The Promise of Emotion Practice: At the Bedside and Beyond

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Article

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Abstract
Emotion scholars have documented the relevance of emotional labor for understanding exhaustion, burnout, and other negative outcomes among workers in care-based occupations. Yet, an emotion management framework that centers emotional labor is not without limitations. The authors use audio diary data from 48 acute care hospital nurses to illustrate how an *emotion practice* approach can empirically capture complex emotional processes beneath and beyond individual acts of emotional labor. This analysis highlights the interplay of context and self in shaping the occupational outcomes of care workers and illustrates how emotions are simultaneously conscious and embodied, dynamic and structured, individual and collective.

Keywords
emotion, practice, habitus, emotional capital, emotional labor, health care, care work

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Emotions are elements of social reality or what McCarthy (2017) calls "social things" (p. 8). Recognizing this, emotion scholars have shown how feelings are embedded in and influenced by the social contexts in which they emerge (Ashforth & Humphrey, 1995; Barrett, 2017; Hochschild, 1979, 1983). The experiences of health-care professionals have been particularly productive for understanding how emotions and their management impact individual and organizational well-being, specifically in regard to the experience of burnout (Diefendorff, Erickson, Grandey, & Dahling, 2011). Self-report surveys, along with experiential sampling (Scott & Barnes, 2011), detail these insights and specify the complexity of emotional labor performance and its effects (Grandey, 2003). Yet, prior research on emotions (experienced, expressed, or managed) in the context of health care has had difficulty tracing the influence of broader social structures on embodied sensations experienced in real time. To do so, requires more "risk-taking with measurement" (Grandey & Gabriel, 2015, p. 327) and a willingness to expand the traditional boundaries of emotional labor theory.

Emotional labor theory and research has changed how organizations and their leaders relate to emotion in the workplace and its influence on worker well-being (Ashkanasy & Humphrey, 2011; Hülsheger & Schewe, 2011; Kinman & Leggetter, 2016). This multidisciplinary scholarship owes much to the simple fact that naming "emotional labor"— the effort required of workers as they align their emotions with occupational expectations—made visible what is often unnoticed and undervalued (Crain, Poster, & Cherry, 2016). Hochschild's (1979, 1983) theory pinpoints the entry of social forces at the construction and transmission of feeling rules—the socially shared expectations for what and how to feel. Individuals may mask feelings that misalign with expectations, display expected emotions that they do not feel (i.e., surface acting), or engage in deep acting as they seek to actively cultivate feelings based on situated emotion norms.

Despite advances in investigating the overlooked emotional labor in health care, emotion management theory still presents certain limitations. In focusing on the secondary act of managing emotions—repressing, masking, cultivating, or faking them—the social relevance of embodied, unintentional, and dynamic emotional processes remains underexamined (Theodosius, 2006). Relatedly, with "feeling rules" as the main link between individual acts and social forces, collective aspects of emotion that stem from shared environments, groups, and social location have received limited attention. As a result, while the individual emotion manager has been of central

interest in emotion management theory (Emirbayer & Goldberg, 2005), less attention has been paid to how the individual's embeddedness within larger social structures shapes for whom and how emotions are managed. These omissions map onto a number of problematic dualisms in social theory, including mind versus body, structure versus dynamism, and the individual versus the collective.

Practice theories have spread from the discipline of sociology to psychology, management, and organizational studies (Vaara & Whittington, 2012). Practices are theorized as the "building blocks of social reality" (Feldman & Orlikowski, 2011, p. 1241) where individuals act as carriers of "patterns of bodily behavior"—routines of knowing, being, and doing (Reckwitz, 2002).[1] A practice approach aims to directly overcome the dualisms of prior social theories while distinguishing itself from a norm- or purpose-oriented understanding of social life (Reckwitz, 2002, p. 246). Integrating elements of practice theory with emotion management promises to address some of the limitations of the lone emotion manager and provide the conceptual tools needed to look beneath and beyond the conscious management of emotions to fit established feeling rules. Addressing these limitations is critical for developing a more holistic understanding of health care and its impact on workers.

We integrate elements of practice theory (field, capital, and habitus) with Hochschild's (1979) emotion management framework to develop an *emotion practice* approach that transcends the underlying dichotomies of mind versus body, dynamic versus static modes of being, and the collective versus individual. We begin by detailing the limits of emotional labor as a framework and the problematic dualisms it can perpetuate; we then offer an alternative conceptualization of emotions as practices or modes of engagement/being (Bourdieu, 1990; Bourdieu & Wacquant, 1992). We analyze qualitative data collected from nurses to delineate the particular strengths that an emotion practice approach (in combination with the audio diary method) adds to our empirical understanding of nurses' experiences. In so doing, we illustrate how feelings exist in tandem with conceptual information (Barrett, 2017), are sources/locations of dynamic change and structural constraint (Erickson & Stacey, 2013), and cannot be disentangled from the persons who experience them (Cahill, 1998). An emotion practice approach promises to resituate emotion management within the broader social structures that become embodied and felt.

Evaluating Emotional Labor and Its Outcomes

Research on emotional labor has detailed the outcomes of emotion regulation. For example, surface acting tends to be more closely associated with burnout and depersonalization than deep acting (Brotheridge & Grandey, 2002; Grandey, 2003), and the social conditions of emotional labor performance impact the extent to which it is likely to be detrimental (or beneficial) for individual well-being (Humphrey, Ashforth, & Diefendorff, 2015). Emotional labor in health-care work has been found to be especially demanding (Erickson & Grove, 2008) and connected with the debilitating outcome of burnout (Erickson & Grove, 2007, 2008; Seery & Corrigall, 2009), although not all emotional aspects of caregiving are seen as coercive or detrimental (Bolton & Boyd, 2003; Lopez, 2006).

Despite these empirical advances, the *social* roots and consequences of *embodied* and complex emotional experiences tend to be lost when the strategic management of emotions becomes the focus (Emirbayer & Goldberg, 2005; Theodosius, 2006). For instance, when feeling rules are theorized as relatively unambiguous and uniformly accepted (e.g., Zerbe, 2009), consideration of the thinking-feeling processes one uses to move through, and make sense of, contradictory or ambiguous norms and experiences remains underexamined (cf. Scarduzio, 2011). Such tendencies can also lead researchers to lose touch with the pragmatist and structural concerns underlying Hochschild's original work (see especially 1983, pp. 211–218), thereby failing to attend equally to the collective components of emotional experience. So, although past work has informed us of the dimensions along which individual actors may deem their management strategies as successful or unsuccessful, the social skills, cultural knowledge, and context-based understandings that are necessary to manage emotion—and that individuals bring with them to each situation—remain undertheorized.

Reflecting these theoretical tendencies, emotional labor researchers often use self-report survey data to address what is "wrong with the worker" and overlook the ways that extraorganizational elements shape emotional experiences at work. Emotional experiences and their management can stem from "unequal power relations" among various groups (Hochschild, 1983, pp. 195–197). Systems of power permeate work environments (Voronov & Vince, 2012) and can reproduce not only intraorganizational hierarchies but also those embedded in broader social hierarchies related to social class and race (cf. Houston, Grandey, & Sawyer, 2018).

The Limitations of Dualistic Thinking in Theorizing Emotion

Critiques of an emotional labor approach overlap with three problematic dualisms entrenched in theories of emotion: mind versus body, dynamism versus structure, and individual versus collective (Scheer, 2012). To be sure, Hochschild's (1983) original theory posits the existence of organismic bodily processes alongside the cognitive appraisals underlying symbolic interactionism. Nonetheless, emotional labor research tends to emphasize actors' ability to consciously manage their feeling and display in line with identified emotion norms (Thoits, 2004). As scholars in neuroscience (Barrett, 2017), sociology (Jasper, 2014) and anthropology (Farnell, 2000; Scheper-Hughes & Lock, 1987) have shown, there is a need to transcend the mind versus body dichotomy. Feeling and thinking are both physically embodied and mindfully made meaningful when adopting a practice approach (Vaara & Whittington, 2012), but this has not been a central concern for emotional labor scholars. Rather than mind *versus* body, an emotion practice approach centers on a *mindful body* that is "simultaneously a physical and symbolic artifact, as both naturally and culturally produced, and as securely anchored in a particular historical moment" (Scheper-Hughes & Lock, 1987, p. 7).

A second problematic dualism is that between static structures and dynamic processes. Goffman's (1959) dramaturgical model underlies such concepts as deep and surface acting (Grandey, 2003). This model, however, maintains an autonomous, dynamic actor who responds to the prescriptions of a culturally defined, normative script. It is for this reason that Hochschild's approach has been critiqued as overly reliant on a rational and agentic manager who "chooses" to manage feelings intentionally (Bolton & Boyd, 2003). Practice approaches suggest that we cannot conceptualize emotion norms, or even experienced emotion, as static states housed within individual actors, but instead as part of the internalized dynamic structures and power relations that actors bring with them into each situation (i.e., habitus; see Bourdieu, 1990). Thus, in an emotion practice framework, the actor and the script (e.g., feeling and display rules) are never isolated. Individuals are swept up into the ongoing social practices that precede them, but they can also dynamically and iteratively tweak ongoing practices to fit the pragmatic needs of novel situations. As we illustrate later, emotion practice offers one way to transcend the mind/body and dynamic/static dualism

and move toward a theory of embodied emotional experience as dynamically structured.

Collective feeling rules operate beyond the individual (Diefendorff et al., 2011), but the individual emotion manager remains at the center. As such, emotion management scholars remain less clear about how collectives of various sizes might be characterized by shared feelings and emotional ways of being (e.g., classed, raced, or gendered practices) and not simply by shared cognitive expectations for expressing feelings in certain ways (i.e., feeling rules). In applying an emotion practice approach to the experiences of nurses, we attempt to illuminate the historical and collective forces that haunt each emergent act of a mindful body. Thus, in our analysis of nurses' emotional experiences, we ask: How can we overcome the *mind/body*, *dynamic/static*, and *collective/individual* dualisms to more holistically capture the emotional dimensions of care work and its outcomes?

Toward an Emotion Practice Approach

In theorizing social practice, Bourdieu (1990) provides a conceptual framework for overcoming the preceding critiques. Bourdieu's work does not explicitly focus on emotion, but it highlights the "systematic unity of practical social life" (Brubaker, 1985, p. 748). Scheer (2012) takes this further to argue that "practices not only generate emotions, but that emotions themselves can be viewed as a practical engagement with the world" (p. 193)—engagements that are both embodied and socially structured. A practice approach focuses on the action of everyday doings and sayings but with special attention to the habitual acts and routines that span the spectrum of intentionality and whose implications stem beyond the immediate situation. We follow Scheer (2012) and other scholars who adapt Bourdieu's work for examining emotion (Reay, 2000) to look before, beneath, and beyond individual acts of emotion management to understand the emotional complexities of health-care work.

Stated briefly, three concepts are key to Bourdieu's approach: field, capital, and habitus. All social practices occur within the context of a *field*. Intentionally hinting at the meanings associated with athletic games (e.g., basketball), Bourdieu's fields are relatively autonomous social arenas (e.g., health care) where (just as in a game) individuals engage in interaction with one another and struggle over desirable resources. All fields are distinguished by a network of social positions that are structured internally by power relations grounded

in different forms of capital (Bourdieu, 1996; Bourdieu & Wacquant, 1992). Thus, practices occurring in any given field are shaped by one's social position, along with its rules and resources, and practices act back on how such positions/rules/resources are located within the larger structural network.

Bourdieu's (1986) concept of *capital* refers to all resources activated in and developed by people's practice. Bourdieu identifies economic, social, cultural, and symbolic forms of capital, with each form able to be converted to and from the others. To Bourdieu's original list, we add *emotional capital*: the emotion-based knowledge, management skills, capacities, resources, and energy that individuals endlessly calibrate as they move from one interaction to another and from one set of distinct practical demands to the next (Cottingham, 2016; Erickson & Cottingham, 2014). Emotional capital is built up and molded based on social location—one's position on field-relevant social hierarchies (class, gender, etc.)—as well as occupational (Stacey, 2011) and familial roles (Gillies, 2006).

Finally, *habitus* refers to the relatively enduring set of internalized dispositions that mediate between structure and agency (Brubaker, 1985). Habitus is both a product of one's past and motivates present and future social practice. As Ritzer and Stepnisky (2017, p. 508) describe it, habitus captures the internalized schemes through which people perceive, understand, and evaluate the social world. It is through these schemes that people produce social practices. For example, the match between the capital that individuals bring to a situation and the demands of a situation within a particular field (e.g., health care) shapes the likelihood that habitus will adjust by generating further capital, or disengage to conserve—a line of thought consistent with other resource conservation models (Brotheridge & Lee, 2002). In this way, emotion can operate not only as a form of power (i.e., when emotional capital is transferred to social or economic capital) but also as part of habitus; it is shaped by previously structured patterns of disposition, taste, and emotional capital while also acting back on the habitus to stimulate the further engraining of known practices as well as the creative generation of novel practices. An emotion practice approach uses the concepts of field, capital, and habitus to theorize the social, embodied, dynamic, and collective features of emotional experiences.

Methodology

To both improve our understanding of the emotional dimensions of care work and refine the development of an emotion practice approach,

we turn to audio diary data collected from bedside nurses in the Midwest. Audio diaries provide a unique mechanism for tapping into the ongoing flow of multiple emotions and for capturing the socially embedded and real-time practices of health-care workers (Cottingham & Erickson, in press; Cottingham, Johnson, & Erickson, 2018; Theodosius, 2008). For this project we aimed for a diverse sample and targeted all men and nurses of color who completed the survey phase of the project and reported interest in further participation. We also explicitly targeted millennial nurses (born after 1980) and baby boomer nurses. After multiple attempts to increase the sample, we targeted nurses of color, men, and millennial nurses at a neighboring hospital system within the same region. The final sample consisted of 48 nurses, including 11 men and 37 women; 2 Asian Americans, 8 African Americans, and 38 White nurses. The mean age was 44 years old; 15 participants were born after 1980.

Members of the research team met with each nurse to demonstrate the technical features of the audio recorders and explain the research aims. Nurses were instructed to reflect on their emotional experiences and reactions throughout each of six consecutive shifts. Nurses could choose when and how to record but were asked to provide as much contextual detail as possible (who, what, when, where, and why) when relaying their experiences. Participants received a $75 check for completing their diaries. Recordings were transcribed, deidentified, and uploaded to a qualitative analysis program (Dedoose.com). The university institutional review board and the health-care systems in which the nurses were employed approved the study.

We analyzed the data in an abductive manner. Established theoretical constructs and relationships are used to interrogate the data, and the data are simultaneously used to critique and extend prior theory (Timmermans & Tavory, 2012). The first author coded the data using a code structure of deductive codes generated from theory, such as *deep acting* and *surface acting* (Hochschild, 1979), as well as inductive codes, such as *mixed emotions*, *the mood of the unit*, *déjà vu*, *catching the emotions of others*, and *empathy/compassion limits*. We used the specific strategies of revisiting, defamiliarization, and casing as part of our analytic process to draw connections across codes and situate them within a passage, shift, nurse, and competing theoretical frameworks (Timmermans & Tavory, 2012, pp. 176–179). Moving from individual codes to broader themes, we developed memos about possible connections. In "casing" (Timmermans & Tavory, 2012, p. 177) or thinking through alternative theoretical frameworks, we iteratively interpreted a

segment using an emotion management perspective and contrasted this with what we saw as key differences with an emotion practice framework. We illustrate this in the findings section where we show how an emotion practice approach extends and complements an emotion management interpretation.

Given our abductive, interpretive approach, as well as the rich and detailed nature of our data, our analysis does not represent the only possible interpretation. But in using thick descriptions from diverse participants to interrogate themes, we aim for qualities of rigor, credibility, resonance, and meaningful coherence, characteristics Tracy (2010) identifies as markers of high-quality qualitative research. We identify participants referenced in the narrative with pseudonyms but use participants' four-digit IDs to identify them parenthetically. Italics represent the authors' emphasis, while all caps represent the original emphasis of the participant.

Findings

We set our analytic focus on transcending the problematic dualisms of an emotion management approach and looking beyond isolated emotions and their management in the context of nursing. We find that nurses' emotion practice is simultaneously (a) embodied and conscious, (b) dynamically structured, and (c) collective yet individual. In contrast to the image of a lone emotion manager who strategically masks or cultivates emotions to match clear social norms, we see emotion as an embodied and dynamic process that emerges from the interface of embodied sensations, professional expectations, and evocative environments. Taking an emotion practice approach, we argue, provides a more holistic understanding of the emotional dimensions of social life (and nursing).

Emotion as Rational and Nonrational, Embodied and Conscious

The framing of emotion as "managed" perpetuates a dualism between the agentic, rational "manager" and impulsive, untamed—and hence, asocial—emotion (Emirbayer & Goldberg, 2005, p. 471). In contrast, an emotion practice approach views emotions as modes of engagement that can emerge intentionally and unintentionally and blur the rational and nonrational. Certainly, the nurses in our study detail conscious emotion management strategies. Throughout their diaries, they speak of reaching their emotional "limits"—often communicated as their limit

in terms of the emotions of empathy, sympathy, and compassion (2870, 2879, 3231, and 5010) and the need to be judicious in how they expend their emotional capital. As Tamara says, "you *try to be nice* . . . but sometimes . . . people try to manipulate you" (5017). Similarly, Regina describes the treatment of patients who have a known history on the unit for being "users of the system" who "take advantage of being there, um sometimes will take more of the resources and leave nothing for other patients." She goes on to explain that this leaves a lasting impression on caregivers:

> We do have families who just take all those things [coffee and tea, for example] and bag them and take them home. If it's a known family that's done this in the past, we do have staff who are very negative about those patients. And while they take care of them, they *don't form an emotional relationship* and at times are pretty curt with that family. (3231)

Turning from an emotion management perspective to an emotion practice perspective, we can view this strategy as a means of conserving valued and limited emotional capital for those deemed worthy (Brotheridge & Lee, 2002)—a point grounded in the social determinants of difference overlooked by other approaches to resource conservation (e.g., Hobfoll, 1989). When nurses see dozens of patients and family members throughout their day, emotional capital must be conserved.

But emotions are not simply deployed strategically by a rational manager. They are particular modes of conscious and embodied engagements with the world. Emotion "stick[s]" (1301), "rubs off" (2389), or is "shrug[ed] off" (1497) by nurses. Nurses' use of emotional capital and the assessments of worth that precede its use are never pure rational calculations. Such assessments are simultaneously conscious and embodied and linked to social hierarchies—including social class. In the example from Regina, we might ask who takes amenities such as coffee and tea from a hospital. Those who see such amenities as rare resources (poor and working-class families) end up, unwittingly, forfeiting emotional bonds with nursing staff, who are themselves habituated to a middle-class lifestyle. When nurses conserve emotional capital, they make judgments about deservingness that are always linked to their own class-based habitus. Unlike prior approaches to stress and resources (Hobfoll, 1989), an emotion practice approach can break down boundaries between objective and subjective resources and theorize the *development* and *activation* of emotional capital in connection with social hierarchies.

Despite their efforts to conserve emotional capital, it can be depleted, with the demands of the job leaving traces in the body. An emotion management perspective focuses our attention on how nurses react to certain emotions but not on the visceral sensations and embodied implications of emotionally demanding work. Yet, frustrations of the job are born out in the bodies of nurses young and old. This includes headaches (3187, 2798), back (2241) and foot pain (1940, 2667), insomnia and sleepiness (1929, 2390, 3132), slurred speech (2667), worries about high blood pressure (2798), depression (2390), dehydration, and a lack of time to urinate (1940, 5002) or eat (5006). Clara, for example, feels physically unwell as she contemplates losing a beloved colleague:

> It makes me just *sick* to think about who I'm going to have to deal with next. And I guess it's the unknown because neurosurgeons are- like cardiothoracic surgeons are [a] pretty high-strung bunch and we were very fortunate to have two very laid-back people. (1940)

In referencing sickness, this seems to be a figure of speech, yet she later says "the Motrin [pain medication] is needed" and the next day records the following:

> So I was running from room to room...had not gone to the bathroom...it is now 4 P.M....I got the opportunity finally to go to the bathroom and I'm going to finally have a cup of coffee and get something to eat. Needless to say, I'm hungry. I'm *tired.* My tummy's a little messed up from having not been able to go to the bathroom when I needed to for 8 hours. (1940)

As an extension of the other empirical examples provided earlier, Clara's reactions to these sensations illustrates the importance of attending to embodied feelings and the ways that these are linked to one's social positioning. Embodied feelings of stress emerge from the continual dialogue between nurses' habitus and situational demands. This dialogue is both rational—intentionally conserving emotional capital—and nonrational, as it plays out in aching, anxious, and exhausted bodies. Rather than bracket out these embodied experiences, an emotion practice approach integrates them into our understanding of nurses' well-being, as "the body [.] consists not only of the sedimentations of evolutionary time, but also the history of the society in which the organism is embedded, and its own history of constantly being molded by the practices it executes" (Scheer, 2012, p. 2011).

Further spanning mind/body and degrees of intentionality, emotions can be contagious—caught unintentionally from (certain) others (Theodosius, 2006, 2008). Andrea illustrates this as she ruminates on a new, particularly heartbreaking admission:

> We got a new admission- *that was sad, oh this little boy just turned 21.* I guess a couple of months ago and uh somebody put some kind of chemical in his drink. He drunk [sic] it and his esophagus was just like you know had chemical burns so he can't swallow. Oh my goodness, that was sad. And now he just started- he was only 21, just started his life. *That's all I can think about cause I have a 15 year old son* and I'm just like 'wow,' if somebody did that to my child I don't know what I would do or where I would be. And that little boy just- and I keep calling him a little boy, he's 21, he's a grown man but just- *he looks like he's 16 years old.* And I just [exhales] it's just *so hurtful*...(1516)

Having a son herself makes Andrea more susceptible to catching feelings of sadness from a similar patient (Hatfield, Cacioppo, & Rapson, 1994). Her social role as a mother renders the suffering of *certain* others more contagious. When stating "that's all I can think about," she highlights the *unintended* nature of her rumination on this "boy's" situation. She suggests that her sadness might be misplaced, but the similarities between the patient and her son make feelings of sadness irresistible.

Emotions can spread unintentionally, from patient to nurse, and another's suffering can become lodged in our minds, as seems to be evident in Andrea's quote. The spread of emotions (as emotional contagion) has certainly been documented in the literature (Sinclair et al., 2017), but the role that shared social location, in terms of social class, race, or gender, may have on one's habitus and thus one's attunement to *certain* others has been underdeveloped. Whose emotions are more likely to overwhelm us? Here, homophily—as shared social location—might shape the kinds of others we define as "our" kind (McPherson, Smith-Lovin, & Cook, 2001) and thus *whose* emotions we might unintentionally absorb.

Compare, for example, Andrea's sadness for a patient like her son with Ashley's disdain for a patient with whom she finds it difficult to sympathize:

> So I was going back and I was like listening [to a previous recording], and I was like 'geez, I kind of sounded really, really mean' um and, you know, not- not very sympathetic for this woman who apparently like got slipped a date rape drug. But she didn't and you know- going back to that, she

was just a more difficult patient to handle. And you know, long story short, just kind of like immature and for a 19-year-old, and you know it's kind of- when you have those patients it's kind of hard you know sometimes to sympathize with them. And you know, you kind of see like, oh they get themselves in these situations and you feel bad, but at the same time, you're just like, 'if you would just make some better decisions maybe, maybe you wouldn't end up in some of these situations'. (1556)

Ashley feels "bad, but" this patient's situation does not immediately arouse sympathy in the way that Andrea's motherly identification with her patient does. Ashley identifies as White and says earlier in the shift that, because another local hospital has closed, her unit has seen an increase in certain types of patients—"we're getting a lot of more- lot-more like *inner-city patients* who do have like a lot of mental issues." She later says that "the demands, the politics, you know, the populace-some populations of patients (pause) is - you know? It wears on you . . . " (1556). Framing emotion as capital, we can see how Ashley might cautiously reserve her compassion for those she sees as worthy, but *who* she sees as worthy is the result of past practices distilled in habitus and enacted in conscious and nonconscious ways. Such others may be similar to oneself and not, as Ashley describes, from the "inner city"—coded language for poor and working-class racial minorities (White, 2007). Social location (race and class) shapes habitus and with it the patterned nature of whose emotions are effortlessly "caught" and who gains sympathy only through effortful cultivation.

Emotion as Dynamically Structured

Further blurring conscious and embodied practices are the static and dynamic moments of reflection in which nurses feel and think their way through competing demands. A single emotion does not necessarily dominate. Emotion practice involves sensing and addressing a mix of emotions that bleed together. This can unfold intentionally—as the nurse molds one feeling into another (2870 consciously tries to transform anger into righteous indignation)—or unintentionally. Emotion norms influence this process, as does a nurse's own needs and sense of a patient's needs.

Marla illustrates the dynamic, overlapping feeling and thinking that characterizes emotion practice. The following is her entry which is a reaction to a recent discovery that her colleague, "C," violated protocol and instructed a younger nurse, "D," to administer medication without

a physician's order on a unit where she was a "float" (a precarious social position in which a nurse works as a temporary substitute on another floor).

> And then, I was *angry* because she [C] did this. She's a float, floated to us, and did this on [unit name]. And so now is this going to give [unit name] a bad rep [reputation]? 'Oh, don't send your patients THERE, they over medicate, or they put their own orders in-' you know, all the rumors that fly. And then I just feel so *sad* for C [deviant nurse]. You know *you kinda wax and wane, back and forth*, and then you kinda get angrier because you wanna say 'Why did you do that to D [complicit nurse]? It was SO wrong of you to do that!' [details of investigation]...it makes you question yourself, you know, [C has] been a nurse for a long time, this is the first time maybe she's getting CAUGHT. How many other patients has she done other things on and things have just been pushed under the rug? But then, why do we have to be the ones to deal with this, you know? So there's just a lot of *anger, frustration, sadness, don't understand why somebody would do this.* (5015)

The back and forth, "waxing and waning" that Marla describes is part of the situated flow between considering nursing norms ("is this going to give [unit name] a bad rep [reputation]?") and new information. Emotions and their consequences—anger at C—can shift through consideration of other emotions—sympathy as she feels sad for C—and through new information as she considers C's long tenure as a nurse which leads to feeling self-doubt ("it makes you question yourself").

Marla's reflections mix emotions with information in a stream of "thinking/feeling" about a past event. If asked to classify her emotion on a survey, how would Marla respond? It might depend on the precise moment at which she is asked, as her narration suggests that she feels multiple emotions simultaneously. Nurses report feelings that are "widely scattered" (1940); you can feel the "full gamut of emotions" (5015) or "a variety of emotions" (5022) in a single day. This multiplicity of emotions can lead to feeling "overwhelmed" (3187) or like "your head is spinning" (5014) and suggests both emotional ambivalence (Rothman, Pratt, Rees, & Vogus, 2017) and the simultaneous experience of discrete emotions in care work. Using audio diaries in conjunction with an emotion practice approach allows us to capture the flow of these emotions as they dynamically unfold rather than artificially limiting her emotion to a "final product" reached after reflection and deliberation. Studies of health-care workers document the shared

feelings of those working in the health-care field (Erickson & Grove, 2008). An emphasis on the dynamics of emotion does not discount these patterns. Yet, each instance of a pattern remains a novel iteration that opens up subtle possibilities for variation. Feelings of stress, exhaustion, and being overwhelmed were certainly featured in our sample along with feelings of pride, fun, and a sense of purpose. Rather than measuring these emotions as static outcomes, an emotion practice approach draws attention to the ongoing flow of embodied emotions across settings and time and in conjunction with cognitions.

An example from Lianna illustrates emotion as both dynamic and structured. Faced with a difficult patient, Lianna turns to another nurse on her floor for advice. Reacting to this, Lianna states:

> And granted, not all patients do act like her, but I just felt *disheartened* the way that this particular nurse kind of perceived the situation with that particular patient, because I think that the nature of nursing should really be about being able to *sympathize* and *empathize* with your patient and [even] if your patient is *angry* and lashing out. . . .To add to that though, her- this patient['s] particular situation brought me back to another one of my patients that I had taken care of about three or four months ago that had passed away that had similar symptoms. So it was more like *déjà vu* and a- and a *fear* that this would also happen to her . . . (1497)

Lianna moves from disheartened by her fellow nurses to fear and sadness about her difficult patient as she calls up the emotion norms (static, structural elements) of the field ("the nature of nursing"), but by unintentionally recalling a patient with similar symptoms, she feels fear. This "déjà vu moment" appears unbidden, as the "situation brought" her "back to another" patient. Here, we see her *intentional* efforts to align with the static occupational norms of nursing (what she "should" feel) combined with the emergence of fear brought about dynamically by the situation. If we focus only on the management of discrete emotions (e.g., deep acting to feel authentic empathy for one's patient), the social relevance of a feeling of déjà vu would be lost, and the dynamic and varied nature of emotion practice would be truncated to fit the manager/managed dyad. For Lianna, the past—a literal past patient who has passed away—haunts this encounter and links spontaneous feelings of fear to prior social encounters and emotions.

Similarly, Andrea illustrates the complexity of dynamic emotional experiences as she reflects on the disconnect between her expectations and her actual experiences working as a float:

And I had two patients with one leaving- three patients with one leaving and one about to go to dialysis. So I knew I was going to start getting some admissions, but it was not a bad float. I was so *surprised.* And I was *kinda mad at myself* for expecting the worst because *all that time I was worried about floating, I could have been using that energy for something else.* (1516)

Surprise, worry, and anger all converge here as Andrea interrogates her unintentional waste of emotional capital. Her expectations of a bad float in which numerous admissions create stress are part of a structured pattern, and her surprise and anger emerge due to the novelty of the situation. Her reflection illustrates the dynamic multiplicity of emotions: "we do not experience isolated emotions, one at a time" (Bericat, 2016, p. 495).

Regina also describes myriad emotions when it comes to the specific task of calculating drug dosages:

I hadn't had that many emergent situations on the pediatric unit. I was very um fright- *frightened and worried and anxious, um grateful* that the senior nurse was there, but personally thinking 'all right, if I were in charge, how would I have handled this?' I might've made a mistake with the calculation. I certainly would've known- would not have known how to calculate the amount of drug necessary for the infusion, the uh slow fusion of the secondary rescue drug, I would've had- I would have had to wait for the resident to do that. And when I did on paper calculate what would be necessary for the night in advance, I had made an error that the senior nurse brought to my attention which *made me feel horrible.* (3231)

Fear, anxiety, and gratitude intermix as she plays through past and future hypothetical scenarios of how she would handle an emergency situation. Summarizing the emotion practice of nursing, Muriel relays that "the most difficult part of [the day] was that you don't have time to deal with any one thing and work it through emotionally until you're hit with the next thing." She later notes: "you never have two seconds to rub together and it can be extremely stressful at times" (1851). Thus, discrete negative emotions encountered in care work or the management of isolated emotional events (e.g., Erickson & Ritter, 2001) might not fully explain the exhaustion and burnout that nurses experience. Rather, their cumulative effect and the seemingly endless introduction of novel scenarios (new machines and

devices, new information on dosages, new policies and procedures) or the unbidden fears of past events intermix to dynamically structure nurses' emotion practice and its effects on present and future well-being.

Emotion as Embodied Collective

The visceral, embodied nature of emotion emerges always from a body in relation to other bodies, objects, and environments. Notions of collective and contagious emotions can pull the lens back from the lone manager/managed dyad and onto the situation to show how emotions are evoked and shaped by collective environments and practices. Collective emotions can be seen in their unintentional spread and in how nurses ascribe emotions to situations (as "chaotic," 1940 and "mayhem," 4102); units as a whole (1986, 5015, 3231, 5002); the shift (or a "night" as "high-energy," 3231 and "crazy," 5002); or their particular specialization ("maternity is 99% sheer boredom and 1% sheer terror," 3231). Marla, for example, senses the collective mood of the unit upon arrival: "So, when I got there, you can always tell when you're walking on the floor, kinda the *mood*, whether call lights are going off or alarms are going off, or just the loud factor" (5015). Before interacting with a patient, nurses confront noisy alarms, moods, and chaos that can permeate units and floors, nights and years. They are bombarded with signals and begin to process such signals as soon as they enter the building and floor, before even a single interaction with a patient.

Hochschild's notion of emotional labor drew our attention to the individual perceptions and strategies of managing emotion on the job. But spaces themselves—as products of past emotional practices—might give off or shape emotions in individuals. Collective moods emerge from intentional and unintentional social practices. For example, Regina and Judy both describe the use of whiteboards in patients' rooms as a tool for communicating key information and managing others' emotions:

> On the children's boards we put the child's name, their weight, uh the parents' names, and who the physician is who's going to be taking care of them while they are there. The reason we do that on the children's boards is that we have a lot of residents who come and *get very anxious* when there's a potential emergency or an emergency and *they may panic*. (Regina, 3231)

Her unit uses whiteboards to preempt feelings of panic from incoming residents:

> They [residents] can look at the board and I- I'll have on the board what the mom's name is, what the dad's name is, what the child's name or nick name is, so that *there is this hope that there can be an almost instant relationship that forms*, and then also the child's weight so that they can immediately calculate any rescue medications that the child needs. (3231)

Regina uses the whiteboard to create an "instant relationship," but not between herself and the children, rather between residents and patients. We can see this as a form of collective, interpersonal emotion management (Francis, 1997) related but distinct from the intrapersonal processes that are often the focus of emotional labor scholarship. Whiteboards are part of the physical environment, fighting against the chaotic mood that tangled tubing and beeping machines creates for residents, nurses, and patients. This strategy is clearly intentional (a single individual must write names and information), but this individual practice becomes embedded in the environment. Regina could leave, but the whiteboard now remains as a part of the environment that new nurses and residents navigate. Taking a practice approach directs our focus to the traces of past practices that exist beyond the lone individual.

Collective moods can also result from unintentional contagion. Empathy is a key emotion in the feeling rules of nursing (Erickson & Grove, 2008)—yet some forms of empathy require little effort and appear as emotional contagion (Sinclair et al., 2017). Take the example of Jackie who works on a surgical oncology unit. She describes her *unit* (not herself) as "emotional and very draining" because of the "life-changing" nature of the diagnoses and treatments administered. While other nurses might work at empathy by, for example, viewing patient anger as a sign of fear (3187), relaying sad childhood stories (3231), imagining the patient's situation (5022), or by saying "if I was the mother [of the patient]" (2450), Jackie relays her own feelings alongside the suffering of her patients without any apparent need to work at evoking compassion. At various points, she can be heard crying, her voice quivering, and releasing sighs and exhales. Concerning one patient, she says

> And you know the *sad* part is today he turned 40 and he was in the hospital and he's dealing with these crazy cancers and he's got these

three great boys and just great amazing life and he's STUCK in this
hospital and just ANGRY at the world and you know h-, how did
cancer pick him and this kind of cancer that they can't somehow get
under control? (1441)

During one shift, her voice can be heard to falter as sadness
overwhelms her:

And it's just *SAD* [voice quivering]. It's *sad* to see young age [patient] and
just this horrible cancer and just the affect it takes on people and [sigh] I
just hope he makes it to see the birth of that baby. (1441)

Here, we see feeling spread almost instantly from the patient's situation
to the nurse. Using audio diaries, we can capture her sighs, quivering
voice, and emphasis on "stuck" and "angry" as she records *while* feeling
these emotions rather than dispassionately after the fact. Absorbing the
emotions of her patients, her reflections point to a blurring between self,
other, and unit.

Positive emotions can also spread. In describing a medicated patient
who comically fumbles as he tries to follow her instructions, Muriel
emphasizes a deep sense of simpatico with a colleague (referred to as T):

[T], the circular I'm working with, is again *someone I've known for years*
and it was just one of those funny moments where we didn't even have to
say anything. . . .It was just one of those silly little moments *that strikes
you as fun* and [T], the other nurse that was with me, was laughing and
neither one of us could talk to the poor guy. He was trying so hard to try
to do what we needed him to do but was just out of it because of med-
ications he had received and didn't understand what we had asked him to
do. Those kind of things, you know, where *you can share that kind of
moment with someone you've known for [a] number of years does release
some stress.* (1851)

Muriel acknowledges repeatedly that her colleague is someone she
has developed a relationship with over the years. This means that she
can share "little moments" where nothing has to be said. Their estab-
lished relationship gives them a shared outlook, allowing them to
operate at the level of intuition and authentic simpatico. Such seem-
ingly authentic moments of bodily connection are beyond the con-
ceptual reach of an emotional labor focus on masking, cultivating, or
faking emotions.

Rather than interrogate their habitus—their assumptions and reasons for acting, as they must do when teaching younger nurses (Cottingham & Dill, 2019)—these older nurses can forego such exhausting reflexivity and instead be in the moment together. This is comfortable, easy, and, in the case of Muriel, fun and relaxing. It feels good. Here, we see a built-in reward for working with those who share a "feel for the game" (Bourdieu, 1998, p. 80). Given the complexities of orchestrating collective work, familiarity is a welcome respite. Applying an emotion practice approach to the audio diaries of nurses allows us to see these experiences of fun and comfort as the product of past social practices now embodied. Seemingly "authentic" emotional experiences are not disconnected from social context but are simultaneously emergent and structured, collective and individual, embodied and conscious.

Discussion

Emotion management theory focuses on what we do with emotions—how we conjure, suppress, fake, or ignore them. Strategic and intentional acts of management, work, and labor have dominated discussions of emotion in occupations (Grandey & Gabriel, 2015), leaving emotions themselves to a murky, ambiguous realm. As we have shown, however, an emotion practice approach demonstrates how emotion itself is as inherently social as its management and illustrates why both should be theorized and studied as components of work and occupations, including caring labor. As an extension to emotional labor research, an emotion practice frame offers a way of seeing and documenting this type of critical complexity within the ever-changing landscape of today's health-care systems and diverse patient populations. In so doing, an emotion practice framework draws attention to the ways in which even unmanaged emotions are socially shaped, as emotion emerges from and acts back upon a mindful body that is dynamically structured, collective yet individual. Emotions are not mutually exclusive of cognitions nor are they fully static or limited to isolated individuals. To begin developing a theoretical framework that grapples fully with the *social* roots of spontaneous, multiple, and embodied feelings, we turned to concepts from practice theory (i.e., field, capital, and habitus). We conceptualized emotion as a feature of social practice, as habitus draws upon and simultaneously adapts embodied resources (emotional capital) to meet the organizational, professional, interactional demands of nursing. Emotions must be

theorized and measured as key outcomes *and* catalysts within the field-habitus dialectic.

Conclusion

An emotion practice approach allows scholars to connect a range of previously disconnected concepts—emotional conservation, contagion, déjà vu, homophily, collective moods, and emotional exhaustion—as well as feeling rules, surface acting, and deep acting. Intentional resource conservation and unintentional contagion are both part of a mindful, yet embodied habitus that reacts as much as it acts. Past practices impart emotional capital (skills and abilities) within an ever-adapting habitus that transcends situations while being subtly shaped by them. Andrea, discussed earlier, cannot resist ruminating over the case of a burned 21-year-old. Her habitus is primed to catch the emotions of others like her son, to immediately think and feel with him regardless of how rational it would be to conserve emotional capital. Homophily—as shared social location—shapes *who* we are practiced in interacting with, whose emotions we catch, and whose emotions will seem foreign (and thus require concerted, effortful labor to match feeling with expectations).

Combining an emotion practice approach with audio diaries can help researchers capture the complexity of care work and its connection with such debilitating outcomes as burnout (Erickson & Grove, 2008). Correlational survey studies have identified similar types of relationships. But the isolated, discrete, and abstract thinking-about-feelings elicited through surveys or experiential sampling might miss the dynamic emotions—both the feeling of multiple negative and positive emotions simultaneously as well as nurses' complicated efforts to match these feelings to ambiguous and changing norms. The distinct emotion practices in nursing, including the combination of positive and negative emotion or the combined effect of two negative feelings, might explain levels of job dissatisfaction, burnout, or higher rates of absenteeism. It might also be possible that any one emotion combined with another is insufficiently powerful, but the fact that nurses run "the full gamut" (5015) of feelings on a daily or weekly basis makes them particularly vulnerable to negative health outcomes.

To be sure, future research could test these combinations of emotions using survey methods. As complements to quantitative methodologies, diaries offer researchers a spontaneous and organic look at an individual's day-to-day experiences (Theodosius, 2008) and "the capacity that

emotions have to transmute and form successive emotional structures, and the multiple compositions that shape the nature of any affective state" (Bericat, 2016, p. 495). Diaries are uniquely suited to an emotion practice approach and its theoretical aims. But diaries also have their drawbacks, including high participant commitment and diminished researcher control (Williamson, Leeming, Lyttle, & Johnson, 2015).

While Hochschild is criticized for relying on an overly rational, individual actor, Bourdieu is criticized as socially deterministic. Synthesizing the two, we show how an emotion practice approach might transcend the dualisms that underlie emotion scholarship and capture the emotional complexities of health-care work. An emotion practice approach enables care work scholars to better connect dynamic emotions with their management, the past with the present, the rational with the embodied, and the collective with the individual.

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Note

1. "Practice" as a generic term has been taken up by some scholars to refer to specific policies within organizations (such as human resource training; Gabriel, Cheshin, Moran, & van Kleef, 2016). This is not the same as taking a social practice approach linked to the theories of Bourdieu, as we do here. See Reckwitz (2002) for a review of social practice as a theoretical stance.

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