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Emotional Labor and Organized Emotional Care

Conceptualizing Nursing Home Care Work

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Based on qualitative comparison of three nursing home facilities, the idea of organized emotional care is proposed as a complement to the concept of emotional labor for understanding care work. It is argued that emotional labor and organized emotional care are distinguished primarily by the presence or absence of organizational feeling rules and affective requirements. Care organizations can be plotted on a continuum with emotional labor at the coercive end and organized emotional care at the other. The proposed distinction restores a positive vision of organizational management of emotion to the sociology of work.

Keywords: *emotional labor, emotional care, care work, nursing homes*

I'm sitting with a small group of elderly residents at the Pines, a county nursing home in Michigan (all names in this article are pseudonyms). The group consists of five of the Pines' residents who are most withdrawn and socially isolated, all classified as "unresponsive": They do not reply when spoken to or show any sign that they are aware of their surroundings. Several appear to be asleep, while the others stare off into the middle distance. Also present is Molly, an activity aide whose job it is to try to connect with these people somehow, to try to bring them back, temporarily at least, from wherever it is that they have gone.

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Molly follows a loose script, first reading to these rural women from a book about farm life, then sitting with each woman in turn, stroking or combing her hair and speaking to them individually about the passage she's just read. She asks them questions about their lives ("Did you grow up on a farm?"), continuing to talk to them even if they don't show any sign that they've heard. The first patient doesn't stir from her apparent slumber, leaving me wondering whether this exercise makes any sense. However, the second patient, Charlotte, surprises us both: Her stare slowly focuses, and she nods. "We had a garden," she whispers. Molly asks her if she canned her own vegetables. "Oh, yes," Charlotte says softly. "Every year. We canned everything. Lots of work!" Her eyes are gleaming. Molly is thrilled. Later, as we're heading back to the activities office, she is nearly overcome with emotion. She wipes away a tear, sees me notice, and reddens. "Sorry about this," she says, with a slightly embarrassed laugh. "It's just that today was such a huge breakthrough with Charlotte. She's never opened up to me like that before. It's hard sometimes . . . but you keep going because you never know whether someone is in there listening."

Arlie Hochschild's (1983) theory of emotional labor provides the dominant lens through which the sociology of work views interactions like these. According to Hochschild's classic analysis, employers specify the "organizational feeling rules" with which workers must align their inner emotions and their outward displays. Thus are personal feelings elicited and pressed into organizational service. However, although the concept of emotional labor has a long pedigree and has been confirmed countless times in the literature, it does not really fit what I saw at the Pines. Here I did not observe management imposing specific feeling rules for workers like Molly to follow. Instead, I found in the Pines an organization that self-consciously tried to create structural opportunities for meaningful social relationships between caregivers and clients. The distinction I draw between the Pines' approach and emotional labor, thus, turns on the difference between organizational imposition of feeling rules (the *sine qua non* of emotional labor) and organizational support for ongoing human relationships in which the emotional rules can be renegotiated by the participants. Inspired by the work of Cancian (2000), I dub the latter approach "organized emotional care." Based on qualitative comparisons of three carefully chosen nursing homes, I argue that emotional labor and organized emotional care should not be thought of as competing concepts but rather as alternative organizational approaches to emotion in interactive work.

Emotional Labor and Emotional Care

Hochschild's (1983) classic analysis defines *emotional labor* as the efforts workers must make to bring their feelings and/or visible emotional displays into line with organizational or managerial requirements. In the sphere of private relationships, people routinely perform "emotion work" (p. 7) applying "latent feeling rules" (p. 18) to manage their emotions and conducting "emotional gift exchanges" (pp. 76-86) with others. This private emotion work, Hochschild said, is "probably no newer than emotion itself" (p. 20). Emotional labor, by contrast, is a form of social engineering in which feeling rules are organizationally prescribed. As work organizations deploy and manage emotions for their own purposes, feelings come to belong more to organizations than to individuals; in the process, service workers are estranged from their own feelings in much the way production workers are estranged from their own labor. This estrangement can take the form of surface acting (in which case, workers are likely to experience their emotional labor as phony, insincere, and unsatisfying) or deep acting (in which case workers are more likely to experience their emotional labor as satisfying or rewarding). Hochschild was more concerned about the second possibility—for in her view the successful "transmutation" of feeling from individual and/or private to organizational and/or public forces workers to submerge their own identities and interests into organizational ones. This not only creates new forms of exploitation but also makes it increasingly difficult for workers to answer basic questions about who they "really" are and what they "really" feel.

Inspired by this thesis, an explosion of research on emotional labor during the past two decades has sought to trace its contours and consequences in a variety of occupational settings (see Leidner, 1999; Rafaeli & Worline, 2001; Wharton, 1999, for reviews of this literature). However, although this research has succeeded in confirming the reality of emotional labor, scholars have not found much evidence for Hochschild's transmutation thesis. Indeed, it seems that Hochschild overestimated the extent to which employers are able to control workers' emotional lives. Paules (1991, 1996), for example, has shown that waitresses not only derive considerable satisfaction from their emotional skills but also deploy these skills autonomously, in the provision of good service and to resist excessive demands from customers. Tolich's (1993) study of supermarket checkout clerks finds that even as management attempts to impose organizational feeling rules, clerks "simultaneously understand themselves as autonomous, as the person in charge of their own emotional management" (p. 373). This allows them to experience relationships with customers as genuine and pleasurable. Bolton and Boyd's

(2003) study of flight attendants shows how Hochschild's view of estranged emotional labor rests on a false analogy between physical and emotional labor: Interactive workers are not expropriated from the means of emotional production in the same way that manual workers are expropriated from the means of industrial production. Workers' decisions about whether to offer emotional gift exchanges are always their own, even though the workplace is a field of power relations impinging on these decisions.

These critics reject Hochschild's implicit theory of false consciousness and restore workers' agency, providing a clear advance over Hochschild's assumption that any worker who experiences relationships with clients as emotionally genuine must be a victim of organizational manipulation. This theoretical progress is particularly important for students of care work involving clients who are powerless or suffering, such as the work of nursing home aides or child care workers (cf. Foner, 1994; Uttal & Tuominen, 1999). Scholars studying these jobs often feel, rightly, that even if the conditions of the work are unfortunately often degraded, the work itself is socially important. It is a good thing, after all, for preschool teachers to care about children. Likewise, the requirements of social justice and dignity for the elderly and infirm who are institutionalized cannot be realized without genuinely caring and nurturing relationships between nursing home aides and residents. This view of things obviously coexists rather uneasily with Hochschild's original concept of emotional labor, and in this respect the insights of the critics mentioned above have been particularly helpful.

However, these theoretical developments also suggest further questions. If workers and clients can sometimes enjoy relationships that are mutually rewarding on an emotional level, are such relationships always carved out by individual workers in the face of organizational pressures to perform emotional labor? Is it ever possible for organizations themselves to support such relationships in ways that do not simply tell workers what to feel? Unfortunately, it is difficult to entertain such questions using the theory of emotional labor because of the continuing assumption that imposing feeling rules is the only way for work organizations to manage emotion. The possibility that emotional labor might represent only one possible approach to the management of emotion at work has not been sufficiently considered. The sociology of work needs to take seriously the idea that organizations can support emotional authenticity instead of attempting to manufacture it.

Francesca Cancian (2000) provides just such an attempt. Cancian avoids using Hochschild's concept of emotional labor altogether, opting instead for an alternative notion of "emotional care," a positive conception not tied to the normative underpinnings of emotional labor. Cancian suggests that it is possible to create rules and standards for emotional care just as there are rules

and standards for physical care. However, it is not sufficiently clear how Cancian's notion of organizational rules and standards for emotional care is different from Hochschild's conception of organizational feeling rules for emotional labor.

In this article, I advance the idea that there are indeed two types of organizational emotion management, and I clarify the difference between them. Emotional labor, whose central element is the managerial prescription of affective requirements (Bulan, Erickson, & Wharton, 1997) to which workers are expected to conform, is an inherently coercive approach. The alternative, which I call *organized emotional care*, is supportive rather than coercive. Organized emotional care does not prescribe feeling states or display rules but rather consists of organizational attempts to create hospitable conditions for the development of caring relationships between service providers and recipients. The defining characteristic of organized emotional care is that managerial attempts to legislate how workers are supposed to feel are replaced by organizational rules, procedures, and recordkeeping, aimed at the creation of organizational spaces within which caring relationships can develop. Emotional labor and organized emotional care thus represent two divergent organizational strategies—two distinctly different ways of organizing feeling at work. Organized emotional care, it must be stressed, is not simply Hochschild's original idea of private "emotion work" brought into the public sphere, nor can it be seen simply as an extension of workers' autonomy: rather, it consists of self-conscious organizational interventions that encourage relationship building and emotional honesty. For these reasons, organized emotional care must be understood as an alternative organizational mode, as its own ideal type whose addition to our theoretical tool kit can help us further clarify the relation between organization and emotion.

I develop this argument through case studies of three nursing homes (referred to here as the Meadows, the Lakes, and the Pines) that I deploy as a heuristic device to demonstrate that actual organizational practices can be plotted on a continuum with emotional labor at one end and organized emotional care at the other. At one end of the spectrum, the organizational approach of the Meadows was dominated by demands for emotional labor. Here, workers were required to perform two kinds of emotional labor, stoically accepting abuse from patients and practicing indifference to the suffering that organizational routines imposed on patients. At the Lakes, an inconsistently developed form of organized emotional care reduced but did not fully eliminate emotional labor. Here management allowed workers to express their feelings more honestly (and even to renegotiate the emotional rules of their caregiving relationships); however, important organizational sources of suffering still required workers to perform emotional labor to

ignore patients' loneliness and pain. Finally, the Pines came closest to the ideal type of organized emotional care. Here, an organizational strategy of "planned spontaneity" reconfigured organizational routines to create new possibilities for meaningful social interaction between caregivers and residents. I do not argue, of course, that the Pines as a workplace was free of coercion or unequal power relations. Rather, I make the more limited claim that organizational power and coercion were not applied to workers' inner emotions and displays of feeling via the imposition of organizational feeling rules for the performance of emotional labor. Support for compassionate caregiving was built into the structure of the organization rather than imposed as a set of rules about how to feel.

Research Sites and Method

The nursing homes I studied, like virtually all nursing homes in the United States, were organized around identical vertical hierarchies and horizontal departmental divisions of labor. The departments and their roles within the organization were the same at each facility: Nursing, Dietary, Housekeeping, Laundry, Activities, Physical and Occupational Therapy, Social Work, and Maintenance. At each facility, department heads reported to the top administrator and supervised their own vertical hierarchies, each of whose levels had virtually identical, and carefully defined, duties, functions, subdivisions, and lines of authority and decision making. The credentials required for each type of position—registered nurses (RNs), licensed practical nurses (LPNs), certified nursing assistants (CNAs), occupational and physical therapists, social workers, dietitians, and so on—as well as the formal job descriptions of each position, were the same at each nursing home. Unlike hospitals, which they resembled organizationally and physically, none of these nursing homes provided much medical care. Instead, most of the "hands-on" work was personal care provided by nurse's aides, who helped residents with "activities of daily living"—eating, bathing, dressing, toileting, and so on—that they could not perform on their own. Even patients' rooms were very similar in the three facilities, consisting of semiprivate rooms with hospital beds separated by privacy curtains on curved tracks in the ceiling.

In addition to these basic similarities, each of the three nursing homes shared other features as well: Each was nonprofit, county owned and operated; each was unionized; each served a similar population of residents (in terms of their medical acuity, their rates of reliance on Medicare and Medicaid, and their demographic profiles); and the employees of each home were demographically similar (frontline caregivers nearly all female, native

born, and roughly equal numbers of Whites and African Americans). All three were located in small-town settings in Michigan, though in different parts of the state. All three homes were well staffed, with similar staffing ratios in the nursing department (one nurse's aide for each eight or nine residents on the day shift). The Lakes, with 108 beds, was smaller than the Pines and the Meadows (160 and 212 beds, respectively); however, the size of individual floors was about the same at each facility—about 60 beds each.

These three nursing homes did, however, differ in one important respect—their relation to so-called culture change models of nursing home care (Weiner & Ronch, 2003). The Eden Alternative, founded in 1991 by New York nursing home physician Bill Thomas, is the largest and perhaps the most well known of these. The insight at the core of the Eden approach is that most of the suffering endured by nursing home residents is caused not by physical pain but by boredom, loneliness, and helplessness. Therefore, the “Edenization” process involves an ongoing organizational self-critique aimed at identifying and implementing ways of addressing residents' emotional and social needs (see Thomas, 1996). Of the three facilities I studied, the Meadows was not affiliated with any culture change organization; the Lakes had begun experimenting with the Eden Alternative approach 18 months before my research began; and the Pines had been on the Eden Registry for 3 years.

Between June 2001 and January 2002, I conducted approximately 100 hours of participant observation “on the floor” at each of these nursing homes, for a total of 300 hours of participant observation. Carried out as a pilot study for a larger, extended ethnographic research project that is currently ongoing, these activities were conducted during intense periods of immersion that lasted 12 consecutive days at each nursing home: 10 weekdays and 2 weekend days per home. Ideally, it would have been desirable to spread my observations out during longer periods of time; however, the locations of the three nursing homes in far-flung parts of the state, combined with the fact that the research was being conducted as part of a 2-year postdoctoral appointment requiring residency in Ann Arbor, made an extended, over-time approach impossible. In addition to the main research visits made to conduct participant observation, I also made two shorter, initial trips to each site to meet with and interview nursing home administrators, managers, and charge nurses. Based on these multiple visits and subsequent contacts, I am confident that my observations were representative of daily life in these three nursing homes at the time of the fieldwork.

Participant observation was necessary for this project because very little of the interplay between organizational structures, everyday routines, and interactions in direct-care areas of the nursing home is recorded in official organizational records. In addition, because people's descriptions of their

own behavior are strongly influenced by social expectations and routinely diverge from their actual behavior, I considered this strategy to be superior to an interview-based approach. On each unit of each nursing home, therefore, I systematically worked shifts as an unpaid volunteer housekeeper and activity aide, and I accompanied nurse's aides and social workers in their daily rounds. Thus, instead of sampling individuals my strategy was to sample social situations by making systematic observations in each unit of each facility and from various social locations within the organization. These observations were recorded in detailed field notes at the end of each shift. To make it easier to recall the events of each 8-hour shift, during my lunch breaks I left facility grounds and used a laptop computer to record notes from the morning's observations that I fleshed out at the end of each day. These were analytic field notes (Burgess, 1982) consisting not only of detailed accounts or "thick description" (Geertz, 1973) of everything that I did and observed during the shift but also of ongoing analysis of the meaning of, and questions raised by, these observations. I applied aspects of the extended case method approach (Burawoy, 1998) in which initial hypotheses are revised as field observations refute or modify them. Each successive entrance into the field, therefore, became an opportunity to test ideas formulated during analysis of the preceding day's field notes.

Emotional Labor at the Meadows

Visitors to the Meadows first enter a foyer just inside the main front doors. There is a set of double doors separating the foyer from patient care areas; one must check in with a receptionist before going through. The receptionists deal with visitors and serve the top administrative staff of the nursing home, whose offices are behind a closed door separating the foyer from the administrative area. Visitors cannot see the top administrator without an appointment, nor can a resident of the Meadows easily come through the heavy double doors, which are always closed. Top staff at the Meadows rarely leave this area, spending most of their time on their side of the double doors. Top staff at the Meadows dress in business attire and take pride in operating a well-run nursing home. During our first conversation, the administrator took pains to emphasize the quality of her management team. I soon learned what she was talking about, because before agreeing to allow me to conduct my study, the administrator asked me to give a formal presentation to the top staff. This group of 9 or 10 department heads and other management staff grilled me extensively and perceptively on the purpose, questions, methods, and ethical dilemmas of the research before convening privately to discuss their decision. Thus my entrance into the field at the Pines was much more formal than at the other two facilities.

Initially I did not view the formality of top staff at the Meadows as particularly significant; however, I soon discovered that it reflected an ethos of professionalism (Becker, 1970; Ritzer, 1971) that differed sharply from the other two facilities and that was deeply extended throughout the organization. I began to realize this during my training period, right before I began to spend time on the floor. I was trained by Cindy, an RN, and one of three nursing shift managers. I watched videos instructing me on such topics as proper hand-washing techniques and the approved methods of making patients' beds. Afterwards, Cindy said:

The most important thing is to be professional. I'm always telling the aides, you're here to be a professional and you need to act like one. This is the residents' home, but it's not your home. A lot of the girls don't understand this. They have problems at home, some of them have hard lives. But when you're on duty, your problems are supposed to be left outside the front doors of this facility. The residents have their own problems, they don't need to know about yours. I tell the girls constantly, you're here to care for the residents, not to talk to them about your boyfriend or your bills or whatever is bothering you.

A few days later, at a brush-up training for nurse's aides on the subject of perineal care, Cindy made much the same speech. My subsequent observations of care interactions led me to conclude that management's obsession with this notion of professionalism was a key source of emotional labor for nurse's aides at the Meadows.

Management's concern with "being professional" created two kinds of requirements for emotional labor. First, the injunction against talking about one's own problems also served as a prohibition against talking about one's own feelings, especially about residents' behavior. In practice this often meant putting up a front, or engaging in self-consciously inauthentic relations with patients. Only in private, or out of residents' earshot, could "unprofessional" feelings be tolerated. Consider an interaction I observed one morning between Karen, a young nurse's aide on the day shift, and Martha, a 60-year-old resident receiving "total care" (meaning that aides did everything for her—feeding, bathing, dressing, toileting, etc.). Karen's job was to get Martha washed, dressed, out of bed, and help her use the bathroom. Because Martha was continent, Karen asked her at the beginning of the process whether she needed to use the bathroom. Martha said, "No, honey, I'm fine." Washing Martha, dressing her, and getting her into her chair was a process requiring about 15 minutes and considerable physical effort. Finally, Martha was in her wheelchair, dressed, and Karen, slightly winded, said "OK, Martha, you're all set!" At this point, Martha announced, rather smugly, "I just had a bowel movement." This was no accident—Martha,

unlike many other residents at the Meadows, was continent, and she could have told Karen at any point that she needed to go. However, she deliberately waited, said nothing, and then soiled herself so that Karen would have to repeat the entire process.

Karen reacted calmly, as if nothing out of the ordinary had happened, and went through the entire process again without complaint. Later, in private, however, she said, “Martha pulls that kind of stunt all the time. She loves being able to make you do everything twice.” When I asked her how she felt about that, she replied, “It drives me nuts! I don’t have time to play these kinds of games . . . but what can you do? You have to be professional. It kind of goes with the territory. You have to just do the job and move on.” Karen’s understanding of “being professional,” in other words, did not include engaging in open discussion with Martha about the real reasons for her behavior but instead meant accepting that behavior in Martha’s presence and limiting open criticism of it to occasions when Martha was no longer in earshot. This version of professionalism thus required the caregiver to act as the uncomplaining target of rather unpleasant and abusive behavior by patients who dealt with their—very real—frustrations about declining health and control over their daily lives by taking their anger out on the caregiver. This was rationalized as one of the requirements of “being professional.” This observation is similar to Lively’s (2001) finding that paraprofessionals use their beliefs about professionalism as a way of coping with negative work situations, and to her observations about front-stage—backstage dichotomies. Here, however, “professionalism” is not merely an individual coping strategy but an organizational one.

This clearly fits Hochschild’s definition of *emotional labor*: Workers were required to bring their emotional displays into line with specific managerial expectations, regardless of the behavior of the client. This emotional labor, far from enhancing care from the recipient’s point of view, actually undermined it, in two ways. First, expecting caregivers to pretend that behavior like Martha’s was perfectly acceptable violated principles of reciprocity and mutual respect that should characterize healthy human relationships, including caring relationships. And second, the real needs of the patient went unmet, her legitimate anger and grief ignored, suppressed under a veneer of civility and politeness. Nursing home residents have a number of good reasons to feel angry and resentful, such as the loss of their homes, their independence, and their health, to name just a few of the innumerable losses they commonly must endure (Diamond, 1992). Encouraging or requiring workers to respond with a kind of detached politeness to residents’ attempts to signal their unhappiness and pain—similar to the detached concern that medical

students must learn to project (Becker, Geer, Hughes, & Strauss, 1961)—may serve a managerial interest in smooth, predictable institutional functioning, by allowing the institution to code residents' behavior as deviant while eliminating any necessity of attempting to ascertain or meet their actual needs. This emotional labor, however, cannot be understood as coincident with good care.

The “professional” view of care at the Meadows also created requirements for a second kind of emotional labor—learning to normalize and remain detached from organizationally imposed suffering. The Meadows was committed, quite rightly, to a rehabilitative model of care in which residents were supposed to be encouraged to do as much as possible for themselves. In practice, however, this often meant forcing residents to do things they did not want to do. For example, residents were not allowed to remain in bed all day unless it was absolutely medically necessary. Residents were, therefore, dressed and put in wheelchairs on the theory that being up in a chair was better for their health. However, many residents wanted nothing else than to go back to bed. In one case, a very frail 93-year-old man with severe back pain followed me around all morning in his electric wheelchair begging me to let him go back to bed. I was not permitted to move patients from chair to bed, so I told him that I would let his aide know he needed help. When I talked to the aide, Theresa, she said

Yes, Mr. White always wants to be in bed. He's getting meds for the pain but he still has it. We're supposed to keep him up for at least two hours no matter what. So just tell him that you're not allowed to put him to bed and that he has to stay up until after lunch.

Mr. White was neither demented nor confused. He was, in the parlance of the nursing home, “alert and oriented times three” (aware of the details of person, place, and time). He understood quite well that staying in bed would hasten his decline; however, he found the level of pain he was experiencing to be unbearable. Charge nurses at the Meadows imagined, based on a self-assured belief in their own superior medical-technical expertise, that they knew better than the patient what was best, and how much pain was too much.

This policy created emotional labor for the direct caregivers who had to enforce it. Later on in the day, I had another chance to talk to Theresa. She said

Sometime I think, what if it was my dad, or what if it was me? I'd want to be able to make that choice. But his care plan says we have to keep him up for 2 hours, so we do. If I put him back in bed I'd get in trouble for it.

I asked her how she dealt with his pleading, with the fact that he doesn't understand why he can't go back to bed. "Now you see what we have to deal with in this job," she said. "It's one of the hardest things there is. You just have to learn how—you can't let it get to you too much, because if it did you'd never last." Theresa viewed the successful performance of emotional labor, in this case the suppression of emotions that might be stirred up by the visibility of residents' unnecessary suffering, as the key to avoiding burnout. On one hand, this fits with Hochschild's (1983) contention that workers who are "too involved" may be at higher risk for burnout; the implication is that it is better for workers to maintain a healthy separation between their private and work identities. On the other hand, it is hard to view the ability to remain impassive in the face of unnecessary human suffering solely in terms of a healthy separation between private and work identities. When one's clients are being brutalized by the organization, accepting this situation as normal may undermine the worker's humanity as well.

So far I have described two ways in which the Meadows' managerial approach created emotional labor for caregivers. This process has its obverse as well: Managers' priorities also inhibited the development of caring relationships between aides and residents. In other words, the same managerial approach that created emotional labor also undermined emotional care. In particular, nursing supervisors at the Meadows were very concerned, as conscientious managers, about frontline caregivers' use of time. Indeed, it would not be too far off the mark to say that they were obsessed with it. Charge nurses periodically swept through the facility looking for evidence of shirking. They wanted to see aides, housekeepers, and nurse aide assistants "working," moving from room to room. During the orientation I received before being permitted to spend time on the floor, I accompanied Cindy (the RN who trained me) on one such round. As we made our way from floor to floor, she grew increasingly angry as she observed things not done to her specifications. When she checked the shower room for any shirking employees, she noted with outrage that a resident's personal items (shampoo, ice water mug) had been left there. "This is *unacceptable!*" she fumed. "See this? It doesn't have the resident's name on it. Now how are we supposed to make sure that it gets back to the right person?" By the time we arrived at the door of a residents' room where two aides were sitting together in conversation with the residents whose room it was, Cindy was livid. The aides, seeing Cindy, jumped up immediately, caught in the act of socializing with residents instead of working on them. It was clear they knew they'd been caught doing something "wrong." This only annoyed Cindy further. She gave them written disciplinary warnings that would go in their personal files—for the errors of the shower room and for being caught sitting. Afterwards, she grouched to me

“I understand this job isn’t always fun, but when you’re here you’re being paid to work, not to sit around and gossip. There’s always something that needs to be done.”

The point is not that Cindy was unreasonably concerned about the issue of unmarked personal items being left in the shower room. However, as Henderson (1981) observes, real human relationships are composed of meandering conversations, nonpurposive interactions, and time spent together, that is, of sociability. The dominant managerial approach at the Meadows ignored these critical dimensions of healthy human relationships, in the process reducing the idea of “care” to the physical tasks involved with caring for people’s bodies (Diamond, 1992; Foner, 1994). Sitting and conversing with residents was not viewed as part of good care but as a dereliction of duty. Thus, emotional labor at the Meadows went hand in hand with a narrow conception of care that actively discouraged the flowering of meaningful relationships that characterize organized emotional care.

Emotional Care and Emotional Labor at the Lakes

In contrast to the Meadows, managers and nurse supervisors at The Lakes never mentioned the idea of “acting professional.” Managers did not talk about the importance of hiding one’s own feelings or problems but rather about the importance of connecting with residents and building relationships with them. Top staff at the Lakes, perhaps not coincidentally, spent much more time in patient care areas than did their counterparts at the Meadows. They knew the residents better, spent more time talking to floor staff about them, and explicitly adopted a holistic view of care that led them to introduce a series of new organizational rules and routines.

Some of these new organizational routines were small changes with important consequences. One such change was that a large photograph of each resident as a young, healthy person was affixed just outside the door to his or her room. This change was aimed at helping direct care staff see the residents as they saw themselves—and indeed, I found that it did have an effect on how I viewed the residents I met. Instead of seeing them only as they now were—wrinkled, immobile, dependent—I was able to see glimpses of the younger people they once had been. These photographs led to all sorts of questions about residents and provided the basis for conversations about the past that might not have taken place otherwise. The Lakes’ systematic use of the photographic image as a kind of “planned spontaneity” thus represented a perceptible shift away from requirements for emotional labor and toward organized emotional care.

Other rules at the Lakes clearly reduced the amount of emotional labor that nurse's aides had to perform. One such set of rules had to do with residents' ability to make choices for themselves. The Lakes had an entirely different policy from the Meadows in this regard. Instead of imposing care that was necessary from a physical point of view based on the medical and technical knowledge, charge nurses at the Lakes explicitly instructed aides and other direct caregivers to respect residents' decisions to the maximum extent possible. The case of Mrs. Johnson provides a clear example. Mrs. Johnson was a relatively healthy resident who, despite having no serious physical maladies (except for paralysis of the lower extremities), never left her bed. I discovered this when, acting on instructions from the activities director, I was going round inviting residents to come play Bingo in the dining room. Mrs. Johnson said primly "No, I don't go to activities. I prefer to stay here in bed! I've been in this bed for 9 years and that's where I'm going to stay." In the entire time I was at the Lakes she never did leave her bed. The official view of Mrs. Johnson was that, of course, it would be good if she could be convinced to leave her bed and eventually her room, and staff were to continue encouraging her to do so; however, ultimately she had the right to decide where she wanted to be. These rules reduced the amount of emotional labor aides had to perform by reducing the number of situations in which nurse's aides had to impose unwanted care on residents and harden themselves against residents' piteous protests.

Top staff at the Lakes were, in general, more conscious than their counterparts at the Meadows of the social roles staff played in the lives of residents. This, of course, applied to nurse's aides but also extended even to positions in the housekeeping department. Managers at the Lakes explicitly viewed housekeeping as a job that provided opportunities for meaningful relationships between housekeepers and residents, and housekeepers were encouraged to view the time they spent in each resident's room as important for its own sake. Indeed, housekeepers were encouraged to use all of their allotted time in each room, just sitting and chatting, if the cleaning was finished, before going on to the next one. "That is important social time," a nurse supervisor said. "We don't see that as loafing or slacking." Thus, there were managerial expectations at the Lakes that workers would attempt to form relationships with residents. Workers were even evaluated, in part, on this basis. For example, management identified as the Lakes' best housekeeper not the most efficient cleaner but rather one who was best at developing caring relationships with residents.

A key question, however, is whether this new emphasis on relationships between staff and residents meant that staff were simply subjected to new requirements to perform emotional labor. There are two related answers to

this question. First, managerial expectations about relationships between staff and residents at the Lakes did not fit key aspects of Hochschild's notion of emotional labor. Emotional labor in Hochschild's formulation is a one-way relationship: Workers are supposed to accept whatever customers dish out. They are supposed to view their wage as compensation for the emotional abuse they receive at the hands of customers. At the Lakes, however, I observed explicit managerial support for emotional honesty in staff-resident relationships, something I never saw at the Meadows. In contrast to the Meadows—where workers were clearly expected to pretend that residents' behavior was never a problem—at the Lakes, workers were permitted to deal with situations more openly, and to enforce limits on the sort of behavior they would tolerate.

An incident from my second day on the floor at the Lakes illustrates this. I was working with Liza, a housekeeper who worked on the "skilled care" wing—the area of the nursing home with the sickest residents. Not long into our shift, an aide found us and told us that a cleanup was needed in Mr. Rice's room, at the end of the hall. Mr. Rice suffered from diabetic blindness and was not happy about being blind or living in a nursing home. He had urinated on the floor of his room—a frequent occurrence despite the fact that he was fully continent. When we arrived to clean it up, he began to curse foully at Liza. Liza took it for a moment as she began to clean; however, when Rice's verbal assault did not let up, she straightened up and said

Now, look, Mr. Rice. I don't mind cleaning up, that's my job, but I'm not going to do it while you yellin' at me like that. If you can't talk to me civilized, then I'm goin' out and waiting in the hall till you ready to behave.

She then led me out the door.

Mr. Rice continued his barrage from inside the room, where his aide repeated, "Mr. Rice, she ain't comin' back in here till you be nice." Finally, Rice said, "All right, all right, tell her to come back in, I won't say nothing bad." And he did remain civil while Liza and I cleaned up. Liza then rewarded him by being extra nice back (thus offering him a voluntary emotional gift exchange; Bolton & Boyd, 2003), and Rice did not repeat his behavior the rest of the time I was at The Lakes. Liza later said to me, "Mr. Rice has got it pretty rough. He's mad at the world. I would be too if I was in the shape he's in. But, you know, you can't just treat people like dirt." In contrast to Karen's private venting about Martha's passive-aggressive behavior at The Meadows, in other words, Liza actually had a very sympathetic understanding of Mr. Rice and his motivations—however, she refused to let him use his misfortunes as an excuse to mistreat her. And in this, she was fully

supported by the charge nurse on the floor that day. In contrast to Hochschild's notion of emotional labor, in other words, at the Lakes managers did not attempt to dictate to Liza how she was supposed to feel about Mr. Rice; instead, they supported her emotional honesty, her sense that it was time to stand up for herself and not allow Mr. Rice to use her unfairly as a target for his frustrations—a key element of the distinction I am attempting to make between organized emotional care and Hochschild's notion of emotional labor.

Second, as Bolton and Boyd (2003), Tolich (1993), and Uttal and Tuominen (1999) have shown, emotional relationships with clients are often more complicated and nuanced than the notion of emotional labor implies. Even in work situations where managers are attempting to extract emotional labor, workers and clients are often capable of constructing and enjoying relationships that are experienced as belonging to the participants and not to the organization. At the Lakes, those relationships created their own motivations for caring. Consider the relationship between the housekeeper Maggie and Daniel, a young man who had been left permanently bedridden and brain injured by an automobile accident. Although his speech was slurred and distorted, and his motor skills severely compromised, Daniel was capable of feeding himself and drinking his own water through a straw. During one of my shifts with Maggie, we entered Daniel's room to find him struggling with some food that he had spilled on his blanket. In his efforts to clean it up, he had also knocked over his water cup, spilling ice water over his bedside table and onto the floor. Our jobs as housekeepers nominally required us to clean up the mess. In addition, we were there to empty the trash, sweep and mop the floor, clean and stock the bathroom, and disinfect surfaces.

However, listing the tasks this way hardly describes the reality of Maggie's interaction with Daniel. Daniel was upset, embarrassed, and agitated by the mess and also frustrated by his physical limitations; he needed immediate help. He was clearly relieved to see Maggie, and she was—despite the crisis—genuinely glad to see him. She gently cleaned up the spill, joking and talking with Daniel all the while. I couldn't understand much of what Daniel said because his speech difficulties were quite severe—but Maggie understood him readily, decoding his request for his favorite plastic sippy-cup, whose whereabouts were not immediately evident. Maggie could have simply told Daniel that she didn't know where the sippy-cup was; however, instead she spent nearly 10 minutes trying to find it for him—rummaging through his cabinets, searching high and low in his room. In the end, she found the cup—it had been mistakenly returned to the kitchen with his breakfast tray. Daniel's relief and gratitude for Maggie's efforts was palpable and, in the context of their relationship, constituted an important intrinsic reward

that cannot be reduced to considerations of managerial rules for emotional labor.

This example also serves as a reminder that, unlike the service-work settings studied by Tolich (1993) and Bolton and Boyd (2003)—or even the child care settings studied by Uttal and Tuominen (1999)—nursing home workers like Maggie confront horrific human suffering on every shift. The concept of emotional labor offers no place for compassion in response to suffering because it views the relationship between worker and client as having no independent reality apart from the exploitative employment relation. Hochschild's analysis of emotional labor as exploitation parallels Marx's analysis of alienated physical labor, leading her to view withholding emotional labor as the obvious and natural way for interactive workers to reclaim control over the self. However, the dramaturgy of this view assumes a particular view of the worker-client relationship—that clients are powerful agents who neither deserve nor really need workers' empathy—that is quite inappropriate in the nursing home setting. It is one thing, after all, for flight attendants to withhold smiles—and quite another thing for a nurse's aide or housekeeper in a total institution to withhold compassion from the elderly who are sick and disabled. The employment relation itself may, indeed, be exploitative in the economic sense—but managerial support for Maggie's effort to take extra time to calm Daniel and solve his immediate problem (in stark contrast to the behavior of nursing home managers and supervisors studied by Diamond, 1992; Foner, 1994; Gubrium, 1975) is more properly understood as a form of organizational support for compassion (Frost, Dutton, Worline, & Wilson, 2000) than as a requirement for emotional labor.

In sum, the Lakes had a number of organizational rules and procedures that tended to facilitate the development of caring relationships between staff and residents, and the resulting organized emotional care was quite distinct from Hochschild's notion of emotional labor. However, this did not mean that workers at the Lakes performed no emotional labor. A key source of this labor was the plight of residents who were socially isolated. Only about 25% of residents attended organized activities, and there was no organized effort to meet the social and emotional needs of residents who were less mobile, or more depressed, who did not attend activities or receive regular visitors. As a result, as I walked the halls I passed many rooms containing residents who sat glumly on the edges of their beds for hours at a time. These residents were often desperate for sustained human contact, a fact I experienced directly as I performed housekeeping work or accompanied aides. Indeed, I found it difficult to leave residents' rooms because so many of them were so starved for interaction that they would keep talking continuously in an effort to keep me there. I often found myself lingering behind, unsuccessfully trying to find an

opening to say, “OK, it’s been great talking with you but I’ve got to catch up with [whoever I was working with].” Finally I asked an aide how she managed to get out of residents’ rooms when she was done with her work. She laughed and said, “It’s been hard for you, hasn’t it? Well, you just have to interrupt them. . . . If you didn’t, you’d never get through the day because some of them would keep you in there talking for hours.” Unlike management at the Meadows, which emphasized professionalism over sociability, management at the Lakes supported sociability but did not ensure that staff and residents who were socially isolated had sufficient opportunities to engage in relationship building. This resulted in unacknowledged emotional labor as workers at the Lakes had to learn to close themselves off to the loneliness and desperation of many residents.

Indeed, sticking to safe, superficial topics was a crucial coping mechanism for nurse’s aides, social workers, and housekeepers alike (Henderson, 1981). Conversation was generally limited to topics such as the weather outside, what was for lunch, what the resident was watching on television, or directive talk about the job at hand. As soon as the job was done—resident toileted, dressed, or fed—the aide or housekeeper delivered a cheery “OK, you’re all set. I’ll see you later” and was gone. This observation accords with the well-established finding that “good cheer is a way of winning the battle for control” especially with difficult customers (Rafaeli & Sutton, 1990). In this case, the cheery, brisk tone was a way of defusing or forestalling any sadness, grief, or other emotion that would be difficult to escape from or deal with quickly. Despite their obvious affection for the residents they cared for, workers at the Lakes could rarely afford to venture far in the direction of serious topics like feelings of loneliness or grief because these are not subjects one can discuss in 10 minutes and then wrap up in time for a neat exit. Managing the interaction from start to finish, keeping things “light” so that timely exit would be possible (see Gubrium, 1975) was thus a crucial, even self-protective form of emotional labor made necessary by the Lakes’ organizational shortcomings.

Organized Emotional Care at the Pines

Many aspects of managerial practice at the Pines were similar to the Lakes: support for mutual respect between caregivers and residents, respect for residents’ right to make choices about their lives to the extent that they are able, and informal understandings of job duties that gave special attention to compassion and kindness. For reasons of space, I will not belabor those points here but instead focus on the respects in which the Pines had developed organized emotional care in directions that the Lakes had not. To ensure

that the residents who were most socially isolated did not fall through the cracks, the Pines deployed organizational rules, procedures, and record-keeping in a far more systematic manner than at the Lakes.

In contrast to the Meadows, where I'd had to take a TB test and was taught how to make beds, and the Lakes, where I got no training at all before spending time on the floor, at the Pines I was required to watch a training video demonstrating the proper procedures for transporting residents who were wheelchair bound. The video not only dealt with safety issues such as using wheel locks when assisting patients in and out of the chair but also contained instructions for interacting with patients: wherever possible staff were supposed to ask patients where they would like to go. Rather than simply wheeling a patient off to an outing or field trip or to the dining hall, staff were supposed to make sure that the patient really wanted to go. In cases where transport was necessary (e.g., to take a patient to a physical therapy appointment), staff were supposed to make sure—again to the extent possible—that the patient knew who the staff person was, where they were going and why. The existence of these clear rules at the Pines thus maximized residents' ability to control their mobility and to understand what was happening to them.

Insofar as these procedures constituted a "detailed prespecification of conduct" (Leidner, 1999, p. 87), they can be considered as an instance of the routinization of interactive work (Leidner, 1993, 1999). These routines were not as tightly scripted as the routines that McDonald's employees are required to recite; however, they were fairly specific. Leidner (1993, 1999) regards routinization as analytically distinct from, but deeply connected to, emotional labor. Routines consist of interaction scripts and often specify feeling rules as well. Thus, routinization is one of the ways firms extend bureaucratic control over interactive workers' selves (Leidner, 1999). Routinizing service work is thus a way of standardizing emotional labor. However, although this often is the case, I believe the example described above illustrates how routines and interactive work can, in some instances, organize emotional care rather than impose emotional labor. In this case, the routine did not impose feeling rules or attempt to extract specific emotional displays or underlying feelings from workers. Instead, it reminded workers of the basic humanity of nursing home residents: an elderly person in a wheelchair is not a thing to be moved here or there as the routines of care require (something I observed at the Meadows) but a human being who needs to be consulted, to the extent possible, about his or her wishes. This did not create a specific "affective requirement" (Bulan et al., 1997) but rather represented an organizational refusal to dehumanize the patient. In a narrow sense, we can view this as a reduction in workers' autonomy; however, this view misses the larger point that seeing the elderly patient as a human being rather than as a

mere object of work also enables the caregiver to retain her or his own humanity in a potentially dehumanizing situation. Creating routines and even interaction scripts aimed at undermining assumptions about those with cognitive deficits is thus not, in my view, an example of emotional labor. Rather, by encouraging workers to relate to residents who are cognitively impaired as persons, the new routines at the Pines created new possibilities for meaningful relationships—and it is in this sense that I view them as part of the Pines' commitment to organized emotional care.

In addition to new routines that organized emotional care, the Pines also developed the idea of “planned spontaneity” further than had the Lakes, by implementing a program encouraging residents—regardless of their abilities—to keep birds in their rooms. Not everyone wanted a bird, of course; however, nearly one half of the residents enjoyed having a live creature of their own to care about and talk to. This was a complex policy change requiring the facility to develop new rules, schedules, positions, and procedures. The Pines had to negotiate with housekeepers who were concerned about the birds increasing the amount of work they would need to do in each room. Procedures needed to be developed to integrate the birds into the housekeepers' routines. Birdseed, along with material from the birdcage floors, tended not to stay in the birdcage. When on the floor, this material was initially tracked everywhere throughout the facility, and housekeepers were constantly sweeping it up. The problem was solved by placing rubber trays with raised edges under each birdcage; these would contain any fallout and could be emptied and cleaned daily, saving housekeepers from having to fight a constant, losing battle with the birds. In addition, because the vast majority of patients were not able to fully care for their birds, a new half-time position also had to be created for an animal keeper to feed and water all the birds in the building, and to maintain new relationships with suppliers of birds, birdcages, and feed. These new organizational routines created new opportunities for spontaneous socializing as residents talked to, and about, their pets.

If organizing emotional care often meant creating new routines, new procedures, and new rules, it also meant allowing more organizational flexibility. Consider the case of Robert, a gentleman who was able to walk with a cane and who functioned at a cognitively high level. When he first came to the Pines, he was quite despondent and angry, and even engaged in several physical altercations with staff and with other residents. Activities staff realized that a major part of Robert's anger stemmed from his feelings of uselessness. He'd been living independently and had a fierce sense of pride in that independence, which had been now taken away. Social workers, therefore, decided to ask Robert if he would be interested in serving as a greeter at the main entrance of the nursing home. His “job” would be to greet visitors and

residents and to open the door for people going in and out by pressing a button. Robert eagerly accepted this offer, and each day he spent part of his time at the front door. His role quickly became an important part of the identity of the nursing home, and his ability to banter with people as they passed through the front doors was legendary. Everyone had their own stories about Robert and the witty things he'd most recently said to them at the door. One of the social workers at the Pines commented:

I think if we hadn't come up with [the role of greeter], he wouldn't have made it. His weight was declining, he wouldn't eat, it looked like a classic case of failure to thrive in the nursing home environment. Plus, he was dangerous to be around. But since he's taken on this role, he's like an entirely different person.

However, the Pines' approach to activities went beyond creative thinking on an individual level about how to meet residents' specific social needs to the systematic employment of bureaucratic rules and procedures in the service of emotional care. The centerpiece of this effort was a formal system of classification, according to which residents were grouped into four categories or "clusters" according to their level of social functioning. Cluster One consisted of "alert and oriented" residents who were able to move about freely on their own or with some assistance, who attended activities, maintained friendship networks, and so on. Cluster Two consisted of residents who suffered from disorientation or mild dementia or who were unable to leave their rooms for physical or psychological reasons; Cluster Three were residents who suffered from serious forms of dementia; and Cluster Four were residents categorized as "unresponsive," like the group described at the beginning of this article. This classification scheme was deployed in two ways that set the Pines apart from the Lakes and the Meadows: first, it affected the way the activities department understood its role, and second, it was the basis for a program of organized social visits. Staff kept detailed records about who would attend events in the main dining room but needed help getting there, and they divided up this list among activity aides to make sure that no one was left out or overlooked. In addition, they also created separate activities for residents in each of the different clusters.

Each weekday between breakfast and lunch, and again for a few hours between lunch and supper, a group of about 20 members of Cluster One gathered in a common room to make pillows and cushions. The pillows were stockpiled until the county fair each year and then sold to raise money to support recreational activities. As I spent time with residents working on the pillows I learned why it was the perfect activity for these men and women. These working-class people had spent their lives in factory and farm work—

and the last thing they wanted to do was sit around with nothing useful to do. They were tremendously proud of the way they contributed to the common life of the home by making and selling pillows, and they enjoyed the routine of the task and the conversation and camaraderie that went along with it. As it happened, my fieldwork at the Pines coincided with the county fair, so I was able to participate in the field trips to the fairgrounds. Activities staff spent weeks in advance planning these trips so that everyone who wanted to go to the fair would have an opportunity. I assisted with transporting residents to the bus and around the grounds at the fair. Residents—even those who did not work on the pillows—were eager to get to the building with the nursing home's pillow display, see the pillows that were for sale, and inquire as to how they were selling.

Making pillows was an activity enjoyed by many Cluster One residents; however, it required physical and mental abilities not possessed by those in Clusters Two and Three. These residents also wanted to feel useful. Therefore, folding rags was a daily activity for Cluster Two residents. When they were finished, nursing home staff unfolded them so they could start over. This might seem pointless (or even demeaning), but in fact this activity was perfectly matched to residents' abilities and needs. This "work" gave Cluster Two and Three residents a crucial sense of purpose and encouraged them to use their hands and arms, thus meeting physical needs as well. Taken together, the organized activities that residents from Clusters One, Two, and Three participated in maximized the ability of residents to find sociability in one another, thus reducing the extent to which staff functioned as the sole or primary opportunity for social interaction.

However, even these efforts did not meet the needs of residents who either refused to leave their rooms or who were involuntarily bedfast. Therefore, Pines staff kept detailed charts, not only on which organized activities residents participated in but also on how many visitors they had and whether they left their rooms. They used these charts to identify the people in the nursing home who were most socially isolated. This way staff could make sure that residents with fewer family visits got regular one-on-one visits from staff to compensate. These visits were organized but nonscripted. Staff doing one-on-ones had a list of residents to visit and a few general topics of conversation in mind but were free to let their conversations take whatever paths seemed natural. Thus, the one-on-one visiting program, like the small-group session described at the beginning of this article, was explicitly conceived as an organized set of opportunities for the development of caring relationships.

My discussion of the Pines' efforts to organize emotional care has emphasized the role of the activities department and activity aides over the role played by frontline staff, nurse's aides, and housekeepers. This emphasis is

not intended to indicate that frontline staff at the Pines did not participate in organized emotional care. Indeed they did, and in much the same way as at the Lakes. I emphasize the role of the activities department at the Pines because this was the Pines' main way of reducing residents' unmet needs, and thus making it easier for aides and housekeepers to provide emotional care in the course of their work—without having to work so hard to keep up their emotional defenses. As a result, frontline staff did not have to close themselves off as much to the unmet social needs of residents they cared for. Whereas aides and housekeepers at the Lakes had to constantly resist the pull of residents who were desperately lonely—for whom their 15-minute interaction may have been the only human contact during an 8-hour shift—their counterparts at the Pines knew that even their residents who were most socially isolated would have other opportunities for social interaction on any particular shift. This is not to say that residents at the Pines who were socially isolated did not suffer from loneliness. Rather, they had more outlets for relieving it. They were not forced to spend so many hours looking forward to a single all-too-brief interaction with an aide or housekeeper but generally had multiple interactions to look forward to. The difference is impossible to quantify; however, it was directly observable: In the shifts I spent at the Pines doing housekeeping work and shadowing aides, I simply did not experience the same level of frantic desperation for human contact among the residents whose rooms I entered, even those who were room bound and/or had no family support. Interactions with such residents at the Pines were noticeably more relaxed, more pleasant, and required less emotional labor—and the Pines' activities program was an important reason for this difference.

Discussion

In this article, I have posited a distinction between emotional labor, with its coercive organizational feeling rules, and organized emotional care, with its organizational support for emotional authenticity. I have tried to demonstrate here the utility of this distinction by showing how three extremely similar work organizations can be plotted on a continuum of organizational approaches to the management of feelings in nursing home work. At one end of this continuum, at the Meadows, workers performed emotional labor, bringing their feelings and outward displays of emotion into line with managerial requirements. At the other end of the continuum, at the Pines, workers entered into systematically organized relationships with the people they cared for, but within broad limits (defined by abuse or neglect) the emotional content of those relationships was not dictated by management. In between

these two contrasting cases, at the Lakes organized emotional care and emotional labor coexisted. These three organizational approaches led to distinctly different styles of care. At the Meadows, workers not only experienced their interactions with residents as inauthentic but also moralized privately about residents' behavior. At the Lakes, frontline staff (aides and housekeepers) experienced many aspects of their interactions with residents as authentic but were compelled by organizational imperatives to ignore much of residents' loneliness and emotional suffering. And at the Pines, frontline staff not only experienced their interactions with residents as authentic but also were spared emotional labor by the presence of an expanded activities program that provided residents with alternative opportunities for sociability.

Conclusion

I tried to demonstrate that these three organizations manage the emotional aspects of care work differently. Offering organizational support for emotional honesty is obviously not the same as requiring workers to practice the emotional detachment called professionalism at the Meadows. However, it might be objected: Is it really necessary to introduce a new concept to capture this difference? Could not the concept of emotional labor accommodate the differences among my three research sites—perhaps by reframing the analysis in terms of the different levels of autonomy with which emotional labor is performed? I would like to make it clear here why I do not think so—why I believe, in other words, that the distinction I draw in this article is not only plausible and useful but also is very much a necessary one for the sociology of work.

To see this, we need to return for a moment to the concept of emotional labor. Hochschild assumed from the beginning that emotional labor (as emotion work performed for a wage) would always mean bringing one's feelings and outward displays into line with managerial or organizational requirements. Hochschild clearly viewed these two elements as inseparable and fundamental to the definition of the concept. Emotional labor consists in the efforts workers must perform to align their inner feelings or outward displays with managerial dictates. This is why she viewed emotional labor as fundamentally coercive—and why she viewed with pity workers who experienced their customer- or client-oriented, on-the-job emotion management as authentic. Unfortunately, as discussed earlier, subsequent studies found—contrary to Hochschild's expectations—that such workers often could not be viewed as unduly influenced by management; indeed, as Paules (1991) and

others showed, it was often quite the opposite. This led scholars to look for new answers to the question of which conditions might allow interactive workers to experience their emotional labor as authentic. Leidner (1999) argued, for example, that “not all employers explicitly direct and monitor the emotional labor of their interactive service workers” (p. 84), adding that some employers “may feel that they can count on workers to provide appropriate emotional labor on their own” (p. 84). In consequence, in some situations workers may “regulate their own emotional labor” (p. 84). Wharton (1993, 1999) has advanced a similar argument: Workers with job autonomy are more likely to experience their emotional labor as authentic. Thus, “emotional labor is problematic for workers when employers control its performance” (Wharton, 1999, p. 168) and, presumably, less problematic when workers control it themselves.

The trouble with these arguments is that employer control over workers’ emotional displays and inner feelings was a central element of the original definition of emotional labor. By definition, it was not autonomous; by definition employers did require it; by definition employers did control it. That is, in fact, what distinguished it from the private emotion management that everyone does in his or her everyday life. Ideas about autonomous emotional labor, or emotional labor provided by employees whose employers do not require it, appear oxymoronic as long as we are still using Hochschild’s original definition of the term. If workers are compelled to bring their feelings into line with managerial requirements, then their actions are not autonomous. On the other hand, if they are permitted to act autonomously, according to their own evaluations of what their work situations require, then they are not compelled to display particular emotional states, and whatever they are doing can no longer be called emotional labor in Hochschild’s sense of the term. Certainly, questions such as how closely employers have to supervise and direct workers to ensure that they do, in fact, produce the desired emotional displays, or what tactics employers use to guarantee the desired results, are obviously legitimate ones for a theory of emotional labor—but treating emotional labor as something that can be separated from employer requirements robs the concept of its original specificity and turns it into a kind of catch-all category for the emotional aspects of interactive work. Concepts do have a way of expanding over time to fill the available theoretical space—but dealing with empirical anomalies by emptying theoretical concepts of their specific predictive content is exactly the wrong way to go. That is why, when we recognize the fact that, contra Hochschild, service work organizations do not always impose feeling rules on interactive workers, we need a new concept for those situations in which organizations actively support emotional honesty and authentic relationship building. Emotional labor

is, as has been documented time and again, a reality in contemporary workplaces. However, as I have tried to demonstrate here, emotional labor is not the only organizational strategy for managing the emotional aspects of interactive work. The notion of organized emotional care thus advances the field by specifying a second such strategy and delimiting it from emotional labor.

That said, I do think organized emotional care is more relevant to care work settings than to other kinds of service work. It is difficult to imagine how or why a supermarket chain, for example, would pursue a strategy of organized emotional care. In such contexts, where large numbers of customers want to get through lines quickly, relationship building between service provider and recipient is unlikely to become the focus of the organization (see Gutek, 1995; Gutek, Cherry, Bhappu, Schneider, & Wolf, 2000, for typologies of service encounters and service relationships). Thus, rather than suggesting that organized emotional care is a viable organizational strategy in a wide variety of customer service situations, I would suggest instead that the viability of organized emotional care as an alternative to emotional labor in at least some care work settings may help future studies to clarify further what makes care work different from other kinds of interactive service work.

I admit, too, that organized emotional care may not be found very often unalloyed, even in care work settings. The Pines, for example, is almost certainly an outlier in the nursing home industry rather than a representative of some large population of nursing homes all practicing organized emotional care. However, the value of the concept of organized emotional care does not really depend on how common it turns out to be in the world as we find it. Emotional labor is, undoubtedly, the dominant form of organized emotion management; however, as I have tried to show in this article, it is not the only form. Part of sociology's mission as a critical science is to document the existence of alternative possibilities hidden within the dominant social order. If emotional labor represents the dominant social order in the world of care work today, organized emotional care may represent such an alternative possibility with benefits for care workers and care recipients alike.

It is worth recalling in this connection that Hochschild's concept of emotional labor was originally framed around Marx's idea of estranged labor. One way in which Hochschild's analogy to Marx's concept of estranged labor fell short, however, was that Marx's optimism about the possibility of transcending estranged labor, of reuniting the worker with his or her social self through democratization of the economy, was absent. Hochschild's theory of emotional labor was strongly pessimistic in this regard; it seemed clear that the worker would be estranged from his or her emotions in any organizational work setting involving work with customers. In this, her argument par-

alleled not Marx's optimism but Max Weber's (1978) pessimistic conviction about the absolute necessity, for any large-scale industrial economy, of expropriating the worker from the means of production. Although Hochschild did not frame the concept of emotional labor in Weberian terms, like him (though for very different reasons) she viewed the modern economy as something like an iron cage with no possibility of escape. As a result, her work, and much of the literature on emotional labor since, has had no positive vision for work except "resistance." It is my hope that the concept of organized emotional care—or someone else's superior theorization of something like it—might restore to sociology a positive, alternative vision of the organizational aspects of emotion at work.

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