses as an essential skill that does not require development, because it is regarded as so "basic,' the techniques of nurses" emotional labor go unappreciated and are not developed as resources for the health services to draw upon. This means that emotional labor remains uncodified and undeveloped in nursing (Smith 1992). Caring relationships in the public domain tend to be perceived as part and parcel of a stereotype of women's private role in the domestic domain (Smith 1992; James 1989; Gray 2010). Nurses are represented as performing a stereotype of female care in the family, as mothers, daughters, wives, and nurses to their children (Bolton 2005). In the health services and nursing, gender stereotypes may indeed sometimes act as a shared link with patients. But this is only in so far as a nurse may sometimes elect to make a patient "feel at home" with familiar gender relationships. For instance, the nurse may choose to dramaturgically act the part of the female carer to make the patient feel "comfortable." Even so, there are obvious differences between the

stereotype of women's private role and the ways in which nurses learn to orientate themselves to care for patients in the public domain. As long as emotional labor is dismissed as "women's work," it remains invisible and the ways that nurses sustain emotional labor are not codified (Smith 1992). Emotional labor, although it has always been an integral part of nursing, should be researched so as to provide an innovative and evidence-based approach of how nurses care for patients. This will result in the clarification and development of nurse practice and education in line with calls by nursing opinion leaders (Smith 1992; UKCC 1999a, 48; DoH 1999a, 2004, 2006, 2008).

Policy and Practice in the Social Care of Children and Families

Overcoming social and economic exclusion is central to the agenda of the United Kingdom's Government. Part of the Government's strategy is modernizing health and social services as well as democratizing access to resources for disadvantaged families (Blunkett 1999; Robbins 1998; DoH 2000a, 2004, 2006, 2008). Innovative and economical interventions that reduce poverty, overcrowding, and social exclusion—which are reported as being on the rise in the United Kingdom—are aimed to prevent compounding health and social care inequalities (CPAG 1997; Audit Commission 1994; Bond 1999). Government, health and social services, and evidence from research suggest that innovative local projects alleviate the pressing welfare needs of children and families (DoH 2000a; Robbins 1998; NCVO 1998; O'Brien 2000; Bond 1999). Local schemes are especially urgent with children and families defined as "vulnerable" and "in need" (DoH 2000a). The target of such projects is families whose experiences of racism, bullying, mental health problems, domestic violence, and physical abuse are the common rule of family and community life rather than an exception in social circumstances.

The central strategy of Government is securing better services and better outcomes for children and families, both locally and nationally. Effectiveness, economy, and quality of support are viewed as compatible linchpins of service provision. Projects are therefore to be efficient, effective, and take account of the needs of local and ethnic minority communities. According to the Department of Health:

> Improving outcomes for black and minority ethnic children is therefore central to our concern. This will be achieved through services which are culturally sensitive and which recognise and value diversity. Users of services must be placed firmly at the centre of service delivery. Methods must engage effectively with children and families in order to discover and understand their needs and wishes. Other stakeholders, including the frontline deliverers of services and operational managers, must be included in order to achieve a balance of perspectives (DoH 2000a, i–ii).

The challenge for frontline deliverers of services is identifying local needs and resources in a participatory way so as to prevent family breakdown and social exclusion.

Social exclusion is compounded by a number of factors. Much of the literature centers on neighborhoods and studies the way factors such as housing, employment, economic development, racial integration, and community capacity impact on the life chances of families living within specific geographical areas (Blackburn 1991; Gregg 1997). For instance, according to Charlton:

> Urban areas (particularly purpose-built inner city estates and deprived industrial areas) tend to be the least healthy (Charlton 1996, 17).

Other studies focus on sectors such as education and health, looking at ways institutions create partnerships to coordinate services that reach out to families on the margins of society. Many of these studies are North American in origin, focusing on the provision of basic parenting skills and education (Tymchuk and Feldman 1991; Ullmer et al. 1991; American Academy of Pediatrics 1998). Various sources, including Government, social services, and researchers, have given attention to the identification of abuse and social support for neglected children defined as in need (Hill and Aldgate 1996; Ferguson 2001; Long and Luker 2000). Some international studies suggest that early interventions through home visiting are particularly effective in preventing domestic violence, child abuse, and neglect, in the UK (Long and Luker 2000; Barker 1988; Van der Eyken 1982), Ireland (Ferguson 2001; Johnson et al. 1993), Europe (Cox 1993), the US (Olds 1992), and Australia (Lines 1987; Taggart et al. 2000). Programs have decreased social isolation through parenting skills, better self-esteem, and competence.

It is extremely important to note, however, that several other studies report increased or exacerbated domestic violence when women seek support such as education, training, and work that would raise women's socioeconomic status in public life (Raphael 1996, 2000; Tolman and Raphael 2000; Pearson et al. 1999). Approaching people outside the family may make some women more vulnerable to a violent reprimand from their partners (Pahl 1982). This is even more of a dilemma if one considers that domestic violence is linked to child abuse. Stark and Flitcraft write:

> Wife abuse… is the major precipitating context of child abuse. Children whose mothers are battered are more than twice as likely to be physically abused than children whose mothers are not battered (Stark and Flitcraft 1985, 47).

To be sure, Frost (1999) notes that inadequate training and the attempt to deal with domestic violence as a family issue may place women and their children at greater risk of abuse. Family support workers and informal carers may be faced with the dilemma of responding effectively to domestic violence and child abuse despite having only limited knowledge of the issues involved. This makes close interface and training with the social work team highly important (Ferguson 2001; Johnson et al. 1993; Houston and Griffiths 2000).

Innovative local projects are a small step and have limitations in addressing the overall impact of relative poverty and social exclusion. Despite overhauls in Government policy the gap between rich and poor in the UK continues to widen. Poverty and inequality continue to grow despite the centrality of health and social care to the Government (Shaw et al. 2001; Davey Smith et al. 2000; Gray 2009a).

Despite this, there is evidence both in the UK and abroad that local projects such as the family support service shore-up an overburdened health and social service system. Family support projects based in the community act as an informal interface between families and social workers. Families are put in touch with the services and resources that they need: whether social services, benefits, counselling services, legal advice, or local action groups. This means that the worst effects of social exclusion and poverty, if not remedied, are at least ameliorated (Van der Eyken 1982; Ferguson 2001; Johnson et al. 1993; Olds 1992; Taggart et al. 2000). Taking into account the breadth of literature, there is the need to look at a multiplicity of factors that combine to exclude individuals from the social, psychological, economic, and political mainstream (NCVO 1998; Parkinson 1998; Scorer and Jarman 1998; Blunkett 1999; Association of London Government 2000).

Chapter 4
The Local Areas and Services

Demographics

The study is set among nurses and social care professionals in Essex, East London, and Tower Hamlets. This includes Redbridge and Waltham Forest and Barking and Havering Health Authorities. These organizations provide services to the local boroughs of Barking, Dagenham, Havering, Redbridge, and Waltham Forest. These boroughs have a total population of approximately 835,000. The population is ethnically diverse, with approximately a third of people from Black and ethnic minority communities in Waltham Forest, approximately one fifth of Black and ethnic minority communities in Redbridge, approximately 7% of Black and ethnic minority communities in Barking and Dagenham. There is also significant social and economic variation in these areas and unemployment varies from around 8–9% in Havering, Barking, and Dagenham to 19% in Waltham Forest (LETEC 1999, 43). The study also draws from N.E. Essex Health Authority and the Colchester borough to provide a point of comparison and a source of generalization of nurses' views. The study draws from qualified nurses working in hospital, mental health, and primary nursing services in the Colchester area. Colchester borough is the main setting, with a population of approximately 150,000. People living in the area are predominantly White/Caucasian and only some 2–3% from ethnic communities. Unemployment is approximately 5% (N.E. Essex Health Authority 1998).

Tower Hamlets and its neighbor Hackney are the two most deprived boroughs in the UK (ELCHA 1995). According to the 1991 census, Tower Hamlets is revealed as a multiethnic borough, with low levels of home ownership, problems of overcrowding, and high unemployment. The non-White population is 36.6%, with a high proportion of Bangladeshis reaching 60.7% of the population in Spitalfields, where the social service is based. Taking into account ethnic minorities in Tower Hamlets is particularly important given messages from Government (DoH 2000a) and research. Nazroo (1997) found that Bangladeshi and Pakistani people are some of the poorest in Britain and are 50% more likely to suffer from poor health than White people. Compared to the rest of Great Britain, Tower Hamlets has the highest

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proportion of unemployed males between the ages of 16 and 24. Less than half of the women are economically active in the west part of Tower Hamlets compared to an average 67.6% in Great Britain as a whole. Tower Hamlets also has the highest proportion of households with three or more children under the age of 16. In Spitalfields, almost a quarter of the households had three or more children under 16. 14.3% had at least four children under 16 years. At least one in six households in Spitalfields have a density of 1½ persons per room —defined as overcrowded.

Description of Education, Health, and Social Services

The study of emotional labor draws from the experiences of nurses in Essex and East London as well as the perspectives of families and social care professionals in Tower Hamlets. Nursing, education, and social care in these localities have service priorities to deal with their populations and challenging health and social care issues. It will be useful to outline these priorities and give a description of the health and social services in the areas under investigation.

Student Nursing in Essex and East London

Student nurses are recruited to the Essex and East London campuses from the local area, nationally and internationally. Most are from inner and outer London and the Essex region. The total number of student nurses at any one time is approximately 1,000 at maximum capacity, although this figure fluctuates and has risen since January 2000. These students are recruited throughout the year, forming three separate cohorts that undergo 3 years of student nursing. Cohort numbers range between approximately 100 and 120 students. The total cohort number is divided so that class sizes are about 30 student nurses on average in approximately four groups. Figures will vary with intake.

The curriculum provides a comprehensive preregistration 3-year higher education diploma in nursing, incorporating the branches of adult nursing and mental health at Essex and East London campuses. In addition to the adult and mental health branches, learning disabilities and children's nursing are offered as well as a BSc (Hons) degree program. There are various clinical placements and specialties that the students are exposed to during their common foundation (18 months) and branch (18 months) programmes. These include general surgery; children's nursing; surgery/urology; medicine; midwifery care; acute care; orthopedics; neuro-sciences; coronary care unit; health centers; care of the elderly; learning disabilities; mental health; trauma and accident and emergency medicine/elderly; infection control; day surgery; gynecology; primary care and General Practitioner units; day services; day hospital; child, family, and adolescent services, oncology/hematology, opthamology/ear, nose, and throat; continuing care/respite; and rehabilitation.

The study focuses on emotional labor in the clinical learning environment. In particular student and qualified nurse responses to four contexts of practice: general nursing/primary care; mental health; HIV and AIDS; and children's oncology were frequently mentioned during interviews and were therefore selected for closer scrutiny. A survey of the four clinical contexts allows contrasting methods of emotional labor to be assessed and the different types of emotional labor used by nurses to be evaluated.

In the educational setting, particular attention is paid to the views of student nurses, lecturers, managers, and representative bodies such as the student's council for nursing (SCN). Themes of study relating to the emotional labor of nursing will include the role of link lecturers, personal tutors, and staff mentors in clinical placements and education.

Link lecturers (often referred to as link tutors) are members of academic staff who are responsible for liaison with identified practice areas. Their prime aim is to support students and staff in the practice area. Link lecturers should make regular visits (once in every 4 weeks as a minimum) and consult students and staff about current curriculum developments. Link lecturers organize the innovations, assessments (normally carried out by staff from the practice area), and audits involved in clinical placements. They may also be involved in the student's learning contract.

Personal tutors are members of academic staff who provide academic support and pastoral care. The personal tutor tracks the development of specific students through their 3 years of education. Practice progress, pastoral needs, and academic issues are recommended as topics of discussion.

Practice assessors (or mentors) are registered practitioners who work within the practice area with students. Mentors are responsible for developing, monitoring, and assessing student progress. As a regular member of nursing staff, the mentor is expected to provide necessary support and advice during the period of the student nurse's placement and act as a role model. Advice is to be given on achievement of learning outcomes and competencies. The link lecturer is expected to liaise with practice assessors/mentors.

The gender mix of student nurses is predominantly female. Taken from the last two cohorts in 1999 the percentage is calculated to 84% female and 16% male. 58% of the same sample of student nurses report themselves as White; 30% report themselves as Black (Caribbean/African/other); 6% are from different Asian communities (Indian/Pakistani/Bangladeshi/Chinese/other); and 6% list no category (listed as other/not prepared to say/not known).

Social Care in Tower Hamlets

The family welfare association's (FWA's) family support services (FSSs) in Tower Hamlets is composed of three projects: family support (FS), building bridges (BB), and quality protects (QP), as detailed in Table 4.1 (FWA 1999).

Table 4.1 Composition of family welfare association's (FWA's) family support services (FSSs)

Project	Function
Family support (FS)	Funded by the Department of Health to set up and develop an innovative service for socially excluded families. Referrals are taken from education and health services for families in E1 and E2 districts
Building bridges service (BB)	Funded by joint finance to provide home-based practical and emotional support to families where a parent has, or is at risk of developing a mental health problem. Referrals are taken from statutory services for Bangladeshi and Somali families resident in Tower Hamlets
Quality protects service (QP)	Funded by London Borough of Tower Hamlets (LBTH) social services, through their quality protects funding stream. Referrals are taken from London Borough of Tower Hamlets social workers in the children and families division to contribute to social work assessments and interventions aimed at preventing children needing to be looked after

The Types of Families Referred

Families have multifaceted social care issues with some of the characteristics described in Table 4.2.

Many families experience a high degree of life changing events, such as sudden bereavements, being abandoned by partners, and movement of family members between Bangladesh and the UK. Families on the margins of society, who may have a history of poor communication with professionals, are more likely to experience difficulties engaging with social and health services. This means that the family support service has built in a period of engagement with families, during which workers are creative in their response to a family's needs. For example, if a family is particularly mistrustful of the service (as is often the case with Somali families), then workers will concentrate on practical support, such as decorating or accompanying a parent on a visit to school or hospital. This demonstrates their genuine willingness to support the family and gives the family time to get used to the presence of the worker. Some families may take from 3 to 6 months to build up this trust before they are willing to discuss and tackle issues of concern (refugee issues in the case of Somali families). Furthermore, even where engaging the family is relatively straightforward, ensuring that real, long-term change is effected is a slow process and requires a gradual approach. Families from ethnic communities have specific dilemmas and needs. The service often mediates within families experiencing intergenerational differences. Children who have attended school in the UK have quite different cultural values and societal expectations from their parents. The service has experienced this with family members from a broad age range: from conflict between a 10-year-old child and his parents, to a mother with career aspirations who is frustrated by an early marriage and childbirth, which was expected by her husband and parents. When such differences create conflict the service can offer a

Table 4.2 Multi-faceted poverty, social exclusion and healthcare issues

Issues and challenges for families and professionals
Families experiencing social isolation (i.e. not having adequate support mechanisms either with friends or family)
Families not communicating well with each other, particularly around their children's emotional needs
Families not communicating well with other professionals
Parents experiencing behavior management difficulties
Parents having low self-esteem

Table 4.3 The aims of the family support service's interventions with families in Tower Hamlets

Aims of the family support service
To prevent child abuse and neglect
To strengthen parents' ability to set boundaries and manage their children's behavior
To promote the family's ability to fully use other services, including schools and nurseries
To ensure that children's health and development is both monitored and fully promoted
To give the family an opportunity to participate in and contribute to the community in which they live
To enable the family to maximize income and manage household finances

mediating or advocating role. This can be delicate and means helping families think about what works best for them (within appropriate child protection practices) without insisting on child-rearing practices that belong to the majority culture.

Purpose, Ethic and Aims of the Family Support Service

The service has several key purposes that are detailed in Table 4.3.

The service aims to assist the agencies involved with the families to give consistent messages and work to agreed ends; maintain and promote changes in order that improvement is sustained; give definition and clarity to the roles of the professionals involved and thus reduce some of the professional anxiety created by child protection; develop practical ways to communicate and work with other agencies. The ethic of the service is to satisfy these objectives in a number of ways, which are described in Table 4.4.

The service expects to work with a core of 10–13 families at any one time, for 3 to 6 months. In addition, building bridges works with up to 18 families per year and quality protects with 25–30 families per year.

Intended Outcomes and Benefits

There are many outcomes and benefits, as detailed in Table 4.5.

Table 4.4 Ethic of the service

Ethic of the family support service
Working alongside families and not for them
Matching family support workers to families' linguistic and cultural needs
Offering practical support and assistance
Setting realistic and achievable goals through mutually agreed family work plans (both weekly and over 3 months)
Providing intensive support by visiting families frequently (usually twice a week) and regularly
Encouraging children as well as parents to provide input to family work plans
Establishing household routines and offering advice on household management
Improving access to local services through appropriate signposting
Monitoring progress and reviewing family work plans as necessary

Table 4.5 Outcomes of engagement with family support services

For families
Reduced likelihood that children experience neglect or suffer significant harm or need to be accommodated
Enhanced satisfaction with services received because needs are addressed holistically
Enhanced relationships between parents and their children
Greater confidence and self esteem and improved parenting skills among adults
Enhanced ability in household management
Improved well-being
A more appropriate, co-ordinated service provided for families
For local service providing agencies
More effective use of services and resources
More appropriate referral patterns
Greater communication and co-ordination

Staffing and Training

Recruitment of staff is specifically aimed at gaining representation from local communities or from those with similar backgrounds to the client group. There are therefore many family support workers from the Bangladeshi community, several White workers, and a Somali worker. Family support workers have a practical focus and work alongside families in the family home, offering practical help and support with developing and maintaining household routines and parenting strategies. They have a wide range of experience and mostly pre-professional qualifications (for example: counselling skills, first year diploma in social work). They receive training and regular supervision from the project manager and middle management which is an intrinsic and essential support for staff.

Table 4.6 Preparation of family support workers during training modules

Training of family support workers
Social services training: "identifying child protection indicators"
Social services training: "foundation in child protection"
Social services training: "Bangladeshi families in child protection"
Social services training: "young people and drugs"
The national early years network: "communicating with troubled children"
Waltham Forest adult education: "supporting parents and carers"
Hackney Asian women's group: "counselling for the Asian community"
"Listening skills: empathy and maintaining professional boundaries"
London Borough of Tower Hamlets (LBTH) education directorate "working with children with emotional and behavioral difficulties"
LBTH education directorate: "Makaton sign language"
East London and City Health Authority: "paan abuse"
"Dealing with challenging behavior"

Training offered to family support workers touches on many issues that they will encounter when dealing with families in Tower Hamlets, as listed in Table 4.6.

The family support service has gathered resources to be used as whole family activities. A member of staff is responsible for identifying appropriate activities and setting up a resource library. The library also keeps a stock of diaries, calendars, folders, and notebooks to facilitate families in organizing their time, attending appointments, and communicating with schools.

A child psychotherapist and a clinical nurse from the Royal London Hospital offer fortnightly case-work consultation to the team. This has proved very useful in gaining expert insight into complex issues and in allowing time to consider specific cases in detail.

Funding and Management

The annual budget is £90,000 per annum for the family support service from the Department of Health. £43,000 is allocated to building bridges by joint financing and £106,000 to quality protects by Tower Hamlets social services. The project manager reports to a designated family welfare association service manager who is accountable through the family welfare association's director of family and community care to the trustee board, which has ultimate responsibility for the service. A number of organizations support the development of the service and, as they were already "signed up" to the project, were invited to join the steering group which was set up to guide and monitor the development and delivery of the service. The steering group has thirteen members with representatives from social services, education, the community partnership section of the local authority, the health authority, and local community organizations including those representing Bangladeshi and Somali groups, as well as the family welfare association service

manager. Thus the family support service is well established locally and well linked with local mainstream voluntary and statutory services.

Recording and Review Procedures

The service keeps open records, which are available for the family to read and are kept secure in the family welfare association's office. At the initial meeting, an information form is completed with the family. A written agreement is completed within the first 2 weeks of work with families, or later if necessary, objectives and work plans are set out in this agreement. During the initial 2 weeks workers spend time breaking down families' overall objectives into goals that are achievable within the 3-month working period. A copy of this written agreement is then sent to the family and the referrer. Following agreement by the user, the project manager can contact other agencies involved with the family. Confidentiality guidelines and approaches to child protection issues are discussed with the family at the first meeting.

Family support workers fill out contact sheets, which contain notes of each visit to the family. These are kept in the case file along with copies of letters, notes of issues agreed at supervision, review notes, notes of planning and/or child protection meetings, copies of certificates of children's achievements, copies of rotas agreed with families, and examples of work completed during family activities.

The project manager and the family support worker meet with the family at the end of 3 months to review progress. They agree either that the work has been satisfactorily completed or they agree to work for a further 3 months with the family. The referrer may be involved in this discussion. A review report is sent to the referrer, a copy kept on file and a copy may be given to the family. The family can contact the service again at a later stage if they feel they want further support.

Progress of the work with particular families and issues of mutual concern are discussed at meetings or by phone with other professionals involved. As many families have several professionals involved, these meetings of professionals are sometimes organized by family support service staff to ensure coordination.

Chapter 5
Sample, Methods, and Methodology

Sample and Methods

The qualitative data of this study of emotional labor were primarily collected at intervals over a period of three years (1999–2002) (Gray 2001, 2002a, b; Gray and Smith 2000b, c). The data were built upon by later research (2005–2009) (Gray 2009a, b, 2010; Gray and Smith 2009). The research took into account a variety of sources in the health and social care sectors, which are described in Tables 5.1 and 5.2.

Notes were taken at interviews to make the encounters as easy for people as possible. Much time was spent in cultivating informal relationships, which also acted as an element for information gathering and furthered the research questions. Some initial research questions and an interview schedule may be found in Appendix, although interviews were largely guided and led by participants. Interviews were semistructured and left open so as to not lead, limit, interrupt, or interfere with people's experiential and first-hand accounts.

Case records were highly detailed and contained many relevant data, which included recommendations made by referrers; notes made by family support workers, managers, and supervisors; service agreements signed by the family support service and families; comments made by families (both adults and children); activities, timetables, and drawings made by children; face-to-face and telephone call records; letters and communication sheets to and from local and national organizations; referrals made by the family support service to other services; written material from case reviews and special/urgent meetings; and records of case closures. Most case records exceeded a hundred and fifty pages. All nine of the families that were interviewed were also part of the data drawn from case records.

There were also meetings with nurses and lecturers at three research seminar groups. There were eight meetings with managers at the family support service and four meetings with family support workers. Two focus groups totaling two hours each were held with family support workers. A dozen focus groups were held with

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Table 5.1 Interviews ($n = 55$)

55 Interviews of 45–90 min	
Families	*Professionals*
9 families engaged with the family support service (FSS)	33 health professionals (14 pre-registration nurses, 15 qualified nurses and 4 general practitioners)
Ethnicity of families	4 managers/supervisors from the family welfare association and family support service (FSS)
6 Bangladeshi (four translated by Sylheti speaking family support workers)	3 members of the family support service's steering group
2 White	3 professionals who had referred to the family support service
1 North African	3 professionals who had not referred to the family support service
Project of family	
4 family support (FS)	
3 building bridges (BB)	
2 quality protects (QP)	

Table 5.2 Case records of the family support service ($n = 30$)

30 case records of families	
Ethnicity of families	*Project of family*
17 Bangladeshi	14 family support (FS)
9 White	10 building bridges (BB)
3 Somali	6 quality protects (QP)
1 North African	

the convenors of the clinical leadership program at the Royal College of Nursing (RCN) around issues of nurse leadership and emotional labor. There were many meetings with staff, mentors, students, administration, management, the social work team, the student council for nursing (SCN), and local nurse representatives. Eleven sample questionnaires on emotional labor and sixteen sample questionnaires on images of nursing were collected from student nurses. Attendance during student nurse classes (for example, images of nursing) on the common foundation program helped to get a grounding on the stages of nurse education, in so far as nonparticipant observation revealed the way that students gradually professionalized and the ways in which emotional labor was slowly internalized by student nurses. There was routine participant and nonparticipant observation of student nurses in educational classes and during formal and informal meetings. The study also draws on curriculum documents, informal meetings, hand-written notes, tape-recordings, and mental note-taking.

Five family support workers were shadowed by the researcher when they visited families. There was participant and nonparticipant observation of interaction with mothers, fathers, and children. Notes were taken discreetly during and/or after these visits. Focus groups were held the family support service project's steering group. Family support workers were trained to proactively translate during interviews with Bangladeshi families who had not acquired the English language and spoke in Sylheti (family support workers described Sylheti as a Dhaka dialect of the Bangladeshi/Bengali language similar to the London dialect of Cockney).

Methodology

The study draws from the traditions of empirical qualitative data collection and ethnomethodology (Garfinkel 1967); grounded theory (Glaser and Strauss 1967), and the collection of data based upon people's views of emotional labor; and feminist studies in health, which are especially relevant given that on average 84% of nurses and 90% of family support workers are women who are relatively underpaid when compared with other public service professionals of similar status such as teachers, police officers, lawyers, and doctors. The methodology echoes some of the components of preceding studies on emotional labor and perceptions of underpaid and undervalued women's work in society (Smith 1992; James 1989, 1993a; Oakley 1974, 1981; Bolton 2005; Gray 2010).

Ethnomethodology (Garfinkel 1967) looks at practical reasoning and purposefully orientated action in social life. In particular, ethnomethodology concentrates on people's commonsense accounts of the social world. In other words, how people make sense of the social and historical circumstances in which they find themselves. Ethnomethodology investigates the tacit and commonsense reasoning of people (termed "actors" or "members") in different social situations or "contexts." Accounts of the social world are termed "members' meanings" and the object of inquiry is to gather these meanings and relate them to contexts of interaction among people. This is called "indexicality" or "context-relatedness" of action, in so far as the person or member will purposefully orientate his/her action not only to a perceived end but also according to the immediate environment/social milieu. For example, the meaning and appropriate type of emotional labor will vary in different clinical contexts of nursing work. The nurse organizes the type of emotional labor that is required according to the clinical context, the needs and views of other people present, interactions with staff and patients and the immediate circumstances of work.

Grounded theory (Glaser and Strauss 1967) uses a theoretical sampling approach to generate explanatory and descriptive models of the social world. Grounded theory looks at the first-order accounts of people and then generates second-order models that offer a complement or fit. In this way it is very similar to the sociological phenomenology of Schutz (1972). For example, a person's account of a difficult incident involving conflict at work might be grouped under the theoretical category of "professional differences," "interpersonal conflict," or "gender conflict." The researcher must look at the person's account closely to generate the most relevant category. Grounded theory works by the continuous collection, coding, and analysis of data. The researcher will decide on what further questions to ask, the central hypotheses of the research, and who to interview depending on data collected and the preliminary categories that are generated.

Feminist studies of the social world are particularly influential in the present study and are helpful in making gender relationships and inequalities at work more visible. This is particularly relevant given that women make up a high percentage of the modern workforce, the sample of the present study, and that stereotypes of

nursing and emotional labor tend to be female. Feminist studies (see Oakley 1974, 1981; Smith 1992; Davies 1995a; Gray 2010) are important in the exposition of gender differences; social and emotional divisions of labor; perceptions of natural and cultural work that determine gender status and remuneration; the influence of capitalism in women's lives, both at home and at work; patriarchy and the domination of professions perceived of as male; and mechanisms of social and emotional exclusion. Feminist studies are predominantly by women, about women, and for women.

An interesting aside to note is that these methodologies all developed and came to fruition during the post second world war and radical counterculture period. Ethnomethodology, phenomenology, grounded theory, and feminism may all be seen as modern attempts to escape from the prison house of structuralism, which is a largely impersonal and monolithic explanatory framework. The counter culture of the 1960s, in particular, brought a new focus on personal and political issues and their impact on emotions, sociopolitical formations, and the shaping of modern identities. The counterculture may also be seen as a reaction by people and intellectuals against the horrors of the second world war and the holocaust, especially the totalizing philosophies and ideologies that propelled Europe to the brink of destruction (the largely structuralist and impersonal ideologies of National Socialism, or Nazism, and Stalinist Communism). Ethnomethodology, phenomenology, grounded theory and feminism return to focus on the person and their intersubjectivity with other people in order to gather the minutiae of people's everyday accounts and hence effect small social and political changes.

Ethnographic research and case studies are ideal for gathering in-depth perspectives on a situation or incident. A sociopolitical picture of the organizational context can be constructed and interpersonal relationships assessed (Bell 1999). Validity and generalizibilty are important concepts in large-scale studies, such as surveys and trials, if studies are to be generalizable and outcomes measured. Qualitative research uses the term "applicability" and "transferability" rather than generalizibilty. Popay et al. (1998) extend these terms to ensure rigorous and systematic reviews that have parity with quantitative critiques. Rather than the "hard facts" and outcome measures of quantitative research, which concentrate largely on cause and effect, ethnographic and qualitative research focus on the understanding of social relationships. An ethnographic and qualitative approach was far more successful than quantitative questionnaires in eliciting comfortable talk and disclosure about emotions.

To fully explore social and emotional relationships to gain understanding it is therefore vital to elicit the perspectives of families and professionals as participants in research. Gibbs (2001), Ellis and Bochner (1999), and De Lambert (1998) all suggest that the qualitative and narrative approach has allowed health care and social work to describe themselves in rich detail. The qualitative approach gives meaning to the multifaceted emotional and social problems that families face and begins a process of giving voice to recipients of social and health services (Gibbs 2001).

Beresford (1992) states that participatory research has developed the notions of emancipatory, user-led and user-controlled research. As Beresford and Evans (1999) write of the participatory and narrative approach to research:

> It values people's first-hand direct experience as a basis for knowledge (Beresford and Evans 1999, 673).

The methodology of this study on emotions in health and social care draws from the tradition of empirical qualitative data collection in the social sciences. Especially relevant are ethnomethodology (Garfinkel 1967), grounded theory (Glaser and Strauss 1967), and feminism (Oakley 1974, 1981; Smith 1992; James 1989, 1993a; Davies 1995a; Gray 2010). These approaches emphasize the importance of gathering data based on the perspectives of people on the frontline, such as women, families, and professionals. Two case studies are reported. In-depth and semistructured interviews were conducted with families around their views of the family support service and nursing. Room was given during interviews and focus groups for participants to put forward their perspectives on health care, social exclusion, and poverty in Essex, East London, and Tower Hamlets. The key objective was to elicit the first-hand direct experience of those taking part in a participatory way (Beresford 1992).

The interview schedule and focus group questions were flexible so as to encourage interested discussion by participants and allow professionals and families to portray their experiences in their own words. The amount of data gathered and the length of the extracts of speech presented in this book are a testimony to the success of the participatory research approach and demonstrate people's willingness and commitment to discuss emotions if asked to do so openly and without pressure. The perspectives of families and professionals are presented to show examples of people's emotional experiences and assess best practice and competencies (DoH 2000a, 2004, 2006, 2008; Ferguson 2001; Davies 1995b; James 1993b). The aim is for professionals and families to describe emotional labor from their perspective and in their own words, which allows study to address needs and service practices. Extracts are quite lengthy to prevent paucity of data and allow perspectives to come across fully to achieve a balance of perspectives (DoH 2000a).

The process of transcription and analysis of qualitative data is guided by several criteria, which are italicized. Extracts of talk have been chosen because they show *consistency* of statements that were made by separate respondents. The best data lead to *clarity* in theory and nursing practice. The *typical* comments made by nurses are also the most *general*. Analysis also looks for *compatibility* of statements that are made by nurses. A *contrast* of opinions on emotional labor is vital to discussion on the subject. Finally, extracts chosen and analysis are informed by the *cogency, polemic*, and *saliency* of items of talk. In other words, how important and relevant items of talk are to participants as well as to contemporary issues in the local and national health and social services (Garfinkel 1967; Schutz 1972).

Methodological points made at meetings and during focus groups included some of the points noted in Table 5.3.

Table 5.3 Research guidance

Guidance given by professionals and families on appropriate methods and foci of study
In-depth interviews and face-to-face contact were necessary to elicit data on emotional labor. Face-to-face contact was more appropriate than questionnaires or impersonal survey tools
It would be useful and interesting to get nurses', patients' and people's views on emotional labor and what it meant to them (see also Garfinkel 1967)
It would be useful to get a variety of nurses and social work professionals' definitions of emotional labor
Emotional labor should be attended to as a routine part of nursing and social care. Close attention should be paid to ordinary talk at interviews to see the strategies that nurses used to manage emotions
The positive and negative aspects of emotional labor should be given equal weighting
Given that emotional labor is a component of all "people" work the question should be asked as to whether emotional labor is unique or special to nursing
Research should collect anecdotal stories and case studies. In part, this would help show that emotional labor was central to the student nurse's experience of education and social worker's learning to care. Anecdotal evidence would be appropriate in the oral culture of nursing and social care, where experiences and stories are shared to solidify relationships with colleagues and clients
It would be informative to describe different contexts of clinical and community practice and investigate the effects of these on orientation of professionals' emotional labor
"Race", gender and ethnicity are socially constructed, reflecting power relationships and inequalities. Inequalities are expressed socially (in exclusion, access to and quality of health and social care) and economically (as poverty, lack of social mobility in professions, access to rank and status). Inequalities are expressed culturally through racism as well as sexism and in language through linguistic inequalities (in the basic terms, words and definitions that try to understand and describe "race" or women, usually from the androcentric perspective of the dominant White and Western male). As such, it was recommended that research be sensitive to different cultures, issues of "race" and perspectives on gender inequalities. Definitions of "race" are largely taken from people's accounts at interview, which means that research tries to elicit how Bangladeshi and Somali people feel about issues of "race" and racism. The terms "White", "Black", "Bangladeshi" and "Somali" were recommended to be used as general definitions of "race" or ethnicity in British society. These terms are in common use in British society but are capitalized throughout to bring attention to the fact that terms of defining "race" are not natural but are socially constructed "Mental illness" and other potentially stigmatizing terminology should be addressed sympathetically. Peoples' own choice of words and language should be employed to define and understand members' meanings (Garfinkel 1967)

Findings: Part I
Emotional Labor in Health Care

Chapter 6
Emotions and Nursing

Nurses' Definitions of Emotions and Emotional Labor

The narratives and stories of this study of emotional labor were primarily collected at intervals over a period of three years (1999–2002) (Gray 2001, 2002a, b; Gray and Smith 2000b, c). These were built upon by later research (2005–2009) (Gray 2009a, b, 2010; Gray and Smith 2009).

One of the main principles of study is to gather nurses' perspectives and relate these views to the modern National Health Service in a way that benefits health policy and the quality of the nursing treatment of the patient. A first step in this process is to define emotional labor. The meaning of the term emotional labor is best taken from members' perspectives and the ways in which nurses construct and understand emotional work in the health services (Garfinkel 1967; Beresford 1992; Beresford and Evans 1999). In other words, asking nurses themselves as frontline workers to provide a definition of what is meant by emotional labor. Studying the way in which nurses' construct and understand emotional labor will also assist in the last step of the research process, in so far as the final aim is to challenge and refine Hochschild's model of emotional labor. The final step will be to propose a new theory of emotions that draws from people's perspectives and the critical work of Bourdieu (1977, 1984, 1992, 1993).

Several nurse respondents echoed Hochschild's (1983) definition and said that emotional labor was "continuous contact," "feeling like you're on-call 24 hours a day and always available to the public" (Hochschild 1997) and "giving the patient the feeling of being safe and warm." All of the nurses identified emotional labor as a chief part of the nurse's role in making patient's feel "safe," "comfortable," and "at home." A student nurse said:

> I feel that emotional labour is the way that nurses look after people so they feel comfortable and their relatives feel that they are safe… A part of nursing is to show you care for them, even if you're having a terrible day and are fed up yourself and with everyone else. You have to give them that extra support they need…Clinical and emotional skills come with the experiences of the job and you have to get in contact with your emotions and how the patient feels.

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Against some of the more critical literature on emotional labor in health and social work (Aldridge 1994; Mackintosh 1998; Craib 1995; Duncombe and Marsden 1998) none of the nurse respondents discounted emotional labor from the work that they did in clinical and nonclinical settings. There was a surprising frankness on emotions and emotional labor. This keenness to discuss emotional labor was explicable by many nurse's views that they had to be "tuned in" to their own and perhaps more importantly the patient's emotions and that talk on emotions had been denied to them in the past. "Talking about emotions," one nurse said, "is a key part of the job that helps you to understand what to do."

The Emotional Routine of Nursing

Emotional labor was seen as "part and parcel of the normal routine of nursing." Emotional labor was identified as social, in so far as it related to "making patient's feel at home," fostered a ward environment that was based on the model of "a sort of family" and involved talking about how staff and patients felt. As in many nursing studies, emotional labor also touched upon subjective and psychological aspects of care such as "friendship," "being more intimate and building up trust with the patient" and "showing the patient a little bit of love" (Hupcey et al. 2001; Lupton 1998; Williams 2001; Hunter 2001; Smith 1992; Swallow and Jacoby 2001; Gray 2009b; Gray and Smith 2009). At its simplest, the emotional labor of nursing was "just making a gesture to the patient and holding their hand to make them feel better." These social and psychological aspects of emotional labor were viewed as a routine part of nursing that helped maintain the running and management of everyday work in clinical areas (Clarke and Wheeler 1992; Drach-Zahavy and Dagan 2002; James 1989, 1993a). A nurse said of elderly care:

> It's just sitting with the patient and feeling that there's a link. I'll just sit on the corner of their bed and take their hand so they feel a little better… I try to do that each day that I'm on duty with the less independent patients… Nurses sometimes don't see how important it is just to show you care. I make the patients comfortable and part of the ward. It helps with the running of the ward and everyone getting to know each other… It's not something that everyone can immediately see, so a lot of the feelings and work you do with the patient just goes unnoticed. You can't put feelings of intimacy in the patient's notes or record. I don't think that's possible. You can communicate with the patient just by looking at them or taking their hand. Just showing that you're attached and that you care. The patient will feel better about talking about their worries. They won't be so afraid if they need to ask for help or talk things through with you.

Emotional labor was reported as making nurse and patient contact easier and "moving things along." In the above extract, emotional labor is an almost invisible bond that the nurse cultivates with the patient. Emotional labor, although it is tacit and goes unrecognized by records, is implicitly acknowledged by the nurse and patient. As confirmed by a host of studies, intimacy and more informal relations help in the running and management of daily life on the ward (Drach-Zahavy and Dagan 2002; Licentiate and Norberg 2002; Wharton 1993; Forrest 1989;

McQueen 2000; Bolton 2000, 2005). The emotional labor of the nurse is reported to help the patient to manage disclosures of an emotional nature (James 1989, 1993a; Froggatt 1998; Phillips 1996).

All the nurses interviewed said that emotional labor made working with the patient much smoother and helped in "oiling the wheels" of nursing work, like the secretaries who "moved consumers through the system" (Saks 1990). Indeed, respondents believed that patients expected nurses to show care for the patient with close interpersonal contact. A nurse said:

> If you don't show that you care the patients soon cotton onto the fact and stop talking to you. If you don't engage the patient as a person and talk about their troubles and reassure them and talk about each other's families and just normal things, it makes nursing really hard. If you're not tuned in to how the patient's feeling and can't show you care, you're not going to be able to deal with all the little problems that come up. You're probably end up in upsetting the patient and the patient's family because you're meant to just be there for them to care.

Patients' expectations and emotions are reported as being almost intuitively picked up by nurses (King and Clark 2002; Tolich 1993; McQueen 2000). This intuitive and humanistic relationship, consisting of a panoply of touch, gesture, and sympathy, helps patients and nurses in many ways that are therapeutic to the patient and valuable to the health services, including: building familiarity, trust, communion, and agency (Licentiate and Norberg 2002; Hupcey et al. 2001; Bolton 2000); managing disclosures (James 1989, 1993a); eliciting patients' narratives, stories, and voices (Leight 2002; Swallow and Jacoby 2001; Beresford 1992; Beresford and Evans 1999); gender sensitivity and gaining women's perspectives (Gattuso and Bevan 2000; Leight 2002; Swallow and Jacoby 2001; Hunter 2001); reflection on ethical and moral dilemmas (Scott 2000; Benner 1994); building democratic and patient-centered services (DoH 1999a, 2008; McQueen 2000; Cheahy Pilette et al. 1995; James 1993b); and maintaining boundaries and practices that are responsive to the views and needs of patients (Twigg 2000; Cheahy Pilette et al. 1995; Allan 2001; Tolich 1993).

As well as exemplifying the importance and complexity of emotions in nurse–patient relationships the extracts so far touch on an initial limitation of Hochschild's model of emotional labor. Hochschild's theory of emotional labor does not address the centrality and intersubjective complexity of the notion of "care." The extracts and existing literature elaborate "care" as a concept that is at the heart of nursing. Care is transmitted in the arteries of nursing in the National Health Service and involves physical and emotional labor that is actively sustained by nurses (James 1992, 1993a, b; Smith 1992; Fineman 1993; Bolton 2000, 2005; Clarke and Wheeler 1992; Benner and Wrubel 1989). According to the calculation of James (James 1992, 489):

$$\text{Care} = \text{organization} + \text{physical labor} + \text{emotional labor}$$

However, despite this formulation, James misses the point that sometimes emotions in the health services do not add up quite so neatly. There are dissonances,

interpersonal tensions, gender struggles, and tensions in the expression of emotional labor and care in the British National Health Service. Care in the health services involves emotionally draining and physically hard work that has to be endured and sustained (James 1989, 1993b). The care of nurses and other professions in the National Health Service is regulated and divided by management systems of supervision and training, or expressed as a simple equation:

$$\text{Care} = \frac{\text{emotional labor} + \text{education} + \text{physical labor}}{\text{organization}}$$

Images of Nursing and Learning to Care

Participant observation during a preregistration unit on images of nursing was very helpful in eliciting data. Student nurses discussed the traditional images associated with nursing, gender stereotypes of the profession, nurse and patient expectations of interpersonal contact, and the foundations of nursing as a caring profession. During group discussion in the preregistration unit, as well as during later meetings with the main interviewees of the research, the images associated with nursing as a caring profession were articulated. For example, patient expectations were thought by nurse respondents to be shaped by conventional images of nursing. In a similar vein to Smith's (1992) study on the emotional labor of nursing, student nurses felt that they were obliged to put emotions into nursing work because nursing was portrayed as the work of an "angel," "Florence Nightingale" and part of the domestic work of "mothering the patient until they feel better". Certainly, the images associated with nurses' emotional labor are predominantly female and matriarchal (Gray and Smith 2009; Gray 2009b, 2010). A first year student nurse said:

> My mother is a nurse… You have a very close involvement with patients… You've got to clean, bathe and wash patients like your own children. You have to talk to them, listen to their troubles and worries like your mothering your own kids.

Inculcation of emotions certainly begins from an early age in the family and emotions are picked up implicitly in domestic arrangements (Bourdieu 1977, 1984; Elias 1978, 1991). Traditional and largely patriarchal images of nursing were seen as two edged, particularly by student nurses who were mainly women. The nurses were in effect trying to outline and come to grips with their professional habitus (Bourdieu 1977, 1984, 1992, 1993), so reflecting on the cultural status (or cultural capital) of emotional care in a patriarchal society. On the one hand, the image of the nurse as a natural carer was seen to be an advantage and "put patients at ease" with a familiar "mother figure." Many student nurses linked the nursing of patients to a mother nursing her child (Elias 1978, 1991). The image of nurses as natural carers was said to be an automatic help in "breaking down emotional barriers" between nurse and patient and assist in establishing "more informal" relations necessary to nursing. On the other hand, many thought that the prototypes of the natural carer

and Florence Nightingale made the establishment of nursing as a profession more difficult. In two separate classroom discussions with student nurses, images of nurses as an "angel" or a "good little woman" were vehemently rejected as "sexist." Almost all in the classroom discussions agreed that stereotypical images of nursing devalued emotional labor and the experiences that nurses have to accumulate throughout a career in nursing. Emotions, so vital to nursing and respected by patients, were not invested with high status and accorded with cultural capital in the National Health Service. Emotions, although valued at the interpersonal level between nurse and patient, were not given any currency in the organizational culture of the National Health Service. Gender issues and barriers to emotional labor were certainly chief among the minds of student nurses in classroom debates. The gender stereotype of the female carer, especially the mother figure, touches on personal and public perceptions of nursing care (Smith 1992; James 1989, 1993b; Gattuso and Bevan 2000; Gray 2010). It touches on gender relations at home and at work, so illustrating inequalities and paid or unpaid work. Perceptions of the unpaid and invisible female carer are present in society and reproduced in health care. The gender stereotype of nursing is certainly double edged and creates a tension in the perspectives of student nurses. The female stereotype is thought by student nurses as useful in making patients feel at ease, as well as simultaneously being thought devaluing to nursing as a profession. Williams (1999) says that there are conscious and unconscious connections made by students about the activities associated with nursing. With guidance on self-awareness and reflection, Williams says that teachers will be able to assist student nurses in making connections between past and present events. In other words, reflection on the student nurse's past and family role models will help in making present relationships with peers, patients, and seniors more explicit. The emotional labor connected to these groups will also be rendered visible and better appreciated by reflection and discussion with the teacher.

Barriers to Emotional Labor

Stereotypical images of nursing, which portray nurses as "angels" and natural care givers, touch on the nature/nurture debate and form gender inequalities in the health services (Ortner 1974; James 1989). Stereotypical images of nursing were noted by interviewees to present barriers to emotional labor in health, in so far as the emotional labor of nurses was not recognized as a professional occupation and was instead depreciated as part of "women's work." Cultural capital in the National Health Service was invested in medicine and male knowledge while emotions were devalued as having little or no currency. Emotions were not viewed as assisting the ethics of medical decisions or as being valuable therapeutically, so were alienated from high status clinical work in the health services (Scott 2000; Phillips 1996; Tolich 1993; Benner 1994; Bolton 2005; Smith 1999a, b). Emotions were ambivalent, irrational, and unreliable when compared to the hard facts and real work of male-dominated biomedicine (James 1989; Smith 1992; Bolton 2005; Gray 2010).

All the nurses interviewed had at one time or other experienced barriers to emotional labor that are embedded in the gender inequalities of wider society and are largely reflected in the health services. Peculiarly, both older nurses and recently enrolled student nurses agreed that emotions were sometimes regarded as a "weakness" by other staff, senior nurses, and doctors. There were certainly perceptions of gender and professional barriers as regarded the recognition and status emotional labor. According to one student nurse:

> Some people see general nursing as being for women and women's work. That's why a lot of men go into mental health… It's very hard to show that you care for a patient sometimes as you're told not to get too close to the patient by some of the older staff and doctors on the wards. But that makes it impossible to empathise with the patient and try to feel what they're feeling… Nurses should feel able to care and to get close with their patients. It comes with the job, really.

Perceptions of emotional labor as part and parcel of "women's work" were said to influence the choice of clinical placement and practice area. Stereotypes of male and female labor in wider society, which regard women as natural care givers and men in more patriarchal roles, were influential in perceptions of appropriate and inappropriate patient contact and the clinical specialism (for example, acute care, obstetrics and gynecology, midwifery, cancer care and oncology, theatre, mental health) that nurses' chose for their nursing career (Smith 1992). There was a split between the head and the heart which distinguished cultural knowledge from natural emotions (Ortner 1974; James 1989). This divided occupations and contexts of health practice regarded as male or female.

It was felt in participant discussion with classes and during interviews that intimacy was perceived in society and the health services as the role of women. Care work is ambivalent, being perceived as demeaning because it is so close to the taboo of the body, its wastes, dangers, and contamination, while at the same time being praised for its links to the valorized status of motherhood, with connotations of love and care. Echoing previous studies, patient contact, and intimacy were said to be more acceptable for women than for men (Lawler 1991; Savage 1987, 1995; Arber and Gilbert 1989; Davies 1995a, b; Twigg 2000; Bolton 2005). According to a student nurse:

> Patients might feel uncomfortable about a male nurse washing, cleaning and looking after them. Especially a female patient.

Care giving, emotional labor and intimacy were seen as the natural roles of women. This perception gave rise to a further perceived barrier, in so far as general nursing was perceived as being exclusively for women and mental health was said to traditionally be exclusively for men. It was almost as if men were given "mind" work while women were allocated "emotion" work. There was heated debate between male and female student nurses in classroom discussions that sometimes became very polemical on the nature of male–female relations and divisions of labor in the workplace. Female students were much more sentient and aware than male students about divisions of emotional labor in the health services as well as the consequences of disregarding the importance of emotions in nursing. Female student nurses were much more able to express and come to terms with the centrality of emotions in nurse–patient relationships than male student nurses, who seemed to

want to play the male role of being tough and in control (Duncombe and Marsden 1998; Bolton 2001; Milligan 2001; Paterson et al. 1995). Gender stereotypes were a recurring theme of classroom discussion and seen as pivotal to divisions of emotional labor between male and female nurses. This was also extended to differences and barriers between professions, in so far as nursing was largely stereotyped as a female occupation and doctors were viewed in the stereotype of a patriarchal male role. Gender barriers of emotional labor raise difficulties of the emotional labor and quality of contact that nurses believe they are allowed to provide to patients (Lawler 1991; Savage 1987, 1995; Twigg 2000). There are taboos of closeness and distance with the patients that are largely tacit in the health services and not evaluated in open discussion. In the above quotation of a student nurse, gender stereotypes and sexual taboos involving close contact and physical intimacy shape appropriate and inappropriate forms of patient care. Gender stereotypes and professional taboos effect the quality of emotional labor and types of consultation that are available to nurses and other health professionals.

The distinction between professions or roles regarded as male and those regarded as female was an almost imperceptible undercurrent in discussion with nurses and hinged around an invisible and symbolic violence (Bourdieu 1977, 1993). Female student nurses seemed urged into stereotypical caring relationships, based on the ideal of motherhood, while male student nurses held back from emotional engagement, to present a detached, tough, and symbolically distant patriarchal father figure. This inculcated female nurses, for the most part, into unequal relationships in the workplace (where they were expected to fulfil the female obligation of emotion work) and excluded male nurses, for the most part but not entirely, from feeling able to engage at more emotional levels with patients (Davies 1995a; James 1989; Forrest 1989; Arber and Gilbert 1989). The symbolic violence of representing emotional labor as female reproduced traditional gender relations in working relationships in the National Health Service.

Gender Divisions of Emotional Labor

There were many gender stereotypes that were mentioned by nearly all of the nurses. General nursing, linked to domestic relations, was seen as feminine work that involved washing and close physical contact with the patient (Lawler 1991; Savage 1987, 1995; Twigg 2000). Mental health nursing was viewed as being more masculine and therefore the occupation of the majority of male nurses. Mental health patients were sometimes presented as a (physical and sexual) danger or risk to female nurses. Male nurses afforded their female colleagues with patriarchal and "strong-arm" protection. Private relationships and emotions in the home certainly influence and help to reproduce gender inequalities in systems of public health care (James 1989, 1993a; Smith 1992; Williams 1999; Tolich 1993; Hochschild 1997; Gray 2010). Female nurses were seen as natural carers and emotional laborers of the patient's body. Male nurses in mental health sometimes had to deal with "physical aggression," had to be "physically stronger," and remedy disturbances of the patient's mind.

The respondents certainly touched upon gender divisions of body/mind and female/male (Ortner 1974) that have implications for the emotional labor of nursing. A female student nurse said:

> I'd like to go into mental health but it's seen as being work for men, even though it's been one of the most emotionally hard placements that I've done as a student nurse in the last three years.

Emotional labor with the body was seen as largely the responsibility of women. In nursing, women were seen to be essential in the duties of cleaning, bathing, maternity, and obstetrics. Male nurses were frequently perceived to be an inappropriate and even sexually threatening presence in these clinical areas. This once again relates to taboos of intimacy and touches on constructions of female nurses as natural carers and male nurses as disengaged from emotions. This time distinction and symbolic violence works more in the opposite direction so that men are excluded from clinical areas deemed to be the remit of female nurses. Intimacy and sexual taboos are implicit and symbolical. Taboos are not stated but remain buried behind the screens of nursing so that workers receive little explicit guidance (Lawler 1991; Savage 1987, 1995; Twigg 2000).

Gender stereotypes also made many male nurses feel uncomfortable with close physical and emotional contact (Lawler 1991, 85; Arber and Gilbert 1989). Mental health was perceived by nearly all respondents as part of male nursing. Women were natural emotional laborers in general nursing, while men contained the emotional disturbances and physical aggression of mental health patients. Gender barriers presented problems in nurses' specialisms, in so far as stereotypes of male and female nurses related to the clinical practice areas. Classroom debate said that male nurses in perceived female clinical settings (general nursing, obstetrics, and midwifery) might automatically be labelled as "gay" (Arber and Gilbert 1989; Lawler 1991, 85–113; Savage 1987, 1995).

Nearly all interviewees said that they felt more personally at risk and in physical danger from patients. In a similar vein to media coverage and research (Feldman et al. 1999), nursing as a profession was said by interviewees to be less respected by the public than it was a decade ago. This helped respondents form the view that the public could sometimes be violent toward nurses. If nurses are generally perceived as female, it could be proposed that violence toward the nursing profession in the health services is related to the level of violence toward women in society (Hanmer and Maynard 1987).

Stereotypes and Taboos: "Good" and "Bad" Patients

Nurses also divided patients into the categories of "good" and "bad." In an extensive critique of the literature on "good" and "bad" patients, Kelly and May (1982) found that patients with certain illnesses, diseases, and symptoms were more or less popular with doctors and nurses. Their popularity also depended on their age, gender, race, and class characteristics. The most popular patients were young,

suffering from curable illnesses which responded to specific nursing and nursing interventions. The "good" patient was also the appreciative patient. These views have resonances with previous research conducted in nursing and mental health (Smith 1992, 2005; Gabe 1995; Castel 1991). In the present study, the division of "good" and "bad" patients was partly based on the social control elements of nursing work, with the "good" patients being viewed as more compliant than those categorized as "bad" (Lawler 1991, 147; Gabe 1995). For example, a "bad" patient was someone who had "brought the illness on themselves and can't really be helped." Mental health patients, alcoholics, pedophiles, and drug users were seen as "bad patients." Quite patently, dividing patients in such a way places severe limitations on interpersonal contact and makes all sorts of demands on nurses (Wigens 1997). The therapeutic ideal of equality in patient treatment sometimes conflicts with personal feelings about "bad patients" (Newton 1995; Marangos-Frost and Wells 2000). According to one nurse:

> Nurses are called on to deal with all sorts of patients. Just there and then and you've got to be ready to go and help them (patients). Some patients can be really horrible and even disgusting, which means you have to really emotionally labour… I suppose you could say there are good and bad patients who you treat differently, even though you're not supposed to, and you're really supposed to treat everyone the same.

Once again, taboos of intimacy with patients were formed to deal with perceptions of appropriate and inappropriate contact. In the case of "bad patients," emotional distance was encouraged. With "good patients" the reverse was true and informal intimacies were said to be acceptable. However, the nurse in the above excerpt notes that "you're really supposed to treat everyone the same." This shows that the therapeutic ideal of equality is still ingrained in her professional view. There is room for humanistic and open discussion, perhaps with a mentor or teacher, of how conflicts between her public role as a nurse and her private feelings about "bad patients." Reflection on conflicting emotions about "bad patients" and difficult events in clinical practice areas is essential to professional development (Morton-Cooper and Palmer 1999; Marangos-Frost and Wells 2000; Benner and Wrubel 1989; Gillespie 2002; Williams 1999).

Symbolic Violence: The Professional Distinction of Emotional Labor

There were also interprofessional barriers to emotional labor. Some of the nurses had very strong opinions regarding the poor quality of interpersonal contact that doctors provided to their patients. This was more than just "doctor bashing" and interprofessional rivalry, in so far as gender divisions between the emotional labor of nurses and doctors emerged during interviews. A nurse working in primary care said:

> I think that doctors are trained early on that they're not supposed to talk about their feelings with staff and patients… It's a much more private profession than nursing and doctors are

> much much less accessible to patients. Feelings are put to one side for the 'real work' of medicine. It's just diagnosis and medical cure, which doesn't stand up to scrutiny, really, as it isn't possible to heal with some cases like terminal patients. There's an unwritten rule that nurses care for patients and that we're the ones responsible for the patient's feelings while they're here. It's left up to us, really. Doctors are detached from that sort of thing and leave nurses to pick up the emotional pieces.

This nurse's view was largely confirmed by the general practitioner who owned the practice:

> Feelings can get in the way if you're trying to make a diagnosis of a patient. You've got to try and remain objective. It might be an embarrassing illness or personal examination of some kind. It's better to get on with the medicine and let the nurses deal with the emotions… My practice works as a team of doctors and nursing staff much like a family. All I can really do is patch people up physically and send them home.

Divisions of emotional labor certainly influence perceptions of the emotional work that may be carried out by nurses, doctors, and other healthcare staff. Emotion work is invested with symbolic meanings and implicit distinctions about who should deal with people's emotions in the workplace (Bourdieu 1993). The patriarchal model of the primary healthcare team as a functioning nuclear "family" is employed in the General Practitioner's extract as a symbol to reinforce the gender stereotype of the subjective female (nurse) and objective male (doctor) that is widespread in society. Male detachedness and female intimacy are portrayed as natural and right by the doctor. Intimacy helps nurses care and disinterestedness allows doctors to come to an objective clinical diagnosis, even though many studies have shown that emotion, intuition, and analysis are combined in ethical and effective medical decision-making (Benner 1994; Mamo 1999; Hunter 2001; Scott 2000; Marangos-Frost and Wells 2000; Smith 2005). In the extracts, nurses' intuitive and emotional experiences are divorced from the objective analysis of medical decisions (King and Clark 2002). Taboos are reinforced as touching on delicate, embarrassing, and personal issues that are best dealt with by the more personable face of nursing (Silverman and Perakyla 1990; Wigens 1997; Twigg 2000; Lawler 1991; Bolton 2005). In the extracts there is an anthropology of medical decision-making where emotions are represented as almost a professional taboo that if touched will infect and contaminate the impartiality and purity of biomedical diagnosis (Douglas 1966). To be sure, there are limitations placed on both doctors and nurses in terms of how these professions are supposed to labor emotionally. This has a direct effect on how the professions consult patients and attend to the emotional needs of patients in medical encounters. In this subtle and almost invisible manner, emotional labor is handed down the line gently and persuasively to nurses. This is symbolic violence (Bourdieu 1977, 1984, 1992, 1993) because it reproduces conventional domestic arrangements in the primary care work setting that are modeled on the archetypal nuclear family. The reproduction of conventional domestic relationships is an exercise of gender power that divides and demeans nurses' emotional labor as unimportant when compared to the real task of biomedicine. Limitations in role and appropriate emotional labor are placed on both nurses and doctors through the stereotype of the subjective female nurse and objective male doctor.

"Doctors," the nurse says in the above extract, "are trained early on that they're not supposed to talk about their feelings." Male nurses are also more reluctant to express their feelings and reflect on the pertinence of emotions in clinical practice. Many male nurses in this study seemed drawn away from emotions toward the mind and social control elements of mental health (Arber and Gilbert 1989; Duncombe and Marsden 1998; Bolton 2001). If, as both extracts suggest, doctors learn to detach themselves from the patient's feelings, an immediate point to note is that this emotional distance is cultivated and conceals feelings to present the rational, emotionally neutral, and patriarchal face of biomedicine (Haas and Shaffir 1977; Elias 1978; Wharton 1993; Wigens 1997). If, as the nurse suggests, there is an issue of training then study must analyze the ways in which nurses learn to be more emotionally available and accessible to patients (Smith 1992; Gillespie 2002; Hoover 2002). An important source of information in this respect is the current educational system in student nursing. Similarly, some of the more recent medical curricula include communication and interpersonal skills training for medical students. More specifically, how is it that student nurses learn to care and labor emotionally for their patients (Smith 1992; James 1989, 1993a, b)?

Chapter 7
Learning to Care in Student Nursing

Emotional Labor and Student Nursing: Reproducing a Culture of Care in the National Health Service

All of the student nurses interviewed said that emotional labor and giving emotional support to patients was a central part of nursing work. Differences emerged between male and female nurse respondents in classroom discussions that revolved around gender stereotypes of general and mental health nursing in particular. As in a host of sociological and nursing studies, women seemed more likely to stress the importance of emotional care. Men tried to sustain a tough and masculine appearance of being in control of their feelings and the harsh medical realities of working in the health services (Duncombe and Marsden 1998; Arber and Gilbert 1989; Bendelow and Williams 1998; Bolton 2001, 2005; Gattuso and Bevan 2000; Leight 2002). Gendered images of nursing were noted by all of the student nurses. Images of nursing and emotion involved personal, social, and political choices, which were shaped throughout the 3 years of student nurse education by mentors, colleagues in ward placements, peers, and lecturers. As suggested in this and many other studies, transformational learning experiences helped student nurses to reflect on their emotions so that they could see the therapeutic value of emotional labor with the patient and sustain high quality of care in the health services (Hoover 2002; Ewers et al. 2002; Gillespie 2002; Morton-Cooper and Palmer 1999; Benner 1994; Smith and Gray 2001a, b; Gray and Smith 2000a, 2009; Gray 2009b).

Personal and Sociopolitical Perspectives on Emotion in Nursing

Perhaps one of the most interesting findings to emerge from interviews and classroom meetings was the ways in which personal perspectives on nursing and emotional labor developed through the 3 years of student nursing. The inherent images and personal perspectives of nursing practice, mentioned by the newly enrolled student nurses,

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focused on the familiar figures of the natural carer, the "mother," "parents," and the like (Elias 1991; Bourdieu 1977; Williams 1999). These images form a type of basis from which to build more elaborate models of the ideal figures involved in nursing. As the student nurses went through 3 years of education and matured in their perspective, other figures and personal perspectives of nursing practice were at the forefront of the nurse interviewees' minds. The role of staff, lecturers, and clinical leaders were mentioned as developing the student nurse's view of emotional labor and the job of nursing. Put simply, emotional labor is accumulated through experience and being able to talk reflectively about nursing experience with staff and colleagues (Gillespie 2002; Wharton 1993; Morton-Cooper and Palmer 1999). According to a student nurse:

> When I first came here,… I went onto placements without much of a clue about what patients wanted… I didn't know how to get to know the patient and how you have to feel your way into things with them… First I thought of what my parents would do at home and thought about it like that, like when you're at home and have to get on… I'm in the last few months of being a student nurse now, and my tutor (link tutor) and my mentor are the most help with what to do… A (student nursing) friend was really upset about a patient dying, you know. The (link) tutor just took a little extra time to talk to her about the patient's death and I talked to her, which helped… That helped with being much more, you know, sympathetic to the patient's relatives because you could talk to them so they felt some comfort.

The personal, social, and political dimensions of the emotional labor of nursing assist the development of best practice, as detailed below in a case study of a student nurse and her link lecturer. As well as adding to quality of care, emotional labor and concern for patients helps to improve and sustain the running of a good clinical regime. At its best, learning to emotionally labor was reported as a humanistic and open process that was highly transformative personally and educationally (Gillespie 2002; Hoover 2002).

Nurse education and reflexive discussion on emotions are not without their difficulties, particularly given time constraints on staff, lack of funding in the health services, and the invisibility of emotions in most syllabi and teaching modules. The lack of formalized, democratic, and nonintrusive methods for eliciting talk on emotions during supervision also raises the dilemma of talk about emotions becoming a ritual or even a confessional, which nurses feel they are obliged to enact in hierarchical systems of health provision, such as the British National Health Service (Bourdieu 1992, 1993; Foucault 1973, 1990). The confessional aspect of supervision may not value a diversity of perspectives and aim at control rather than discussion of emotions. Students and nurses may feel, while enacting these rituals of self, that they are under surveillance and have learned little about themselves or their emotions that would improve their nursing practice (Cotton 2001; Gilbert 2001).

To be sure, nursing and student nursing are not smooth processes and are often punctuated by political struggles over pay, status, systems of supervision, methods of care, and the value of emotional labor. In the case of a third year student nurse, emotional labor and commitment to high standard patient care shaped a political awareness of political issues in nursing, such as safety at work and pressures on health resources. The student nurse attempted to improve the quality of patient care

and staffing that was provided on an acute surgery ward and challenged the ward staff as well as her link tutor. In the words of this third year student nurse:

> I had to put a complaint in about a ward, because it was just so bad and just bad practice. The ward was understaffed and annoying everyone: student nurses, relatives and patients. Volunteers were being asked to come in and feed people and that's happening everywhere. No one wanted to rock the boat, really, but I got really angry and complained. My link tutor organised a meeting of the two of us with the sister. Everyone knew that the ward didn't have enough staff and were just fed up. I had to put a complaint in because it's really important as you've got controlled medicines, observation, pre-ops, and all sorts. We didn't have enough time for the patients. We didn't want the ward taken off student nurse placements. The sister was doing all that she could with not enough staff. Me, the other student nurses and my link tutor felt it was best to put a complaint in so at least it came to everyone's attention.

The personal and emotional aspects of patient care in nursing also shape this student nurse's political and medical commitment to her patients (Tolich 1993; Scott 2000; Benner 1994; Smith 1992; James 1989; Gray 2009b; Gray and Smith 2009). Although an anomalous and rare case in the research, in so far as formal steps were taken and an official complaint was lodged, the above extract shows how emotional labor shapes the nurse's concern for high standard patient care. The student nurse felt obliged to complain to senior staff as understaffing meant bad practice and poor interpersonal contact with patients. The above extract shows how important the management of emotions are on the ward and in the National Health Service as an institution. It shows how vital the role of the link lecturer's support is in this exceptional case of a formal complaint. By raising a complaint of the "annoying" level of "bad practice" the nurse is in effect helping in the running of the ward and orientating herself to the concerns and anger of other "student nurses, relatives, and patients." The student nurse involved is also showing a political and social consciousness that helps in the assessment of the problems on the ward.

This ability to reflect on the difficult and sometimes conflicting issues involved shows the potential for leadership on other wards in the future (Drach-Zahavy and Dagan 2002; Gillespie 2002; Hoover 2002). Fortunately, this student nurse's potential was given the pastoral support of the link lecturer. The link lecturer was a chief element in creating a space and a support for the student nurse's reflection. A balanced view was formed by the student nurse with the support of the link lecturer, which takes into account the pressures for everyone (other student nurses, relatives, patients, the sister) on the ward. A meeting was arranged to discuss the issues of understaffing and poor patient contact that were involved. The extract shows the student nurse reflecting on the issues and being able to organize these issues so as to attempt to improve clinical practice (Gillespie 2002). Pressures on resources are a problem in many healthcare trusts. The case study of the student nurse is indicative to other staff and trusts who find themselves under similar pressures and therefore in a comparable situation. This case study may be useful for others to think about in developing good practice and student support. Locally, the Student Council for Nursing provided an important outlet and support for students who found themselves in difficult situations.

Developing Emotional Labor: The Role of the Link Lecturer, Mentor, and Personal Tutor

The link lecturer or tutor has many educational roles to play in student nursing. However, several key points concerning the link lecturer's role in sustaining the emotional labor of student nurses came up in interviews. First, link lecturers acted in liaison and advocacy capacities with senior staff/mentors on behalf of the student. Second, they raised personal, emotional, and pastoral concerns on behalf of student nurses. Third, link lecturers fostered reflective learning and informal emotional support. Emotional labor and reflective learning were based largely upon sharing experiences and talking them through sensitively. Link lecturers were humanistic and gave examples of their past experiences and difficulties in nursing to illustrate a present problem that student nurses had and therefore helped student nurses to "move on" (Gillespie 2002; Hoover 2002; Cotton 2001; Morton-Cooper and Palmer 1999). A link lecturer said:

> It's better if you can give an example from your own nursing experience. I'll tell the student nurses what it was like when I was learning and tell them stories from when I was a student nurse. If my student is having a hard time with a really ill patient it helps if I can link that with difficulties I've had. That way you actually feel more about it and can relate to the student. It helps to work it through with them and see what to do next.

Reflective learning was itself seen as a form of emotional labor. Difficult issues and problems with others (patients, other staff members, other students, or relatives) were discussed and worked through by using shared experiences of the emotional labor involved with nursing (Lupton 1998; Morton-Cooper and Palmer 1999; Benner and Wrubel 1989). Discussion was used to shape the educational experience of the student nurse and also worked to support the student nurse's emotional labor. The emotional labor of the link lecturer and student nurse worked so as to relate difficult nursing experiences to issues in nursing practice. In other words, learning how to emotionally labor helped in resolving "what to do next" in nursing practice, thus having a therapeutic effect for staff as well as patients through improved and motivated care (James 1993a, b; Smith 1992; Davies 1995a, b; Phillips 1996; Gray 2009b; Gray and Smith 2009).

There is a section in the curriculum document on "The Reflective Practitioner" which begins with the statement: "Fundamental to the philosophy of the course is the development of reflective skills." Reflection is an important activity for students as part of experiential learning, particularly in relation to their placements (Schon 1987). Kolb and Fry's (1975) Model of Reflection is indicated as an underpinning framework for group work as a way to access this experience. Storytelling was also frequently mentioned by student nurses, education staff, and others involved in clinical placements. Storytelling helped to establish interpersonal relations between the student nurse and link lecturer. Sharing stories also helped to locate nursing experiences and apply these experiences to nursing practice, as in the above example of reflective learning. Similarly, an evaluation of the health promotion component of clinical placements in local acute and community settings using a specially designed

audit tool revealed the importance of the oral culture among nurses (Smith et al. 1998, 1999b; Leight 2002; Froggatt 1998; Gray 2010). Students and mentors were asked to document evidence against a list of dimensions related to their clinical experience of promoting health with patients and clients. In discussion with lecturers, they reported that they found it easier to *talk* about good practice rather than *write* about it as requested by the tool. Storytelling and open talk are important strategies for the development of aesthetic, moral, ethical, emotional, and pragmatic knowledge in nursing as well as acting to facilitate competent nursing practice (Fineman 1993; Leight 2002; Ellis and Bochner 1999; Staden 1998). Storytelling is rich in metaphors and elicits women's voices, so enabling us to hear women's perspectives of emotional labor (Froggatt 1998; Leight 2002; Fineman 1993; Gattuso and Bevan 2000; James 1989; Bolton 2005).

As in other studies, the importance of "talk" (and by inference discussion) also ties in with student nurses' perceptions of high quality education (Gillespie 2002; Morton-Cooper and Palmer 1999; Froggatt 1998; Forrest 1989). The "best" or "good" link lecturers were said to employ a "more informal" method of teaching and supervision. Student nurses said the "best" link lecturers acted as "friends" and "are really more like personal advisers." All students valued personable and informal relations with link lecturers and other staff (mentors, personal tutor) involved with student nurse education. This made staff "easier to approach and talk to about problems." The only reservation that student nurses had about link lecturers was that there needed to be "more contact." The visits the link lecturer made could be "a bit up in the air" and were seen as "not regular enough." Visits by the link lecturer to the student nurse's clinical placement were said to be approximately every 2 weeks. Both students and staff said that any more than 3 or 4 weeks was too long to be out of contact. Four weeks out of contact with a link lecturer allowed emotional worries, with subsequent poor practice, to build up. Under such circumstances where emotions were not actively managed and discussed there was a subsequent drop in nursing competence and the emotional confidence of student nurses plummeted.

Together with link lecturers and peers, mentors (or practice assessors) were seen by student nurses as a chief source of guidance and emotional support. Mentors were said by nurse respondents to organize reflective learning in a similar way to the link lecturer. In some cases, small forums of the mentor, sister, and ward staff would be convened to share experiences and difficulties with patient care. A student nurse said:

> It's good to have a group talk at the end of a shift with my mentor and the sister. Then you've got the opportunity to ask questions and sort out any problems. It helps if you've had a really hard day, just to go over it with other people.

These forums were said to help in reflective learning and also were reported to act as an emotional support for student nurses. However, as suggested in a variety of studies, many student nurses and mentors felt that they had no time to deal with emotions and that debriefing was too informal a strategy to effectively cope with difficult emotions (Cronin 2001; James 1993a, b; Benner and Wrubel 1989; Smith 1999a).

Student nurses thus had several difficulties with mentors. The first involved the time that the mentor had available to actively instruct the student. They felt particularly vulnerable at the beginning of new placements if there was "Nobody there to deal with first day 'jitters'." Junior students in particular described how at first they lacked experience to effectively communicate with patients and valued their mentor's help in developing their interpersonal skills. Students described their inexperience in the following terms: "a fear of getting it wrong"; "not knowing the answer to questions or how far to go"; "finding the right way to talk to patients"; "being dropped in at the deep end"; and "knowing what to say so as not to make them (patients) feel worse." These comments are an implicit recognition of the need to learn to communicate effectively with patients as a component of emotional labor and its importance in ensuring their well-being.

Pressures on the mentor and student nurse meant that prearranged teaching sessions might be cancelled due to the obligations of work. In one case a student blamed poor mentoring on "the ward being understaffed and run-down." In a few interviews, student nurses felt that they had been "used as just another pair of hands" and had not had time to learn or engage with patients as they had hoped. This had been a common refrain in Smith's (1992) study. Student nurses and mentors also said that there was a break between nurse theory and practice. Some mentors did not keep up to date with new advances and methods of consultation in nursing. Understaffing, poor resources, and "bureaucratic mentor forms" were seen as causing too much management pressure and stress on staff.

The pressures of the job and on the National Health Service in general were seen as directly limiting the quality of patient contact. This also limited the possibility of emotional labor with the patient. One mentor complained that "students don't know their stuff" and said that he felt unvalued as offering advice as a mentor. Poor interpersonal relations between the mentor and student were mentioned and all nurses felt this pertained to "getting a match and balance of personalities." There was certainly need for a more humanistic and open approach in some cases to liberate the therapeutic effect of emotional labor (Gillespie 2002; Morton-Cooper and Palmer 1999; Phillips 1996; Cheahy Pilette et al. 1995). A mentor summed up some of the issues involved quite neatly:

> It's important to get the personalities right and to have time to talk with the student as well. Some students can be treated really badly when they arrive on their placements. I was myself. It's hard, because we're all run off our feet so much… It's hard just getting the chance to talk over a patient's notes and asking what the student thinks… It means that the way that we're feeling, me and the student, gets pushed right to the bottom of everyone's agenda, you know?

Interestingly, student nurse and mentor interviewees mentioned both social–psychological (the match of personalities) and sociological/economic (resources, socioeconomic pressures) reasons that prevented emotional labor with patients. External and internal pressures in the National Health Service presented their own social and emotional difficulties. By explaining these difficulties, nurses were seeking out routes to improve their emotional labor with patients.

Table 7.1 "Good" and "bad" mentors

The "Good"/"Helpful" mentor	The "Bad"/"Obstructive" mentor
Implicitly recognizes and attends to the student's emotional state. Actively manages transitions in the student's emotions. Helps student to appreciate new nursing experiences. Shows the benefits and drawbacks of different emotional contact with patients. Helps with reflection on different emotional strategies and ways forward	Ignores or is largely unconcerned with the student's emotional state and the student's transitions in feeling. Does not attend to student's emotional labor and does not assist in helping the student nurse to make transitions in thinking about emotions. Will avoid or does not have time for reflection
Helps work out learning requirements. Responds to individual's concerns and interests	Organizes learning without consulting the student nurse and other members of staff
Addresses student nurse's career outcome	Does not discuss career possibilities
Evaluates role as mentor and student's role while in placement	Has limitations in doing in evaluating these roles, particularly given pressures of time and normal duties
Establishes concept of nursing as a career and socializes the student nurse to the profession	Leaves model of nursing tacit and unexplored
Respects the student and the student's views. Does not rush to judge the student's abilities, but help student to develop those abilities with reflection	Rushes the student. Shouts and is not respectful, especially in front of other ward staff. Does not consult or organize reflection
Is genuine and honest (not defensive, inconsistent with the student, closed to discussion). Shows flexibility	Shows an inconsistency toward the student and is inflexible (perhaps due to pressures of time, normal ward work, intergenerational conflict)

In a study undertaken by Wilson (1998) to investigate student nurses' learning and support in clinical placements, different forms of mentoring relationships were described as "discretional" or "appointed." Appointed relationships referred to those mentors who had been routinely or "bureaucratically" assigned to work with students. Discretional relationships were infrequent but more satisfying and in line with the view that mentoring cannot be forced nor mentors chosen by anyone other than the mentee. Student assessment was seen as an accepted part of the role by appointed mentors whereas discretional mentors saw it as inappropriate to the development of a positive mentoring relationship.

In summary, student nurses said there were "good" and "bad" mentors that were defined by certain characteristics, which are detailed in Table 7.1.

Supportive mentors worked with the emotions of student nurses. Emotional labor was used to develop the student's perspective on nursing and helped to develop techniques for dealing with patients. Egan's (1990) model of the skilled helper touches on similar themes as the "good mentor." Both the skilled helper and good mentor help with pragmatism and ward work, competence and problem resolution, respect, and are informal and genuine (Egan 1990, 56). The "good mentor" is particularly helpful in organizing reflection on emotional labor and helping the student nurse to overcome transitions in their emotional experiences (Morton-Cooper and Palmer 1999; Benner and Wrubel 1989; Williams 1999). These transitions in the

Table 7.2 Avoiding "toxic mentors"

Ways of avoiding and minimizing poor mentoring relationships
The selection by the student of a mentor on a specified program/specialism
The examination of the mentor's and student's interaction for signs of toxicity at regular intervals
If necessary, the de-selection of poor mentors
Frequent high quality liaison between the student nurse, mentor, link lecturer and other members of staff
Regular updates of advances and new techniques in nursing
Less of a generation gap between student nurses and mentors. A fit of interests in nursing and a match of personalities
Required time and space to invest in mentoring
Remuneration, either financial or in time owed to the mentor

student nurse's emotions are monitored by the mentor to consult the student nurse. In this manner, the good mentor assists in sustaining the emotional labor of the student nurse and acts as an interpersonal support (Oatley and Johnson 1987; Marquis and Huston 1992). The "bad mentor" has similar limitations to the model of the toxic mentor that is proposed by Darling (1986). In particular, toxic mentors tend not to facilitate the student nurse and reproduce poor nursing skills, if they pass on any at all. Techniques of avoiding toxic mentors and poor interpersonal support (even neglect of the student) are shown in Table 7.2. These strategies were mentioned by student nurses and mentors, as well as being present in the literature (Darling 1986).

The role of the personal tutor was seen by student nurses as mainly academic but offering pastoral support if required. The "fit" and "match" of personalities was viewed as being vital if a more interpersonal relationship could grow in the 3 years of education (Gillespie 2002; Smith and Gray 2001a, b; Hoover 2002). One of the students had changed her personal tutor because she felt that there was a "personality clash." A student nurse said:

> My personal tutor has helped with my (written) assignments but I haven't really talked about anything else with him. I don't think he's there for that and wouldn't feel right about talking about problems… I'd go to my friends first and then my link tutor.

In a study of the experiences of a variety of link teacher roles, Ramage (2000) suggests personal tutors are ideally placed to work with their students in the clinical setting to bridge the theory–practice gap.

Emotional Labor and the Role of the Student Council for Nursing

The student council for nursing was in the early stages of development during the beginning of research in 1999. Meetings with student council representatives showed that this organization had several important roles to play. The student council for

nursing helped in the socializing of students, both formally and informally at recreational activities and events. The student council for nursing was also said by a representative to act as “an emotional support if a student needs it.” The council was also a source of information and action on issues relevant to student nurses. According to a student nurse:

> I haven’t really been to the student council too much because I haven’t really needed it. It’s good to know they’re around. They’ve helped easing students into things and are a good source of information and support.

Many student nurses seemed quite apathetic and undecided about the role of the student council for nursing.

Given the above excerpt and other views expressed by student nurses, the student council for nursing will certainly act as a forum for discussion of issues in nursing. Certainly council members were involved in recruitment drives in the local community and regularly talked about the realities of being a student nurse at open evenings. The student council for nursing representatives were aware of several points interviewees raised such as: “bad transport to placements and being late to placements”; “poor nursing accommodation”; “no choice with clinical placements”; “some lack of depth in reflection groups”; “no choice with the Trust” and “no choice in deciding which Trust to be in”; “late pay”; and being able to “change mentor.” All these issues were mentioned to have a knock-on effect on the emotional labor that could be sustained in the local trusts.

The student council was certainly said by some student nurses to be there for direct “emotional support” and indeed council representatives saw their role in this way finding themselves ideally placed for potential discussion between students, clinical staff, and lecturers. They described their roles as helping their fellow students to “untangle the threads” of their diverse experiences and “knit them back together again” or to “unload and repackage the cargo of emotional labor” as a way of making sense of their anxieties and fears. The process of talking to the student council therefore was seen as providing opportunities for students to vent their feelings which in turn would act to sustain the emotional labor of student nurses and provide social support.

Discussion also raises nurses’ political awareness of local and national issues in the health services (Smith 1992; Scott 2000; Benner 1994; Bolton 2005). It was the student council who mobilized students to take part with lecturers and practitioners in a lively debate about the future of nurse education organized by the Nursing Times in the Spring of 1999 (25th February 1999).

Peer Support and the Subculture of Care in Student Nursing

The emotional support of peers and colleagues was a main point that student nurses mentioned in interviews. Friendships at college and during clinical placements were seen as vital to continuing in nurse education and managing the emotions of nursing

work. In nonparticipant observation at Essex and East London educational sites, one of the most palpable aspects of student nursing was the ways that student nurses supported each other. This emotional support was particularly visible in informal settings about college and also could be noticed during seminar group discussions. The establishment of good interpersonal relationships with colleagues as friends was reported to be an emotional, educational, and social support. In Smith's (1992) study, which applied the largely conservationist notions of Hochschild (1979, 1983, Smith 1999b), the sister or charge nurse was the chief role model for gaining knowledge and appropriating a "style" or technique of emotional labor. Peer relationships were not central to accumulating emotional labor and education but informed political awareness and psychological feelings of being supported as a student nurse.

However, interviews and nonparticipant observation in this research suggested that relationships with peers were also an implicit method of gaining cultural capital (Bourdieu 1977, 1984, 1992, 1993). Essays, oral presentations, exams, books, forms, tests, interviews, and the like were all first discussed by nurses with their peers. This built peer-based knowledge and also bonded people in working to become a nurse, which was itself arduous and an emotional labor to sustain over the 3 years of nursing education. Successful peer relationships enabled nurses to slowly melt into the habitus of the nursing profession. Informal links with peers and colleagues enabled student nurses to "buy into" the nursing profession and pick up educational and emotional "styles" as well as nursing know-how. There was noticeable excitement of most first year students when being handed out the nursing uniform, which was effectively a rite of passage and symbolically admitted student nurses into the profession. Three people were noticeably unexcited about the uniform as symbolic goods and during participant and nonparticipant observation were unable to engage or play the nursing role. Two of these cases said that they did not know what to do, felt like a fish out of water and uncomfortable with their new roles. These jitters or insecurities were not picked up by mentors, link lecturers, or other staff. All three subsequently had difficulties in building peer relationships that informally supported student nurses and enabled private individuals to slowly melt into the public habitus of the nursing profession. Those excluded from peer relationships were unable to draw emotional support and not able to share stories of critical events that punctuated their student nursing experience. They were unable to share feelings about lessons, essays, patients, experiences in the classroom or on the ward, and get support as well as feedback from peers. Those who could not engage in emotional support and sharing stories in the oral culture of nursing (Smith et al. 1998, 1999b; Leight 2002; Froggatt 1998; Gattuso and Bevan 2000) were not able to accumulate the currency or appropriate cultural capital of the nursing profession. All three of these students left within the first 6 months of their education. Such findings not only demonstrate the importance of peer support in student nursing but also suggest the importance of maintaining relationships with colleagues and patients as a technique of avoiding burn out and high attrition in clinical areas of the nursing profession (Sandall 1997; Cronin 2001; Benner and Wrubel 1989).

The informal style of peer support was seen as mirrored by "good" members of nursing staff and especially the link lecturer. Senior students described how as third

years, they might act as mentors to their junior colleagues in the clinical areas. This was also a common finding in Smith's (1992) study. The most well-received seminars and lectures incorporated a peer atmosphere of informal discussion (either during or at the end of sessions). Students talked about the development of group identity (habitus) and responsibility (field) for helping each other to learn (accumulate cultural capital). There were drawbacks however when there was a wide range of learning needs within a group, since feeling the need to help others could be stressful. It is not surprising to find therefore that student nurses appreciated building up knowledge from more passive learning in more formal lectures.

Both active learning (involving "group discussion," "feelings," and "emotional disclosure") and passive learning ("sitting and writing things down") were important modes of education for student nurses. According to a student nurse in mental health:

> It's really important to have peer support and friends to talk to. It's good to know people have similar feelings and to be able to talk about a patient's case… When we're having group discussions it can help you get over things with lecturers and the group… It helps you to think… It's about sharing your feelings and making a disclosure—an emotional disclosure, yeah—which is what we have to do a lot of in the mental health branch… Lectures are more formal, I suppose. You can pick up things and learn the latest info by sitting and writing things down… It's really being told what to think about and helps build up the nursing basics, especially the medical information that you need as a nurse.

An interesting point to note in the above excerpt is how the student nurse differentiates his learning experience. On the one hand, the active and more informal method of learning is described as an emotional and socially shared experience. This is said to be necessary and quite usual in mental health, where "emotional disclosure" is seen as an accepted part of dealing with a "patient's case" and giving support to "get over things." On the other hand, the gathering of "information" and "writing things down" to think about is associated with the more formal context of the lecture hall. There is a notable differentiation between "feeling"/"peer support" and "what to think about"/"the medical information." Both methods of learning are seen as shaping the student nurse's learning experience and helping him to think and feel as a nurse. Particularly important is the informal style of learning, which is seen to encourage peer support and sustain emotional labor in a "patient's case." To be sure, it might be suggested that the extract of the mental health nurse is a struggle and reflection over the field (Bourdieu 1992, 1993) of his education and practice. There is a tension in the excerpt between head and heart as well as feelings and knowledge. There is a struggle in the extract between the emotional and medical components of mental health education, which is prevalent in the health services and reflected in conflicts between humanistic and biomedical philosophies of care.

There was an interesting distinction made by one senior student between mental health and adult nursing. The former was described as "a melting pot of ideas and thoughts" rather than the specific technical procedures associated with adult nursing. Adult nurses were described as working as individual autonomous practitioners whereas mental health nurses were more likely to work collectively in pooling ideas and helping others (whether patients or staff) to work through problems.

Finally, student nurses tended to gather in groups based on a shared background and similar characteristics. To a greater extent, students would seek out peers of the same gender, ethnicity, and to a lesser degree in terms of age. Students seemed to seek out similarity to gain coherence and shared experiences of nurse education. Movement between groups was commonplace but much less visible than students seeking peer similarity.

Encouraging the Heart: Leadership in Nursing During a Time of Change

The Royal College of Nursing's clinical leadership program is an ongoing project to provide consistent, dynamic, and motivated leadership in senior and middle rank grades of nursing (RCN 1997, 1998, 2000). Several of the program's major themes center on areas where clinical leaders need to develop skills to become more patient centered, encourage the heart, and learn better management methods of laboring emotionally with patients and colleagues. Themes touching on emotional labor include: encouraging the heart; self-management; building, developing, and managing effective relationships with team members; patient focus; listening to nurses' and patients' stories; internal and external networking; increased political awareness; and action learning. As in other studies, the highly humanistic, democratic, and dynamic methods of the program helped to shape experiences of transformative learning (Gillespie 2002; Leight 2002; Hoover 2002; Revans 1980, 1997). This motivated nurses to resolve conflicts and poor practices, so improving the quality of care of patients and better managing the workplace.

The themes of networking and increasing political awareness promote involvement in service development, which in turn enhances understanding of and contribution to meeting national policy targets. Building, developing, and managing effective relationships strengthens interdisciplinary and interagency working, recognizes stress, and promotes health at work. Patient storytelling provides a mechanism for assessing quality based upon the patient's experiences and is aimed at the development of patient-focused quality indicators that contribute to clinical governance.

The program has an important part to play in helping clinical leaders to "work through emotions." According to a clinical leader:

> I felt I had let patients down most of the day… I came away just feeling that it was a horrible day and I had to sit back and reflect on what areas I did do that day… We had another admission and there was a woman dying… The woman had not spoken to her family for about two years… I had to work through the emotions on the phone (with the woman's daughter) and also go back to the carer and talk about it and go to the patient and talk about it as well… Bring them back together… So I went back to the daughter and she seemed willing to come in. I walked her daughter in and she sat there… and gave her a big cuddle. And my eyes just filled up… I just felt totally behind with everything again and that is why I ended up thinking it was a terrible day… I did go to the nurses' station but there was so

> much going on… They were kind of with me… but everyone was so busy and had to get on with their own work… I never understood it but I am just wondering if those pent of emotions over the busy periods are not being dealt with and that is manifesting itself as conflict with teams and just general anxiety and stress retention.

The above quotation of a clinical leader reiterates the case study of the student nurse and her link lecturer, where resource conditions limited emotional labor. To be sure, one task will be to sustain emotional labor under great internal and external pressures in the National Health Service. In part, this will help in the assessment of how nursing staff work to sustain emotional labor in an overburdened healthcare system. Emotional labor is certainly a vital resource in the health services. To a large degree, emotional labor is invisible. This means that emotional labor is often devalued and goes unnoticed. In the case of mentors and other staff nurses, emotional labor and support goes unpaid, either financially or in terms of time owed for guiding the student. Mentors and link lecturers are not seen as emotional laborers who guide the student's own development of emotional labor. In part, this may be explained by the fact that nursing and the role of women in the domestic sphere are linked. Gender stereotypes of the nursing profession certainly reduce financial rewards, the move toward professionalization and the visibility of emotional labor.

However, even though emotional labor is not economically rewarded and remains largely tacit in the health services, many nurses continue to consider emotional work at the very heart of the nursing profession and a central aspect of patient care. The way forward in the future is to consider the methods by which the emotional labor of nurses is best codified and sustained (Smith 1992). To be sure, sustainable emotional labor is a matter for research, development, and consultation between different organizations. Methods to sustain emotional labor will no doubt incorporate innovative developments in the education, leadership, and training of student nurses. In the future, it is not altogether inconceivable that a reallocation of resources will take into account the emotional labor of nurses.

With student nurses the study has investigated how emotional labor is learnt and more importantly how emotional labor is experienced by the student nurse. A central part of the student nurse's educational experience is members of staff and peers. Staff and peer groups act as role models of nursing and give interpersonal support. In the 1980s, studies of student nurse learning emphasized the importance of the ward sister or charge nurse in the provision of a good ward learning climate (Orton 1981; Fretwell 1982; Ogier 1982). In Smith's (1992) study of the emotional labor of nursing, the importance of the ward sister to student nurse learning was clearly demonstrated. Care was seen as a form of emotional labor in relation to the care not only of patients but also of nurses. According to Smith:

> When nurses felt appreciated and supported emotionally by the sisters, they not only had a role model for emotionally explicit patient care but they also felt better able to care for patients in this way (Smith 1992, 140).

In the current study the sister and charge nurse were mentioned less frequently and with less depth than link lecturers, mentors, and peers. These groups appear to play a much fuller part in shaping the image and emotional labor of student nurses.

The task remains to fill the void created by the ward sister's decreased involvement in student nurse learning by developing leadership and educational methods, so as to sustain student nurses in their academic and practical emotional labor (RCN 1997, 1998, 2000; Drach-Zahavy and Dagan 2002; Hoover 2002).

Chapter 8
The Clinical Contexts of Emotional Labor

Four clinical settings were mentioned by nurse interviewees and involve different types and orientations of emotional labor. The four contexts have different sorts of patients, emotions, nurse narratives, and methods of managing emotions in patient care. The settings involve different cultures of care in the National Health Service and the varied techniques of emotional labor that are employed by nurses. The selection of these specialties for closer scrutiny in relation to emotional labor is also indicated in previous work (James 1989, 1993a; Smith 1992; Smith et al. 1993; Gray 2009a, b, 2010; Gray and Smith 2009).

Primary care, mental health, HIV/AIDS, and children's oncology will be surveyed as case studies of emotional labor. The intention is to illustrate the ways in which nurses engage in emotional labor in different clinical settings. The section will also show the ways in which different frameworks (sociological, psychological, psychotherapeutic) help in forming an appreciation of the multifaceted aspects of emotional labor (Fineman 1993; Smith 1992; James 1989). Although they are brief, the case studies will be useful in guiding future development. More research and development needs to be done in a variety of clinical and nonclinical contexts, especially given that the case studies demonstrate that emotional labor is employed as a technique by nurses in many different ways to care for patients. The case studies indicate the importance of collecting a rich evidence base on emotional labor to both improve understanding and maintain high standard nursing care of patients. A concrete evidence base is particularly necessary given that emotional labor is tacit in the nursing profession and needs to be made more explicit (James 1989, 1992, 1993a; Smith 1992, 1999a; DoH 1999c, 2004). The contexts of emotional labor need to be codified to assist nurses in their day-to-day interactions with patients, relatives, and other members of staff.

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The Routine of Emotional Labor in Primary Care

In primary care, emotions were engaged as a matter of routine. Emotional engagement, befriending, and labor were an everyday but vital part of nurses' work. It made patients and relatives feel comfortable and at home in their treatments when coming into the "alien" and perhaps threatening space of the doctor's surgery. The routine engagement of emotional labor by practice nurses added to the quality of care in the nurse–patient relationship and maintained the smooth functioning of the clinic. According to a practice nurse:

> I have a baby clinic once a month at the surgery. All the babies are screaming and screaming, which isn't at all good for my head and is, you know, really painful for a four or five hour clinic. The babies are frightened, they're only a few months old, and the mothers are worried and upset… Sometimes the mothers will scowl at me because I'm hurting their babies. I have to give the babies their injections. I might even be interrupting a feed… All the time I've got a headache and keep things going. I have to keep the babies and the mothers happy, and have to smile to reassure them and really resist the temptation just to get out of the room.

Several important features of emotional labor are being accomplished by the nurse in this excerpt. The nurse is providing emotional labor in so far as she is managing her own and others' emotions. Emotional labor makes mothers and children feel more comfortable in the baby clinic.

The nurse is therefore engaged in "dealing with other peoples' feelings, a core component of which is the regulation of emotions" (James 1989, 15). Appearing caring is a core component in what Hochschild (1979, 1983) terms "the managed heart." The nurse resists her own feeling to "just to get out" of the baby clinic and juggles with her own emotions as well as the feelings of mothers and babies. Surface gestures, such as a smile, are performed to "keep things going" at the clinic (Tanner and Timmons 2000; Bolton 2001; Smith et al. 1998; Smith and Gray 2001a, b). In a similar way to Hochschild's study that focused on flight attendants, acting techniques are employed by the nurse as a strategy for managing interpersonal relations. The nurse has a personal and work self that helps her to orientate herself toward the mother and the baby. This is a presentation of the nursing self as an image of the nurse as a carer, supporting with a smile and by "being there." The nurse presents an emotional self to smooth over psychological and organizational upsets that might otherwise limit care (Saks 1990). The emotional labor of the nurse helps to solidify the interpersonal relationship with the mother. The emotional labor of the nurse therefore works to create a relatively comfortable environment for patients and relatives. This maintains a functioning work environment and makes the baby clinic a consistent atmosphere for those coming into its "alien" space. The nurse maintains good relations irrespective of her own feelings (Saks 1990; Bolton 2001; James 1992; Smith et al. 1998).

A "Schizophrenia" of Emotions? Tensions Between Emotional Care and Social Control in Mental Health

Emotions in mental health are complex and sometimes emotionally stressful. Mental health involves ambiguous and often undecided upon emotions which, if left unresolved, mean that nurses take unmanaged feelings from work back to their own home. Conflicting emotions may mean that work becomes home and home becomes work, due to poor time management and the avoidance of underlying feelings in supervision (Hochschild 1997; Newton 1995). Tensions of emotions in mental health revolve around complex issues of nurses feeling that they have a duty of care toward people with mental health issues, in so far as mental health nurses want to care for, communicate, and engage with the emotional difficulties and "psychoses" of patients, while at the same time requiring the exertion of a social control element in the everyday psychiatric activities of nurses.

There is, in short, a tension between feelings of caring and emotions associated with controlling the patient. In many cases this tension or knot of feeling is left untied and is not unraveled during discussions in reflexive supervision and mentoring. This may result in many nurses taking unresolved emotional issues and contradictions of care or control of the patient from the workplace to the home. Taking unresolved emotions home may precipitate subsequent problems in the families of mental health nurses. According to a mental health nurse:

> It's almost impossible not to take the way you feel home with you. We do get some chance to talk about patients at work but I usually end up taking work home with me and feeling very stressed… I talk things over with my family, minus the details, you know… One of the most emotionally difficult things about mental health nursing is trying to get to know the patient and feeling that they might do something like try and hit you at any moment.

There are two points to begin to unpick in this nurse interviewee's account. First, stress and "taking work home" are seen as a direct result of not enough reflection with colleagues. Similar findings were mentioned by Smith et al. in a study of the emotional labor of nurses who worked in orthopedics:

> The demands of emotional work can be as tiring and hard as physical and technical labour but are not so readily recognised and valued… Home was the place used to express emotions not acceptable in the public arena of the ward. Nurses also talked about the importance of having other nurses, friends, or family to help them work through their emotions (Smith et al. 1998, 32).

No doubt the interviewee's "taking work home" with him might cause problems away from work with the mental health nurse's family. Second, there is the issue of "trying to get to know the patient and feeling that they… might try and hit you at any moment." Physical aggression and labelling difficult patients as "mad" and "bad" are certainly stereotypes of those with mental health problems in the health services and in public life too. To be sure, patients were divided into "good" and "bad" categories by many of the nurses and general practitioners at interviews and during participant observation. The social control elements of healthcare view "good" patients as more compliant than those categorized as "bad" (Lawler 1991, 147; Gabe 1995; Rose 1990).

What is particularly of note is the stress that is caused by difficulties that the nurse has with the care and social control elements of his work. "Trying to get to know the patient" sits in sharp contrast to the image of mental illness as physical aggression. A study by Handy (1990) shows that the mandate to both care for and control patients with mental health problems leads to unresolved conflicts and distresses for all involved. This is said by Handy to reproduce distress and inequalities in health, especially where discrepancies arise between daily practices and therapeutic ideals, as is recognized by the nurse in the above excerpt (Handy 1990, 1991; Newton 1995, 94–96). Studies suggest that the social control elements of mental health present a decision dilemma for many psychiatric nurses. The dilemma between the contextual and ethical conditions to care or control the patient leads to a conflicted nurse and may enflame feelings of inadequacy and result in burn out (Scheid 1999; Marangos-Frost and Wells 2000).

According to a recently trained community psychiatric nurse:

> Sometimes you might feel very unsafe. There's always a feeling of danger and maybe physical violence; however much training you've had there's always an amount of danger involved with mental illness and going into mentally ill people's houses. Some of the worst schizophrenic patients are hard to communicate with, may be frightening if you're not used to them and can come across as physically dangerous. I'm used to the behavior of some of our more badly behaved schizophrenic patients (laughs)… When you're dealing with dangerous patients who might just lash out at you or go and smack you one for no reason, then you have to look at the risk. You have to be very aware of any danger or risk if you visit a home with a female nurse, I think so anyway, as some patient's can be quite funny and it's best to keep an eye out just in case they have a go.

An initial point to note is the protection that the male nurse says is afforded when dealing with dangerous patients who threaten female nurses. "Bad" patients are stereotyped as especially physically or sexually dangerous toward women in general and female nurses in particular. "Bad" patients (Lawler 1991) are seen as recalcitrant and resistant to medical and interpersonal demands made by healthcare professionals, in so far as "bad" patients are perceived as more voluble, labile, tend to reject suggested treatment regimes, and exhibit more emotionally disturbing, physically unmanageable, and bizarre patterns of behavior (Littlewood and Lipsedge 1989; Fernando 1989; Rogers and Pilgrim 1993; Hiday et al. 1999; Gray 1998, 1999). Perceptions of the "bad" patient are linked to a lack of reciprocation and communication of emotions with a subsequent vacuum in emotional contact between nurse and patient. "Bad" patients are described as emotionally "frightening." This creates a vacuum in the nurse–patient relationship, affecting the quality of care of patients and divisions of labor in mental health.

There are also echoes of stereotypical gender relations and traditional male–female relationships made by the community psychiatric nurse. In society and in mental health nursing, men are often characterized as doing less emotion work and instead seen to fulfil the masculine role of being tough or in control of their environment and feelings (Duncombe and Marsden 1998; Arber and Gilbert 1989; Bolton 2001, 2005; Newton 1995). This stereotype of male and female emotions prevalent in society and reflected in the health services is a symbolic caricature that works to

reproduce gender divisions of emotional labor. The male nurse seems to condone unequal and protective relations in the home and this leads to the reproduction of inequalities in public systems of mental health care. Patriarchal protection, he says, is to be furnished to female nurses inside the patient’s home, inside the private sphere, by the public face, and protective arm of men and male nurses. Private relationships and emotions in the home certainly influence gender inequalities in systems of public health care (James 1989, 1993a; Smith 1992; Williams 1999; Bolton 2005; Gray 2010).

This reproduction of gender inequalities will limit the practice of female nurses. Such limitation by gender is a form of symbolic violence, in so far as symbolic violence is unrecognizable and expresses common and everyday forms of expectation, obligation, and imperceptible, gentle exploitation (Bourdieu 1977, 1993). In the present case of reproducing unequal gender relations in public healthcare apparatuses, symbolic violence involves a misrecognition in relationships of power between men and women. In the excerpt, the male nurse avows patriarchal expectations as being for women’s own good and as a legitimate form of patriarchal protection. Such symbolic and almost imperceptible violence involves expectations of how women should naturally behave at home and how this should automatically be transferred into the workplace.

There are resonances in both extracts that relate to emotions concerning the intrinsic dangerousness or violence of people with mental health problems and calculations or assessments of risk. There are emotions of physical and sexual fear. In the first extract, the nurse links the duty of care and emotions of closeness with feelings of possible physical violence and dangerousness. The care and control elements of mental health nursing are palpable in the excerpt and in such tension with one another that they are said to cause psychological stress for the nurse. Specious ideas of dangerousness and feelings of the “mentally ill’s” propensity toward violence shape public stereotypes of people with mental health problems as well as influencing practice and policy decisions in the National Health Service. Sensationalist media coverage of the Stone and Zito inquiries and other emotionally shocking events certainly precipitated an immediate Government response toward compulsory mental health powers in the community that have been described as “knee-jerk” by several leading sources (BBC News 1999; Woodman 1999; Taylor and Gunn 1999). Black people are often stereotyped as dangerous and are perceived by mental health professionals as given to dangerousness and risk-inducing behavior in terms of perceptions of smoking cannabis and mental toxicity for instance. Black people with mental health issues are certainly at the brunt of the perceptions and emotions involved in dangerousness and risk, which leads to high rates of diagnosis of severe mental health problems such as schizophrenia and high incidences of compulsory medical and electroshock treatment (Littlewood and Lipsedge 1989; Fernando 1989; Rogers and Pilgrim 1993). Emotional fears and the stereotype of the “mentally ill” as dangerous or violent is somewhat contrary to current views, especially in a study in the USA where people with “mental illness” were found to be more statistically likely to be victims of crime and physical violence (Hiday et al. 1999; Independent 1999).

Certainly, feelings of being threatened by patients' dangerousness and risk are noted by a variety of sociologists to play a substantial part in the regulation of "problem populations" (Rose 1990; Scull 1984; Foucault 1991, 1992) as well as interventions into general society toward the "normal population" (Armstrong 1983b, 1995; Hacking 1990). In keeping with the tone of the second extract of the community psychiatric nurse, Castel (1991, 287–288) suggests that mental health professionals organize a "*real* presence of danger" that is based on bureaucratic formulations of the "*probabilistic and abstract* existence of risks" and also says that there has been a move from discourses of danger to those of risk in modernity. Douglas (1990, 2) and Carter (1995) argue that risk is little more than the technobureaucratic extension of the term danger. In recent years, the vocabulary of risk has colonized discourses of health and illness (Lane 1995; Castel 1991; Douglas 1990). Quality of care, the experiences, and emotions of people with mental health issues are subsumed by probability indicators and outcome measures (Lane 1995). Grinyer, citing Wynne (1989, 1991, 1992), writes:

> Central to the compilation of official information on risk, appears to be a deeply embedded assumption that it is only scientific knowledge which merits the status of 'expertise'… Lay expertise, founded on experience in a particular social world, does not necessarily invalidate technical expertise, rather it brings an added dimension… Risk… is part of a multidimensional, complex and socially embedded process (Grinyer 1995, 40. See also, 49–50)

Experts are regarded as practitioners in the esoteric sciences, which means that danger and risk are not treated as socially or emotionally embedded languages and negotiated processes that require debate (Castel 1991; Gabe 1995). The languages of dangerousness and risk, and health allocations and decisions, can certainly be argued to be colonized by professionals to form the monologue of expert groups. Both the medical and the human sciences have arguably consolidated such a monologue (Foucault 1992). Stifling debate polarizes social relationships and reinforces stereotypes of people with mental health issues, leading to the reproduction of healthcare methods (Grinyer 1995; Foucault 1992; Wynne 1989, 1991, 1992). Stifling debate and representing people with mental health issues as dangerous also reproduces contradictory feelings involving the care and control elements of mental health nursing. Poor healthcare practices, feelings of inadequacy or stress, and even prejudices or stigma go unreflected upon and are reproduced. People with mental health problems are the targets of such languages and the repositories of feelings of dangerousness and risk in the community (Gabe 1995; Pilgrim and Rogers 1996).

As evinced in the second extract, the emotive languages of danger and risk may also be given to prolepsis and metonymy. Prolepsis (Billig 1988, 91–111) is used as a rhetorical strategy and in the present case constitutes all people with mental health issues as tending toward violence, moral recalcitrance (stereotyped as a "bad" patient), and mental failure (Gabe 1995). This may set up surveillance of the possibility—rather than the actuality—of failure in the future. If the person with mental health issues does relapse, or "fail," this is used as a justification or as an "I told you so" of treatment. Put simply, there is no concrete evidence, only the possibility and feeling that there might be violence, and this possibility may be used to precipitously legitimate intervention. While this occurs, consideration is not given to the

views of those felt to be dangerous or a risk, so that the weighting of phenomenological and experiential issues such as emotions are not contemplated in the risk equation (Lane 1995). Both the danger and the risk of people with mental issues health are self-fulfilling prophecies of medical and social "failure" (Lane 1995, 57). While focusing on risk evaluation in obstetrics and the exclusion of women's views from risk debate, Lane writes:

> The very term 'risk' implies the possibility of mischance… Adverse events are not only regarded as inevitable, but their timing is seen as capricious and unpredictable… By deduction, therefore, all… are subject to… control and surveillance because all… are regarded as 'at risk' (Lane 1995, 60).

Lane continues:

> In many cases, intervention occurs precipitously and defensively 'just in case something goes wrong' (Lane 1995, 65).

Without listening to the views and emotions of people with mental health issues, they may become the repository of discourses of danger and risk and the scapegoat for the social fears of the community, such as regards perceptions of criminality, moral failure, recidivism, aggression, and violence (Lane 1995; Cowan 1994). The setting up of community care centers for mental health service users are shown in several studies to be resisted by social fears of danger and risk posed to the "normal" and upsets to the "normal" functioning of the community (Cowan 1994; Carter 1995; Jodelet 1991). Fears concerning people with mental health issues include stereotypes and emotions that touch on danger, risk, sexuality, child physical and sexual abuse, hygiene, suicide, genetic taints, drug and alcohol abuse, unemployment, homelessness, and violence (Jodelet 1991; Castel 1991; DoH 1999b; Douglas 1966; Rose 1990). Without study and consultation these fears go unchallenged, are generalized and applied to all mental health service users (Dominelli 1992; Billig 1985, 1988), and are reproduced in society and reflected in health care.

Pilgrim and Rogers note that the two conceptualizations of danger to the public and risk to self have dominated mental health discussions. The risk to the patient that psychiatric services pose is also another issue that Pilgrim and Rogers raise in relation to dominant ways of conceiving risk. They go on to say that iatrogenic risk posed to the patient by health services is largely ignored by policy makers as a matter of course (Pilgrim and Rogers 1996; Rogers and Pilgrim 1993). Mental health patients' views of service provision are often neglected, which is unfortunate as these opinions are invaluable to researchers, professionals, and policy makers. People with mental health problems favor less invasive procedures, such as "the talking cure" of psychotherapy, and dislike compulsory medication, continuous supervision, and electroconvulsive therapy (Rogers and Pilgrim 1993).

How far recent mental health policies contemplate the consultation of nurses and patients remains to be fully seen (DoH 1999b, 2004, 2006, 2008). If these views do form a substantial part in future consultation, "this raises… the problem of how to integrate this additional knowledge when it does not simply supplement, but challenges or contradicts technical expertise" (Grinyer 1995, 50). How far policy makers will go to resolve unmanaged emotions that nurses report as arising

from tensions in the care and control elements of their work also remains to be seen. A comparison of views and feelings about danger and risk is certainly helpful in processes of consultation, balancing alternatives, and emotional sensitivity to stigma and managing "spoiled identities" in mental health (Goffman 1990). A comparison of views is integral to appropriate decision-making, as well as the supervision and regulation of unresolved emotions in mental health. Gathering a range of perspectives on danger and risk will feed into professional training and education. Eliciting views and feelings involving danger and risk during training will open up more democratic patterns of care by drawing from patients' perspectives. Training and education of this kind will help to resolve buried emotions about the care and control elements of mental health that often result in a conflicted nurse and even burn out (Harper 1994; Gabe 1995; Silverman 1981; Ewers et al. 2002; Scheid 1999; Marangos-Frost and Wells 2000).

Emotions and Sexuality in HIV and AIDS

Conflicting emotions about HIV and AIDS were discussed in a conversation with another nurse:

> I went to make a visit to a patient the other week. He's gay and his parents don't know. So there are issues, like making him comfortable. And there's his partner's grief. In some cases, the partner may have HIV and is in effect staring down at their own death bed. You can't say that "it's not going to happen to you". There won't be anyone for them if their partner dies. You can support them, but it's a poor substitute. There's what to tell the family. You constantly have to deal with everyone's feelings. You have to give advice and support to patients, their families and other carers.

The nurse went on to explain difficulties of disclosure, in situations where patients wanted their private lives left alone but distraught relatives were asking questions. Consequently, nurses found themselves dealing with a range of emotions associated with public and professional prejudice and stereotyping. The nurse concluded:

> There are emotions about what to tell people. How do you cope with telling someone about HIV or AIDS? What do you tell the parents if they don't know that their son's gay? It's a complete shock to find out like that and the parents in my patient's case were very reluctant to deal with their son being gay. There's a lot of prejudice out there with people and even with some nurses. Some nurses may find it emotionally difficult and some nurses have prejudices about homosexuality. It's all very difficult when you're on the frontline and you're on the spot for what feels like twenty four hours a day… But we have to get emotionally in touch with the patient and their needs. Part of what we do is just acting as a long-term emotional buttress for everyone and helping people get over the difficult times. That's what's expected. We get much closer because that's what we're trained to do now.

This last comment is interesting in so far as the nurse implies that she is prepared for the difficult task of managing complex emotions and that she recognizes that training is required to get closer to patients rather than remain distant and detached.

Nurses, patients, and relatives are all involved in emotional labor and engaged in reflections of how to manage medical and emotional demands. This means that all involved have at some level to manage their feelings. In HIV and AIDS the nurse is faced with managing highly complex and buried emotions. This might involve working at maintaining the belief that everything is normal in the patient's life and in other cases it means being faced with the uncomfortable task of disclosure (James 1993a; Silverman and Perakyla 1990). The nurse states that it is also necessary to manage the partner's grief, which is particularly important in the gay community where multiple deaths due to AIDS might lead to feelings of anxiety and anger when people are faced with many bereavements (Viney et al. 1992).

The extract touches on microprocesses and the nurse's management of "delicate issues" involving the patient and family, such as taboos and stigmas involving HIV, AIDS, and sexuality (Silverman and Perakyla 1990; Strong 1990; Taylor 2001). As the extract implies, HIV and AIDS are often represented as stemming from unsafe sexual behavior, which is often regarded as contracted through "sexual weakness." HIV and AIDS are conceived in terms of indulgence, delinquency, addiction to illegal drugs, and are vehemently marginalized to sexual identities perceived as dangerous, deviant, or perverse. In the largely homophobic and rightwing politics into which the disease first emerged, AIDS was represented as the product of a permissive society and almost as the just visitation of a "gay plague" (Meyer 1990). The public, meanwhile, were depicted as threatened innocents and "terrified citizens" (Karpf 1988; Wallack 1990). The AIDS virus not only invades the body biologically but also invades society as a whole (Sontag 1991; Fox 1993) and in the extract threatens the stability of the nuclear family. According to Weeks:

> The history of AIDS since the early 1980s revealed less a compassionate stirring of the sympathy and empathy of society at large than a fear and loathing, and an increase in hostility toward those… who still remained outside the mainstream of sexual life, gay men (Weeks 1992, 300).

HIV and AIDS have revitalized old phobias and social fears (Gilman 1988; Sontag 1991). Emotional fears are clear in the story of the nurse, while she is talking of homophobia as well as managing emotions involving disclosure. AIDS fosters dark fantasies that mark individual, familial, and social vulnerabilities (Sontag 1991).

Stereotyped as pathologically sexualized and dangerous, the HIV and AIDS patient is depicted as a sociopathic drifter, drug user, or as sexually or racially marginalized. Traditional representations of sexually transmitted diseases, such as the nineteenth century's portrayal of syphilis, find a modern echo in the twenty-first century's representation of AIDS as despair, contamination, and death (Gilman 1988; Sontag 1991; Fox 1993; Taylor 2001). In the extract, as in the ideology of society, people with HIV and AIDS are marginal men, sexually (or even racially) excluded, especially from the safe and heterosexual context of the patient's nuclear family. People with HIV and AIDS are presented as isolated or depressed, thus linking a flawed body and sexual identity with a spoiled mind. The AIDS patient may even be represented as the suffering hopeless male. "AIDS dementia," for example,

is the modern equivalent of discourses concerning hysteria that were carefully targeted to control women's emotions and sexuality in the nineteenth century (Gilman 1988; Showalter 1993).

Difficult Emotions in Bone Marrow Transplant and Managing a Good Death in Children's Oncology

In the children's oncology setting, nurses have to deal with long-term palliative care and manage extremely difficult emotions and complicated psychosocial issues that involve dying, death, and bereavement. In a similar vein to a host of other studies all nurses who were interviewed were sentient of emotions in oncology and emphasized the therapeutic importance of engaging the cancer patient's emotions as a means of facilitating healthy survival (Benzein and Saveman 1998; Field 1989; Haberman 1995; James 1993a; Smith 1992; Shuster et al. 1996; McNamara et al. 1994; Kelly et al. 2000; Gray 2009b; Gray and Smith 2009). The visibility of emotions and recognition of their therapeutic value is partly due to the medical legitimizing of emotion work in oncology. The facilitation of physical and technical tasks is explicitly linked by nurses with the expressive and emotional elements of psychosocial care. The link between technical tasks and psychosocial care is further encouraged in the oncology curriculum, during medical training and in supervision/mentoring (Strauss et al. 1982; Roberts and Snowball 1999; Luker et al. 2000). At the same time, however, palliative care and bone marrow transplant generate highly problematic and often unresolved emotions for nurses, patients, and their families. People suffering from cancer are often stigmatized, in so far as the disease is very often perceived as the "fault" of the patient because it is seen as being contracted through bad living, inattention to lifestyle, poor diet, smoking, alcoholism, and promiscuity. The heart of cancer care revolves around highly emotive issues of dying and bereavement, which are often avoided because they are subject to social taboos that are reflected in the health services. Very often strategies of emotional detachment, intellectualization, and the biomedical paradigm are employed to escape from the harsh and disturbing human reality of death in cancer care. Many studies suggest that the dominance of the biomedical paradigm results in a vacuum of psychosocial understanding and research that would clarify dilemmas in caring for patients in oncology and bone marrow transplant (Bauman 1998; Bradbury 1999; Cameron 1986; James 1993a; Jeffrey 1995; Kelly et al. 2000; Winters et al. 1994).

As a nurse said of emotions in the children's oncology and bone marrow transplant setting:

> You get attached to the patient and attached to the family. The last little boy I looked after was diagnosed as leukaemic, had chemotherapy and had bone marrow transplant. The transplant failed and by the time we met him he'd had lots of problems at school and also with his family. He was dying and his parents just wanted him to be an ordinary little boy. They were 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… People can go through years and years and years of hoping that someone close to them might live, but knowing in the end that 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… I think if you emotionally burn out, you don't give anything emotionally and patients soon cotton onto 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.

Children's oncology is a protracted and painful event for all those involved. Such an evocative narrative certainly lends further weight to the argument that an appreciation of emotional labor needs to be augmented so as to allow a more explicit focus on systems of social, psychological, and emotional support (Mamo 1999; Roberts and Snowball 1999; Thomas et al. 2002; Luker et al. 2000). As James suggests:

> Cancer is a particularly apt disease to review in order to analyse the management, control and 'labour' of emotions in health organizations (James 1993a, 96).

In the children's oncology setting this includes looking at the ways that nurses manage their own and the patient's emotions. It means focusing on the organizational methods that are employed by nurses to come to terms with the difficult processes that are an unavoidable part of emotional work in children's oncology. Many issues need to be explored to attend to emotional labor in the children's oncology setting, such as maintaining hope, feelings of survivorship, strategies of coping, grief, loss, and managing perceptions of a good death. Systems of emotional support and ways of coping are central, especially given the rates of burn out and the emotional difficulties of nursing staff.

As the extract of the nurse bears witness, the experience of cancer patients who fail to recover with palliative treatment or those who die due to treatment-induced complications is not very well understood or researched (Kelly et al. 2000; Roberts and Snowball 1999; Mamo 1999). Despite, and perhaps because of high mortality rates, there is a propensity to focus narrow professional attention solely on biomedical treatments. This sidesteps difficult issues of death, dying, and emotional labor within oncology care. Current technological, medical and quality of life discourses characterize palliative care and are particularly dominant in bone marrow transplant (BMT). Such a narrow and medicalized focus is highly problematic, undoubtedly disadvantaging patients who will not survive difficult transplant procedures and harsh therapeutic regimes. A more broad and humane concern might better serve the psychosocial needs of oncology patients by examining the interpersonal meth-

ods and emotional labor employed by nurses to manage a good death and facilitate difficult process of bereavement with grieving family and friends. The provision of effective palliative care in oncology settings remains open to review through further research, policy development, and psychosocial training that better fits the emotional needs of patients. The role and emotional labor of nursing needs to be rethought within palliative care. This will allow humane concerns such as suffering, hope, despair, and the emotional difficulties of caring for cancer patients to be better understood (Mamo 1999; Kelly et al. 2000; Thomas et al. 2002; James 1993a).

The extract illustrates that the emotional and practical role of the nurse in palliative and bone marrow transplant settings is crucial. Responsibilities include supporting patients and families through difficult medical procedures as well as assisting very closely in recovery. According to several studies, the struggle with cancer is a joint responsibility that is wrestled over by patients, nurses, and families. Very often, nurses and informal carers symbolically share the illness so that very strong emotions, both positive and negative, are transferred between patients and carers (Luker et al. 2000; Thomas et al. 2002; Mamo 1999). The nursing role in palliative care involves monitoring changes in the patient's medical and psychological condition as well as administering therapeutic interventions, for instance, blood products or antibiotics, while clotting and the immune system's response are weakened by aggressive treatment (Roberts and Snowball 1999; Kelly et al. 2000; James 1993a). Until the donor marrow is engrafted the patient is at a high degree of risk of a number of debilitating side effects as well as a range of potentially fatal infections (Freedman 1990).

Medical research is highly established and in bone marrow transplant has focused almost exclusively on improving survival, as well as gaining more control of harming or toxic side effects. This biomedical research has been highly effective, in so far as during the last 20 years there has been significant progress in improving palliative care and the bone marrow transplant process, which has significantly contributed to reducing mortality and morbidity (Hansen 1995).

However, as the extract suggests, there has been far less emphasis placed on those patients that fail to respond to palliative care and survive the process of bone marrow transplant, either as a result of treatment failure or in the natural course of disease progression. Research has tended to adopt a largely biomedical view of patients' needs while trying to ensure that effective interventions are available to nurse the patient. Topics of oncology research include graft versus host disease (Brown and Kiss 1981; Caudell and Schauer 1989), fatigue (Molassiotis 1999b), stomatitis (Beck 1979; Eilers et al. 1988; Holmes 1991; Armstrong 1994), infection and infection control (Caudell and Whedon 1991; Wujcik 1993; Poe et al. 1994; Dunleavy 1996), effect on sexual function (Molassiotis 1999a), and pain management (David and Musgrave 1996).

Much of contemporary research, particularly in nursing, shows an incipient concern with the uniquely challenging demands that palliative care and bone marrow transplant present to patients and healthcare staff of all levels. Of particular importance to the emotional labor of nursing the patient in oncology are complicated psychosocial issues that inevitably impact on recipients of palliative care and bone

marrow transplant (Molassiotis et al. 1996). There is a significant burden of evidence on the impact of protective isolation, which is a common requirement following bone marrow transplant until normal hemopoiesis is achieved. Space, sexuality or body image changes, and pathways of psychosocial rehabilitation have become a staple of modern research (McConn 1987; Holmes et al. 1997). In particular, nursing research has clearly brought into focus a variety of complex psychosocial processes, such as coping, adaptation, and emotional responses in patients, their families, and relatives (Collins et al. 1989; Andrykowski 1994; Zerbe et al. 1994; Molassiotis 1999b).

Quality of life has been another source of research in the last 2 decades. Indeed, quality of life assessment is a requirement of research studies investigating new medical technologies or drugs, forming the cornerstone of psycho-oncology. Assessments of quality of life address a variety of aspects of living with cancer and undergoing palliative treatment such as bone marrow transplant, looking at functional status, independence, self-esteem, social role, and general life-satisfaction (Belec 1992; Baker et al. 1994; Haberman et al. 1993; Yau et al. 1991). However, most of these studies quantify and measure the objective and statistical dimensions of bone marrow transplant. This avoids difficult experiences and sidesteps the highly problematic subjective feelings of patients, which are better addressed by patients' stories in ethnographic and qualitative research. Until recently, the unidimensional assessment of quality of life and health outcomes was so firmly embedded in the culture of cancer care and cancer care research that it passed by almost unnoticed and went largely unquestioned.

By way of contrast, the excerpt of the nurse suggests that the quality of life of the patient and its psychosocial impact on the family and staff is emotionally complex and multidimensional. The recognition that quality of life issues are multidimensional and complex has challenged researchers in oncology and palliative care to address physical, psychosocial, and disease or treatment side effects in their research. Haberman (1988), for example, achieved better psychosocial understanding of quality of life by reviewing the six stages of the medical management of bone marrow transplant. Haberman gathered similar psychosocial responses previously identified in other research and concluded that uncertainty was a central theme that underpinned and permeated all stages of the experience of bone marrow transplant, for both patients and healthcare staff (Brown and Kelly 1984). Uncertainty and ambiguity of feeling are undercurrents in the extract of the nurse. Her story is a plain expression of the difficult and unresolved emotions that permeate the stages of cancer care for patients, their families, and healthcare staff. Given existential doubts and uncertainties a range of nursing interventions were proposed by Haberman to enhance psychosocial functioning. Certainly, this has been the zeitgeist of research in the last decade. An eruption of quality of life studies in the 1990s and 2000s also produced themes that revolved around hope and survivorship.

As stated in the extract, hope is often cited as a reason that patients choose to accept and undergo sustained and difficult periods of cancer care and bone marrow transplant (BMT). Feelings of hope in aggressive palliative care are taken step by step. They are counted minute by minute because of emotionally disturbing setbacks that

are an inevitable part of aggressive treatment. Feelings of hope are continuously checked, regulated, and nurtured by nurses to ensure the smooth running of patient care and to instill feelings of comfort. Hope is integral to the subjectivity of patients and nurses help to engender feelings of hope to maintain a safe and comfortable environment, even in circumstances of great pain, psychological setbacks, and with the ever present possibility of death. According to Haberman:

> BMT patients live by the numbers, the mathematical odds of surviving BMT or experiencing BMT complications, as a way to impose order on the BMT experience and to give meaning to the protracted suffering that accompanies this aggressive therapy (Haberman 1995, 28).

Nurses play a vital part in helping bone marrow transplant patients and their families to count their successes. In this way, hope is related to remission and healthy survival. There is a growing evidence base formed from research involving hope and the cancer experience, as well as the ways in which feelings of hope influence the continued functioning and success of cancer care settings (Herth 1989; Raleigh 1992). Benzein and Saveman (1998) applied a phenomenological approach, which explored hope in relation to a cancer diagnosis. Nurses were discovered to play a significant role in maintaining feelings of hope. Such findings suggest that cancer care nursing plays a significant part in relation to treatment outcomes as well as touching on the phenomenological importance of caring for patients who will not be cured.

Survivorship, from the beginning of palliative treatment up to a period of several years, explores a wealth of patients' perspectives, which range from finding new meaning and managing awareness of personal mortality to coping with infertility, fatigue, and a compromised immune system (Molassiotis 1995; Winters et al. 1994; Haberman et al. 1993; Shuster et al. 1996; Corcoran-Bichsel 1986; Whedon and Ferrell 1994). An important concern that resulted from these studies is whether the attention paid to quality of life has coped with patients whose life-quality is so diminished and painful that further treatment cannot be justified ethically. For these patients, as with the child in the extract, the primary need is being helped to die in comfort.

The extract of the nurse is testimony to the fact that coping is another key experience and strategy in the oncology and bone marrow transplant settings. A study of coping by Shuster et al. (1996) examined the adaptive techniques required to manage the physical, medical, and psychosocial demands involved in palliative treatments (Shuster et al. 1996). Shuster et al.'s study found that the patients who managed to cope focused on a variety of factors, including remaining involved in social relationships, maintaining a sense of alertness, positive attitudes, being sentient of spiritual concerns, and basic physiological functioning. Thomas et al.'s (2002) and Mamo's (1999) studies had similar findings, with a heightened emphasis on the therapeutic power of emotion work.

Research on coping, hope and survivorship underline the challenge of conceptualizing and understanding the complex medical, psychosocial, emotional, and spiritual demands of a life-threatening disease such as cancer. To a great extent this challenge

has not been taken up by research and new paradigms in cancer care. The extract of the nurse illustrates the lack of psychosocial awareness in oncology and bone marrow transplant. Neither the concept of coping nor hope, for instance, has been applied to palliative and bone marrow transplant where the outcome is uncertain or when patients relapse (Kelly et al. 2000). Examining psychosocial strategies, such as hope and coping, following unsuccessful aggressive palliative therapy by people who are facing imminent death will no doubt raise emotionally difficult issues, as the extract of the nurse attests, but it will also engender new perspectives and research questions that will feed into the better support of cancer patients. Such research would complement an established and burgeoning field of study that has examined symptom management, the nature of suffering, and perceptions of the good death (Benoliel 1983; Field 1989; Glaser and Strauss 1968; James and Field 1992; McNamara et al. 1994; Kahn and Steeves 1995).

In the extract, the medical outcome is the child's death. The risk of mortality associated with palliative care and bone marrow transplant is certainly significant, so there is great relevance in assessing notions of the "good death" or "appropriate death" for patients who will not survive. Weisman defines appropriate death in terms of:

> A death one might choose, had one a choice. It means dying in the best possible way, not only retaining vestiges of what made life important and valuable, but surviving with personal significance and self-esteem. In effect an appropriate death is one we can 'live with' (Weisman 1988, 67).

In the extract the nurse is very ambiguous and undecided about the management of the child's death by herself and other caring agencies. She feels that psychosocial issues, emotions, and disclosures were left unresolved by herself, other professionals, and the boy's family. There is the vital issue of the yardstick or measure of appropriateness in decision-making. After all, who makes the decisions of when curative interventions should cease? When does the promotion of a comfortable death become more suitable? Should the doctor or nurse take the lead in the decision or should the patient have the final say? What are the medical, professional moral, ethical, and emotional issues that inform such decision-making? How are dynamics of medical disclosure and decision-making shaped by the fact that the cancer patient is a child? Appropriateness raises challenges for patients, families, and professionals. For the professionals involved there are particular challenges as regards information giving and disclosure (James 1993a), usually centering around whether to disclose the severity of side effects and risk of mortality. For patients and families involved there are issues of freedom of information, emotions, and ethics, access to services and full information on therapies. For the patient there is the emotional blow of being told that medical interventions have failed and the existential terror of facing your own death, perhaps alone (Elias 1978).

The requirement for further research involving professional, ethical, and emotional issues is supported by shifting constructions of palliative care and is relevant to wider patient populations (National Council for Hospice and Palliative Care Services 1997). Palliative care aims especially at assisting people with advancing

disease and disability to live as fully as possible as well as to cope effectively with symptom control (Jeffrey 1995). The work of Weisman (1988) exemplifies the philosophical tone of much of the literature in early palliative care, which concentrated on delivery through hospice services:

> The hospice program has various formats and procedures, but the central goal is the same: to prevent bad death and to promote better death. Prolongation of life at all costs, regardless of suffering, is clearly objectionable (Weisman 1988, 65).

As the nurse implies in the extract, managing the good death in palliative care remains underdeveloped and problematic in many healthcare settings, including the prime example of bone marrow transplant, where the ideology is highly technological and medical procedures focus primarily on curative outcomes. Given the dominance of biomedical ideology, there are significant gaps in palliative care in relation to the notion of the good death in bone marrow transplant. The ethical and no doubt emotionally coloured basis of clinical decisions, which might include when to discontinue blood transfusions for a patient who has endured aggressive treatments and whose condition is deteriorating, is another aspect of psychosocial research in need of further analysis.

Such a combination of complex emotional issues suggest that simple solutions to the problems facing patients and professionals in the cancer care and palliative treatment settings will continue to elude, vex, and frustrate us. Perhaps an initial step is to draw from the Department of Health's driving philosophy and reflect on what innovative solutions are needed in clinical areas where traditional biomedical methods of palliative care are problematic and fail to answer the psychosocial needs of patients? The nurse is beginning just such a process and in the extract is reflecting on the psychosocial needs of the patient and family. She is questioning the limits of the biomedical model of care that was provided to her patient and the inevitable negative impact that a narrow medicalized approach had on the bereaved family. She is informed by her recollection of her emotional labor with the boy and his family. The nurse is reflecting and informing herself with her emotions. This reflection on her emotions raises many ethical, emotional, psychosocial, and practice issues. Emotional labor thus works to produce a positive outcome (Hochschild 1983; James 1989, 1993a; Smith 1992; Bolton 2005). The positive work achieved by the nurse's emotional labor feeds into her notion of good and appropriate practice, in so far as the nurse's reflexive and emotional awareness help her to construct what should have been done to manage the boy's good and appropriate death. This reveals the depth and practical relevance of the nurse's emotion work (Mamo 1999).

By way of contrast to the positive outcome noted, perhaps the most disturbing and horrible aspect of the extract is the feeling of emotional deadness that it can finally leave. This is not a call for emotivism or for the wringing of hands and irrationality. Rather, as the nurse implies, emotion is being sidestepped and issues are being avoided to maintain a false conception of normalcy. The disparity between the fabrication of normalcy and the nurse's actual feelings of not being able to cope results in burn out as well as the feeling that the child's death will return to haunt the family, as it is plainly haunting the nurse who was undoubtedly less attached to

the child than the boy's parents. One is left in the extract with the ultimate feeling of loss and grief, resulting from avoiding the horror of a young child's death, and this is clearly unsettling for the nurse and family of the boy.

The extract of the nurse conveys a common tendency by those involved with the harsh and painful realities of oncology and palliative care to consciously and unconsciously avoid the issue of dying (Laakso and Paunonen-Ilmonen 2001; James 1993a). A common focus for nursing research in oncology has thus been with patients who achieve remission and survive, which is disturbing as in the UK the relative five years survival for all treated leukemia patients is only approximately 25% (Cancer Research Campaign 1999). The majority who receive aggressive treatment, such as bone marrow transplant, will die and may leave behind bereaved families without emotional closure. Although a small amount of research explores the psychosocial needs of patients and families, the broad sweep of research has been conducted from a physiological bias (Wujcik et al. 1994; Wujcik and Downs 1992; O'Quin and Moravec 1988). This is in sharp contrast to other contexts of specialist nursing, such as accident and emergency or intensive care, where caring for hopelessly ill patients and the emotional dilemma of caring for the dying has been explored in more depth (Atkinson et al. 1994; Cooper 1993; McNamara et al. 1995; Simpson 1994). Both the nurse in the extract and a review of literature suggest that there has been a lack of attention paid to difficult questions raised by death and dying in oncology care and bone marrow transplant. To meet the needs of patients and families, as exemplified in the nurse's story of looking after a dying child, palliative nursing and bone marrow transplant require further research and practice development in psychosocial care. Sensitively conducted research is required to examine the dilemmas and tensions of witnessing unsuccessful therapies or treatments with the inevitable emotional and psychosocial impact on patients, families, and healthcare staff.

Until now, the psychosocial demands of specialist bone marrow transplant nursing have particularly been assessed to define technological and interpersonal skills. According to Winters et al., the psychosocial nature of bone marrow transplant:

> Will be characterized by a rapid tempo of practice, changing research protocols and standards of treatment, a lack of personal control, and diagnostic uncertainty (Winters et al. 1994, 1153).

Palliative care and bone marrow transplant patients are usually treated in closed and protective ward environments. As the extract of the nurse suggests, this creates dilemmas of managing a good death on the ward or discharging the patient so that they can die in comfort and familiarity of their own home. Each nursing unit may adopt different isolation techniques for varying periods of time. The experience of isolation and intensive caring fosters relationships between patients, families, and staff that usually focus on achieving disease control or at best a cure. Maintaining this intensity of interpersonal relationships is emotionally draining work that results in some degree of stress among staff (Firth-Cozens and Payne 1999; Newton 1995; Molassiotis and Haberman 1996; Molassiotis et al. 1996).

Various research and the nurse in the extract suggest that staff adopt psychosocial strategies when working intimately with patients and families in palliative care (Roberts and Snowball 1999; Mamo 1999; Luker et al. 2000; Thomas et al. 2002; James 1993a). Sometimes the psychosocial tactics of staff may involve the establishment of emotional distance in the nurse-patient relationship to cope (Papadatou et al. 1994). In the extract, emotional distance and social detachment precede the child's death. There is a tangible social and emotional death before the child's actual biological death. Such detachment is a technique of coping with the disruption caused by facing death and works to maintain a feeling of normalcy for families, staff, and society. In other words, there is a civilizing process that confines and restricts feelings to cope with the existential terror of death (Elias 1978). This is problematic in many ways because there is always the painful issue of appropriate detachment or as the nurse later said, of "knowing when to let go." Several oncology nurses at interview reported that emotionally sensitive systems of supervision, mentoring, and reflexive discussion with colleagues after shifts were employed as methods of regulating the feelings of staff and helping them "let go." However, as the extract illustrates, letting go emotionally is especially difficult with young children, particularly as the modern West valorizes childhood as the exemplification and purest expression of vigor, life, and innocence (Ariès 1962; Laakso and Paunonen-Ilmonen 2001).

In the extract and during the most severe cases of life and death in oncology the reservoir of pressures placed on professionals may burst, eventually resulting in a tidal wave of unregulated emotions and emotional burnout. Unregulated emotions, which are not coped with adequately by colleagues, seniors, and systems of supervision, will inevitably help create a declining sense of role satisfaction, decreased levels of motivation, and an inflexible approach to care (Molassiotis and Haberman 1996; Vachon 1987). The extract suggests the fact that failure to examine the personal costs of nursing cancer patients within educational programs or clinical supervision is likely to mean that the anxiety caused by processes of death and dying will continue to be avoided (Cohen and Musgrave 1998; Smith 1992; Kelly et al. 2000; Savage 1987, 1995; Lawler 1991; Smith and Kleinman 1989). It is important to study the multifaceted social, cultural, psychological, and organizational reasons that make death and cancer such a taboo.

The anxiety and tension of emotions that are expressed by the nurse in the extract are palpable and moving. The nurse's feelings about the child's cancer care and subsequent death are noticeably unresolved. Forty years ago, Menzies (1960) suggested that institutional techniques played a significant role in managing the anxiety that arises in health care when dealing with human suffering. Organizational methods that attempted to manage anxiety were especially apparent among recently qualified nurses and student nurses. In palliative care and bone marrow transplant settings patients are, by the necessity of their very condition, under constant observation and in very close proximity with staff. Self-protective behaviors, such as concentrating on routine tasks and welcoming new patients, will be magnified, especially if treatment is not working and the patient is perceived as a medical failure. Mount (1986), for example, discusses the emotional dilemmas experienced by

doctors when repeated losses occur in their professional life as a result of the deaths of many patients. These losses may certainly be related to the social problems of alcohol abuse, divorce, and the relationship difficulties that are well publicized in this group. Similarly, multiple deaths in the gay community due to AIDS also lend credence to the view that anger and anxiety build up when people are faced with continued bereavements (Viney et al. 1992). While staff in palliative care will not undergo the same degree of loss as a relative or friend the very nature of relationships that can develop in cancer care are highly intimate and intense (Lawler 1991; Savage 1987, 1995; Smith 1992; James 1993a). This exposes healthcare staff to repeated and perhaps unmanaged emotions involving loss, which might like in the story reported by the nurse lead to feelings of resignation or even futility and burn out in the nursing role.

The perspective of the nurse in the extract is an echo of the findings of Knight and Field's (1981) study, which examined the methods employed by staff to cope with dying patients in an acute ward. Nurses and medical staff routinely failed to disclose to dying patients about their deteriorating condition. Knight and Field (1981) offered an explanation to account for this lack of disclosure that is very similar to the understanding reached by the oncology nurse in the extract:

> Physicians and nurses claim that 'not telling' protects the patient from depression and anxiety… Not telling protects physicians and nurses from becoming too closely implicated in the patients' dying and so they can maintain the pretence of 'everything as normal' and not get involved in the handling of death… The work routine of the ward may become disrupted by disclosure of impending death (Knight and Field 1981, 221).

Cameron (1986) calls the situation facing our oncology nurse a "moral schizophrenia."

Nurses, patients, and relatives are all involved in emotional labor and engaged in reflections of how to manage medical and emotional demands. "Cancer," as James (1993a, 97) says, "is hard to hide." This means that all involved have at some level to manage or even hide their feelings. In some cases, this means having to work at maintaining the belief that everything is normal in the patient's life and in other cases it means being faced with the uncomfortable task of disclosure (James 1993a; Silverman 1981). James writes:

> 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 are controlled through information, optimism, routine living and social expectation (James 1993a, 97).

The split in "knowing" and "telling" may even be detrimental to the patient and certainly raises medical–ethical questions. Moral schizophrenia also raises issues concerning the openness, transparency, and democracy of nursing practices, such as appropriate disclosure to patients. Moral schizophrenia may further impact on morale and lead to dissatisfaction or even staff burnout. According to Huy (1999):

> 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 (Huy 1999, 13).

The conflict between front-stage work (maintaining feelings of safety and security) and backstage work (having unresolved emotional dilemmas or even feelings of futility) is a by-product born from the limitations of the curative philosophy underpinning palliative treatment, where death is a common occurrence but an unwanted medical outcome (Goffman 1959; Mamo 1999; Bolton 2001; Thomas et al. 2002).

Several studies (Bauman 1998; Bradbury 1999; Jeffrey 1995; Winters et al. 1994) suggest that aggressive palliative care and bone marrow transplant environments are dominated by technology and rapidity of decision-making. Death is perceived by the medical profession as a biomedical and professional failure. The malfunctioning, unreasonable, and dying body is failing to be controlled. This challenges the limits of biomedicine and technology, as no cure has been found to control the diseased body. It is therefore vital to interrogate if a prejudice toward a technobureaucratic health service is placing efficiency above quality of care and the psychosocial needs of patients, family, and staff. It is pivotal to further question if technobureaucratic biases are operating in cancer care and palliative treatment settings and if these limit the ability of staff to cope with disclosures and the emotional pain of managing a patient's death. The Department of Health's plan for investment and reform of cancer care emphasises the need for cancer services to provide support for nurses and informal carers as well as for patients (DoH 1999c, 2000b, 2004, 2006, 2008). Even though there is growing recognition that healthcare staff and carers have psychosocial vulnerabilities the exact nature of the emotional labor, activities, and needs of care providers has received relatively little attention and human understanding.

Summary: The Emotional Labor of Nurses in the National Health Service

Many principal themes were mentioned by nurses at interviews and by key informants during meetings, observations, and focus groups.

Emotional labor is largely implicit at a national level. There is room for the explicit development of emotional labor in policy, practice, and nurse education including its incorporation into specific and holistic competencies (UKCC 1999a, b; DoH 1999a, 2000b, 2004; Samson and South 1996; Davies 1995b; James 1993b).

There has been a shift from the central role of the sister/charge nurse (Smith 1992) to the link lecturer, mentor, and informal peer support. It is now the link lecturer and mentor who officially shape the student nurse's learning experience and act as chief role models, especially as regards how student nurses learn to care. Peer relationships act as an informal method of education in the nursing profession. Peer relationships support student nurses through their 3 years of education (Smith 1992). Many student nurses are young and under 25. Student nursing has a subculture

(Hebdige 1979; Tripp-Reimer 1985; Birnbaum and Somers 1986, 1989). This allows the unofficial accumulation of knowledge about emotions and helps student nurses test in a safe environment with peers appropriate techniques and feelings of care. Peer relations are largely free from the scrutiny of seniors or staff so student nurses share informal knowledge, emotions, and nurse stories. Peer relations offer implicit inculcation of nursing values and the accumulation of nursing culture's "cultural capital" (Bourdieu 1977, 1984, 1992, 1993). A student nursing subculture shared with peers forms an informal basis of professional experience about health care and what it means to care and emotionally labor as a nurse. It forms the nursing/caring habitus (Bourdieu 1977, 1984, 1992, 1993). Nursing is largely an oral rather than a written culture. Storytelling is full of metaphors and especially elicits women's narratives on emotions, so enabling women's perspectives on emotional labor to be heard (Froggatt 1998; Leight 2002; Fineman 1993; Gattuso and Bevan 2000; James 1989; Gray 2010). Sharing stories, swapping anecdotes, emailing and passing notes, comparing essays, telling narratives about patients or ward staff, engaging in practical or intellectual arguments before or after lessons, talking about feelings, and the like are informal techniques engaged by peers that accumulate cultural capital and shape a habitus of care in the nursing profession.

As confirmed in an abundance of literature, both the link lecturer and mentor support the emotional labor of student nurses in similar ways: with liaison between clinical placements and the education setting; providing a symbolic and practical link between clinical placements and the nursing college; encouraging reflective learning that elicits talk on emotional labor; by encouraging student nurses to learn from personal stories and storytelling; by sharing their experiences of nursing, communicating, and listening to student nurses; by establishing both formal and informal teaching methods; establishing informal and supportive relationships based on peer support; and encouraging peer support in student nurses' seminar groups and reflective sessions (Egan 1990; Williams 1999; Morton-Cooper and Palmer 1999; Benner and Wrubel 1989; Gillespie 2002; Hoover 2002; Smith and Gray 2001a, b). Link lecturers were said to need more regular contact with student nurses. Mentors needed to balance their ward duties with the education of the student nurse, so as to give more time to student nurses. Form-filling was identified as interfering with mentor and student nurses' learning periods. Student progress reports that mentors filled out were said to be drawn up in "incomprehensible" language and waste time on clinical placements. Internal and external pressures on the health services, such as understaffing and economic shortages, were said to prevent space for emotional labor and as in Cronin's (2001) study leave no time to deal with emotions.

The roles of the link lecturer and the mentor in sustaining the emotional labor of nursing should certainly be recognized. In particular, mentors have difficulty in balancing their responsibilities. Ways of ensuring that student nurses receive appropriate guidance need to be established. One way of doing this is more contact, as mentioned by nurse interviewees, and better liaison between student nurses, link lecturers, and mentors. The role of the personal tutor was seen as mainly academic. Although academic support is important, the pastoral role of the personal tutor is integral in the 3 years of student nursing. The role of the personal tutor might be

expanded in the pastoral area and into the clinical setting. Informal methods and peer support, as with the link lecturer, create an environment for student support.

Nurse leadership is vital in the area of emotional labor (RCN 1997, 1998, 2000). Leadership informs the interpersonal techniques of emotional labor, raises social and political consciousness, and sustains the emotional labor of nurses. Many experience transformative education that encourages the heart and motivates nurses to improve clinical practice. Humanistic methods of reflective and action learning assist in discussing emotional labor and help sustain the best practice of nurses (Revans 1980, 1997; RCN 1997, 1998, 2000; Gillespie 2002; Hoover 2002; Morton-Cooper and Palmer 1999). Peer support is to be strongly encouraged and drawn upon by staff to increase the capacity for reflection on emotional labor and prevent burn out through sharing stories and emotional experiences.

Gender and professional barriers were noted by respondents and informant groups. Gender stereotypes led to the invisibility of emotional labor. Symbolic violence (Bourdieu 1977, 1984, 1992, 1993) employed traditional gender stereotypes of female emotional "weakness" and masculine toughness or being in control. There was a split between the head and the heart and labor perceived as male and female, which maintained stereotypes of men working in mental health and the protective male function of social control (Duncombe and Marsden 1998; Bendelow and Williams 1998; Newton 1995; Marangos-Frost and Wells 2000). Symbolic violence was gentle and invisibly divided nurses' emotional labor from biomedical practices, such as diagnosis carried out by doctors and General Practitioners. Emotions were divorced from clinical decision-making and presented biomedicine as objective and capable of competent decisions via affective neutrality (King and Clark 2002; Scott 2000; Haas and Shaffir 1977). Gender and professional differences are present in wider society and reflected in the structures of the National Health Service (James 1989). Women and men should not feel discouraged from providing emotional labor and support (both to patients and colleagues). The portrayal of emotion as a "weakness" to the nursing profession needs to be strongly discouraged, particularly as many studies suggest that emotional labor is therapeutically valuable to patients, families, informal carers, and healthcare staff (Thomas et al. 2002; Smith 1999a; Benner 1994; James 1993b; Davies 1995a, b; Phillips 1996). If feelings are dismissed and made invisible, gender divisions of labor will be reproduced and a continuing facet in nursing and in other health professions (for instance: barriers to women going into mental health nursing; limitations to the emotional labor of General Practitioners and doctors, which effect patient consultation and decision-making).

There is the task of grounding the emotional labor of nurses in a formal and systematic way. Clarification is required in nurse training and education. This will be based on sociological, psychological, and psychotherapeutic models of emotional labor (Hochschild 1983; Fabricius 1999). As feminist studies suggest, emotions and emotional labor need to be made visible and not discounted as merely "women's work" (Oakley 1974, 1984; James 1989, 1992; Smith 1992; Gray 2010). In addition, the potential for abusing staff and patient's emotions needs to be countered by education and training (Ewers et al. 2002; Leight 2002; Cotton 2001).

As suggested in other studies, emotional labor was said to be a routine part of nursing the patient and contributed to the smooth running of everyday life (Saks 1990; James 1989; Tanner and Timmons 2000; Bolton 2001; Hochschild 1983). The type of emotional labor varied with the clinical context and nurses orientated their emotional labor to attend to patients' needs for intimacy or distance (Swallow and Jacoby 2001; McQueen 2000; Mamo 1999; Thomas et al. 2002; Benner 1994). Emotional labor was seen as vital to how nurses care and part of the culture of care in the National Health Service. More research on emotional labor in nursing needs to be done and emotions require codification (Smith 1992). This will make emotional labor explicit and develop the techniques of care in the health services. There is great scope for evidence-based research leading to informed practice on emotional labor. Emotional labor needs to be recognized and developed in policy legislation as an explicit technique that is valuable therapeutically (UKCC 1999a, b; DoH 1999a, c, 2000b, 2008).

The culture of care in the National Health Service needs to be examined as part of a wider context in which there has been an increase in private health services. The interactions between the public and private sectors, and the ways these interactions shape emotional labor and commodify emotion work, need to be researched. Comparative research on the different types of emotional labor in nursing and social care need to be carried out. A comparison of different educational methods is also required to show how different professions learn to care (for example: by looking at the different emotional labor in the education of doctors, occupational therapists, nurses, family support workers, social workers, and other public service staff) (Firth-Cozens and Payne 1999). The present research, for instance, compares and assesses the emotional labor of nurses, doctors, social work professionals, and family support workers, to whom the focus now turns.

Findings: Part II
Emotional Labor in Child and Family Social Care

Chapter 9
Emotions in Frontline Social Care

The Perspectives of Families and Professionals on Emotional Labor

Gathering family perspectives provides first-hand information on the interventions and emotional labor of family support workers as well as by other health and social service professionals in Tower Hamlets. It allows a focus on families and children, their social and emotional difficulties at home and in the community, and an examination of how welfare needs are better addressed through sustained social and emotional support. It provides first-hand accounts of interventions that have been made by family support workers, in people's own words and in their own experiences. This is crucial to gain a clear picture of what the family support service does, the techniques of emotional labor that are employed, and the ways in which workers interact and intervene with families. It is crucial to look at the ways in which semi-professional family support workers and professional social workers engage and modify the emotions of families that are at the sharp end of poverty, racism, and social exclusion.

The themes and issues explored are taken from nine interviews with families and from thirty highly detailed case records that are kept on-site at the service's base in Underwood Road, Whitechapel, London. A variety of professionals from within the family welfare association and also in the Tower Hamlets area were interviewed to elicit information on the service and perceptions of the area in which it is based. Family support workers took part in two focus groups. Each focus group had five to six workers taking part. A focused session was conducted with members of the steering group. Three members of the steering group were also interviewed. As set out in the methods and methodology section, interviews lasted between 45 and 90 min and were tape-recorded so as to be transcribed to written form as presented. Documentary analysis of case records, which ranged in length from between 150 and 200 pages approximately, is another source of in-depth data by which to assess views on the service and the value of emotional labor. Excerpts and speech from interviews are primarily included on the basis of typicality, in so

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far as many families mentioned similar views on emotions, the service, and its affects in their lives.

All of the families, both the nine interviewed and thirty sampled from detailed case records held at the family support service, said that there had been positive outcomes from the emotional labor of family support workers. All of the families said that work with the family support service helped to give them social support, psychological and emotional balance, and assistance in household and financial management. The majority of families said that working with the family support service had been a good experience and had made a significant contribution to emotional stability and family functioning. Indeed, the family support service was so popular that many of the families said that they wanted more time with family support workers and longer periods of service contact with the family support service. Family support workers were trusted and befriended professionals. Because of family support workers' peer relationships and emotional labor, they were sometimes seen, as in the words of one mother on the quality protects project, as a "friend of the family." Managers and professionals welcomed this close emotional support, while expressing reticence about the need to create professional and personal distance through mentoring and supervision. Child protection cases and quality protects families presented issues and challenges of a highly emotive and unsettling nature, including child physical and sexual abuse. Emotional labor, particularly in such problematic and disturbing cases, is "hard work" that is regulated by organizations because it tests the emotional, interpersonal, and professional boundaries between social care staff and families at the harsh end of life in the United Kingdom.

Emotional Labor with Families that Have Multiple Problems

Family support workers started off by saying that families had multiple social, economic, and psychological problems and therefore had complicated needs. According to a family support worker:

> Money is tight. Bills get left. The families have lots of children, four to five children. They are on income support and don't realise that social services can help them in ways with clothing, furniture and things. So I've gone in and ensured that these are provided and bills do get paid, that families are not running-up debts. I'm trying to get them on household routines, bills, budgeting, getting good food for the children.

As confirmed during interviews and in the literature, Tower Hamlets was seen as a very disadvantaged community and families had severe economic, social, emotional, and psychological problems (ELCHA 1995; FWA 1999; Hillier and Rahman 1996; Banatvala and Jayaratnam 1995; Association of London Government 2000; Davey Smith et al. 2000; CPAG 1997; Shaw et al. 2001; Gray 2009a). Families had, in the words of one supervisor, a variety of "micro- and macro-problems":

> Families have macro-problems: overcrowding, poor housing, low income, crime, poverty, no English language, unemployment, physical and mental health problems. These cause

micro-problems at home between children and parents and the way that people feel. In a sense, there's only so much that you can hope to change, but we can set up impacts in the family's life that begin to help and benefit the children… There's so much out there needing to be done. It's not something you can just dismiss. Unfortunately it's on the increase, where there's so many families out there who need help.

A referrer echoed this view:

Tower Hamlets is a priority area and has a crying need for services to go out and help families. There are all sorts of issues: overcrowding, unemployment, poor housing, drug and alcohol abuse. Families in the area are in such need of close support and care from services but rarely get the amount of help they deserve. There are a lot of Bangladeshi and families from ethnic minorities that are difficult to contact and it's hard to gain their trust if they don't talk English. So, there's a crying need for lots of services and especially those ethnic minorities.

Tower Hamlets is recognized as one of the two most deprived boroughs in the United Kingdom (ELCHA 1995). Family support workers were expected to go into people's homes and work through their difficulties in a practical, emotional, and supportive manner. A referrer said:

My expectation is for the service to give practical and emotional support. In one case storage was an issue and the family support worker needed to give advice on creating and monitoring a child-friendly environment. I didn't have time to go through each room with them, of the safety and danger of certain articles in the house, practical things like that. I start with diets, routines, household management and the family support worker carries on. Family support workers can do everything that social workers can do but I expect them to do the little practical and emotional things rather than the more complex things.

Referrers would identify need. Family support workers would then carry needs-led services to the family in the home to help with emotional and practical difficulties that the family was experiencing. Family support workers were mainly female frontline workers who would carry services and resources to families in the safe context of their homes. Emotional labor is frontline work that is predominantly carried out by women (James 1989; Hochschild 1983; Smith 1992; Bolton 2005). As several other studies suggest, this type of community work is very successful, as families feel more comfortable in their homes and are more willing to stay in contact with services that cater for their specific emotional and practical problems (Ferguson 2001; Baldock 1990; Duxbury 1997). A referrer said:

If I refer families to family centres they are shy and do not attend. The family support service takes resources to families and maintains good contact. There's someone coming into the house to work on the family's specific needs and problems.

As in Ferguson's (2001) and Duxbury's (1997) studies, improvements suggested by referrers were sustained by workers because of regular visits and emotional engagement with families in their homes. A referrer said:

The family were very aware that it is hard to keep a new idea of parenting or responding going for a week between appointments. It's crucial to have a skilled family support worker and the mother reinforcing behavior. The workers speak Bengali so can communicate achievements and add new targets.

Negotiating Safe Access Into the Private Home: Feelings of Physical Safety and Emotional Abuse

Visiting families in their homes was not without its problems and emotional stresses. Many families had multiple economic, social, and emotional problems which raised issues about the safety of work on the frontline. Frontline health and social care workers are often the targets of physical violence or suffer verbal and emotional abuse, which may be related to more general issues of violence against women or those perceived as occupied in low-status "female" professions such as in health and social care (Tolman and Raphael 2000; Raphael 1996, 2000; Pearson et al. 1999; Hanmer and Maynard 1987). There were practical and emotional issues about visiting families in socially excluded neighborhoods, which suffered from high rates of poverty, unemployment, drug use, and crime. More generally, the act of stepping over the threshold of the private home was something that had to be handled sensitively. Frontline work in the community by public health and social care workers could not just "barge in" with interventions in the private household (Ferguson 2001; Duxbury 1997; Baldock 1990). Public social care workers, such as family support workers and health visitors, had to carefully manage the emotions of families to get safe and consistent access to families and children (Cox 1993; Gordon 1997). A manager at the family support service said:

> There are general safety issues about visiting people in their homes. It's getting to their homes, especially on darker evenings. It is something that needs to be checked out with new referrals, whether there's been any past incidents, any violence, whatever. We had an unfortunate episode where a mum threw a shoe at the worker. Or it may be visiting another mum, where dad had left but was coming and going and had a history of schizophrenia and domestic violence. So that was a big safety issue that meant workers had to visit in pairs or with the health visitor. Workers have to be sensitive to what's been going on and aware of all the emotional and little difficulties of just getting into the family's home to start off with.

New referrals would be assessed by management for possible problems of home visits. Workers visited families in which physical violence, sexual abuse, and mental health problems were common. Workers would often visit in pairs if cases were especially difficult or had become strained. This would allow a feeling of security for family support workers and an emotional safety net in numbers. Visiting in pairs in emotionally strained circumstances would also allow further negotiation into the home, in so far as two workers would allow a new interpersonal dynamic with families and sometimes move the situation on. For example, in one case a Bangladeshi mother had a problem with an abusive partner who lived outside the home but would often visit at irregular intervals. A young Bangladeshi female family support worker was allocated to the case. Assessment by social workers mentioned there was a very real possibility of domestic violence. The male partner became very verbally aggressive with the female worker on her first visit. The male partner transferred his abusive and possibly violent feelings onto the family support worker, as both the mother and the family support worker were about the same age and both were Bangladeshi. On the next three visits, the family support worker was joined by a White female

worker. This completely changed the dynamic of intimidation and emotional abuse so that family support workers were able to request that the male partner was not present until the mother and children had been consulted. Thus, the emotional labor and persistence of family support workers negotiated safe access to the home and smoothed over volatility. This gained access to the mother and children, whose views and social care were being blocked by the abusive male partner.

Joint visits occurred in many difficult cases and worked to maintain feelings of safety and negotiate safe access into unstable homes. A psychiatric referrer illustrated a case in which the return of the husband, with a history of schizophrenia and violence, necessitated careful consideration and joint visiting. The referrer wrote:

> On admission, (the mother) was found to be moderately depressed and we thought it was appropriate to continue with the Dothiepin 75 mgs… (The mother) is pregnant and is due to give birth in late March or early April… Following long discussions, we noted that (her) husband had some allegations of sex abuse and left the United Kingdom… My concerns on the husband's return was that people were making lone home visits, particularly the family welfare association, the health visitor and home help. It might be physically or emotionally threatening. Perhaps the health visitor and family welfare association could visit together?

Discussion by managers at the family welfare association and referrers often established strategies for continuing support in the home in a safe and emotionally stable way. Joint visits were often encouraged if risks were seen to be increasing or if the family had reached a crisis.

Emotional Sensitivity to Changing Needs and Problems

Support workers carried on with problems and needs identified by referrers in a flexible and practical way (Ferguson 2001; Duxbury 1997). At the same time, support workers would liaise with referrers and families so as to "add new targets" and make new improvements to families that had not been originally identified. Family support workers would engage practically and emotionally with problems in the home as they arose. Family support workers said that it was a vital aspect of their job to manage referrals in at least two senses. First, family support workers would actively engage with families on the issue that they had been referred for to the family support service. Family support workers would deal with identified problems that referrers had mentioned in a referral form. Second, family support workers would actively detect new problems and emotional needs as they arose. Families would go through changes, with emotional peaks and lows, and workers were able to manage and respond to the initial reason for referral as well as meet new practical and emotional challenges on the ground. Emotional labor is frontline work that requires a range of people and interpersonal skills. Predominantly undertaken by women, it requires the engagement, negotiation, and management of feelings on the ground to produce a neutral or positive outcome (James 1989; Smith 1992). Family support workers were sensitive to emotional problems as they arose and so mitigated the possibility of small problems becoming larger ones.

A support worker summarized the main point that social care is liable to abrupt changes in people's circumstances and feelings. This requires frontline workers to combine management of emotions with input into practical support. Support workers helped to manage personal and emotional changes. The worker said:

> When families get referred it always states what the referral is for. Sometimes that changes, because you go in and something else takes over. On one case, I had a referral to help with finances. But when I went in there, there were obviously child protection issues. The mother was admitting to hurting her children. So, I had to go straight back to social services and tell them that there were bigger issues taking over. The family welfare association go in and see a lot more because they are hands-on and in the home a lot.

Referrers said that they would refer as many cases as they could to the service and that it was in high demand. A variety of client groups were mentioned by one respondent:

> I've made a dozen referrals and they've all been accepted. I refer a variety of types: families with lots of children, single parents with a new baby, Bangladeshi families who had newly arrived, refugees and asylum seekers, those with mental health problems and learning disabilities.

Workers would give one-to-one support, engage other resources and services, and work toward the autonomy of the family in managing its social and emotional difficulties.

Interpersonal, Practical, and Emotional Labor

Family support workers helped with emotional and practical difficulties that families experienced as they arose in the home. Family support workers helped to focus in on particular problem areas and engage other services to ameliorate difficulties. Family support workers had a step-by-step approach to the problems being experienced by families. A family support worker said:

> Families can talk to us about their problem. We'll go through their problems with them step-by-step. It's just the small things in life that gradually build-up.

Dealing quickly and effectively with the "little things" (Smith 1992) would often prevent problems from becoming compounded into much larger problems. As suggested in several international studies, emotional and psychological support was very important in establishing good interpersonal relations, particularly with young single mothers, and noticeably helped to motivate families (Booth and Booth 1999; Duxbury 1997; Ferguson 2001; Taggart et al. 2000). A family support worker said:

> We give them emotional support. One of the mother's had a child recently with bad physical development, so she was shocked and I had to talk things through with her to help her understand about her child. I helped make a list of things she would like to discuss with doctors.

Emotional difficulties were listed, step by step, to express deeply felt concerns. Family support workers established close working and peer relationships with families.

They befriended young mothers and worked together with families as a unit (Booth and Booth 1999; Cox 1993). Workers often came from a similar background as clients. Face-to-face and on-the-ground work was a vital way of approaching problems as they arose. According to a manager (1) and two supervisors (2 and 3) at the family support service:

1. I think the families and the family support workers build up a very close relationship. This is because they are probably the only workers who actually speak Sylheti and are working without going through an interpreter.
2. It's being able to go in and identify problems, because we're working closely with families. In one case, it was a minor sort of thing of discovering what a huge problem the bed-wetting was with the children. Fairly small things like that, but ones that make an impact.
3. I think one of the advantages is taking the stigma away in families that say, "he or she is the problem". Methods of engaging families and getting them to work together are difficult but get families to work their shared problems out.

Workers often came from the same community as families. Many workers were Bangladeshi and so could communicate more easily without an interpreter (Hillier and Rahman 1996). Close emotional labor helped to build trusting and non-threatening relationships that broke down perceived barriers between services and families. A manager said:

> One advantage is that they don't see us as so much of a threat, such as in quality protects cases where the children may be taken away. So, with that, they feel closer to workers and able to work with the family welfare association. The workers have got more time than social services and build relationships with families and children, taking them out and doing activities with the children.

One of the main difficulties of bringing services to people in their homes is the disruption or "threat," as the manager says in the extract above, that private individuals feel when dealing with official public health and social work professionals. This feeling of a "threat" with services that are meant to be stabilizing families is compounded if intervention is not negotiated in an interpersonal and emotionally sensitive way. According to a referrer:

> One of the problems we've encountered is that there are families where so many agencies are going in. It raises issues of does everyone know what role they're playing and is the family clear of what the family welfare association provides as a service to them. It raises issues of being sensitive to the needs and emotions of families. It's not just stamping in and saying "I can fix it!".

The Little Things: Emotions, Building Trust, and Making Practical Interventions

Family support workers were seen as trusted and proactive workers who negotiated service involvement with families. Their emotional labor dealt with the "little things" (Smith 1992), establishing one-to-one trust to gain access to homes and

make practical interventions (Ferguson 2001; Duxbury 1997). Family support workers engaged families to work on recurring practical and emotional problems in the home. Family support workers informed families of local organizations and helped families to contact appropriate services and resources. Family support workers worked with other professionals from the health, social service, and voluntary sectors to solve family problems. Some families were illiterate or did not speak English. This posed difficulties of service contact if not helped on the ground by support workers who could interpret and educate (for example, by reading immigration correspondences and helping to complete official forms, which not only helped in citizenship issues but also prevented feelings of panic at the possibility of being deported). According to a support worker:

> A lot of families can't read, so unless you've got a worker or someone who can help with letters from services, that's them lost and panicking. They might get an important letter and not be able to read it. They might not know of a court case, or hospital appointment, just because they can't read. They need someone just to go through the letter with them.

Two principal roles of family support workers were (a) providing information on appropriate resources and (b) facilitating access to local services that would help families. A support worker said:

> It's helping families to focus and get into the system and get help from local resources. It's trying to make their life a little more easier and back to normal with support.

Because they engaged emotional labor and won the trust of families, family support workers were able to increase the uptake of access to other services, where it was appropriate. Workers were on the ground, working together with families and giving clear explanations that created a comfortable and confident environment for accessing other services. A support worker said:

> As you work with families they build-up their confidence, become more vocal and contact more local services, such as mother's groups. They may start at college again or go to the women's centre to learn English.

The adult client group was reported as being composed predominantly of mothers. Engaging fathers was thought to be more difficult due to conventional domestic relationships (mother at home and father the breadwinner), the large number of single mothers in Tower Hamlets, and the tensions sometimes involved in families between parents. A manager said:

> The service is very successful with mothers and their children and less successful with fathers. With a lot of families the father isn't present. Sometimes we've had tension because mum is keen to be involved and dad isn't. That can be very delicate, because if you intervene in a family, you change things just with your presence. So it's something to be aware of, to take parent's concerns and be child-centred.

Part of family support work often got parents to work together and was very often successful in creating better cooperation between mothers and fathers. However, fathers sometimes proved difficult to engage in the private space of the home and emotionally.

Support workers used a variety of activities to encourage parents to engage with their children. These activities were simple and included game-play, such as connect four, and play-doh; helping parents to be able to participate in and manage children's imaginative game-play (for example, making imaginary chocolate biscuits from sofa cushions and making up stories together); reading stories; painting and drawing; eating at the dinner table; writing down and sticking to agreed timetables; preparing visual charts and cues for children; giving stars, glitter, and stickers for good behavior; giving praise to children; giving treats, such as sweets, for good behavior; setting routines and boundaries in the home; engaging in activities in the community (for example, shopping together; going to the mosque; after-school classes for parents and/or children; mother's and children's groups; and visiting the park and playground); and a trip to Margate with the family support service. During these activities, family support workers would engage the emotions of mothers and children, and so were in a position to better win their trust.

Many of the families were single mothers with multiple children. One mother had seven children in her home. Several children had mental health problems or a learning disability. Adults had difficulty in coping alone and without advice sometimes found it difficult to engage with their child. Many adults felt unable to cope and incapacitated in the home because of multiple responsibilities and problems. This would lead to further deterioration, especially with the behavior of children. The family support worker would engage in game-play with children and act as a role model for both children and adults. Role modeling would establish activities as a normal and routine part of family life and demonstrate basic parenting skills. Family support workers would engage practically and emotionally with children during game-play, which helped to consolidate feelings of trust.

The words of a young Bangladeshi mother illustrate the emotional difficulties involved and the helpfulness of engaging with the "little things" (Smith 1992) in life. According to her:

> When my family support worker came in May I felt physically unable to do anything. I was fed up of having children year after year. I used to lay on the sofa and look at her (the family support worker) and that's it. I wouldn't be able to sit up and sit with her and talk with her. That was my attitude, just lying there, depressed on the sofa. After a few months she convinced me to get out of the sofa and sit down with her and the kids. She said the kids are often hungry and that's why they play-up. They go into the saucepans and put their hands in if they're hungry. They used to go in and make a mess, get food on the carpet. But things have changed. My family support worker told me to get prepared before the children come back from school, so that I'd have drinks and juice ready. To make set times and dinner times. The children never knew time, so the support worker said: "Look, you can't eat now. Look at the clock on the wall". They used to eat and eat and eat, and go on eating between meals and vomiting. Now we have regular meals and drinks. My support worker also showed me how to play games with the children. Like playing a game to clean the house. Count "one, two, three and packing up the shoes", or saying "if you put this up I'll give you stars". They did get in a routine of cleaning. I could never sit and eat and talk with them. But now we sit and eat and so that's improved. We have the chance to sit with them and talk. We turn off the TV and talk about Allah and doing our prayers. Before the support worker came I never knew about play-doh. But that was a real treat for them, so I used to sit down and play with them and then they would sit down by themselves for about two hours.

> The family welfare association encouraged me to sit down and do drawings and read stories with my children. I have learnt to cope more by myself. I used to rely on other people, but my support worker encouraged me to become more independent. I was always treated as a baby by other people, not an adult, so how could I look after my own kids? My support worker has helped a lot.

Establishing set times, routines, and emotional boundaries lifted pressure on families. Families had time-keeping skills and better knowledge of parenting, so they no longer felt that they had to cope with 24 hour emotional responsibility. Support workers would role-model and encourage better parenting skills that engaged feelings between parents and children. Family support workers taught disassociated and depressed mothers to emotionally engage with their children so as to better manage their behavior. In the above extract, there is a marked change from the mother's emotional apathy with her children to an active emotional and practical connection. There is an almost invisible transfer of emotional labor involved between people, where the worker engages the emotions of the mother who in turn engages the emotions of her children. This is also present in the next case of another Bangladeshi mother of three:

> The children used to go to bed and it would take hours to settle into bed. The kids used to pinch and kick and pillow fight under the covers. I had to go up to them all the time and tell them to be quiet. But now with the worker's help and routines I can sit down and my kids know when it's bed-time. They fall asleep within an hour with a story. Before I would go and shout and scream at them to go to bed. They were up to eleven and the eldest is seven years. Now they're in bed by half-past eight at the latest. We've a set time for bed, for meals, to go to the library and get some books.

Another mother of four had similar difficulties and was assisted by her family support worker using comparable techniques:

> I thought I'd tried everything, I really had. I tried keeping them awake to get them to go to sleep at a reasonable hour. I tried watching their diets. Nothing made any difference at all. It got to the stage that I was pulling my hair out. I really was and felt really low. My family support worker… made suggestions that worked and improved their behavior. I was giving in to them for a quiet life and my family support worker told me that I needed to set boundaries and be fair and firm, not to lash out. It has worked. When they behave civilized, I praise them. It's getting together and sorting out things with support from the family welfare association.

Emotional labor with mothers and children allowed the family support worker to become a conduit or repository of feelings. Family support workers were often transferred upon in the psychotherapeutic sense. Family support workers were said to be a mother figure to the children and an elder sister to young mothers. This meant that emotional and practical activities established by family support workers were perceived by families as natural and normal to the home environment. They were not seen to be making intrusive and unwelcome interventions against the will of the family. Emotional labor broke down barriers between public health and social care professionals and families in the private home. Emotional labor connected private emotions with practical endeavors to do with everyday "little things." Emotional labor allowed public social care interventions to be perceived as natural family activities, so role-modeling, setting times, and establishing routines and boundaries

were welcomed into private lives in the home. These were helpful in alleviating emotional stress and improving personal relationships between parents and children. Families were better able to manage their routines and their emotions. According to a 22-year-old mother on the quality protects project:

> My family support worker said to have play times where the children could mess about for a little while after school. Then they would have to do homework. At other times they had to behave and got treats for being good. They're not so destructive anymore. Before they'd get knives and forks and dig at the walls and damage things. They used to be quite destructive. My eldest son used to break walls and swing on the gate. They used to hit the walls with brooms. Once it got so bad I hit my eldest with a tin opener. I was so tired and so angry. They're much better now. My family support worker has helped make routines and set boundaries. I'm better at giving praise and talking to my children. Two of my kids didn't talk much. By sitting together and doing activities with the support worker they've started talking and their English has improved. They've started talking a lot. I get on much better with my eldest and he behaves much more better than he used to. I let them have play times, so don't get angry with the mess, because they will help clear it up. They built pillows on top of each other and said to me: "Look, Mum, we've made chocolate biscuits!". When they finished making chocolate biscuits, with all the pillows in a mess on the floor, I told them to put everything back into the biscuit tin and we tidied it all up.

Family support workers often gave praise to mothers and encouraged mothers to give praise to their children in turn. Many socially excluded mothers felt incompetent or emotionally unable to look after their children, so praise was necessary to benchmark achievements. Emotions of insecurity and failure in motherhood were negotiated successfully by family support workers so that positive achievements could be listed, recognized, and reproduced. Before the involvement of family support workers, many young mothers were so dejected that they felt unable to list anything in domestic or community life as positive. Visual aids and colorful charts with reward systems (such as stars, sweets, or praise) were a successful favorite with young children in their primary years. According to a mother:

> We had quite a bit of fun with the charts. The kids loved getting the stickers for being good and used to sulk if they didn't get one, so it was a good incentive for the kids to behave.

Visual charts and graphs are rewarding and encouraging to both children and adults. They teach good behavior to children, in so far as they provide visual cues of good behavior, for example. They also teach adults to positively reinforce good behavior and the value of emotionally engaging with their children in "fun" activities. Emotional engagement helps in the management of the home and ensures regulation in the routines of family life.

Sometimes mothers commented that they would have liked more free time for themselves and space at home. Home life was highly claustrophobic for women with lots of young children in often overcrowded homes. In these cases, family support workers had to negotiate a balanced approach that took into account these feelings of claustrophobia with the necessity of making positive interventions in basic parent–child interaction. According to a mother:

> The one thing I didn't like was that I sometimes didn't want to be there. I wanted the support worker to be with my kid. I just wanted to be out of the scene and have my own space

for a while. And my support worker said: "You must come and sit down". I just didn't want to be on the scene for ten minutes. She said: "You have to sit there and do those things, because it's for you and your children". I didn't agree with that completely, because I'm there all the time. But I did find it helpful because it let me pick things up, let me learn. We wrote down a rota, why the children were crying, wanted attention, and this whole folder of my thoughts and feelings. We made stickers for drinks, meal times and bed as praise for the kids. I planned ahead to get more organised and it has helped.

In these cases of domestic claustrophobia, home help, home care, and parent and baby centers were usually contacted. It was essential for support workers to say that role modeling and activities together were necessary for improvements to be made in family functioning. It was important for support workers to stipulate that both parents and children should be engaged to knit the emotions of the family more closely together. Family support workers had to explain their role to families and differentiate their role from that of other professionals who would be able to give mothers more space and free time to themselves. In the above excerpt, the family support worker deals with feelings of domestic claustrophobia in two vital ways: First, outside services and voluntary agencies are contacted so that the mother can get out of the home, both by herself and with her children; second, feelings of claustrophobia are listed and made transparent so that the mother makes them real in the home and is able to deal with her insecurities about domestic life.

Positive Outcomes of Emotional Labor

Managers mentioned several outcomes of emotional labor, including the improved functioning of the family; gaining access to other services; improvements in the care of children; parents giving more in emotional and interpersonal terms to children; better organizational abilities of adults; and better attendance as well as functioning of children at school. Positive emotional and social outcomes were reported by all social care professionals as being a principal highlight of work with families (James 1989; Smith 1992).

Certainly, referrers noted many positive outcomes for families. Workers had helped families practically, socially, emotionally, psychologically, and economically. The following six extracts clearly illustrate positive outcomes (James 1989; Smith 1992). Family support worker's engaged emotional labor to empower families and address their emotional and social care needs.

I've seen one family come through really well in terms of lots of contact with the family support service. I saw a great improvement in the safety of the children and general presentation of the family. The mum had been depressed for quite a long time and seemed to be coming out a bit more with the family welfare association's regular support. She had more confidence and self-esteem.

The work of the family support service met cultural needs a great deal more than a White worker could. I don't think it would have been possible to be trusted as "a member of the family" and help so intimately without personal knowledge… It would take much longer. The level of knowledge of the family support worker is priceless. It would be interesting

> to look at how much your staff "adjust" what they translate to make it more culturally comfortable.
>
> Mrs. "X"s' confidence and competence of parenting seven children has improved dramatically. After so much criticism and denigration of her parenting in her marriage she needed the family support worker's affirmation and real support in resuming parental authority. This gave her children the message that she should be respected.
>
> I liked the way the worker helped to empower the mother and wondered if with time you would be identifying a syndrome or cluster of skills which "unwesternised" Bengali parents have to assimilate in order to feel empowered as parents in this country.
>
> At the beginning of the work (the daughter) was nervous and unable to express herself fully. Now (the mother) feels that (the daughter) has made good progress so far and has done well, despite the difficulties with her daughter absconding.
>
> I really value the quick telephone call with the project's manager just prior to sending in the referral form, just to get an idea of the waiting time. It's very useful to have the phone call chats on updates and other agencies involved. It's excellent to have interim reports and summary reports… The family welfare association feel that there is still work to be done with the family particularly regarding (the son's) emotional needs. Getting a letter for (the son) to empower him to show at "translation" meetings was very particular and pertinent for him. The mother's needs were supported and linked to other agencies.

Rather than financial remuneration, which motivates private companies and individuals, the central motivation of public service carers such as family support workers seemed to involve sustaining basic human relationships that valued emotions as their own chief reward. According to a supervisor at the family support service:

> When you see a family and they're flying, that's the best thing about my job. We had a mother who barely spoke, at all, and sat with her head-scarf pulled over her face. She muttered and was very depressed, so she slept all day and her kids never went to school. We felt very stuck with her at one point. We did the final review in the Summer and you wouldn't believe the difference, as you couldn't stop her talking, she was so full of energy. She's going to English classes and she's loving it. The kids are going to school on time and the mum is really proud of herself. You can feel high from that for weeks. You can say: "I know that it was us that did that because no-one else has really been in. She did it, we helped her". That's the best bit.

Interpersonal Support: Social and Emotional Relations of Families and Workers

Many families said that they felt very socially and emotionally isolated. Some said that before engagement with the family welfare association, they rarely left the home and had little knowledge of social amenities. As in several international studies, single mothers who spent a great deal of their time in the home were especially susceptible to social isolation, depression, and feelings of being threatened by life outside the home. In many cases, breakdown and depression in the home had concomitants of alienation and agoraphobia in the community. Sometimes the lack of support at home, and multiple responsibilities with many children, led to feelings of inadequacy, resentment, and violence (Cox 1993; Taggart et al. 2000; Featherstone 1999; Krane and Davies 2000).

Many families had limited social and emotional resources to draw upon. An underlying strength of the family support service was that it cultivated quite close interpersonal relationships between workers and families. From the family's point of view, close interpersonal relationships were very helpful:

> My family support worker listens to me. My family support worker paid me a visit at five and was still with me at seven listening to my problem. So, she takes time for you. It's not flying in and that. That is the biggest help of all, someone who is actually willing to listen to me and to understand how we feel amongst all of this. My family support worker helped me through a very difficult patch and is on-hand to help. The people at the family welfare association go out of the way to make you feel comfortable and relaxed. The trip to Margate and the coffee mornings are a really good way to get the chance to meet the team, other families and people in your position, and just to have an outing to get away from the flat.

Over a period of some months, families said that they felt greater and greater trust of support workers. Building this trust was especially pertinent in cases where interpersonal problems were causing difficulties in the home. The family support worker acted as an intermediary, giving advice to reconcile family difficulties. Family support workers established close relations, verging on peer relationships, but maintaining some professional distance. This stimulated trust between workers and families. Trust helped to facilitate personal disclosure about problems, further assisting the process of communication so as to appropriately support the family (Hupcey et al. 2001).

In the above excerpt from a mother on the quality protects project, the attentive presence and sustained emotional commitment of the family support worker are seen to help stimulate disclosure of difficult feelings. Previously, as a quality protects case, these feelings were expressed as anger, resentment, neglect, and violence toward the children. The mother also said she felt very wary of disclosing to other services as she did not trust them. The outcome of the worker's interpersonal and emotional support therefore had four chief components:

1. The worker helped the mother to establish trust of services;
2. This trust assisted in making disclosures and communication;
3. The mother felt more confident and had more self-esteem;
4. This meant that the mother was visibly able to better manage her feelings and her four children. This created a stable environment that was more suitable to child rearing in the family home.

Worries and emotional upsets were talked over so as to be better managed.

In the following two extracts, talking over difficult emotions is reported to help counteract stereotypes and insecurities about learning disability and physical ill-health (Booth and Booth 1999). Discussing emotions and giving close support help to create a forum for listening and information giving. Family support workers are fully informed and able to manage people's problems. Support workers are also able to engage the expertise of other professionals, such as the counselling service, who may deal more fully with underlying emotional and personal upsets. In the words of a North African mother (1) and a Bangladeshi mother (2):

1. My son was born with Down's syndrome and learning difficulties. He has a hole in the heart. It is a great worry and my family support worker has talked and listened to me and given emotional support. He sleeps in the same room as my two other children and so wakes everyone up in the night. I can get tired or angry or resent losing my sleep. My family support worker is an easy person to talk to about all this. You know, when you just want to talk to somebody. It's good to get advice on what my son needs and what he doesn't need. She (the support worker) used to talk to me and the other children. She'd explain things about learning disability. There's no one to talk to here. I have to keep myself to myself. She was a nice lady to talk to.
2. I was very depressed during and after my pregnancy. I was feeling very down. I went to the psychiatrist and he said I was depressed. But my aches and pains were bad and I went to the hospital and my family support worker booked me in and came. I was diagnosed with lupus (a chronic illness). The lupus has affected me quite badly because when I tell people, people don't believe me, because basically I look okay and healthy. But day-to-day is like-pain. Pain all the time. In the beginning, I didn't know what it was. I didn't even believe it and I still find it difficult to believe I've got lupus, really. My family support worker explained to me what it was but it's difficult. It's hard. The family support worker was helping and talked to me about how I was and how I was feeling. It was nice, as there was no one there. I could talk to someone. Before I didn't go out and was afraid to go out. I was worried and didn't know what to say to people because they didn't believe it when I said I had lupus. I talked to my family support worker who sent me and my husband to a counsellor. The counsellor's experienced and you can talk to the counsellor about lupus, the pain, being down, yeah. In the appointments, was telling him everything: my pain, my depression, about my panic attacks. It really helped. I remember telling my support worker about my panic attacks. I tried to rest and stay indoors but that made it worse with my heart beating. I had panic attacks indoors and outdoors a lot. The family support helped me and we all held hands: my children, the worker and me. She took me outside, so I didn't have the panic attacks.

Close relations between workers and families were an important first-step in decreasing a sense of alienation from the community and wider society (Baldock 1990; Morehead 1996; Gordon 1997). Talking about emotions contextualized family problems and helped to discuss steps to move beyond negative feelings. Many single mothers said that the presence of someone to talk to was a great source of personal and emotional support. This sense of being supported at home, rather than being isolated or alienated, had led to trust, disclosure about family problems, communication with the worker, and growing self-esteem and confidence. Families said that their increase in confidence had led to more community involvement.

Family support workers play a tacit sustaining role, in so far as they sustain people's emotions, in addition to the service's clearly defined preventative role (FWA 1999). Workers are said by families to engage in sustained emotional and interpersonal support. They talk feelings over with families and win trust by close

involvement. Workers listen to emotional disclosures and assist in resolving emotional problems. Workers discuss and consult families about their feelings so that families will be better able to manage emotions and create stable family environments for children.

Breaking the Emotional Mold: Helping Children Who Take on the Role of an Adult in the Family

In three of the families that were interviewed, it was said that the eldest child had in some way assumed a role that was similar to that played by an adult. Often the role was of the father, who was not present. Children assumed an adult identity for a variety of reasons, including the mother's absence from the home for long periods, the father's absence (at work, due to separation/divorce, prison, or overseas), the death of the mother and/or father (for example, a 17-year-old Somali girl had assumed the role of mother with her younger siblings because the parents had been killed in the Somali civil war), and adult's inability to organize the home. (For example, one mother had learning disabilities, so the eldest assumed an adult role with his younger siblings. The social isolation and resultant depression of young mothers often meant that children took over domestic routines, with limited success.) Elder children with younger siblings would sometimes play the role of a father or assume years beyond their experience.

All three of the respondents were single mothers with dependent children (see below—cases 1, 2, and 3). The type of role that the child assumed varied with the child's age, the exact nature of the family's difficulties, the project to which the family was assigned (family support, building bridges, or quality protects), and the family's ethnicity.

Case 1—A mother with moderate learning disabilities raising three children

One single mother had learning disabilities with concurrent problems in knowing appropriate steps of child-rearing. The family's flat was littered with children's toys and was said by the mother and support workers to have smelled of urine. Her son, in his early teens, used to wet the bed and so the mother had to put him in nappies. The family support worker said this was inappropriate and introduced routines and activities to model good behavior. The mother unknowingly encouraged infantilism with allowing such things as tantrums, thumb sucking, battles around the boy's TV in his bedroom, and jealousy of his younger siblings that was expressed as physical violence. At the same time, the mother said that the boy had assumed the part of an elder brother to his younger siblings. This was natural in

so far as the boy was the eldest dependent. But it raised difficulties in so far as the elder son was being infantilized by the mother. The role model being set for the younger siblings was an infantilized one. The younger siblings were said to be beginning to copy him, and the youngest daughter was becoming increasingly uncontrollable and violent. The family support worker introduced routines, rotas, and activities, and was able to begin to show an appropriate role model to the mother and children in activities. The support worker was leading by example, shaping a clear role model, and encouraging family interaction and talk over play/activities. The elder son had also been bullied for a long period and so the worker contacted the school and the educational social worker. One-to-one emotional support and family counselling also pursued difficulties between the elder son, his mother, and younger children. The boy's confidence and self-esteem were said to have improved, the bed-wetting had almost stopped and had become less of a problem if it occurred, and violence was replaced by a more stable family environment.

Case 2—A mother with four children on the quality protects project

The eldest boy of eight was assuming the role of a father with his younger siblings. The actual father lived nearby, cared for relatives, and was often present to help with family responsibilities. The mother found the child's behavior funny but worrying. The mother said:

> It is funny when he says he's the Daddy and bosses everyone around. He used to get angry sometimes and there'd be trouble. There was a lot of arguing. Before the family welfare association it was a cycle of vengeance. One kid would hurt the other, so the other would have to hurt them back. Now, with the family welfare association, I explain to them to come and tell mummy because mummy will sort it out

The role of father is a central one to children. Images of mothering and fathering in the family are invested with symbolic meanings and will often be play-acted by children in the genesis of selfhood. Mothering and fathering are invested in emotionally and psychologically by children during social and symbolic game-playing, which helps to establish a personal identity and a sense of social self. Mead terms the social psychological and symbolic function of game-play in the genesis of self "play, the game and the generalized other" (Mead 1913, 1922). In the extract, the eldest son tries to play the role of father as the "generalized other," which is acted imperfectly and breaks expectations of proper social behavior. This causes friction with siblings and worries with the mother. The support worker helped by role modeling, setting routines, and engaging in activities/game-play with all the children. The support worker acted an example or role model of parenting and encouraged the children to interact as equal siblings. The father was encouraged to take on more of a role and to help with responsibilities such as picking the children up from school.

Case 3—A Bangladeshi mother with seven children, suffering with depression and medical complications. She is unable to speak English, so her eldest son acts as an interpreter during hospital visits arranged during school hours, which interferes with patient confidentiality and is seen as "embarrassing" by both the son and the mother. To maintain visits with the mother to the hospital, the eldest son is effectively absconding from school.

The mother had many children living in cramped conditions. She was a single mother and widow. The elder son had assumed the role of father during his mother's illness. This was especially noticeable during hospital visits in which the son would accompany his mother and act as an interpreter. This was felt to be embarrassing to both the mother and the son. It raised problems of confidentiality, disclosure, and impact on school attendance. The mother said:

> The support worker could take me to the hospital. When I go, my son has to go with me and I have to take all the kids. My son is translating so it's very difficult if there's something embarrassing that I don't want him to know about. He gets embarrassed too, as he's only fifteen. I worry as I have to take him out of school. The worker helped me get an interpreter for my appointments. The family welfare association could help by coming with me so I'm not so scared.

The worker helped to engage an interpreter on hospital visits. The hospital and family were informed that it was better to get someone else to translate because of the issues involved, such as confidentiality, feelings of embarrassment, and stigma. The family said that it would be helpful if support workers would sometimes escort them to hospital and other meetings.

The three cases illustrate that role modeling and emotional engagement are vital aspects of the worker's activity with families. Families are encouraged, by example and over game activities, to take on appropriate roles to their age. Children are encouraged to help their parents and join in, for example, on shopping trips and cleaning the house, but not take on the role of responsibility in the home. Rotas, routines, and worker's explaining roles, all help reinforce role models and encourage positive emotions.

Chapter 10
Emotions, Ethnicity, and the Case of Child Protection

Sharing Emotions, Culture, and Ethnicity

As confirmed in several studies (Cameron and Field 2000; Chand 2000; Nazroo 1997; Association of London Government 2000; Blackledge 1999), the match of the worker's and family's culture was seen as being vital to assisting emotional contact and practical accomplishments. In common with other research in East London, a match of cultures was said to provide shared aims and goals, break through language barriers for non-English speakers, and establish befriending and mutuality of feeling in so far as a shared culture solidified interpersonal and emotional relationships between workers, parents, and children (Hillier and Rahman 1996; Hillier et al. 1994). In the extract from an interview below, a Bangladeshi woman summarizes how the basis of a shared culture helps to establish close interpersonal relationships and emotions between workers and families. According to the Bangladeshi woman:

> The children know when the family support worker's coming. They know that Auntie's coming. My youngest used to say: "Auntie, Auntie!", and that was one of his first words. She used to teach them bits of Bengali too. It was a good time, after so much trouble in our lives. The children knew Auntie was coming, was going to play with them and help me to play with them, and they got happy and excited. My relationship with the family support worker was as an elder or mum and respected person.

A shared culture, as well as breaking obvious language barriers, establishes a mutual cultural context in which workers and families know where the other is coming from. Workers would often be from the same community and were women. This meant they were aware of the views, social problems, and emotional difficulties that were encountered by families in the local vicinity, in a way that someone outside of the culture and area might not be. The importance of a shared background, culture, and gender was especially notable in interviews and non-participant observation that followed family support workers into Bangladeshi homes. Shared gender and culture facilitated emotional labor (James 1989; Smith 1992; Gray 2009a). Most of the workers and users were Bangladeshis and were women. This meant that

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interpersonal relations were culturally sensitive and interventions could be discussed in Sylheti or sometimes in Urdu.

Ethnicity and gender particularly cemented, not excluded, staff–family interpersonal and emotional relations. In the extract, the term "Auntie" denotes both a trusted and a respected relationship with the family support worker. The term is in widespread use in Bangladesh and the rest of the Indian subcontinent. The term also sometimes denotes a power relationship between individuals. To be sure, the excerpt shows that family support workers and families were drawn into close relationships that resembled traditional kinship ties in Bangladesh. Managers provided supervision and informal debriefing sessions after visits, which are detailed more fully later in the chapter, to ensure that families did not transfer their problems onto workers. This supervision was especially important as there was such a close match between families and workers, in terms of ethnicity, gender, parenthood, and perspective, which might otherwise lead to over-identification and emotional transference (Taggart et al. 2000; Gray and Smith 2000a). Reflexive supervision and regular debriefings, usually weekly/fortnightly or more often informally at the end of the day, sustained the work of the family support service by acting as a repository for the discussion and reflection on emotions. Family support workers were able to communicate challenges and emotions, which helped to smooth upsets to provision and "oil the wheels" of social care (Saks 1990; Huy 1999).

Perhaps surprisingly, non-referrers said that they did not know that the service tried to offer a fit of ethnicity between workers and families. They also said that it was very important to get a cultural match to establish good rapport. Workers from ethnic minorities were especially mentioned by non-referrers as meeting the needs of families from the different ethnic communities in Tower Hamlets (Bangladeshis, Indians, Afro-Caribbeans, Somalis, and other refugees from the Balkans/Eastern Europe, Asia, and Africa). The family support service offered workers from the Bangladeshi and Somali communities to deliver effective and high-quality service to families from these ethnic communities.

Workers from the Bangladeshi, Somali, and Afro-Caribbean communities communicated and appreciated problems better because of their greater knowledge and experience of the ethnic community that they served. Families had specialist and culturally bound needs. With the support worker, culturally bound needs were quickly identified, talked over without an interpreter, and sensitively engaged. Workers were able, in the words of a manager, "to sensitively give practical, emotional, and cultural support."

Emotions and Cultural and Religious Sensitivity

Ethnicity was considered as cementing staff–user interpersonal and emotional relations. This ethnicity and emotional awareness of family support workers helped to inform interventions that were sensitive to the cultural beliefs, emotions, and views

of families. As in other studies, an essential quality for successful family support work is cultural and gender sensitivity between semi-professionals perceived as volunteers and families. A social and emotional glue is established through the shared Bangladeshi language and family support worker's training in listening skills and appropriate information-giving. This means that volunteerism is now viewed as a form of community participation leading to social solidarity (Morehead 1996; Baldock 1990). Volunteerism in the family–family support worker relationship also cements an emotional glue. In many cases, this feeling of being safely and sensitively supported led to the formation of emotional solidarity between families and family support workers. A Bangladeshi woman echoes this view of cultural sensitivity leading to a feeling of emotional solidarity and shared community involvement:

> We're from the same country. My family support worker speaks the same language and she knows about my religion. She knows all about the difficulties of being a mother in England when you're from a Bangladeshi family, about problems getting a visa, looking after seven children who don't all speak English. My mother died recently and the rest of my family are in Paris, so she knows that I'm alone and don't have anyone to talk to but her. She helped me get out more in the community, to mother's groups, and I go to local groups, where we can sit and talk and respect each other whatever our problems and our ethnic group. Whether we're Bangladeshi, Black or White. My family support worker talked to my children about Islam and encouraged my children to attend the mosque and say their prayers. We talk about God and Allah and it's not time to watch TV but to do our prayers. I have the chance now to sit and to talk with my children. I feel that they have a better understanding and respect for me and Bangladeshi culture and Islam now.

In line with Government aims, the work of the family support service is culturally sensitive to families and their emotions, ethnicity, and beliefs (DoH 2000a, 2004; Blunkett 1999; Robbins 1998). Family support work not only satisfies Government policy but also helps families to establish community relations and a sense of wider social solidarity with one another, giving families the opportunity to interact with other cultures (Morehead 1996; Baldock 1990). The family support service introduces families from different cultures to one another, primarily by encouraging attendance in community groups, such as Newpin. This helps families to establish relations with one another and gives them the opportunity to interact with other cultures and points of view. Cultural and emotional sensitivity, shared language, and listening skills are the cornerstones of a multiracial service in a multiracial urban area. According to a Bangladeshi woman:

> We sit and eat at the same table and see that we have shared problems and concerns. We know that despite our differences we have the same problems, but we also know that we are different and can still respect each other. At Newpin the kids go to the crèche and play and the mothers go to another room. We kind of sit in this room and, you know, we close our eyes for a few minutes and don't say anything, and show respect. We share our feelings about things and you can connect with other people and say: "Look, she has the same problem as me". Seeing different mothers there, not just Bengalis—there are Jamaicans, Somalians, English people, and Bengalis. And, it's like, we're all sitting at the same table. If anything happens, everyone's supportive. And it's like we're a second family. They know your situation and they support you.

According to another elderly participant who had suffered from a stroke:

> I had a heart attack and there was no-one to look after my three children while I was in hospital. My wife hadn't got a visa so she wasn't here to look after my children. She was in Bangladesh. The children had to stay with relatives and were very upset that their mother wasn't here and that I was ill and wasn't with them. When I got out of hospital and felt a little better, the family support worker arranged a day centre for me so that I could meet people from Bangladesh twice a week. The day centre would provide a day time meal. There are Bangladeshi people to sit down with, eat with, talk with and you can make friends where you can't before. I couldn't go out before, especially after my heart-attack. Now with the advice of my family support worker I can go out more and have somewhere to go. My worker helped write a letter so that my wife could get a visa and so now she is here and helps with the children.

In these two extracts, the family support service helps very vulnerable people to engage with the community. The service helps establish informal methods of support at home. Formal services are also called upon as necessary, such as the hospital and a day center. The referral to a day center breaks language barriers and enables people to establish peer relations as ways of informal support.

Family support workers played a very active role with Bangladeshi families in establishing links with the Bangladeshi and wider community. For those men and women who had just arrived from overseas, the family support service provided basic support that was very much like an introduction to the United Kingdom. Basic tasks that workers helped new arrivals with included routines such as shopping; language barriers; contacting other health, social services, and benefits; dealing with currency and banks; making applications for housing and furniture; bill paying; hygiene; cooking for healthy diets and the well-being of children; dealing with visas; orientation; public transport; and college educational courses such as computing and English language (Duxbury 1997; Hillier and Rahman 1996; Hillier et al. 1994; Blackledge 1999). Family support workers were said by many families to have an integral role in referring them to local networks and centers of social and emotional support. These groups catered to the needs of the Bangladeshi community and provided a point for Bangladeshi people to meet, which was vital particularly for non-English speakers who felt excluded. Family support workers helped with the "little things" (Smith 1992) and their emotional labor assisted the smooth running of everyday social life.

As illustrated in the above excerpts, family support workers from ethnic communities were sentient of the impact and importance of culture. Family support workers from the Bangladeshi and Somali ethnic groups acknowledged and welcomed the centrality of Islam. More problematic, for one White manager, was the role and place of religion. In an interview and during participant observation, the centrality of Islam was played down so as to attempt a negation of the religious belief of families. "We wouldn't," said the White manager, "encourage families with Islam." Although such comments were exceptional and unusual, they are indicative of "color-blind" views in which cultural differences are played down to present everyone as the same (Littlewood and Lipsedge 1989). This "color-blindness" entails cultural misreadings because it is not emotionally or politically sensitive to ethnicity, culture, and religious beliefs. There is certainly an underlying cultural

divergence in the United Kingdom and more generally the West between secular (perceived as White/Western) and religious (perceived as Islamic fundamentalism) modes of understanding. These systems not only impact on cultural assumptions and beliefs but also structure the activities of organizations and polarize communities. Islam, particularly when spuriously connected with extreme fundamentalism or even an act of terrorism following September 11th in New York, is certainly perceived to be a challenge for Western society in general, and for social and health services in particular (Pinto 1999; Hillier and Rahman 1996; Hillier et al. 1994; Ahmad 1993).

Encouraging Bangladeshi Women and Men to Invest in Emotional Relationships and Care for Their Children

In many cases, families were at the brunt of social isolation and economic deprivation. This placed considerable emotional and psychological strain on individuals and families. One consequence of this strain was reflected in relationships between mothers, fathers, and their children. Often, mothers were left to cope with many children at home, while fathers were engaged in breadwinning at the minimum wage and during unsocial hours. This not only increased a sense of social isolation from the community, but also meant alienation between different members of the family.

One strength of family support work was that it actively encouraged the basic emotional and social relationships between parents and their children. In particular, Bangladeshi fathers were asked to take a more active role in managing the household, establishing routines, and engaging with their partners and in activities with children. One of the most prominent examples of the family support service bringing family members together, despite many years of difficulty and also physical abuse, was given in the eloquent account of a young Bangladeshi mother. This account shows the multifaceted social, emotional, and economic strains on relationships in the family. It goes on to note the way in which the emotional labor of the family support worker helps parents to communicate and take on more responsible roles with their children (Booth and Booth 1999; Cox 1993; Blackledge 1999). This is said by the mother to have improved the relationships of the parents with each other and with their children. The extract shows the family support worker helping the husband and wife to communicate. It shows emotional and practical engagement in the home between the parents and the children, which in turn sets good examples for the four children. There is a palpable change in the extract below which moves from feelings of isolation and abuse to communication, community involvement in a mother's group, and taking an active role in child development. According to the Bangladeshi mother:

> I didn't want kids and my husband said he wanted kids and we kept on having kids. I could not cope. I had my mother to support me with money and everything. She passed away. My Dad left. Just family problems. I didn't want kids and I didn't really want to cope. I could

> never sit, eat and talk with my kids. I used to hate sitting with them. As a young mother, at the age of twenty two, having four kids and a difficult husband was a very stressful job. I was depressed and couldn't sit-up and talk. That was my attitude, just lying there, depressed on the sofa. Now things have changed. My husband beat me for nine years without me saying nothing. I've been in the relationship since I was a child. I was only fourteen. I was so angry when he beat me. For three months I was constantly screaming at him: twelve o'clock, three o'clock, all through the night. He did it because my mum's dead and my family's in France, so he got the chance. By talking things over with my family support worker it has been a lot of help to us all. Before he was beating me and my kids had physical abuse. My worker gave advice to me and my husband. She said if my husband beat me up to call the police. She even spoke to my husband and my husband doesn't talk to anyone. He's always in a corner. But the worker talked to him, saying "I think you're depressed. You need to get out" and he thinks it has helped. He used to call her his sister. They used to speak in Urdu, her language. She used to tell him "this is the way I want you to behave for your children's future". I remember once my husband saying "my face has gone black", in reputation his face has gone black, because he beat me up and I called the police and he thinks that's a bad reputation. And the worker said: "You're saying your face has gone black? What's going to happen to the kids? Do you understand?! You do the fighting and they'll take the kids away. Do you understand? Do you ever think about the kids?". So, when she said what's the children's future if they see their parents fighting, what future do they get, I think that was a straightforward way that really got into him to make him understand about the kids. Now he thinks a lot more about the kids and he says things like: "We send the kids to school and don't think about what they're doing in their education. We need to look at the school, not send them to school and get them home".

The work of the family support service, as in this further example of community involvement (Morehead 1996; Baldock 1990), helps individuals move on from a sense of social isolation, depression, alienation in the family, and domestic problems and physical abuse. The intervention of the family support worker moves the parents toward communication and a mutual sense of being involved in their children's development and education. Both the mother and the father are encouraged to move from their depressed circumstances and take a more active role with their children.

The family support worker helped by sharing the culture and language of the family and being seen much like an advising elder sister, and so was able to encourage the parents to think about the example they set and to behave responsibly and engage with their children. An interesting point to note in the extract, and which shows the movement from isolation to communication at home, is the way in which the speech of the mother moves from using the words "I" and "you" to establishing the family and their mutual roles as a "we" (Schutz 1972). There is a sense in the extract of moving from individual problems and alienated circumstances to shared and mutual concerns about family relationships and particularly the children. The parents are seen to share a mutual concern in the children's future as a direct result of the intervention and advice of the family support worker. As in Taggart et al.'s (2000) study, the family support worker enables the mother to "feel human again" and the family becomes less socially isolated as a result.

On a more critical and cautionary note, Frost (1999) suggests that inadequate training and the attempt to deal with domestic violence as a family issue may place women and their children at greater risk. Family support workers and informal carers

might be faced with the dilemma of responding effectively to domestic violence and child abuse, despite having only limited knowledge of the issues involved. For the family support service, such a dilemma is rectified by close interface and co-working with social workers. Family support workers attend monthly training in domestic violence and child protection run by the social services team.

The family support service also has an important role in dealing with the social and health services' tendency to pathologize cultures. Decision making is affected by the ethnic origin of the family, with the cultural and emotional misreadings that this entails (Hillier and Rahman 1996; Hillier et al. 1994; Pearson 1983; Ahmad 1993; Loring and Powell 1988). In the above extract, the work of the family support service involves appropriate decision making on a Bangladeshi quality protects and child protection case. The key to the success of the family support service was that family support workers communicated in Sylheti and Somali, and so were culturally and linguistically sensitive to the circumstances of families. Family support workers had culturally appropriate knowledge (Hillier and Rahman 1996; Hillier et al. 1994; Brown 1985), intuitive awareness (Long and Luker 2000), engaged mothers and children emotionally, and were trained in listening skills (Taggart et al. 2000). These were extremely influential in informal decision making about whether to deal with the family as a child care problem through the family support service, or whether to refer back to social workers as a child protection case. As several other studies have shown, family support workers contextualize appropriate steps and actions for child protection. This goes part of the way to solving the challenge of pathologizing non-White cultures, as well as avoiding stigma and the overrepresentation of ethnic minorities in health, social care, and child protection systems (Blakemore 2000; Humphreys et al. 1999; Humphreys 1999; Spratt 2000; Chand 2000; Long and Luker 2000).

Emotions and Ethnicity: Increasing Access and Quality of Support

Families mentioned three interrelated issues that pertained to uptake and equality of access to services; feelings about distribution and amount of professional input; and quality of emotional and service contact with people from the ethnic community. Family support workers had to engage emotional labor so that they could sensitively manage appropriate access, resources, and support in the homes of ethnic minorities.

Uptake and Equality of Access to Services

Because of language and cultural barriers, many recently arrived families found it hard to get to know the area and the health and social services that were available in the area. Many families had individuals who had recently arrived from Bangladesh

and Somalia and felt threatened by the United Kingdom. Language barriers, differences between overseas and British cultures, and the specialist requirements of recently arrived families all made it extremely difficult to contact services and for their cases to be put into process (Hillier and Rahman 1996; Hillier et al. 1994; Ahmad 1993; Pearson 1983).

Family support workers were key to establishing links with the wider community and getting access to other services. This was a special role for family support workers as they shared the same language as families and so could communicate easily and effectively (Bangladeshi/Somali). Family support workers were perceived as "in-group" and were emotionally sensitive to cultural and linguistic barriers that new arrivals experienced. Family support workers were said to be extremely helpful in family support and building bridges cases and assisted with access to services in the area. Workers also helped with applications and forms (for social services, housing, the council, hospital appointments, and visas) that were written in English and could not be read by Bangladeshi families. Somali families were particularly difficult for the family support service to contact, and all services found it very difficult to increase access because of specialist refugee needs.

One key benefit of the family support service was being able to increase uptake and access to health and social services. The family support service was said by Bangladeshi people to be very good at putting families into contact with social workers, general practitioners, day centers, counsellors, education and college courses, hospitals, housing and income support, home help, child-led services, and the local council. The family support service was said by families to be less successful in liaison with health visitors and the mental health team. Family support workers represented the needs, views, and feelings of families to other services and resources.

Feelings About Distribution and Amount of Professional Input

Bangladeshi families tended to be extended and have quite large numbers of dependents and children in cramped conditions. One family had seven children and an adult in a three-bedroom flat. Another family had two children, with one expected, and two adults living in a one-bedroom flat. Two single beds were pushed together for the whole family to sleep on in the bedroom. In a family, there were often a variety of complex and interrelated health, economic, emotional, and social care needs that family support workers needed to assess and act upon in tandem with other services (Hillier and Rahman 1996; Hillier et al. 1994).

Because of the size of Bangladeshi families and their complex difficulties, there was a tendency for a large number of services to be involved. This increased service involvement was seen as positive by families using the family support and building bridges projects where issues usually revolved around establishing basic domestic and practical tasks in the home with children. All respondents in these projects said

that a key benefit of the service was being put into contact with other services and that this had helped greatly. On the quality protects project, where child protection issues were involved, Bangladeshi families often said they felt worried and upset by the activities of a large number of professionals. One mother on the quality protects project said she felt she had to withdraw from the family support service because there was too much professional involvement in her home. She felt her confidentiality might be compromised by too much service involvement. According to the Bangladeshi mother on the quality protects project:

> I've had a few problems with my husband. There's been a lot of domestic violence in the house with the kids and me. My mum died, she was the main supporter of me, so when my mum died I found things hard. And that's when my husband started beating me up. My family support worker got the social services involved. Ever since then I didn't like the family welfare association. I thought they were interfering because of the social services. I was really angry with the family welfare association lady. I thought she was stirring it up. I thought it was too much professional input. My husband didn't like me letting people in the house. He used to say: "You're opening the door to anyone and everyone". There were too many workers. It used to go on and on: one day, the social worker; the next day, the health visitor; the day after, counselling; the day after, the family support worker, and so on. After social services became involved, the family support worker didn't get back to me because I was angry and had shouted. I said sorry and everything but she said goodbye on the 'phone. But she still rings me up and says "hi".

Quality protects cases involve particularly sensitive issues and will be addressed in a case study later in this chapter. Family support workers were important in giving nonjudgmental and beneficial advice and support. Family support workers gave practical and emotional input that lifted quality protects families from neglect and abuse. Bangladeshi families, and also White families under the quality protects project, are a special case and differ from building bridges and family support projects. For example, family support and building bridges cases welcome a high degree of service contact. Quality protects cases are more resistant due to child protection issues.

Both families and workers said that too many professionals engaged with a case could lead to emotional tensions and also blur professional roles. According to two workers:

> It's difficult sometimes, with everyone's involvement. The family might have a family support worker, a social worker, a health visitor along with a doctor, with the mental health worker, and a children's organisation. For me, working with the family, I have to have a clear understanding of each agency's involvement in order to find out the main issues and problems that I can work with and who I can involve.
>
> Some families don't want too many agencies and different people involved. Some families are quite happy if it's spread over, so they don't have too many every week. Some families, it's too much for them. If there are too many people coming to the house it's difficult to get the parent to go to other places and get out and make appointments, because it's too much for them to take. But once they actually do go, and it does work for them, then they tend to make and keep appointments.

Workers were a key to maintaining quality support and explaining the need of service involvement to families.

Quality of Emotional and Service Contact with People from the Ethnic Community

Somali families had specialist refugee issues that were listened and attended to by a Somali family support worker. For Bangladeshi families, a main issue is around communication and full information giving. Families want to be kept informed of the progress of their case and regularly debriefed on an informal basis in their own language. Families want to feel that their work with family support workers is confidential. Many families implied that it was useful to give praise as well as bring up problem areas.

Large Bangladeshi families have multiple social, emotional, and psychological difficulties, with knock-on effects for all members in the home. This means that the reasons for increasing service involvement, especially where child protection is an issue in quality protects cases, need to be fully and sympathetically explained. Being consulted mitigates any sense of guilt or blame, decreases already intolerable levels of vulnerability, and so would pre-empt anger or resentment and subsequent breakdown of relations with services.

It is apparent that being consulted is a delicate process in which the family support worker acts as an emotional bridge between parents, children, and other services. Keeping families informed in their own language is a vital first step. Discussing the complicated issues involved in quality protects cases, and being able to listen and advise, is a skill that family support workers undertake with families, discuss at supervision sessions, and which needs to be sustained and built upon.

Certainly, it was sometimes difficult for families from the Bangladeshi and Somali communities to understand the implications of contact with various health and social service professionals (Hillier and Rahman 1996; Hillier et al. 1994; Loring and Powell 1988). There were often clear language barriers between Bangladeshi and Somali-speaking families and English-speaking health and social service professionals. Mainly, and because family support workers were from the Bangladeshi and Somali communities themselves, they could explain the roles of professionals and where to go for other support. Family support workers were especially successful in doing this with family support and building bridges projects, and introduced a wide range of services that were said to be much needed by the families involved.

Until involvement with the family support service, people on the family support and building bridges projects said that they had found it difficult to access services and communicate their needs. The involvement of a family support worker was said to have been of practical and emotional benefit as well as providing orientation to the United Kingdom and local amenities. The input of health and social services was urgently called upon by new arrivals, sometimes desperately because of language barriers and the lack of any systems of cultural orientation. Families welcomed the facilitation of their cases by support workers and others who were appropriately engaged.

As in Chand's (2000) study, quality protects cases were somewhat different, in so far as being consulted had to be more delicate, involve everyone, and was

more psychologically and emotionally draining for families and workers (Chand 2000). Child protection issues were involved. There was a fine line for all to tread between informal relations that support workers used to mitigate problems and possible abuse. There was the need to keep families and other professionals informed of developments in quality protects cases. There was the need for support workers to explain the situation to families at an early stage, talk over possible ways forward, and describe the roles of health and social service professionals. There were also more formal mechanisms and legal implications that needed to be explained and considered by services and families. Workers gave practical advice and were in regular contact with quality protects families. This facilitated and helped assess any improvement or watch for possible deterioration in the family's relationships. Providing basic practical help and being on hand to talk over problems involving difficult emotions were ways of nipping in the bud more serious problems. Nonjudgmental support and advice ameliorated problem child protection issues by propping up the parent socially and emotionally. In addition, because of their continuous and supportive contact with quality protects families, family support workers were a valuable source of information on the events and issues involved to other health and social service professionals at case review hearings.

In quality protects cases, work was more complicated, under more review by a larger number of professionals, and needed to be more actively sustained by family support workers and members of the family. This activity, together with problematic child protection issues, created great personal stresses for families and professional stresses for family support workers (Cresswell and Firth-Cozens 1999). Family support workers had to hold things together emotionally for families, other services, and themselves. In quality protects cases, the strength of the family support worker, apart from sharing first language, was therefore being on the ground and frontline on a regular basis. The strength was that the relationship was informal and voluntary rather than formal and compulsory. Workers helped families to establish basic routines, patterns of behavior, and informal ways of support in the community, and with making practical accomplishments (and helping families to realize and praise when they had made a step forward). This informal but practical approach prevented breakdown and acted as a gate between the family and other services. It prevented quality protects cases from complete emotional and social breakdown, and allowed active work on the family's problems from day to day. The family support service created a comfortable environment for service delivery. According to the Bangladeshi mother on the quality protects project:

> The family support worker took me to Newpin, a family support centre, where you go and someone looks after the children and the mothers have some time out from husbands and kids and the home. You spend some time with other mothers in a similar situation and no one judges you and you can talk and not feel stressed.

The emotional impact and management of child protection cases will be explored later in this chapter as a substantive topic that is often disturbing and upsetting for all involved because it involves emotive issues of child abuse and neglect.

Social and Emotional Isolation: Bullying, Crime, and Racism in Tower Hamlets

Some Bangladeshis felt very vulnerable in the Tower Hamlets area and family support workers did all that they could to establish close links with the families and introduce them to organizations that would decrease social and psychological vulnerability and increase community participation and feelings of safety.

The young and the elderly in the Bangladeshi community said they felt especially vulnerable and cited multiple incidents of emotionally disturbing theft and bullying. Cameron and Field's (2000) study of Bangladeshi and White neighborhoods had similar findings, in so far as the Bangladeshi population experienced high degrees of social exclusion, felt that their options were significantly constrained by low income, and feared crime and racial harassment. According to an elderly Bangladeshi woman:

> I had a mugger who took my money. The mugger was a boy from the flats. The mugger hit me as well, so I reported it to the police like my family support worker told me to. I lost so much blood and was in a very bad way. I worried that I wasn't there to look after my son, as we live by ourselves, and I was in hospital without him. Now I'm afraid to go outside myself and I'm afraid for my son to go outside alone. My son is not okay going out. I am scared someone might come and take him away or hit him. The family support worker and the home-help take me to pick up my widow's pension so that I feel safe and so no-one can take my money.

Phillipson et al. (1999) studied elderly people's experiences of community in three urban areas, including Bethnal Green in East London (see also Phillips et al. 2000). Elderly Bangladeshis were found to be especially unable to mobilize support networks, apart from local friends and family, if any were available. Complementary and voluntary services, such as those made available by the family support service, extended community involvement in local schemes and support centers. This, in turn, led to feelings of emotional and personal stability and safer access to the community.

In common with several studies in Tower Hamlets, many families at interview and in case records reported that their children had been bullied at school and that this bullying sometimes had racial overtones (Centre for Bangladeshi Studies 1994; Banatvala and Jayaratnam 1995; Hillier and Rahman 1996). This had profound social and emotional impacts on children and families. Children who had arrived recently in the United Kingdom were especially victims of discrimination, racial taunts, and name-calling. According to a Bangladeshi woman whose son was in his teens and had been bullied at several intervals over the last 2 years:

> We've had bullies spitting, hitting and name-calling with my son. My son's had to deal with bullies calling him lots of racist names. They can be really nasty and go for you because you're Bangladeshi, Somali, a Jamaican. They don't care—you're not English, you're poor and we've no money. He has to go to school in very old clothes and they make fun. His English has improved but he misses his brothers and sisters so it's holding him back. My son has been bullied on and off now for two years and we've spoken to the teacher. Before our family support worker helped my son was excluded for not going to school. His attendance

> got better after the family support worker and social worker helped and we went to talk to the head teacher at the school and explain what was going on with the bullies.

Somali children were particularly prone to bullying as they were the newest ethnic community of refugees in the Tower Hamlets area. As suggested by several international studies of refugees (Anderson 2001; Weinstein et al. 2000; Vargas 1999), Somali children in Tower Hamlets had severe feelings of emotional and psychological insecurity. Those in secondary school, between the ages of 11 and 16 years, were reported as being bullied the most. Visible poverty and cultural differences were said to be easily identified and picked upon by others at school. Those living in large families, who were newly arrived and could not speak English very well, and where money and clothing were limited, were discriminated against as an outsider group and vulnerable to physical and emotional bullying. From the cases surveyed and people interviewed, racial bullying could be (a) sporadic and brief, or (b) could occur over a number of years and be sustained for longer periods. If either of these types of bullying were not effectively dealt with by the school, it had serious consequences in terms of self-esteem, emotional and intellectual development, and on school attendance. Most of the Somali and Bangladeshi children who had been reported by their parents as suffering racial bullying had absconded from school. Many had been excluded from school as a result. They were considered by the school as too emotionally difficult, recalcitrant, unmanageable, and illiterate. Blackledge (1999) describes similar findings in Birmingham's Bangladeshi and multiethnic community. Vargas' (1999) and Zarzosa's (1998) studies note that culturally appropriate mediation into educational systems is required with refugees who are often traumatized by painful experiences and emotions associated with dislocation, exile, and war.

In two cases, the support worker had informed the educational social worker. After liaising and getting the family's permission, they had arranged to speak to the head teacher on the child's behalf. Racial bullying was reported as having stopped in cases in which the school, educational social worker, and family support worker had coordinated appropriate steps with the family. Family support workers, because of their close interpersonal and emotional engagement with children, were able to alleviate bullying and subsequent absconding from school. Family support workers acted as informal detectors, facilitators, and mediators when dealing with cases that involved bullying, racial harassment, and absconding from school:

Detection

Several international studies suggest that it is almost impossible to provide non-stigmatizing and culturally appropriate surveillance of refugee populations, especially with Somalis who are perceived to be almost unmanageable and suffer from emotional difficulties, psychological trauma, and specialist mental health needs (Bracken et al. 1997; Weinstein et al. 2000; Anderson 2001; Watters 2001; Hauff

and Vaglum 1997). Family support workers, because they were engaged with children on a regular basis at the home, acted to detect any problems of bullying and discrimination. Family support workers provided an outreach intervention that informally assessed Somali refugees' health, education, and social care needs. Family support workers provided outreach and assessed these needs in an informal way, in so far as work with children is largely in the home and involves such things as talking about feelings over game-play.

Facilitation

The family support worker had a role in facilitating communication about bullying and racism in four ways: first, listening to the children about their problems at school and talking things over with them in the safe context of the home; second, aiding communication between child and parents; third, contacting the educational social worker, the school, and other services, if appropriate to the case; fourth, helping to make arrangements for parents to visit the school and/or visiting the school with the educational social worker to represent and discuss the child's problems and needs.

Mediation

All of the parents whose children had been bullied or racially harassed said it would be good if family support workers escorted them to meetings and represented their children's problems at school. Family support workers were therefore thought of as good mediators and provided culturally sensitive outreach that connected the school, other services, and the family (Vargas 1999; Hauff and Vaglum 1997). Family support workers combated stereotypes, stigma, and exclusion, from school and the community (Blackledge 1999; Hauff and Vaglum 1997; Anderson 2001). Family support workers were able to explain bullying and racial harassment in depth and in the English language.

Bullying was a problem for children of all ethnic groups. Children from disadvantaged and mixed race families were prone to bullying. In addition to issues of bullying and racism, there were economic difficulties, a lack of clothing and toys, and poor educational support at home. These led to the problem of bullying being compounded and present in the White community. In one case, a child was systematically bullied at school for a period of 2 years when he was 11 and 12 years. The boy transferred this peer bullying at school to aggression and violence toward his younger siblings and also his mother. According to the mother of the boy:

> My eldest had a couple of difficulties at school. He was being bullied. In his first year he was bullied three times. He was bullied for weeks before he told anybody because he was afraid of anyone knowing. He was having his face slapped in class and again he didn't want

> anyone to know. Some kids were spitting on him, spat all over his blazer because it didn't fit. My family support worker said to find the teacher if it's in the playground and if not his teacher then the head teacher. I've only been with the family welfare association for two months. My eldest wets his bed. There's money going missing and he'll hit anyone and everyone just for walking past him. He hits his baby sister and they bash each other up, given half a chance. I don't know if it's he's jealous of them, but he never wants me to help him with his homework or read stories with him, so it's hard for me to do something with him when he doesn't actually want me there. What ever I suggest, he doesn't want to know. Maybe he needs more counselling about his bullying? Every now and then, counselling will do one-to-one sessions with my eldest about his behavior and about how he's getting on at school. Every few weeks we'll do a family group.

The family support worker was able to offer advice to the mother and young son about bullying. Referral to the counselling service (child and family consultation service) was reported in helping to discuss issues such as bullying, bed-wetting, homework, and the like. The mother said that aggression and fights with siblings had decreased since the involvement of the support worker. The son had shown improvement and emotional stability, and the bullying had stopped. Another young boy, aged eight, had also been bullied at school. The presence and emotional encouragement of the support worker had helped the boy to make new friends in the flats where the family lived.

Emotional and Cultural Awareness: Shaping the Appropriate Referral of Ethnic Minorities and Refugees

For the most part, referral was made smoother and services were said to be opened up by having a family support worker on the ground who worked practically and regularly with families in their own language and engaged mothers and children emotionally. The family support worker was able to listen, advise, explain, contact, and escort to other secondary services. The family support worker was also around to monitor changes in the family. The family support worker was also around to notice minute changes in the family, with clear intuitive awareness (Long and Luker 2000) and almost emotional antennae, so as to prevent the first signs of breakdown. A family support worker from Somalia was emotionally and culturally aware of refugee issues, such as experiences of armed conflict and the death of relatives. This family support worker was able to contextualize Somali people's problems and advocate on their behalf.

In many cases, when families were referred for one reason, a new one would emerge as its source or another problem would develop that had not been picked up during initial assessment of a case by a referrer. Early detection is especially important in child protection cases (Spratt 2000; DoH 2000a). Family support workers had a role in identifying problems as they occurred and mitigating their worst effects (Gordon 1997; Stanley 1997; Campbell 1997). Family support workers, engaging emotions and listening to families in trusted relationships, also helped to informally assess families. Family support workers for instance, because of their

close emotional and physical proximity as well as shared culture, were able to assist social workers (SWs) in determining whether a case was still at the point of a child care intervention or was a more serious child protection issue (Spratt 2000; Chand 2000; Humphreys et al. 1999; Humphreys 1999). Family support workers, because they were engaged in the frontline with emotions and listened to families, knew when it was emotionally and practically appropriate to call on the help of secondary (and perhaps compulsory) services.

For example, one Bangladeshi family was referred for hygiene and general domestic problems. Upon contact, the family support worker had to refer immediately to social services for obvious child protection reasons, as the mother was being beaten by her husband and, in turn, being violent to her children. Indeed, Stanley (1997) notes the link between domestic violence and child physical abuse. The family support worker was around regularly and therefore had more time to assess the emotional situation at the family's home.

From interviews and case records, it emerged that Bangladeshi women were especially likely to be referred as depressed and Somali people were also referred with mental health problems. There is an amount of bias in the sample, because the majority of Somali families were referred to the building bridges service as having one or more parent at risk of mental illness. Once referred, however, family support workers were able to work on and contextualize mental health difficulties with their shared language, emotional awareness of the family's situation, and cultural knowledge. There is a large amount of literature and research that shows that there are difficulties in referring to mental health services and guaranteeing equality of access and treatment for the ethnic community. Some people from the ethnic community are overdiagnosed because their illness is not contextualized by social circumstances. The mental health problems of the ethnic community are not represented by advocates from the appropriate peer group and culture at mental health Tribunals. Others from the ethnic community do not gain access quickly enough and so mental health problems become worse. There is a wealth of literature on medical responses to Asian women's depression and the overdiagnosis of Black people with schizophrenia, whose symptoms are seen as more physically and emotionally threatening and thus often at the harsh end of psychiatric services (Fernando 1989; Littlewood and Lipsedge 1989; Watters 1996; Samson and South 1996; Hillier and Rahman 1996; Hillier et al. 1994; Pilgrim 1997; Gray 1998). Refugees from Somalia are also perceived in this way and are regarded as difficult to manage in systems of health and social care. Refugees are quite understandably, as noted by one Somali, frightened of people in uniforms and United Kingdom officials who might dislocate them from the safe environment they have found. Mental health and social service provision in the United Kingdom is often not culturally appropriate and tends to make harsh and compulsory interventions which are not sensitive to underlying refugee issues of war, grief, emotional stress, loss, and feelings of exile (Zarzosa 1998; Anderson 2001; Bracken et al. 1997; Watters 2001).

Family support workers helped service users from the refugee and ethnic community gain access to mental health services and also gave information that threw light on personal circumstances and difficulties of the people being referred to the

Table 10.1 Case study

A Bangladeshi woman in her early 30s, with general problems at home, and who was diagnosed with depression. The family support worker helped to facilitate hospital visits and the diagnosis was changed to a chronic illness as a result
A Bangladeshi woman was diagnosed as suffering from moderate depression. The support worker helped the mother at a time when she felt unable to move, was agoraphobic and did not want to leave the flat, could not talk and so appeared depressed and withdrawn, and where she felt unable to look after two children (with another baby expected), while her husband worked on night shifts. The outcome of the family support worker's emotional labor was that the family support worker encouraged timetables and activities with the children, and helped contact the hospital as the mother was complaining of back and neck pain. By helping the mother to keep to these hospital appointments, which had previously been missed due to child care responsibilities, it emerged that the mother was in fact suffering from a rare and debilitating physical condition. The support worker helped with child care and escorting, and enabled other agencies to be called upon. Hospital visits eventually resulted in the correct diagnosis. The woman had to be treated for a physical condition. The support worker had to give advice, explain the illness in Bangladeshi, and help the woman contact support groups.

mental health team. Family support workers, because of their close proximity and emotional closeness with families, were able to contextualize mental health problems. Support workers were able to act as advocates from the appropriate peer group and culture. There is certainly room to increase this sort of advocacy role for family support workers in more formal settings and conditions, such as mental health tribunals and social service case reviews. At present, though, such tasks are largely beyond the remit of the existing family welfare association projects.

Tables 10.1 and 10.2 show two notable cases where mental health problems were the initial assessment but where the family support worker was able to clarify the context, personal and emotional circumstances of the individual involved. Match of ethnicity, emotional engagement, and cultural knowledge are crucial to appropriate use of mental health services, which otherwise might tend to pathologize rather than understand non-White cultures (Hillier and Rahman 1996; Hillier et al. 1994; Littlewood and Lipsedge 1989; Fernando 1989; Chand 2000). The two cases demonstrate the need for appropriate referral and the vital emotional labor of support workers in facilitating and informally managing referrals to secondary services (Vargas 1999). They also demonstrate the importance of mediation and advocacy (Booth and Booth 1999) and getting a balance by listening to the views and emotions of families (DoH 2000a, 2004; Featherstone 1999; Rogers and Pilgrim 1993). The cases clearly illustrate family support worker's emotional commitment to providing quality social care that invests in Bangladeshi and Somali people's emotions and relationships at home.

Family support workers were said to explain and clarify issues pertaining to mental health and learning disability. From interviews and case records, it was evident that support workers had many important roles when in contact with families at their homes, as detailed in Table 10.3.

Another mother from North Africa had a teenage son with Down's syndrome. According to her:

Table 10.2 Case study

A Somali woman, in her early 20s, was diagnosed with depression and disorientation. She was on the brink of a section under the Mental Health Act. The family support worker, also a Somali woman, was able to contextualize the diagnosis with events from the civil war in Somalia and work to help the family. The outcome was that the diagnosis was put into the context of the civil war in Somalia, practical help and orientation were provided, and the younger siblings were not taken into care as they would have been had the woman been put under section in an acute unit. The family was not further split up, and their integrity and commitment for one another were sustained by the encouragement of the support worker
A Somali woman was diagnosed as being depressed and in an agitated state. Concerns were expressed by health and social services that the woman could not travel on a bus without getting completely lost and panicking. The mental health team was on the verge of a section and admission to hospital under the Mental Health Act. At this stage, the family support worker became engaged with the Somali family. The support worker was on the ground and at regular hand to help practically, giving advice on transportation and the area so that the woman did not feel lost, and to ensure that the younger children went to school on time. The family support worker was aware of the emotional impact of being a refugee in the United Kingdom and was able to represent this to other agencies and professionals. Rather than a section under the Mental Health Act, which would have placed the younger children into the care of the local authority, the family support worker was able to talk the woman's problems over and the service represented them to the consultant psychiatrist at the point of case review. In common with international studies on the refugee experience (Zarzosa 1998; Anderson 2001; Hassan 2000), it emerged from discussion with the woman that her translocation from Somalia to the United Kingdom had been abrupt and frightening. The family support service was able to contextualize the mental health problems involved. There were refugee issues, and the family support service gave practical and emotional support that alleviated difficulties and prevented the necessity of a section to secondary services. The family support worker was an informal outreach worker and advocate on behalf of the Somali family's refugee issues and contextualized the woman's mental health problems (Bracken et al. 1997; Hauff and Vaglum 1997; Vargas 1999)

> Every time I was stuck my family support worker helped me. She talked through problems with me and the kids and made us all feel better just by being there. I said: "What can I do?", and my family support worker did a lot for me to do with the council, with other services, and getting my son to and from school with his brothers and sister at home. The family support worker sits with the kids and helps. She gives a lot of information, as I don't know what's going on. My son's got learning difficulties and I can't cope with him. He can't do anything by himself. You always have to keep an eye on him. My family support worker is an easy person to talk to about all this. You know, when you just want to talk to somebody. She'd talk to me and the other children. She'd explain things and say that their older brother had learning difficulties and encourage them all to get on. They get on very well with each other.

Family support workers increased involvement of the family with each other, gave practical and emotional support, and increased participation in mechanisms of professional support in the community. All families suffered from poverty and emotional stress in their social and economic lives. Many worked long hours and lived in poor and cramped conditions, which catalyzed subsequent stresses on relationships at home. Many said that they felt very isolated and alienated from the community. Indeed, prior to contact with the family support service, many said they had little conception of the local community or ways in which to become involved so as

Table 10.3 Mental health and learning disabilities

- Explaining the processes involved with mental health and disability teams
- Giving information on received diagnosis and pathways to secondary care
- Combating stereotypes and discrimination toward mental health service users and the learning disabled by (a) explaining diagnosis to the user, (b) explaining the situation to the family, and (c) helping integration in the community
- Helping users with emotional problems, such as stress or stigma
- Involving users in ways forward and strategies to manage mental health and learning disability in the home
- Giving information on user and voluntary organizations in the area and nationally (for example, support groups, mother's and children's groups to combat depression)
- Contacting other services to give access to home help, home care, and other appropriate social and psychological support
- Referring to specialist secondary services, such as counsellors, psychologists, consultant psychiatrists, family therapists, and child and family consultation service.
- Monitoring the mental health and learning disability of individuals and assessing the effect on the family as a whole
- Being in close proximity and monitoring—therefore able to refer if there was need and deterioration
- Being in close proximity and monitoring—therefore able to mitigate breakdown and deterioration by involving the user and family at home
- Involving the user in voluntary community activities rather than in compulsory care systems
- Workers were able to contextualize mental health and learning disability with their substantial knowledge of families
- As in a wealth of other studies, Bangladeshi and Somali families were prone to being diagnosed with mental health problems, especially depression (Watters 1996; Fernando 1989; Littlewood and Lipsedge 1989; Samson and South 1996; Hillier and Rahman 1996; Hillier et al. 1994; Pilgrim 1997; Gray 1998). Workers were sensitive to the needs and emotions of these groups and spoke the service user's first language. Workers could contextualize the problem, such as the civil war in Somalia or the pressures of being a non-English-speaking Bangladeshi mother in the United Kingdom. Workers were very familiar with family's situation and could clarify this situation to other professionals
- There was scope for support workers to act as advocates, if called upon to do so by the family. Workers had given practical support, could trace service history, inform on improvements to the family's functioning, and contextualize mental health and learning disability issues with their high level of information and knowledge about the family
- Workers had been called to give information at reviews before and would certainly be able to perform similar advocacy during tribunals, if called

to gain support from health and social services. In the above extract, for example, the respondent mentions that she did not know what was going on in the local community. She did not have access because of blockage of information about home help, the council, and learning disability services. The support worker helped to remedy this and increase support by the various means detailed, such as access to services and giving emotional support to the mother and children.

Workers were able to come into homes and work on these emotional worries. Workers would often refer to appropriate services and resources, make practical input in both the home and the community, and so help to prevent any worsening of social, emotional, or psychological problems (for example, family support

Table 10.4 Referral patterns for ethnic minorities

Referral of ethnic minorities
Communicating work with the family to the referrer. Giving feedback over the telephone in English and notifying the referrer of developments
Making appropriate referrals to other services based on close work with the family and knowledge of their needs
Being aware of practical and emotional matters as they arose. Managing changes in the family and providing support if circumstances altered. Managing a family's crisis and preventing complete breakdown or return to "step 1 of the problem"
Contextualizing the referral and responding appropriately to changing diagnoses and new difficulties
Being able to act as the family's advocate if called upon to do so. Family support workers had in-depth information on families, the steps families had taken since referral, and the ways in which families had moved forward. Family support workers were able to contextualize a family's problems and work with the family on those problems in a practical way at home. Families felt so comfortable with family support workers that they saw them as "in-group" and able to represent their problems to other agencies
Describing, mitigating, and ameliorating problems so as to actively manage referrals

workers prevented the deterioration of families and the inappropriate use of other services).

Workers therefore acted in two ways: as a bridge to other mental health and learning disability services and resources; and as a gate that contextualized and supported mental health and learning disability at home. Working with families in their homes prevented emotional and economic strain on individuals and services by unnecessary compulsory admission or long periods of hospitalization. Family support workers acted as a gate or door that referred appropriately. Family support workers would limit unnecessary referrals by closing the gate or door if the problem that the family had could be successfully worked on at home. Because of their emotional labor and first-hand knowledge of families, family support workers sifted cases and were good at knowing when to "switch on" or "switch off" services. Family support workers knew when it was appropriate to refer or not to refer because of their ethnic match and close proximity to the family on a weekly basis and because emotional rapport with families elicited pertinent information relevant to needs assessment (Goldberg and Huxley 1980, 1992; Hillier and Rahman 1996).

In summary, family support workers' emotional labor had at least six key results as regards patterns of referral with the ethnic community, as detailed in Table 10.4.

Managing Emotions in Child Protection and Quality Protects Cases

It is a running theme that quality protects families differ considerably from building bridges and family support families. In particular, the views of quality protects families as regards service involvement offer a stark contrast with that of family support

and building bridges projects. Family support and building bridges families welcome a large amount of sustained service involvement over a long period of time and are reluctant to let services go. Quality protects families are likely to feel more suspicious and worried about service involvement due to emotionally charged child protection and abuse issues. Two quality protects families, one Bangladeshi and one White, said they sometimes felt that there were too many professionals working on their case. They said that service involvement was for too long a period without sufficient explanation. They also felt that there had not been enough communication between the family and social services. Conversely, as in other successful projects both in the United Kingdom and abroad, family support workers were reported to befriend and participate with quality protects families, engaging emotionally and practically with mothers and children assessed as at risk (Taggart et al. 2000; Hicks and Tite 1998; Campbell 1997; Long and Luker 2000). The effect was to overturn stereotypes and defeat stigmas, gaining the emotional trust of families and enabling disclosures. This particularly enriched understanding of child neglect and presented practice options that took account of the voices of mothers and children (DoH 2000a; Featherstone 1999; Stanley 1997; Krane and Davies 2000; Mills 1998).

In the case study below, the words of the respondent are quite striking. The extract shows that support workers have an integral role in winning the trust of quality protects families and establishing rapport through emotional labor. This builds up confidence with services. Workers promote access and communication between quality protects cases and social and health services. The quality protects case below exemplifies some of the points raised, and the narrative of the respondent is striking:

> The biggest way the family welfare association have helped me personally is that my family support worker listens to me. She takes my feelings and my views into consideration. I feel that I can basically pour out my heart to her. A few months ago, I was really stressed out. I had a difficult pregnancy and everything just came to a head. We call it my 'full-on meltdown'… My children are also on the at risk register. Our second child has behavioral problems. Our third child is now following suit. The family welfare association helped to find new ways of managing the children. The family support worker reassured me that I wasn't crazy and wasn't a bad mum and there were other mums in similar situations to me. "At some point or another", she said, "everyone goes through a stressful time", especially if you've got five kids like I have, from eight years to one. The family support worker has been really good. She's done things politely and not imposed things on us. When your children are involved with social services and child protection there are a lot of people wanting to know what's going on in your home. It does make you feel quite uncomfortable (laughs lightly). I don't get on with our social worker. The family support worker hasn't said to do this, this and this—she says there may be a chance of doing this if we can and if you want. With the other services I've felt that I've had to prove myself innocent. The family support worker has such a relaxed relationship with us as a family. The boys don't think she's another professional, they think she's a friend of mine. They're really comfortable and relaxed with her. My eldest is quite uncomfortable around the social worker and the reason is that I had a flaming argument with the social worker and it got a bit out of hand. When the social worker comes up the children hide. When the family support worker comes up the children say her name and are really pleased because they'll get stories, colouring and worksheets. The family welfare association deal with lots of families with similar problems to us so they get to know certain ways of dealing that are more understanding.

Family support workers are able to calm down volatile situations and suggest improvements for managing relationships at home. The mother said:

> Before the family welfare association got involved with the kids, it was getting to the stage where it was like a cycle of vengeance. One kid would hurt another, so the other would have to hurt them back and then it would go on and get worse and worse and worse, until I had all of them sitting there and crying and all hurt. Now, with the family welfare association, I can explain to them and say come and tell mummy because mummy will sort it out. My family support worker's managed to get through to them, like, that it's no good to bash him one back, 'cos you don't get nowhere. She said to go tell mummy, you don't need to be spiteful, and mummy will sort it out. You don't need to be aggressive. My second eldest had no friends at school. He was so mean that he had no friends. But because the support worker taught him, he's making friends and calming down now

Child protection and quality protects cases are especially sensitive. There is the need to keep both families and other services democratically informed. The mother continued:

> I've felt with the child protection thing that they haven't had to prove us guilty, we've had to prove ourselves innocent. At the middle of the child protection, I really did feel persecuted and I couldn't cope with it anymore. The family welfare association are different. I don't think anyone at the family welfare association has treated us with a prejudiced idea. All the questions and allegations and people saying I'm doing it wrong, I'm doing it wrong, I'm doing it wrong. You try the best you can. My family support worker helped me put the pieces back together and work things out by explaining everything. My family's been there and she spoke up for us so many times with social services and explained things to them when I couldn't cope. My second boy hurt his neck. He self-injures and pulled the curtain cord around his neck as he's got behavioral problems. When he was a baby he used to cut his mattress with a knife. He had a friction burn from the cord. Social services claimed I tried to hide it. I was able to say: "This is what he does and it's not me". Not two minutes before I'd walked past the door and they were playing quite happily. There were quite a lot of problems over that and because my support worker was there when it happened she could make things clear with social services and tell them what happened. My family support worker is around so much and sees the children so often, that if they were beaten or neglected they wouldn't be as happy

The respondent felt that there had been too much professional involvement. The support worker had been of great help in clearing up issues and handling the family in a nonjudgmental way. The worker has sustained the family unit and explained the situation to the children so that they felt less frightened. The mother said:

> There's been so many people in and out asking questions. It does make the kids uncomfortable. We've had five different social workers. My family support worker really helps me and the kids and explains to the kids that the social workers aren't going to come and take the kids out of their beds. My family support worker reassures me and the kids

The mother touches on the fact that interpersonal peer support from the family support worker helps to establish trust. Workers are in close proximity, and contact with families is on a voluntary basis. The family support worker works collaboratively on issues in a nonjudgmental way, unless a plain child protection issue arises with families. Befriending has gender connotations as the family support worker gains the mother's disclosure and narrative (Featherstone 1999; Mills 1998). This achieves a balance on appropriate steps to take with regard to risk

assessment and contextualizes whether a family needs a child care intervention or should be referred to social services for child protection reasons (Houston and Griffiths 2000; Spratt 2000; Long and Luker 2000; Mills 1998). The emotional labor, befriending, and practical interventions of the family support worker are indicated by the quality protects mother to be non-stigmatizing, nonintrusive, and responsive to the views of families. The mother, as well as Government and researchers, identifies such facets as alleviating child protection issues and preventing social exclusion (DoH 2000a, 2008; Spratt 2000; Holland 2000; Gordon 1997; Krane and Davies 2000).

Holland (2000) suggests that the assessment relationship between social workers and parents in child protection is determined by several factors. Most assessment decisions are verbally based and depend upon the performance of parents at interview. Cooperation, articulateness, and an agreed plausible explanation for the family situation are all important in assessing child protection. Gender and ethnic match between workers and mothers facilitate articulateness and cooperation (Holland 2000; Featherstone 1999; Mills 1998). In the above case, the family support worker was able to approach a quality protects case with emotional sensitivity and gain the trust of the mother. The family support worker's shared culture and gender with the mother, as well as the informal nature of family support work, were to later inform a child protection assessment. The family support worker was able to act as an informal advocate and help articulate the family situation. Difficulties between the mother and social worker were raised with social service managers and supervisors so that issues could be discussed during child protection assessment. The presence of the family support worker facilitated discussion and informed child protection assessment because the family support worker acted as a key intermediary and interface between the family and social services.

In another problematic case of child sexual abuse, the emotional labor of the family support worker and service management team produced a neutral outcome (James 1989). A young Bangladeshi boy had gone to stay with relatives in Dhaka. On his return the boy, in his mid teens, had exhibited bizarre and inappropriate sexual behavior. On three occasions the boy had been found engaging in sexual activity with his younger siblings, aged three and five. Assessment by the social worker (SW) and mental health team elicited information from the boy that he had been sexually abused by his uncle while visiting Bangladesh. The boy was now reproducing this sexual abuse on his younger siblings (Stark and Flitcraft 1985; Hanmer and Maynard 1987; Humphreys 1999; Stanley 1997). Despite the emotional labor of the family support worker and the close involvement of a manager at the family support service, the team was unable to negotiate the conflict of emotions generated by sexual abuse inside the family. The mother and father steadfastly refused to believe that the boy had been sexually assaulted by his uncle, perhaps due to the inviolable and authoritative kinship position he held in Bangladeshi culture as the mother's eldest and most respected brother. The boy was taken into the care of the local authority. This assisted in two ways: first, it protected the younger siblings from any further inappropriate sexual activity or assault; second, it offered the boy counselling and appropriate services that he was finding difficult to access due to his

Table 10.5 Challenges of child protection

Challenges of quality protects cases
Establishing trust with sometimes suspicious quality protects families
Monitoring family volatility and stresses
Establishing routines to prevent volatility and crisis
Workers could explain the strengths and weakness of the family in a nonjudgmental way (to both the families themselves and other agencies)
Maintaining family stability through peer support of parents
Engaging in activities with children and explaining the situation to them. Allaying the children's worries
Offering children advice and role-modeling their behavior
Workers could contextualize child protection issues. They had close knowledge of circumstances and difficulties from their close work with quality protects cases
In the above quality protects case, the worker was able to advocate during an assessment. This established that the child self-injured and the mother had not physically abused or shown neglect
Workers had clear first-hand knowledge of families. They would refer building bridges or family support cases in which child protection issues arose
Workers could clarify with social services the events since referral and contact social workers to give up-to-date advice on the situation at home

parents' blockage and denial of sexual abuse. After a period of 2 years, when the boy was 16 years, the family support service carefully negotiated the feelings of the mother so that the boy could make weekly visits to the family home. This once again generated emotional and interpersonal conflicts between the mother and boy about the reality and actual occurrence of his sexual abuse by the uncle. The mother did not want to believe the boy's story. The family support worker therefore visited the family home at the same time as the boy so as to manage everyone's feelings and provide a calming influence.

To be sure, there are elements of "blaming the victim" in this problematic case of child sexual abuse (Frost 1999; Humphreys 1999). The abused child, in this case a teenage boy, reported that he felt punished again by being removed from the family home. Child sexual abuse certainly carries stigmas and strong emotions involving taboos of incest, moral failure, and the fundamental violation of the innocence of childhood (Ariès 1962; Humphreys 1999; Frost 1999; Irwin 1998). The family is in emotional denial of the sexual abuse by the uncle on the boy and also wants to forget the abuse by the boy on his younger siblings. Given that the original abuser was reported as the uncle, who lived in Bangladesh, the case could not be factually or legally resolved. The family support service and social services therefore had little choice but to protect the younger children and the teenage boy, whose conflicts with his parents were becoming more aggressive and physical, involving an exchange of physical blows. The involvement of the family support service neutralized emotional problems and family conflict. The boy accessed counselling and psychological services so that he could talk about his feelings and hopefully overcome his sexual abuse. The emotional labor of the family support worker and manager resulted in a neutral outcome (James 1989).

Family support worker's emotional labor was therefore said to have many integral functions that were relevant in extremely difficult and emotive quality protects and child protection cases, as detailed in Table 10.5.

Family support service staff acted as a trusted and proactive worker with quality protects families. They had regular access to the family home and gave practical and emotional support as well as advice. They were trusted and established peer support that was of benefit to families. Support workers dealt in an in-depth and involved way with quality protects cases. There are many issues involving quality protects families and strains on workers that need to be further considered. These include issues that touch on education, mentoring, and supervision during child protection (Cresswell and Firth-Cozens 1999; Newton 1995; Brown 1985).

Chapter 11
Managing Emotions in Education and Supervision

The key to appropriate engagement and disengagement of emotions with families was solid and transparent systems of education and supervision (Smith 1992; James 1989). In the family support service, education and supervision deal explicitly with practical problems that family support workers face from day to day, while implicitly discussing and regulating emotions between managers/supervisors and frontline family support workers. This largely implicit and unstated emotional regulation functions at both personal and organizational levels. Emotional regulation during mentoring and training maintains the emotional integrity of workers and reproduces desired relationships between families and family support workers in the family support service as an organization. As confirmed in other studies of managing emotions in health and social care, supervision and training were received on an ad hoc footing (Cresswell and Firth-Cozens 1999; Smith 1999a; Cronin 2001; James 1993b). Family support workers felt that there was little time to deal exclusively with difficult emotions. Support workers reported that when they had begun, there had been an informal induction session. Often, new workers began by going through case records and shadowed more experienced workers as part of their introduction to the service. Managers and supervisors were available to give information if needed. Induction was said to be good but in need of further definition. A worker said:

> We came into the job and not many of us were quite aware of the agencies that were involved and what their input into each individual family was.

Induction was largely informal and required a specific program to be drawn up by managers and supervisors that especially took into account the emotions and befriending activities of family support workers with families. Codification of emotional labor and befriending was necessary to provide good supervision and leadership on managing emotions (James 1989; Smith 1992; Gray 2002a, b).

As opposed to nursing in the health sector, where emotional labor was expected as a matter of routine care of the patient, supervisors and managers in the family support service and social work sector were far more skeptical about the idea of emotional engagement and particularly befriending of families. This skepticism

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amounted to being almost threatened in terms of a professional “fear” of emotions. On closer examination, this feeling may been seen as stemming from two interrelated issues: the first is present in nursing and involves the close management of feelings and boundaries of frontline staff. Education and systems of supervision in nursing are more formalized and less on an ad hoc basis. Nurses are often encouraged to engage in reflexive talk and swap stories. Conversely, supervision of family support workers is much more informal and unplanned, involves little formal education and training, especially as regards emotions. Discussion is mainly practical, not reflexive, leaving little time to discuss emotional problems about families. Second, social work is professional and hierarchically superior to family support work, which is offered to families on a voluntary basis by semi-professional family support workers. In family support, emotions and befriending are smothered by the social control elements of social work. Social work, like in the earlier case of mental health nursing, sometimes tries to maintain emotional distance and a “tough” masculine face of order and control (Duncombe and Marsden 1998). This is necessary to ensure child protection, reduce stress, and maintain professional integrity (Aldridge 1994; Newton 1995).

Role conflict existed because it was vital for family support workers, in their semi-professional role, to engage emotions while being aware at the same time that it might be necessary to advise social workers (SWs) that compulsory orders or powers were necessary. Rushton and Nathan’s (1996) study found that effective supervision of child protection work combined “inquisitorial” and “empathic-containing” functions. These were largely employed by the family support service on an ad hoc basis during supervisory sessions and brief meetings after family support workers visited families to ensure professional integrity, give advice, and maintain quality support.

Child protection training was therefore especially important. Emotional labor and befriending by family support workers engaged child care problems so that they did not deteriorate into child abuse issues, which would then require social control or custodial arrangements such as being taken into the compulsory care of the local authority. Workers would engage families as both peers (i.e., friends) and professionals (i.e., formally). Training was said to help in reflection about maintaining emotional and practical boundaries with families. Training helped family support workers to think about ways to engage families, especially when to engage families as a peer or when to engage more formally as a professional. A worker said:

> Training is very helpful. Because being a parent, and having children yourself, it helps getting a view from both sides, working and being a parent.

According to a supervisor:

> I do supervision with one person every two weeks. At the moment I see about four or five people a week. In supervision, we talk about all aspects of the job. We discuss individual cases and how things are affecting the worker. Things outside work might be affecting them. We talk over issues that they want and reflect on ways forward with individual families. Some of the workers are mothers themselves. They can identify with the families and

> take on board some of the problems and not pull themselves away from it. It can be very difficult for workers when they think, "I must do this for the family and I must do that and this too", while remembering to stick to their hours and their other commitments.

Family support workers were semi-professional and largely in need of gaining more qualifications. At the family support service, they would be introduced to child protection and other policies during internal training schemes that were available with social services. As in Cresswell and Firth-Cozen's study (1999), social work training was in-house at no cost but was said to be "a bit hit and miss" or ad hoc. A manager said:

> There's internal training, as the staff are very unqualified. Training is on-site and at the supervisory level. The family welfare association is a very poor organisation on a small training budget. It would be good to develop a training budget, which doesn't exist at the moment.

Clear mentoring and supervision were valued by all family support workers as important. They gave workers space to reflect, time to plan ways forward with specific cases, and allowed interpersonal support at work. Families had complicated and multiple problems. Part of family support work meant the projection of problems onto workers, in so far as the close contact that workers had with families often meant that they became repositories or containers for problems. Many families in Tower Hamlets were very needy and implored all for help. Family support workers and others found this very draining. A referrer said:

> We are aware that Mrs. 'X' sees every adult (and particularly those from Bangladesh) as a substitute family member, becoming extremely dependent. This is emotionally challenging for a range of adults.

A family support worker confirmed this view:

> Families throw their problems at the family support worker, which means we have to take a lot of emotional impact.

And in the words of a manager:

> You hear of staff despondency where there's been not much of a response. Either not very much is happening or the family support worker is regarded as a practical helper rather than a psychological sort of helper and enabler. The other side of that is a very dependent relationship that can develop with families and a lot of input from the family support worker concerned. Often you're dealing with people who have not experienced a balanced way of being supported and helped, perhaps even with their own parents in early life. They don't actually know how to ask or relate to caring agencies. Generally you're dealing with dependence and independence. This is reflected in how staff feel, when they're feeling overwhelmed at having too much or dejected at having too little involvement with families. If you maintain staff in an open and caring enough role and put boundaries in, you help people understand what can be offered. Supervision is quite regular and you go through what to do next. Even if staff are ground down by a process they are nevertheless going in with something in mind that they are going to try, which keeps them more buoyant. There is something very mirrored about the sense of isolation the families experience and a member of staff can go in and experience the same isolation and begin to have the same kind of feelings. They can feel as useless and immobilised as the families do. There's something about the supervisory process that sustains their feeling and ability to work.

The emotional labor of family support work was draining and needed to be actively managed by supervisors and mentors to sustain the workers' befriending and practical endeavors. A worker said:

> There's a mother with learning disabilities and three children. She has a two-bedroomed flat. She thinks that if she buys lots and lots of toys, so the house is packed full, her children will be happy. There are toys and clothes everywhere. You go in and help her by telling her she needs to pack things in boxes, which she does. But two days later you go back and it's exactly the same and everything you've done counted for nothing and it's a mess. So, you think all the work is done, but then you go back and it's exactly the same and it's back to stage one. So you don't feel appreciated. Other families can be quite demanding and expect you to do things for them. I was also verbally shouted at on the 'phone and treated aggressively, because families expect you to do so much for them… It would be good to get more advice on the next step to take with families. Good to discuss things and get them off our chest. If the family upsets us, we can come back, sit down and talk about it. If a situation is hard or depresses us, we can ring the office or a colleague to get some advice. We meet weekly with our supervisors and discuss particular problems and what the next step should be.

Supervision, mentoring, and debriefing sessions between managers/supervisors and family support workers were identified as methods of implicitly talking about emotions, so sustaining the quality and effectiveness of the family support service. Practical steps and complicated emotional issues were talked over in confidence with managers and supervisors. Reflection and practical guidance helped resolve complicated issues and move work forward. Care-giver support by supervisors during training taught staff about the importance of support work, provided core skills, and educated family support workers about participatory problem solving (Murphy et al. 1995; Hecker 1997).

Group work was mentioned as a way of establishing peer support between family support workers. Group work augments team-building activities and strengthens the solidity of family support workers. A respondent said:

> The family support workers need looking after, as they do a very stressful job and can get very isolated. They need time where they come together, not on the cases, but on where they are.

Reflexive talk and educational activities with other people at work were a clear way forward in both educational terms and in respect to establishing team-working. Mentoring by peers, "buddy" work, and action learning were all mentioned as being of possible benefit. Work redesign and small innovations, such as visiting in pairs or problem solving with colleagues, would combat stress. Innovative coping, in terms of changing objectives, working methods, and relationships, would help lead to new skill development (Revans 1980, 1997; Bunce and West 1996; Murphy et al. 1994; Molleman and Van Knippenberg 1995). Action learning sessions for family support workers were mentioned as augmenting core skills and group reflection. Action learning sets and regular team-building exercises would foster family support workers by giving them peer support and problem-solving abilities and also let family support workers have a say in a democratically run service, which would in turn reduce role conflict and augment integrated care (Murphy et al. 1994, 1995; Hecker 1997; Revans 1980, 1997).

To sustain the emotional labor of family support workers and the quality of service provided to families, it was felt important among managers to instill an organizational culture that would form shared beliefs, assumptions, and establish an intrinsic ethic of the family support service (Schein 1990; Jansen and Chandler 1994). A manager said:

> It would be useful to establish greater organisation in the structure and perspective of the project. The supervision structure needs review, as some workers have two or three people supervising them when it should be a one-to-one. It would also be good to link the project into the larger organisation, such as social services where the workers are based. This would help foster and keep a sense of a wider organisation. It would help to acquaint workers with the agency's view, such as on procedures if witnessing smacking.

A shared ethos was a target of the family support service and managers and grass roots wanted to be democratically involved in the service. However, there were limitations of time and budget that limited organizational goals such as the development of family support workers' emotional labor and befriending. Several international studies illustrate that three factors are required to achieve an emotionally and occupationally supportive organizational culture: first, there needs to be a culture in which workers are personally valued, have authority to take actions, solve problems, and are encouraged to express opinions and emotions involved in decision making; second, there needs to be management commitment to company values which emphasize employee growth and development, as well as integrity and honesty in communication and workforce diversity; third, management practices such as active leadership and strategic planning are required to assist workers in planning their future. If these factors are not satisfied, then deskilling, excessive workload, speed-ups, and employee attrition often result (Murphy and Lim 1997; Sauter et al. 1996; Pindus and Greiner 1997; Jaffe and Scott 1997).

Summary: Social Care and Emotional Labor in Tower Hamlets

There was a good match and consensus of opinion about emotional labor between families, support workers, and managers at the family welfare association/family support service, as well as key professionals in Tower Hamlets (referrers, non-referrers, and steering group members). The bulk of what families and professionals had to say was very positive about the emotional labor and general outcomes of the family support service.

As suggested by the literature, family support workers were mostly women who were engaged in invisible emotional labor in a low-paid and low-status semi-professional occupation (James 1989; Smith 1992; Gray 2009a). Family support work was relatively low paid and low status compared to other health and social care professionals, such as doctors, nurses, teachers, and certificated social workers. However, even though much of the emotional labor carried out by family support workers was invisible and not rewarded economically, it was praised highly

by families who said that they received valuable care and quality support. Although comparatively low paid and low status, the emotional labor of family support workers was lauded by families and produced highly desirable and demonstrable outcomes, especially with Bangladeshi and child protection (QP) families. Family support workers' investment of emotion was not returned in an economic or financial sense. Emotional labor was taken for granted as a routine part of the job and so was invisible as hard work that should be remunerated (James 1992, 1993b). Family support workers invested their emotions into building relationships with families. Bourdieu's (1977, 1984, 1992, 1993) studies suggest that feelings were invested as cultural capital and allowed a free and open market for the exchange of emotions and information with families. Emotional labor was paid for in the sense that there was a return in reciprocal human relationships and in feelings of making a difference in the lives of impoverished and socially excluded families. The emotional labor of family support workers was an investment in reciprocal human relationships and particularly elicited invisible narratives of women and mothers on the nature of social exclusion, poverty, domestic violence, and child abuse (Featherstone 1999; Taggart et al. 2000).

For all of the 30 families whose case histories were examined, there had been many positive and several neutral outcomes from the emotional labor of family support workers. All of the nine families interviewed reported that work with the family support service helped to give them social support, psychological and emotional balance, and assistance in household and financial management. This was supported by material in the case records. For the 21 families for which only case records were examined, evidence was present in each of these cases of positive outcomes due to emotional labor. The majority of families said that working with the family support service had been a good experience and had made a significant contribution to family functioning. Indeed, the family support service was so popular that many of the families said that they wanted more time with family support workers and longer periods of service contact with the family support service. Family support workers were trusted professionals, and families said that association with the family support service had been successful. A minority of families had such severe difficulties that there was a limitation on what could be achieved by family support workers in the time allowed. Quality protects families had child protection issues. Quality protects and child protection families were especially sensitive to the interventions of the family support service and other organizations (Taggart et al. 2000; Hicks and Tite 1998; Campbell 1997; Long and Luker 2000; Featherstone 1999; Stanley 1997; Krane and Davies 2000).

Families and professionals also indicated limitations on service provision and emotional labor, given constraints of time and budgeting. Recommendations made by families, such as crisis telephone contact, longer periods of service contact, and access to immigration advice, have implications for all stakeholders in Tower Hamlets. Some of the recommendations that families made, although currently unrealizable on the family welfare association's budget and remit, have implications for other professions and stakeholders in their strategic planning of services. Crisis telephone contact, for example, might well be included as part of the remit and

focus of the service provided by NHS Direct and also in the scope of Parent Line Plus.

The emotional labor of family support workers made multiple social, organizational, financial, and psychological impacts, including the following:

For families

Monitoring and promoting children's health. Reducing the likelihood that children experienced neglect, suffered significant harm, or needed to be accommodated.

Combating social exclusion. Helping families to gain access to the community. Families, who previously indicated that they were socially excluded, felt more inclined to participate, draw peer support, and contribute to the local community with the intervention of the family support service.

Encouraging Bangladeshi and Somali families to participate in the local community. Increasing access to services and resources for ethnic communities in Tower Hamlets.

Setting boundaries and managing children's behavior.

Maximizing income and managing household finances.

Encouraging the use of other services. Increasing access to other health, voluntary, and social care organizations, if needed by families.

Giving greater confidence, self-esteem, and improved parenting skills among adults.

Enhancing relationships between parents and their children.

Sustaining an appropriate and coordinated service for families.

For local service providing agencies

Enabling more effective use of services and resources.

Enabling more appropriate referral patterns.

Enabling greater communication and coordination between agencies.

Local projects such as the family support service are a small but important step in assisting local residents to cope with what a manager coined "macro-problems," such as social exclusion, crime, and poverty, as well as accompanying "micro-problems," such as emotional or psychological difficulties, child care or child protection issues, and unsettling feelings of bullying, isolation, and racial harassment. In line with Government policy, the family support service is an innovative, frontline, and economical way of mitigating some of the multifaceted aspects of social exclusion (DoH 2000a, 2004, 2006, 2008). This is especially necessary in urban areas such as Tower Hamlets that have historically been deprived and that have not been invested in socially, emotionally, politically, or economically. Certainly, there are severe limitations on such locally based schemes in addressing the overall picture of poverty and social exclusion in the United Kingdom. The gap between rich and poor continues to widen despite health and social care being at the center of the United Kingdom's Government agenda (Shaw et al. 2001; Davey Smith et al. 2000).

However, similar schemes in the United Kingdom and abroad have been shown to be at the frontline with families and have been described as non-stigmatizing,

nonintrusive, and responsive to the ethnicity, emotions, views, and specific social care and health needs of families (O' Brien 2000; Bond 1999; Ferguson 2001; Johnson et al. 1993; Taggart et al. 2000; Barker 1988; Olds 1992). This is largely because family support workers match families very well, in terms of gender, age, ethnicity, background, language, and point of view. Family support workers befriend families and win their trust, engaging practically and emotionally with mothers and children. Some family support workers experienced role conflict. Family support workers had an implicit function to befriend and engage the emotions of families. Family support workers acted like peers or "friends" of parents and children. At the same time, family support workers also had a professional duty to report child protection issues or serious problems to social workers that might entail the compulsory or custodial care of children. Reflexive supervision and regular debriefings after visits helped prevent the transferring and over-identification of problems from families to family support workers. During mainly ad hoc mentoring and debriefings, family support workers communicated challenges and emotions, helping to smooth upsets to provision and "oil the wheels" of social care (Gray and Smith 2000c; Huy 1999; Saks 1990). The emotional labor of family support workers was regulated largely by informal and ad hoc systems of mentoring and supervision that explicitly discussed practicalities while implicitly exploring emotions (Cresswell and Firth-Cozens 1999; Cronin 2001; James 1993b).

Because family support workers befriend and engage emotions, family support, building bridges, and particularly quality protects families felt comfortable to disclose. This elicited rich narratives on the nature of social exclusion, poverty, child welfare, and racism in the borough of Tower Hamlets (Featherstone 1999; Taggart et al. 2000; Hicks and Tite 1998; Hillier and Rahman 1996). Family support workers shared the cultural knowledge and the first language of families. Families from ethnic minorities had an advocate who was able to listen to and understand the family's point of view, and then communicate the family's specific health and social care needs to other agencies. Pathways of ethnic minorities to and from social and health services were sifted by family support workers. Ethnic minorities were filtered to services and resources (Hillier and Rahman 1996; Pearson 1983; Ahmad 1993; Goldberg and Huxley 1980, 1992). More problematically, a White manager had difficulties with Islam in so far as it was not seen as centripetal to service provision. This entailed a form of "color blindness" that was not culturally, emotionally, and religiously sensitive (Littlewood and Lipsedge 1989). This was in stark contrast to Bangladeshi and Somali family support workers who shared and therefore acknowledged the religious, cultural, and ethnic beliefs of families. The role of Islam is certainly misunderstood and seen as a challenge in the West and for social and health services in the United Kingdom (Pinto 1999; Hillier and Rahman 1996; Ahmad 1993).

Family support workers acted in an informal and semi-professional role, working so as to communicate the needs of families to the relevant user groups and professionals. Particularly important was close interface with the social worker team. This was made possible because the family support service was located in office space inside Tower Hamlets' social services building. Frost (1999) says that

inadequate training and the attempt to deal with domestic violence or child abuse as a family issue may place women and their children at greater risk. Close interface and training with the social work team was, therefore, highly important to ensure good and appropriate practice (Johnson et al. 1993; Houston and Griffiths 2000). A prime example of semi-professional family support workers interfacing with families and social work professionals was with quality protects families. Family support workers, because in trusted relationships at the frontline with families, were able to gather in-depth understanding of quality protects cases and inform risk and child protection assessments (Holland 2000). Family support workers based in the community acted as an informal interface between families, social workers, and other resources. Families were put in touch with the services and resources that they needed: whether social services, benefits, counselling services, or local/national action groups. This meant that the worst effects of social exclusion and poverty, if not remedied, were at least mitigated (Van der Eyken 1982; Ferguson 2001; Johnson et al. 1993; Olds 1992; Taggart et al. 2000). The policy stance of the United Kingdom's Government on keeping expenditure at a minimum and the burden of evidence from initiatives at home and abroad mean that economical and locally based projects similar to the family support service will be at the frontline of services. This is particularly the case in urban and multiracial areas such as Tower Hamlets that have historically not been invested in and which have high levels of poverty and social exclusion (ELCHA 1995; Shaw et al. 2001; Davey Smith et al. 2000; Gray 2009a). The emotional labor of staff on the frontline is an invisible force that builds, sustains, and improves the health and social care of families in Tower Hamlets.

Chapter 12
Conclusion

Face to Face with Emotions in Health and Social Care

The stories and experiences of people on the frontline clearly illustrate the therapeutic vitality and organizational importance of emotional labor. The complex experiences described show that emotional labor, befriending, and caring are multidimensional and at the heart of interpersonal relationships in health and social care (Fineman 1993; Benner 1984; Ellis and Bochner 1999; Staden 1998). The experiences of people in this study exemplify the fact that emotional labor is the artery or vessel for expressing feelings of hope, fear, despair, loss, and grief, which are so often a part of work on the frontline. Emotional labor ensures healthy survival at the cutting edge of health, illness, poverty, and social exclusion. Engaging emotions certainly assists in medical and ethical decision making, working to elicit the views of patients, children, and families so as to be democratic in the processes of consultation and service delivery (Scott 2000; James 1993a; McQueen 2000; Tolich 1993; Phillips 1996; DoH 1999a, 2000a, 2008). Emotional labor prevents upsets that might otherwise limit trust, silence disclosures, and interrupt the smooth provision of care (Saks 1990; James 1989; Smith 1992).

Women seem to be far more emotionally aware and willing to discuss their emotions than men (Bolton 2001, 2005; Arber and Gilbert 1989; Duncombe and Marsden 1998). The stereotypical gender division of emotional labor has serious implications for both men and women engaged in health and social care. Women become invisible emotional laborers, while men are forgotten carers (Arber and Gilbert 1989). Emotional labor is linked to work conducted in the family by women in their roles as mothers and daughters. The emotional labor of women is a taken-for-granted activity that is perceived as duty or obligation and not ranked as hard work that should be remunerated. Emotional labor is buried in symbolic relationships between men and women, and so passes by unseen, uncodified, and unpaid (James 1989; Smith 1992; Bourdieu 1977, 1984, 1992, 1993; Gray 2010).

Gender divisions of emotional labor in the home are reproduced in the health and social services. Emotional labor is invisible and not hard work when compared to

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the “real” task of medicine or social work. The tasks of befriending and emotional engagement with patients and families are therefore routinely passed down the line to women (Bendelow and Williams 1998; James 1989; Smith 1992; Gray 2009a, 2010). Such gender divisions of emotional labor place limitations on both sexes and structure the emotional activities of men and women in health and social care organizations. Doctors hand emotional tasks down to nurses in primary care. The model of the primary care team is patriarchal, in so far as a General Practitioner and nurse represented the primary team as a functioning nuclear family. Work is split between the important medical activities of doctors and the menial emotional labor of nurses. This further cements the invisibility of emotional labor as taken for granted and delegated. Emotional labor is unimportant to cultured men in the medical profession because it is perceived as merely the natural activity of women (Ortner 1974). The professionalization of nursing and establishment of nurse practitioners, which attempt occupational autonomy, will certainly challenge the medical model and help in the attempt to systematically redefine a more holistic approach to patients' healthcare needs (Austin 1979; Salvage 1990; Salvage and Kershaw 1986, 1990; Beardshaw and Robinson 1990). Whether care and emotional labor are left behind in the process of establishing a more intellectual and clinical knowledge base is the essential tension involved in the process of modernizing nursing (Armstrong 1983a; Oakley 1984; Wigens 1997). There is a continuing struggle, as Smith (1992) suggests, to grapple with the conceptual complexity and explicate the worth of care, particularly in relation to the components and demands of emotional labor.

Similarly, emotional labor and befriending by family support workers (FSWs) were said by a manager and senior social worker to be “just something that they do.” Emotional labor is often portrayed as part and parcel of women's work in both nursing and social care, leaving it undeveloped as a key technique for supporting patients and families (Gray 2002a, b; Smith 1992; James 1993b). Presenting emotional labor as a “weakness” or a “women's work,” or passing it to juniors as inferior to medical work is a symbolic violence (Bourdieu 1977, 1984, 1992, 1993). Symbolic violence gently and convincingly persuades men and women to engage in stereotypical gender roles. Symbolic violence in the division of emotional labor in health and social care is subtle, mundane, and occurs every day in the delegation of emotion work. The division of emotional labor by symbolic violence is invisible as violence as such, because it is naturalistic and reinforces common images of women as natural carers as well as reproduces the stereotype of male affective neutrality. Emotions are the obligation and natural remit of women.

There is also a patriarchal tension in mental health nursing between the care and social control elements of dealing with patients perceived as dangerous or a risk. Both male and female nurses report that mental health is the domain of men. Male nurses are characterized as patriarchal protectors and involved in the role of looking tough and being in control of emotions (Bolton 2001, 2005; Smith 1992; Duncombe and Marsden 1998; Gray 2010). This excludes female student nurses from feeling that they can safely enter into a long-term career in mental health. This also produces role conflict, with subsequent emotional stress, for male mental health nurses. The reality of physical social control contrasts with the therapeutic ideal of emotional

care (Newton 1995; Handy 1990, 1991; Wynne 1989, 1991, 1992; Marangos-Frost and Wells 2000). Often, as suggested in an abundance of studies, nurses deal with such emotional turmoil by taking work home with them or by stereotyping people as "good" or "bad" patients (Hochschild 1997; Newton 1995; Kelly and May 1982; Gabe 1995; Wigens 1997; Lawler 1991). This side-steps the conflict between the reality and ideal of nursing by projecting unresolved feelings onto a particular individual, perceived as "bad." People with mental health issues, drug addicts, pedophiles, gay men with HIV/AIDS, Somali refugees, those with an unhealthy lifestyle, and alcoholics are all felt to be repositories of danger or risk and hence are sometimes stereotyped as "bad" or unmanageable patients (Gabe 1995; Rogers and Pilgrim 1993; Douglas 1990; Rose 1990). Reflexive supervision on emotional conflicts is therefore necessary to prevent nurses taking work home with them after shifts, stop stress, burnout, and attrition as well as improve quality of care for patients perceived as challenging or "bad" (Harper 1994; Scheid 1999; Gillespie 2002; Morton-Cooper and Palmer 1999; Marangos-Frost and Wells 2000; Hochschild 1997).

Family support workers have a comparable role conflict with child protection cases, and workers experience emotional tension similar to that of mental health nurses. Family support workers experience emotional conflicts because their implicit role is to befriend and care for young mothers and children, which is pivotal in preventing deterioration and abuse (Featherstone 1999; Taggart et al. 2000; Ferguson 2001; Gordon 1997). At the same time as engaging emotional care, however, family support workers have the dual function of informing the social work team should compulsory orders be required to take children into the care of the local authority.

Care staff from ethnic communities are a hidden part of the workforce. Their provision of support, care, and emotional labor is undervalued, swept aside, and relatively underpaid. Family support workers are mostly women from the Bangladeshi or Somali communities. In parallel with gender imbalances in nursing, there is a "racialization" around the care–cure divide. Professionalization in nursing has historically been at an impasse because of the dominance of the medical model, the subordination of women's care, and subsequent eclipse of the therapeutic potential of emotional labor (James 1989; Oakley 1974, 1984; Friedson 1970; Graham 1983; Davies and Rosser 1986a, b). Family support work is semi-professional and workers match the ethnicity and culture of families. In this type of social care, there is a care–cure divide which revolves around informal social support of Bangladeshi and Somali families and the formal procedures sanctioned by professional social work. Child protection (QP) cases and Somali refugees particularly challenge family support workers with a decision dilemma of care/support or social control. This is similar to the experiences of mental health nurses and explains why family support workers felt such emotional tension between the emotional labor, care, and befriending aspects of their work when compared with the more formal nature of compulsory care in mental health or the custodial arrangements of social work. The formal procedures of senior social work and key decisions made by middle management are arguably dominated by White men and women, while semi-professional family support workers act as a bridge and advocate for the perspectives and social

problems of Bangladeshi and Somali families on the frontline (Hillier and Rahman 1996; Goldberg and Huxley 1980, 1992; Chand 2000; Booth and Booth 1999).

Care staff from ethnic communities are often employed as a part-time and disadvantaged labor reserve, which cheapens the high costs associated with health and social services while ensuring that support is labor-intensive (McNaught 1988; Doyal et al. 1981/1982). Individual and collective mobility is promoted for White men and women in management and supervisory positions. Men and women from ethnic minorities come into care work with little or no formal education, meaning that the care elements of nursing and family support are low status, low paid, and deskilled. Such implicit treatment of workers from ethnic communities mirrors that of women, with a heightened emphasis on regulation and exclusion from career mobility (Williams 1987). The “racialization” of care–cure/family support–social control is a power imbalance that hinders the careers of ethnic community workers and goes some way to explaining the high turnover and attrition in nursing as well as family support staff from the Bangladeshi and Somali communities. Most family support workers left the family welfare association within 1 or 2 years, while the lucky few found recruitment into higher status social work.

Even though economically unrewarded, undervalued, and hidden behind a professional cloak of competence (Haas and Shaffir 1977), the emotional labor of nurses and family support workers nevertheless elicits rich narratives on the nature of illness, poverty, social exclusion, racism, refugee exile, and child abuse. Case studies in a variety of contexts, such as AIDS/HIV, children’s oncology, the exile of Somali refugees, domestic violence, and child protection, suggest that emotional labor helps to establish trust and elicit disclosure, so making health and social care decision making and allocation more open to consultation with patients and families (James 1989, 1993a; Booth and Booth 1999; Houston and Griffiths 2000). More understanding health and social care is the result (DoH 1999a, 2000a, 2004). Stereotypes and stigmas are better managed and in some cases overturned, particularly as regards ethnicity, cancer, sexuality, HIV/AIDS, and child protection issues (Featherstone 1999; Hicks and Tite 1998; Hillier and Rahman 1996).

Emotional labor enables family support workers to elicit and engage the stories and experiences of marginalized women and children in the Bangladeshi and Somali communities. Family support workers are mainly women and communicated in Sylheti and Somali, avoiding cultural misreadings (Hillier and Rahman 1996; Hillier et al. 1994; Pearson 1983; Ahmad 1993; Loring and Powell 1988). Family support workers are culturally, emotionally, and linguistically sensitive to the circumstances of families. Family support workers have culturally appropriate knowledge (Hillier and Rahman 1996; Hillier et al. 1994; Brown 1985); have intuitive and ethical awareness (Long and Luker 2000; Lupton 1998; Benner 1984; Scott 2000); engage mothers and children emotionally, often over game-play, eating, or during daily chores; and are trained in listening skills (Taggart et al. 2000). These are extremely influential in informal decision making about whether to deal with a family as a child care problem through the family support service’s projects (family support, building bridges, and quality protects), or to refer back to social workers or onto other secondary services. This goes some way to solving the challenge of

pathologizing non-White cultures in the United Kingdom, as well as avoiding racism and stigma leading to the overrepresentation of ethnic minorities at the harsher end of health, social care, and child protection systems (Blakemore 2000; Humphreys 1999; Humphreys et al. 1999; Spratt 2000; Chand 2000; Long and Luker 2000; Fernando 1989). Pathways to and from health and social services are sifted appropriately and more effective resources are engaged by family support workers because close interpersonal and emotional proximity better appreciates the nature of families' needs (Goldberg and Huxley 1980, 1992; Pearson 1983; Ahmad 1993; Hillier and Rahman 1996). Nurses' emotional labor engages with a variety of stigmas, including death and dying in palliative cancer care, marginalized homosexuality in AIDS/HIV, and images of dangerousness and risk in mental health. Emotional labor in these cases resulted in a neutral or positive outcome (James 1989), most noticeably in the attempt by a nurse to manage the good death of a child suffering from leukemia and cope with the bereavement of the family.

Learning to Care

In contrast to Smith's (1992) study, where the sister/charge nurse's role was found to be central, the figures of the personal tutor, link lecturer, and mentor shape the modern student nurses' official experience of learning to care. Reflexive supervision and teaching enable nurses to share stories, metaphors, and experiences in an oral culture that implicitly communicates and values emotions (James 1993b; Smith et al. 1998; Smith 1999b; Leight 2002; Froggatt 1998; Gattuso and Bevan 2000; Gillespie 2002). The studies of Bourdieu (1977, 1984, 1992, 1993) suggest that emotions are a chief component of nursing's cultural capital and help reproduce a culture of care in the National Health Service. Student nurses report that supervisory practices have to be open, accessible, democratic, and peer based. The most successful lecturers and senior staff are thought of as peers and nursing colleagues who encourage a diversity of emotions and perspectives. "Bad" or "toxic" staff avoid or try to control student nurses' emotions, which leads to feelings of dissatisfaction, emotional dissonance, burn out, and poor practice (Darling 1986; Oatley and Johnson 1987; Marquis and Huston 1992). Supervision of emotions, if controlled so as not to be open to diversity and reflection on a range of feelings, has the power to be a hegemonic or confessional exercise in the hierarchical structure of the health services (Gilbert 2001; Cotton 2001; Foucault 1973, 1990; Huy 1999).

As well as formal educational methods, there is an informal subculture in student nursing that assists in learning about emotional labor (Hebdige 1979; Tripp-Reimer 1985; Birnbaum and Somers 1986, 1989). Successful peer relationships have supportive and acculturating functions, enabling private individuals to comfortably melt into the "habitus" or culture of the public nursing profession (Bourdieu 1977, 1984). Students share their feelings about lessons, essays, patients, or critical experiences in the classroom or on the ward, and receive support as well as feedback on appropriate patterns of care from peers. There are

resonances between student nursing culture and youth subculture, particularly as the majority of new recruits are below 25 years of age; heavily "into" the London music scene, social events, mobile phones, computers, and email; and also tend to smoke quite heavily. Those who could not engage in emotional support and sharing stories in the oral culture of nursing (Leight 2002; Froggatt 1998; Gattuso and Bevan 2000) are not able to accumulate the currency or appropriate cultural capital of the nursing profession, thus limiting informal learning from peers on appropriate techniques of care.

The principal difference between nurses and family support workers is formal qualifications, supervision, and education. Nurses are moving toward professionalization and are propelled by the ideology of the "new nursing" (Salvage 1990; Salvage and Kershaw 1986, 1990; Reverby 1989; Armstrong 1983a; Beardshaw and Robinson 1990). Family support workers are semi-professional with little chance of career or professional advancement, except in one case of a part-time worker also engaged in social work studies at a London university. Mentoring, lecturing, and supervisory relationships are much more solid in nursing and there is a clear leadership structure in the Royal College of Nursing that is based around action learning and encouraging the heart (Revans 1980, 1997; RCN 1997, 1998, 2000). Sharing stories and reflection is valuable for implicitly discussing emotions in supervision, mentoring, and leadership (James 1993b; Smith 1999b; Leight 2002; Froggatt 1998; Gattuso and Bevan 2000; Gillespie 2002). Emotional labor and befriending are greeted with far more reserve in social work than in nursing (Aldridge 1994). This may be because there is a strong echo with the care–cure divide, which in social care is reflected in a divide between the dilemma of support–social control. Family support workers are semi-professional, so their emotional labor is sometimes portrayed by seniors as unimportant and "just something that they do" when compared to the real professionals' task of compulsory social work. Informal social care fails to establish emotional clarity because it has less well-established systems of mentoring, supervision, and education, which tend to be piecemeal and ad hoc (Cronin 2001; Newton 1995; James 1993b; Smith 1999a; Cresswell and Firth-Cozens 1999).

With perhaps the exception of oncology (Smith 1992; DoH 1999c, 2000b), in which emotions are still far from clear-cut and resolved, the complex and more difficult problems associated with emotional labor remain mainly implicit and so are buried in language and policy legislation. Emotions are an undercurrent or an ancillary topic in mentoring and supervision (DoH 1999a; UKCC 1999a, b). Reflexive supervision and mentoring in nursing touch on emotions, but debriefings are informal, sometimes ad hoc, and often a coping mechanism rather than a full and explicit discussion on emotional conflicts. This leaves many nurses and family support workers feeling that they have no explicit time set aside to deal with emotions. Many report that they often took work and emotions home with them after a shift (Cronin 2001; Hochschild 1997; Newton 1995; Cresswell and Firth-Cozens 1999). If emotions are not dealt with explicitly and openly, it often results in feelings of dissonance or even burn out so that

nurses and social carers leave their jobs (Sandall 1997; Beaver et al. 1986; Huy 1999; Newton 1995).

Several innovations are mentioned by nurses and social carers as techniques of coping more adequately with emotions. These innovative methods might find their way into future education and policy legislation so as to more effectively deal with the emotional labor of nurses and social carers. Caregiver support, for example, instructs staff about the importance of support work as well as sharing knowledge about participatory problem solving and providing core skills (Murphy et al. 1995; Hecker 1997). Group work concretizes peer support and cements team-building activities to strengthen the emotional solidity of staff. Changing objectives, working methods, and relationships helps create emotional flexibility and leads to new skill development (Bunce and West 1996; Murphy et al. 1994; Molleman and Van Knippenberg 1995). Action learning provides peer support on problem solving as well as a forum for grass roots nurses and social carers to have a say in the management of a democratic service. Action learning helps reduce role conflict and misunderstandings between grass roots and management, so augmenting integrated care (Revans 1980, 1997; Murphy et al. 1994; Hecker 1997; Murphy et al. 1995). Nurses, family support workers, and their managers said that it is important to establish an organizational culture that operates from shared beliefs, assumptions, and an intrinsic ethic (Schein 1990; Jansen and Chandler 1994). Emotional labor is at the heart of health and social services, and so is valuable in establishing an ethic based on a shared culture and commitment of care. Fundamentally, if policy and educational innovations are not made that take into account emotional labor, then feelings of dissatisfaction, speed-ups, excessive workload, deskilling, and employee attrition result (Murphy and Lim 1997; Sauter et al. 1996; Pindus and Greiner 1997; Jaffe and Scott 1997).

The Heart of the Matter: Emotional Labor and Cultural Capital

Hochschild's (1979, 1983, 1997) studies of emotional labor and the managed heart focus on the everyday interactions of frontline staff, and so are an invaluable benchmark when reflecting on the implicit and gendered nature of emotions in social life. Hochschild's studies stem from the symbolic interactionist tradition of Goffman (1959, 1990) and the Chicago school of sociology, and so draw attention to the presentation of the emotional self in everyday life. This North American methodology assists greatly in elucidating shared metaphors as well as throwing light on implicit meanings in social interaction. In Hochschild's studies, there is a focus on common symbolic exchanges involved in depth or surface acting that are involved in the routine of managing the heart. The present study draws from the foundational work of Hochschild and others sociologists in the North American tradition, such as Garfinkel (1967), Glaser and Strauss (1967), and Schutz (1972), who emigrated from Europe to the USA to escape Nazism in 1939. The study is indebted to these

sociologists, principally in the form of a methodological approach that is qualitative, participatory, and narrative and searches for people's meanings, stories, metaphors, and symbols when expressing deeply felt emotions.

The qualitative approach employed in this study elicits rich narratives and was found to be a highly successful methodology, in so far as 55 semi-structured interviews encouraged open and honest discussion on emotions. Face-to-face contact, as the title of this book suggests, evoked the disclosure and sharing of complex emotions during sensitively conducted interviews. Quantitative data collection methods, such as questionnaires on emotions, were greeted with skepticism and lack of interest. Questionnaires drew relatively low response rates, with only 27 respondents out of a sample size of 220 (a 12% response).

The qualitative approach, which should be sympathetically exercised in sensitive talk about emotions, stimulates reciprocity as well as some degree of mutuality and hence mutual understanding. Qualitative and participatory methodology values people's views and emotions as a shared and robust basis for knowledge (Beresford 1992; Beresford and Evans 1999). The methodology is robust in so far as extracts are lengthy, so allowing intertextual comparison and concept generation. Interviews, as well as focus groups and qualitative methodology, provoke frank and stimulating discussion on the nature, conflicts, and management of emotions in frontline health and social care. The length of the extracts and bravery of participants to share their emotional experiences, which sometimes touch on troubled and disturbing talk involving death, racism, or child abuse, are testimony to the success and pertinence of qualitative and participatory methodology. The participatory and qualitative approach is apposite to people on the frontline and their experiences because it inspires open-hearted talk on emotions.

Many studies take qualitative research a step further, documenting the multifaceted nature of emotions through logbooks, diaries, photographs, photo-essays, images, and drawings (Oakley et al. 1995; Smith 1999a; Casey 1999; Martin 1999; Fineman 1993). Several studies suggest that collecting pictures and even humorous short stories from young children is a relaxed, robust, and pertinent method that draws attention to younger people's perspectives and experiences of health, illness, and social care (Dixon-Woods et al. 1999; Oakley et al. 1995; Shucksmith and Hendry 1998). According to Oakley et al. (1995):

> Young people and children can provide detailed information about their perceptions and beliefs regarding health… The use of drawings in collecting data from children shows that this is a valuable research tool. From a methodological point of view, the research makes a contribution to… "children's studies". Scanning the children's pictures into a computer database allowed these to be retrieved and analysed like other qualitative and quantitative data (Oakley et al. 1995, 1032–1033).

Pictures by children help to illustrate the nature of health and social care. Drawings symbolize the way children feel, both about their emotional problems and about contact in the private home with public care professionals. It is a constant regret, albeit a necessary one because of the moral imperative to respect children's rights, that this study decided on an ethical basis to treat drawings as highly personal and as children's personal property. Thus children and young people were not

approached to ask if numerous pictures and charts held on file at the family welfare association and by other services could be photocopied. Many of these drawings expressed emotional troubles and the impact of worker's emotional labor with sincerity, immediacy, and stunning visual clarity.

In one picture, for instance, a Bangladeshi mother was drawn with a thick black fence around her with the words: "Mum's not happy." The fence resembled a prison or enclosed pen. The Bangladeshi mother was referred as depressed, so lacked the ability to establish domestic routines and feeding times. Later on in this case, there were drawings of the mother and children holding hands with the words: "The FWA lady helped a lot," as well as ordinary drawings of cars, trees, familiar domestic scenes, and utensils such as knives, forks, and plates with food. Several drawings stored by psychological services metaphorically illustrated the physical and sexual abuse of a young child. The child had been asked to draw what they felt and had been encouraged in a safe environment to visually tell grown-ups about the abuse. Three sheets of paper were scattered with hasty blotches of sharp purple and had been intentionally torn at both sides. Green pen had been pressed angrily in a zigzag onto the paper so that it cracked and punctured the surface. Around the edges in each of the three sheets was a swirl of cloudy yellow and smokey-white colors. This might well have been a symbolical association, as the child and family verbally reported that the abuser smoked a lot of cigarettes. The drawings illustrated from the perspective of a young child the trauma, pain, and psychological disruption caused by abuse. The child had also attempted to write the first name of the abuser at the bottom of the three pictures, perhaps putting a word or name to the abuse to try and take charge and move beyond the experience, but the script was unintelligible due to the child's age and lack of schooling. Later, after a period of approximately a year in contact with psychological and social work services, the abused child sketched a much happier and more familiar scene when asked about feelings, so drew a house, a sleeping cat, and a smiling dog wagging its tail. The emotional labor of social carers was symbolically implied in the safe and reassuring figures of the family, who were pictured together in a small terraced garden with a family support worker walking up the pathway to the front door of the family's home.

A final note on qualitative data collection, such as gathering stories and illustrations, should therefore warn unwary or unpracticed researchers to treat their subject matter with a high degree of emotional consideration and ethical respect. Refugee exile, child abuse, death, and bereavement are shocking and highly upsetting for even the most well-established and qualified professionals, let alone researchers. Even the most emotionally neutral and official-looking case records or documents are loaded with the potential to embroil, frighten, frustrate, and disconcert. Qualitative data collection on the nature of illness, social exclusion, racism, and child abuse is an emotional and intellectual labor that is best resolved in a participatory way, which means involving the subjects of research as well as the reflective aid of academic colleagues and via discussion with experienced health and social care professionals. Focus groups, action-based learning exercises, and research workshops are participatory methods of involving others to gather a balance of perspectives. Such methods help to establish intellectual and emotional support that

facilitates the tireless and robust activity of social research (Beresford 1992; Beresford and Evans 1999; Watters 2001; Revans 1980, 1997; Hecker 1997).

Hochschild's (1979, 1983, 1997) original studies exemplify the applicability and productiveness of qualitative methodology in understanding the nature and regulation of emotional labor. Hochschild's studies draw from actor's meanings, surface and depth gestures, and the presentation of the emotional self in everyday working life. The benchmark offered by Hochschild's work is the founding block of this study and aids the qualitative examination of emotional labor in health and social care.

Hochschild's studies also reflect the cultural context in which they were written and produced. The studies are North American in origin and largely a soft-spoken, uncritical, and conservationist account of emotional labor (Smith 1999b; Craib 1995; Duncombe and Marsden 1998). This impedes a more incisive focus on the reproduction of differences and the symbolic violences involved in the unequal distribution of emotional labor. It is left to a variety of feminist studies, for example, to better emphasize the unequal gender distribution of emotional labor and discuss the centrality of care in the management of emotions (James 1989, 1992, 1993a, b; Smith 1992; Smith 1999a; Bolton 2001, 2005). James (1992) formulates that care is equivalent to organization plus physical work and emotional labor. This is as much to say that care is hard and draining work that requires careful management by seniors as well as colleagues in regulating emotions.

There is one pivotal issue that is not emphasized in antecedent studies on emotional labor. Previous accounts do not engage in a critical way with social structure and the reproduction of a culture of care. The focus in preceding studies is the organizational regulation and management of emotions (Hochschild 1983; James 1989, 1992; Smith 1992). This study, which takes into consideration the concepts of Bourdieu (1977, 1984, 1992, 1993), suggests a more critical equation than the formula noted by James (1992). Care is divided metaphorically, symbolically, and by implicit and subtle violence in organizations, or expressed more simply:

$$\text{Care} = \frac{\text{emotional labor} + \text{education} + \text{physical labor}}{\text{organization}}$$

Perhaps the main reason that preceding studies have not fully engaged with social structure in the reproduction of a culture of care is because there is the potential of reification. Emotions are subjective and intersubjective. The reproduction of a structure of care is perhaps resisted because studies fear they might reify emotions and so miss vital accounts of people's experiences, the complexity of emotions, and even people's agency.

Bourdieu's (1977, 1984, 1992, 1993) studies offer a solution because his key concepts engage at the levels of social structure and agency. Bourdieu's anthropological studies generate the concepts of cultural reproduction, field, habitus, symbolic violence, and cultural capital. Despite their differences and the traditions which they draw from the studies of Bourdieu and Hochschild, both focus on the

labor involved in the production of symbolic capital. Both Bourdieu and Hochschild have been described as soft-Marxist in so far as neither is economically determinist. In Hochschild's (1979, 1983, 1997) studies, there is an implicit exchange of emotional labor between actors, which reflects gender inequalities and so goes unnoticed and unpaid in capitalist societies. Bourdieu suggests that actors and groups exchange symbolic goods and cultural capital to define and reproduce taste, the value of art, educational status, social hierarchies, and make minute distinctions of power. This study therefore draws vital lessons from both Hochschild and Bourdieu in the study of reproducing emotional labor and a culture of care in the health and social work services.

Nurses and social carers are engaged in a culture of emotional reproduction, which regulates emotional labor through systems of education, mentoring, and supervision (Hochschild 1983; James 1989; Smith 1992; Rushton and Nathan 1996; Gilbert 2001). Educational techniques, such as reflexive supervision and mentoring, reproduce consistent patterns of care in the health and social work services. There are also implicit methods of learning to care, such as sharing stories in the oral culture of nursing (Gillespie 2002; Smith et al. 1998; Smith 1999a; Leight 2002; Gattuso and Bevan 2000; Froggatt 1998; Gray 2010), a student nurse subculture of care (Tripp-Reimer 1985; Birnbaum and Somers 1986, 1989), and inculcation from an early age in the family (Elias 1991; Bourdieu 1992, 1993).

Emotional labor implicitly defines the habitus and field of nursing and social care. For the most part, emotional labor is an invisible and tacit disposition that shapes the pattern of working relationships with families, patients, and colleagues. Bourdieu's notion of habitus suggests that emotional labor is as a tacit disposition or "feel for the game" that moves nurses and social carers to act in a predisposed and almost unconscious way when caring for patients and families (Bourdieu 1977, 72; 1992, 53; 1993, 5). Only oncology nursing, for example, regularly discusses emotions in an explicit manner during supervision. This is because the facilitation of physical and technical tasks is explicitly linked by oncology nurses with expressive elements and feelings. This link between technical medical tasks and psychosocial care is encouraged in the oncology curriculum, during medical training and in supervision/mentoring (DoH 1999c, 2000b, 2008; Strauss et al. 1982; Roberts and Snowball 1999; Luker et al. 2000). Conversely, most nurses and social carers suggest that they have little or no time to deal with emotions, which are often supervised only on an ad hoc basis (Cresswell and Firth-Cozens 1999; Smith 1999a; Cronin 2001; James 1993b; Cronin 2001).

The care–cure and family support–social control divides indicate that distinctions are made about the value of emotional labor in the health and social care professions. Distinctions are made partly through symbolic violence, which denigrates emotional labor and so is an emotional violence. Echoing other studies, both a doctor and a practice nurse in primary care suggest that emotions are menial when compared with the hard and real task of biomedicine (Oakley 1984; Graham 1983; Davies and Rosser 1986a, b). Mental health nursing is tipped in favor of men, as those with mental health issues are considered a physical danger and sexual risk to female nurses (Cowan 1994; Gabe 1995; Jodelet 1991; Castel 1991; Douglas 1966).

Male mental health nurses offer patriarchal protection by appearing tough and in control of emotions. This prevents many female nurses from entering the mental health field. Male mental health nurses also suffer emotional conflict, because the therapeutic ideal of care clashes with the reality of social control (Duncombe and Marsden 1998; handy 1990, 1991; Marangos-Frost and Wells 2000; Newton 1995). Family support workers experience similar emotional conflicts because they are required to befriend and emotionally labor with child protection cases while having a social control capacity in the form of informing social workers of potential child abuse. Symbolic or emotional violence thus involves expectations of how women and men should behave and feel in the workplace. In such a scheme, women are obliged to fulfil natural and invisible emotional labor, while men are forgotten as carers (Arber and Gilbert 1989). Symbolic or emotional violence goes undetected because it is not coercive, crudely manifested, or oppressive. Emotional violence is not so much undergone as chosen, involving the violence of obligation, routine, expectation, confidence, and duty.

Finally, study suggests that nurses and social carers invest emotional capital in their relationships with patients, children, families, and colleagues. Emotional labor and befriending are reported by staff and the public as valuable and therapeutic commodities. Because emotional labor is not formalized, codified, or accredited with academic qualifications, it is considered menial and goes unpaid (Graham 1983; Oakley 1974, 1984). Emotion work is part and parcel of women's domestic duties in the family and so is submerged by patriarchy, which considers emotional labor to be of little economic value (James 1989; Smith 1992; Oakley 1974, 1984; Navarro 1988). By way of contrast, emotional capital is suggested by participants in this study to be rewarded by reciprocal and intersubjective human relationships that are a vital part of making a difference in people's lives and which are essential in the very act of care. According to Smith:

> The absence of these 'little things' is stark evidence of the lack of care. So why when they make such a difference to how people feel do we refer to these things as 'little'? (Smith 1992, 1–2).

Investment by health and social carers in emotional capital and emotional labor is rewarded by the "little things." The stories of professionals, patients, and families emphasize the support afforded by the "little things" and the therapeutic value of emotional labor. Emotional labor and the value of the "little things" are particularly noticeable when observing nurses or social carers comforting distressed patients and families. Emotional labor is almost set to a dance of tiny gestures, touches, and quiet confidences that establish disclosure, feelings of trust, warmth, and safety. The experiences of participants in this study exemplify the fact that emotional labor and the little things are at the therapeutic heart of nursing the patient in the health services and the arteries that carry quality support to disadvantaged children and families in social care.

Appendix

The framework for the research questions is shown below. Semi-structured interview questions formed the bulk of the inquiry (see questions numbered 1–9). These nine questions would be expanded upon by the researcher and interviewee to take into account other important issues involving emotional labor. Questionnaires were used to help in guiding the semi-structured interviews and asked almost the same questions (see questions numbered 2–9). Questionnaires were also collected on images of nursing. Focus and seminar group participants were asked to discuss emotional labor in an open way but were directed in their discussion (see questions 10–14). Participant and non-participant observation occurred in seminar groups, classes, and informal settings. Terminology would be changed according to the respondent's profession (student nurse, nurse, lecturer, general practitioner, family support worker, manager, social worker, etc).

Research Questions

1. How would you define emotional labor? What does it mean to you?
2. What was your image of nursing/social care before you started?
3. What is your image of it now?
4. Have you got any role models that shape what you do (how you act) as a nurse/social carer? i.e.—sister/charge nurse, link tutor/lecturer, mentor, personal tutor, parents.
5. Do you get emotional support? If yes, please list who you get support from and how they help.
6. Have there been any negative or positive experiences in your student nursing/ social care (i.e.—a patient's death, a child's birth) that have affected you? How have these experiences affected you? Who has helped you to cope with these experiences? How have you learned to cope with these experiences yourself?

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Alternatively, how is emotional labor something you have to do from day to day in your work?

7. What are the differences in the ways doctors/other professionals care? How do nurses/social carers provide care to patients in ways other staff don't?
8. How do you think you could be better prepared to deal with the public and the emotional labor involved in care?
9. Why are emotions and emotional labor important in the health and social services, if at all?
10. How do you think nurses/support workers learn to care? From whom?
11. How do health/social care professionals differ in their provision of emotional care?
12. What are the main issues involved in the emotional labor of student nursing/social caring in the local healthcare trusts/Tower Hamlets?
13. If you were conducting research or drafting a study or writing an essay on emotional labor, what questions and issues would you want to explore and why?

Interviews were semi-structured, so would be directed, open and shaped by participants, allowing themes to emerge in conversation on emotional labor and emerge naturally from people's accounts.

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