



Edge Hill University

“Danger: Men at Work?”: An exploration of emotional labour of male health/care workers

A thesis submitted for the award of PhD (Health)

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Abstract for PhD Thesis “Danger: Men at Work?”: An exploration of emotional labour of male health/care workers by Imo-Obong Emah

Background:

Men make up about 11% of the care industry (Williams, 2017), and their low engagement in this field has been associated with inability or unwillingness to meet demands for care and emotionality (Guy and Newman, 2004). Similarly, men are poorly understood in studies of emotion management within the workplace (emotional labour) – a practice associated with negative mental health outcomes (Van Dijk & Andrea, 2006). Available studies on men in caring professions largely describe their emotional performances as limited by male socialisation and directed by aspirations to “masculinity” (Cottingham, 2015; Pullen & Simpson, 2009). However, considering the multiple ways “masculinity” can be constructed and the influence of social contexts on masculine identities and norms of emotional expression (Anderson, 2009), such reductive and decontextualized evaluations typically side-line important nuances of individual emotional practices and obscure differences of understandings of between researcher and research participants (Brody, 1999).

Aim:

This study examines the ways in which male healthcare workers perceive, represent and address emotional labour within their respective roles.

Method:

Individual in-depth interviews and photo-elicitation were used to prompt discussions and explore five participants’ understandings and representations of emotional labour. Transcribed audio data was examined through Interpretative Phenomenological Analysis for themes related to content and construction of accounts. Preliminary findings were provided to participants for their authentication and clarification to reduce the influence of researcher’s interpretations.

Outcomes: Three key themes – Identity in Care Work, Emotions in Context and Policy in Care Work – were surmised from interviewees’ accounts in relation to their experiences and perspectives on emotional labour. The dimensions and interconnections of these themes are discussed.

Original Contribution to Knowledge: This project addresses gaps in three overlapping bodies of research: gender and emotions, masculinity and emotional labour. The methodological approach enabled a contextualised interpretation of the interrelated elements of self-direction and socio-cultural

influences in shaping emotional and care practices. This could address some of the limitations identified in literature on masculinity, emotionality and care work, and guide future research and related policy.

Key words: Emotions, Emotional Labour, Care Work, Nursing, Masculinity

Contents

| | |
|--|----|
| Abstract for PhD Thesis “Danger: Men at Work?”: An exploration of emotional labour of male health/care workers by Imo-Obong Emah | 2 |
| Acknowledgements | 6 |
| Preface: What motivated this study?..... | 7 |
| Introduction and Background of Study | 8 |
| Literature Review | 10 |
| Emotions in Emotional Labour..... | 10 |
| Emotions and Gender | 14 |
| The Issue of “Masculinity” | 17 |
| Emotional Labour in the Research Context..... | 22 |
| Research Aims | 26 |
| Chapter Summary | 27 |
| Research Design | 28 |
| Introduction..... | 28 |
| Epistemological Foundations..... | 29 |
| Methods | 31 |
| Sampling and Recruitment..... | 31 |
| Data Collection | 34 |
| Data Analysis..... | 41 |
| Ethical Concerns | 43 |
| Positionality | 47 |
| Chapter Summary | 48 |
| Identity in Care Work | 50 |
| Bob, Your Uncle | 51 |
| Lawrence Nightingale..... | 59 |
| Manfred | 67 |
| Patch Adams | 72 |
| Trevor Keepsakes | 76 |
| Chapter Summary | 81 |
| Emotions in Context..... | 82 |
| Personal Dimensions | 83 |

| | |
|--|-----|
| Relational Dimension | 89 |
| Environmental dimension | 96 |
| Chapter Summary | 100 |
| Policy in Care Work | 102 |
| Boundaries to Emotion: | 103 |
| Contests in care | 109 |
| Values of Care..... | 117 |
| Chapter Summary | 125 |
| Research Outcomes and Impact: Recommendations, Limitations and Conclusions | 127 |
| Methodological Strengths and Weaknesses | 127 |
| Recommendations from Findings..... | 130 |
| Directions for future research | 137 |
| Postface: What happens now? | 139 |
| References | 143 |
| Appendix A: Participant Information Sheet | 160 |
| Appendix B: Interview Topic Guide | 164 |
| Appendix C: Images Selected for Photo-elicitation | 165 |
| Appendix D: Data Management Plan..... | 171 |
| Appendix E: Participant Consent Form | 177 |
| Appendix F: Distress Protocol for: “Danger: Men at Work”? An Exploration of the Emotional Labour of Male Health Care Workers..... | 178 |

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Preface: What motivated this study?

My interest in “emotional labour” arose from my experiences with patient care as a junior doctor: the “bedside manner”, regularly emphasized as an expectation of good clinical practice, was an aspect of my role I often considered an additional demand given the physically and mentally stressful nature of the profession. I found this view to be shared by many colleagues, and despite personal reservations, we indulged in the affective performances with the understanding that it hardly reflected our clinical competencies or aptitudes for care.

This experiential context informed my approach to the research topic, particularly regarding the notion of gendered capacities for managing emotions in working environments. Though I acknowledged some truth in aspects of emotionality depicted in existing literature, my knowledge from the field also contested some of the dominant ideas regarding men’s (in)ability to care. So, I chose to further investigate the subject area, using the blend of my historical familiarity as a health professional and my current “outsider” position as a researcher to interrogate both personal and popular understandings, with an aim to hopefully provide richer insights into the nature of male emotional labour.

The research context of men in traditionally feminine roles made this inquisition even more fascinating, as it offered a background against which any differences of the gendered experience would be cast in greater relief. This dimension of the study equally appealed to another aspect of my biography: a long-held sceptical (and consequently irreverent) outlook towards popular impositions and expectations of gender. This perspective spurred my ambition and approach to exploring the research area, and I hoped my unconventional standpoint could potentially provide alternative interpretations and understandings of the research topic. While some interesting and notable insights emerged over the course of the study – especially critiques of my own considerations and other dominant interpretations – I believe more can be done to better understand this research area. I remain eager to see where future endeavours may lead.

Introduction and Background of Study

Men are under-represented in caring professions and account for only about 11% of nurses both in training and the workforce (Williams, 2017). This proportion has remained relatively stable even with increasing appeals for male recruitment to bridge the gap between demand and supply of care services (Day, 2015; NHS Improvement, 2016). Several studies have explored barriers and enablers to men becoming integrated into care professions, such as gender and sexual identities, institutional and public discrimination (Coleman, 2008; Egeland and Brown, 1988; Evans and Frank, 2003; Meadus, 2000; Meadus and Twomey, 2007). Of the potential barriers, the emotional demands and deferential behaviours required in these roles – features which constitute “emotional labour” (Hochschild 1983) – have been highlighted as an important contributor to poor male engagement and the continued stereotyping of nursing as a “feminine” profession (Whittock and Leonard, 2003). This finding has provided one among several reasons for studies that explore and analyse the actual emotion work that male professional carers do, and its effects on them, colleagues, service users and the quality of service.

In terms of offering emotional investment, earlier studies referencing men who are involved in care have alluded to some form of intrinsic or learned ineptitude, such as being worse at offering emotional support to patients (Roter, Lipkin and Korsgaard, 1991) or being less attentive to emotional distress (Lutzky and Knight, 1994). Other theorists have framed men’s emotional engagement in such occupations within the context of maintenance of power and hetero-masculinity as understood within cultural and social contexts (Cottingham, Johnson and Taylor, 2016; Ribeiro, Paúl, and Nogueira, 2007). These studies suggest that men are unsuitable for these roles by pointing out the difficulties that they face providing necessary care and emotional support as these requirements are at odds with their expected emotional capacities (Kring and Gordon, 1998).

However, these understandings of male capacities for care frequently rely on certain assumptions of male perspectives and emotional experiences while side-lining differences in individual attitudes which do not fit with prescribed

gender norms (Brody, 1997). What Brody means is that many studies use limited understandings of men's capabilities to interpret empirical findings, a process which largely reproduces the initial assumptions by giving less attention actions which deviate from preconceived expectations. Also, when working in care roles, men have been observed to manage their seemingly divergent gender and professional expectations using varying degrees of co-optation of "feminine" traits as they consider necessary for providing care, such as emphasizing their capacities for care and drawing on similarities between themselves and female co-workers (Herakova, 2012; Holyoake, 2002; Loughrey, 2008; McDowell, 2015, Simpson, 2007). Such findings support the existence of more intricate and nuanced dimensions of the complex and poorly-investigated male emotional experience.

Research on male care workers with respect to the emotional labour they are required to undertake in these non-traditional roles reflect these complex interactions between gendered expectations and occupational practices (Cottingham, 2015; Simpson, 2004). Though they provide evidence to support and/or challenge different theories on male behaviours, they rarely explore beyond commonly-held understandings of male emotional expressiveness (emotionality), or the range of contexts which male workers consider emotionally laborious. Of note is the recurrent use of "masculinity" as an explanation for men's activities (a term which is typically left undefined despite its varying connotations), and a lack of explanations for emotional performances based on the individuals' own perspectives. This study seeks to address this gap through an exploration of male carers' experiences with and representations of emotional labour, with a view to better inform knowledge on care practices and, potentially, aid the support, recruitment and retention of men in the health and care industry.

What follows is a review and critical evaluation of several interrelated bodies of work which provide key concepts and understandings of the research area. These concepts include emotions, gendered expectations of emotionality (tied to understandings of gender and masculinity), and emotional labour as applied to the research subjects/scenario – men in professional care roles. The main narrative of the review as identified so far

is that men's socialisation leads to a limited capacity for engaging in professional care practices, a claim which does not fully stand up to critique. Other forms of care (such as male carers for family members) are not explored in this review, as those entail a different kind of care relationship not necessarily influenced by emotional labour.

Literature Review

Emotions in Emotional Labour

Though this study centres on emotional labour, it is useful to begin with an explanation of "emotions" as theorised in sociological literature. Burkitt (1997), through a synthesis of many disciplinary and theoretical approaches, provides a comprehensive exposition of emotions as "complexes composed of different dimensions of embodied, interdependent human existence" (ibid, p. 42). By this, Burkitt means that emotions have both biological (subjectively felt sensations) and socially-constructed aspects (through recognised bodily displays, context-dependent interpretations and linguistic descriptions and associations) which are produced in response to individuals' relationships (with selves and others) and largely serve to substantiate or influence these social interactions. To provide an example, the sensation of a racing heart and body tremors could only be understood as "excitement" or "fear" depending on the circumstances that produced them; the sensations alone do not determine the emotion, and the emotion would equally not be recognised without the existence of sensations. Furthermore, emotions are bound in power relations: the descriptors and meanings ascribed to bodily sensations and displays are socially determined through the approvals and penalisation of others who are positioned to do so (Burkitt, 2002; Elias, 1978). Following from the previous example, the feeling of a racing heart and bodily tremors is only interpreted as "fear" within a given context because this description was learned in the social environment, and this socialisation equally shapes understandings of the situations where fear is considered appropriate. It is with these understandings of what emotions are permissible or prohibited that individuals learn to manage their feelings and expressions to successfully navigate the social world (Burkitt, 2012).

This multiplex conceptualisation of emotions by Burkitt provides a useful start point for sociological studies on emotions as it bridges multiple aspects of the phenomenon, as opposed to definitions which present emotions in terms of biological dispositions (Lyon, 1995) or social/cultural discourses (Baerveldt and Voestermans, 2005; Loseke and Kusenbach, 2007). The depiction of subjective feelings and outward displays as separate but interlinked constituents of emotions enables for an understanding of dissonance between these aspects. Equally, by acknowledging the roles of discourse, social regulation and power dimensions on emotions and their expressions, it shows that emotions are contextualised by social interactions and not signifiers of some “inner self”. These features make it most applicable within the proposed research area. Yet its theoretical robustness cannot give an account of how emotions operate in individual experiences, or how individuals interpret and engage with their emotions in a specific social setting (as is the focus of this study). Its view of emotions as primarily products of interpersonal interactions also does not accommodate feelings which are *not* produced by such interactions (such as agitation which could be due to bodily stress or sleep deprivation) which may nevertheless influence emotional performances. This is where other theories on emotions may provide a better understanding of the concept (Bericat, 2016; Turner, 2009), and are explored and integrated into the study where appropriate.

If Burkitt’s theory describes the ontology of emotions as a social phenomenon, seminal work by Hochschild (1979; 1983) has drawn attention to the regulated nature of women’s emotions as situated within a particular service- sector workplace – as air stewards. Central to Hochschild’s theory is the idea of “feeling rules”, and individuals are said to perform “emotion work” to intentionally accommodate differences between their true feelings and the emotions that would be considered desirable in the social environment. In her classical study *the Managed Heart* (1983), Hochschild emphasizes how these rules are made explicit within working environments due to sanctions (like commendations, promotions and reprimands) given in accordance to the ability to abide by the emotional displays expected by employers and customers/clients. Thus, emotion work within the setting of paid employment

takes on the form of *emotional labour*, a term Hochschild defines as “the management of feeling to create a publicly observable facial and bodily display” (ibid, p33).

While many occupations require emotional labour, certain characteristics were identified by Macdonald and Sirianni (1996) to increase the demand for such labour. These included roles with extended contact and communication with clients/service users (front-facing roles), where displays of friendliness and/or deference to service users are expected, and where the individual has little organisational power and is frequently subjected to the employer’s attempts to monitor/control their interactions. These constraints on employees’ emotional displays are intended to produce a desired emotional state in the service users (such as feelings of affection), which ultimately leads to their continued or increased utilisation of services and consequently, increased revenue for the service institution. Jobs which fit these characteristics include nurses, school teachers, restaurant servers and customer service representatives, among others.

To comply with institutional demands, Hochschild (1983, pp.33-35) describes two techniques that employees utilise: surface acting and deep acting. Surface acting entails making changes in outward expressions to mirror the organisational expectations, such as adopting a cheerful disposition despite being upset. Deep acting involves an internalisation of ideas regarding clients or the nature of the job to make expected emotions more spontaneous (such as imagining clients as friends to provoke a more naturalised friendly reaction). In either case, organisational expectations form the precedent for these emotional acts, and the use of these techniques to comply with employers’ demands can produce tensions and discrepancies between felt and portrayed emotions, often leading to exhaustion and burnout (Adelman, 1995; Grandey, 2003; Van Dijk and Andrea, 2006). Hochschild (1983, p. 90) referred to these discrepancies as “emotive dissonance” and suggested that those who regularly perform emotional labour may develop a sense of self-estrangement over time due to the deep connection between emotions and self-identity. Female air-hostesses reported that the they felt that the fakery or inauthenticity they had habituated due to their jobs was bleeding into

relations in personal life. This illustrated one of the potentially damaging effects of emotional labour and has led to increased interest and investigation into the phenomenon (Wharton, 2009).

Yet Hochschild's accounts overemphasized the degree of influence that organisations could have as well as the boundaries between personal and professional emotions; workers are not completely regulated and are given or create opportunities to think and act autonomously. Personal emotions can still be expressed within the working environment, and workers can challenge and even subvert rules and expectations overtly and covertly. For instance, Bolton and Boyd (2003) demonstrated how airline crew members used humour and fake performance assessment forms to ridicule the practises expected of them, suggesting a more nuanced view that recognises diverse emotional and behavioural responses, and a greater scope for agency by the emotion worker. Hochschild's reports were also partial to where this estrangement could be witnessed and relied on gender stereotypes when representing the impact of emotional labour on individuals. Male debt collectors were portrayed as instrumental with their use of emotions by employing rationality and aggression, while female air stewards were bearers of authentic emotions that had been exploited for capitalistic gains. This allows little scope for imagining male emotionality and female aggression/rationality. This assessment also reinforces a limited understanding of men's emotions by conflating restrained emotional expression with a lack of awareness or capacity for emotions, a view which has been challenged by subsequent studies on emotional labour (Gray, 2010).

The effects of emotional labour are not always negative though; where employees' genuine emotions are in keeping with expectations (whether through deep acting or personal alignment with organisational commitments), such labour could boost job engagement and satisfaction (Humphrey, Ashforth and Diefendorff, 2015). Such views of emotional labour as productive and rewarding suggest/open out a wider terrain of knowledge about and diverse responses to situated emotion work. With this in view, a desirable emotional disposition should ease the ability to appropriately

regulate emotions and reduce the constraints encountered with emotionally-laborious jobs (Kammeyer-Mueller et al, 2013), and this premise of suitable emotionality is closely aligned with understandings and expectations of gender.

Emotions and Gender

Having discussed emotions and emotional labour, I now examine debates on emotions as influenced by gender. Where other disciplines may use the terms interchangeably, “sex” and “gender” are considered distinct but interconnected concepts in modern sociological literature. “Sex” refers the state of being male or female as determined by biological development, while “gender” encompasses the social characteristics attributed to sex (Butler, 1990; Connell, 2009). The separation of these concepts resulted from several theorisations which challenged dominant understandings of men and women as social actors (Fausto-Sterling, 2000), some of which would be examined to better understand their emotional performances.

Women have typically been considered more emotionally-adept than men, and this traditional understanding of emotionality has been corroborated in psychological research that examine associations between emotional regulation and biological sex (Timmers, Fischer and Manstead, 1998). Yet conclusions derived from such studies tend to obscure the social influences that produce the sex-differentiated attitudes towards emotions by either failing to elaborate on findings or depicting the sexes themselves as self-evident explanations. This tendency ultimately perpetuates a sort of circular logic: like women are more emotional because they are women. Conversely, empirical studies have showed that men are frequently discouraged from engaging with their emotions (except within particular situations) through the stigmatisation of emotionality as an undesirable weakness (Asher, 2017). Similarly, language can be used during early socialisation (based on the assumed disparity between genders) to shape and reinforce differential attitudes towards emotions and the acceptability of emotional displays (Neall, 2007). These influences of socialisation thus indicate that observed differences in emotionality are not determined by biological sex, but rather by a learned (dis)engagement with specific emotions as determined by the

social context. For example, a study by Reid et al (2018) showed that even in male-dominated occupations where “masculinity contests” – which include avoiding displays of emotions – were expected, actual practices were more varied; firefighters were more aligned with emotional regulation as a means to maintain their mental health and performance during emergencies, as opposed to consultants who largely regarded their acknowledgement of emotions and adaptation to social situations as critical for their success through fostering openness to learning and maintaining client relationships.

The notion of limited emotionality has not passed without criticism; the emotions considered to be repressed depend on both the observers’ understanding of emotional displays and the purpose for which these limitations are placed (de Boise and Hearn, 2017). For instance, theorists concerned with how limited emotions produce social privileges are less likely to be concerned with how men experience, engage with and understand emotions. An example of this is Sattell (1976), who argued that the failure of men to develop certain emotional aptitudes like compassion or intimacy is merely a means to an end, as desensitization to such emotions allows for the persistence of abusive practices which contribute to social inequalities. This was to explain why emotions which denote a regard for social relationships, vulnerability and interdependence are typically discouraged among men while those that contribute to social control (such as anger) are permissible (Pease, 2012). While this view is supported by findings from studies on male emotions within various social relationships (Brody, 1999; Coyle and Morgan-Sykes, 1998; Walton, Coyle and Lyons, 2004), it also challenges the reductive stereotype of men as it indicates that emotional practices are not fixed features of gender and can be determined by personal aims which are dependent on unique social circumstances (Wetherell, 2012). As such, it stands to reason that differing motives for emotional expression – such as the need to provide care, which is an expectation in the context of this study – would result in different degrees of emotionality.

Nevertheless, differences between men and women with respect to engagement with emotions have contributed to occupational segregation, leading to an overrepresentation of women in professions where emotional

displays and regulations are important for their roles, like nursing, teaching, hospitality and the service industry (Guy and Newman, 2004). Due to this overrepresentation, these jobs are often considered “feminized”, and this gendered association influences how individuals of both sexes engage with such roles through a combination of self-imposed and socially-mediated influences such as alignment of identity, peer group dynamics and economic factors (Nixon, 2009; Pullen and Simpson, 2005; Wright, Eaton, and Skagerberg, 2015). However, such gendered associations for occupations are neither fixed nor universal – for instance, nursing has been a male-dominated profession in Jordan until recently (Al-Maaitah and Shokeh, 2009) – and social prescriptions of occupational suitability are influenced by constantly shifting cultural values. The rise of automation within the manufacturing sector (diminishing the need for physical labour) and the expansion of the service industry have resulted in increased male involvement in these “feminized” jobs (Bradley, 1989; 1999; Johnston, 1994) and contributed to changes in gender affiliations for these roles. These transformations of workplace compositions and affiliations were enhanced by socio-political shifts towards neoliberalism (deregulated markets, reduced involvement of state in economic affairs, increased competition and focus on individual attainments), producing narratives on a “crisis in masculinity” due to loss of male-dominated (and historically valorised) occupations requiring skilled manual labour and reduced ability for men to assume the traditional role of the breadwinner (Walker and Roberts, 2017). These neoliberal ideologies have also impacted on the arrangements within the care sector, with an increase in the care supplied by private agencies with competitive prices and zero-hour contracts which have promoted reduced wages and employment benefits over time (Charlesworth et al, 2021; Donaldson, 2011; Foubister et al, 2006).

In line with the changing gender compositions in occupations, expectations of the genders themselves – particularly for men – have undergone changes as well (Mac an Ghail and Haywood, 2006; Roberts, 2013). Differences in tendencies such as sociability and sexuality which have historically been attributed to biological differences (Fausto-Sterling, 2000) have been largely

discredited by critical social theorists who argued for the strength of socially-prescriptive and discursive influences on understandings and expectations of gender (Glover and Kaplan, 2008). These, along with social changes such as the gender equality movements and consciousness raising campaigns on the health risks associated with emotional repression, have contributed to shifting attitudes towards emotionality as a gendered concept in both observed social practices and social theories (de Boise and Hearn, 2017). An examination of these theorisations is thus needed to better appreciate male emotional practices and engagement with traditionally feminine roles, and this requires an exploration of the concept of “masculinity”.

The Issue of “Masculinity”

The term “masculinity”, as used in such most research on gender and related social dynamics, represents male-attributed characteristics commonly observed in contrast to female social actors (Connell and Messerschmidt, 2005). While physical attributes of masculinity (like body size/shape or hirsutism) are well established as rooted in biological differences, social attributes (like emotionality and other communicative behaviours) remain a subject of debate (Fausto-Sterling, 2000; Mac an Ghail and Haywood, 2006). Cross-cultural studies in the field of anthropology have attempted to establish commonalities of masculine and feminine characteristics and social roles between geographically and culturally separated societies, but findings supported a substantial degree of heterogeneity in identities and practices, highlighting the *absence* of any universally applicable gendered presentations or actions (Errington and Gewertz, 1989; Friedl, 1975; Goheen, 1996). Similarly, the patterns of behaviour referred to as “masculinity” in Western societies – which are more applicable to the setting of this study – have changed over time, shifting from the concept of “manliness” which typified the tendencies to which men were expected to aspire (Tosh, 2017), to more recent (and pluralistic) forms of male self-representation (Anderson, 2009; Connell, 1995).

Historically-recurrent components in descriptions of “masculinity” have included an avoidance of emotional expression and “feminine” attributes, hyper- and hetero-sexuality, an ambition for success, exhibition of a strong

will, acquisition of material possessions, and a penchant for violence and aggression (David and Brannon, 1979; Easthope, 1992, Siedler, 1998, Schrock and Schwalbe, 2009). This understanding of masculinity has been critiqued by Connell (1987; 1995) for failing to represent varied social realities and the many ways in which men behave and express their identities. Connell instead proposed an expression of *masculinities*, describing different forms of acceptable male behaviours observed in constantly changing social contexts. Yet within this diversity, some attributes were valued over others, resulting in a socially-observed stratification where a certain cluster of features (and thus a certain presentation of masculinity) was the most commonly idealised variant of masculinity: the hegemonic masculinity. While no single individual (or very few individuals) may meet all the expectations of the ideal, the commonly accepted understandings of ideal masculinity still functions as an aspirational model and influences individual behaviour and relationships towards women and other men. The notion of masculine hegemony is also maintained in Brittan's work (1989), where the term "masculinism" is posited to portray an ideology that depicts the position of men over women as natural and maintains certain forms of masculinity as superior.

Connell's Hegemonic Masculinity Theory (HMT) provides an expanded conceptualisation of masculinity as a varying and contextually constructed social ideology while also acknowledging the existence of a dominant archetype as was earlier represented in "manliness" (Connell and Messerschmidt, 2005). The distinct hierarchies included categories such as "complicit masculinities" which describe forms of masculinity which benefit from masculine privileges without enacting masculine dominance, "subordinated masculinity" which describes disempowered masculine identities and "marginalised masculinities" like gay or black masculinities which were acknowledged but not given the legitimacy of being considered masculine. In this way, HMT accommodates multiple individual and structural elements like race, social class and political power which shape the ideals and gender identities, making it conceptually flexible. Its depiction of masculinity as an aspiration helps explain empirical findings on male

behaviours and attitudes towards women and other men (Hearn, 2004), and would be applicable in the context of this study if subjects' aspirations of gender differ from their own identities and performances.

However, hegemonic masculinity is a theoretical construction not necessarily based on any identifiable exemplars in the real world, and its constituent attributes depend on the *commonalities* of male aspirations within a given population. This means individual variations must be discounted to establish the pattern considered "hegemonic", thus creating a concept which is both evidenced by and transcendent of the individuals on which it is based (Moller, 2007). For "hegemonic masculinity" to be used as an explanation for men's emotions and practices, it must be assumed that all men hold the same understandings of (and regard for) this construct of masculinity, which is highly unlikely. This reliance of commonalities of patterns also leads to a discounting of diverse contexts which influence aspirations; for instance, applying the same model of hegemonic masculinity to male factory workers and medical doctors will only produce partial understandings of both groups. So, while hegemonic masculinity might suffice for explaining findings at a population level (since its features are curated based on how frequently they are observed in members of the population), its applicability is somewhat limited at an individual level, as one must first establish that the aspirations of hegemonic masculinity are recognised by the individual.

The stratified dynamic produced by hegemonic masculinity has been contested by Anderson (2009), whose ethnographic and interview-based studies of college and university-age adolescent and young adult men led to the proposal of Inclusive Masculinity Theory. According to Anderson's findings, heterosexuality is less considered as an exclusive criterion for masculinity and emotional expression is increasingly acceptable. As heterosexuality and homophobia have historically been used to establish and stratify masculine identities, Anderson argues that the observed reduction in overt homophobia and increasing acceptance of non-heterosexual identities in Western societies would serve to diminish any hegemonies as "more diverse forms of masculinity become more evenly esteemed" (Anderson and McCormack, 2018, p248).

While Anderson accurately identifies some contemporary changes in understandings and practices of masculinity, Inclusive Masculinity Theory may simply reflect changes produced by new socio-political constraints such as the establishment of anti-discriminatory and pro-LGBT legislation (de Boise, 2015). As homophobic acts are criminalised and increasingly viewed as socially undesirable, then an acceptance of non-heterosexual identities could be motivated by self-preservation rather than a true transformation of ideals. Also, the rise in acceptance of different sexualities and emotionality does not mean other expectations (like physical strength or sexual performances) are not used in the social stratification of masculinities. Given the record of shifts in masculine expectations (Segal, 2007) and Connell's description of hegemonic ideals as "historically mobile" (Connell, 1995, p.77), inclusive masculinities may simply represent a new hegemony, one where the acceptance of emotionality is seen as superior to old-fashioned ideals (and possibly class ideals, considering the economic and educational backgrounds of Anderson's study population) of stoic rationality. Still, Anderson's theory provides evidence of the importance of the social environment in promoting male emotionality, a finding which should be applicable in the research context.

Representations of masculinity have also been criticised for depicting these male-associated behaviours as biologically intrinsic and/or exclusive to men while simultaneously failing to explain how/why these behaviours are produced and maintained (Haywood et al, 2015, Martin, 1998, Whitehead, 2002). In opposition to such biologically-rooted understandings, Butler's seminal work in *Gender Trouble* (1990) discusses the *performativity* of gender, which describes the process where certain ideals and practices are adopted, imitated and perpetuated to the point that they become taken for granted and assumed to originate from differences in sex. Butler's arguments were useful in representing masculinity as a discursively-produced *practice* which was adapted until it could be carried out spontaneously, a process which consequently shaped norms of expected male performances. The concept of performativity is also highlighted in Halberstam's *Female Masculinities* (1998), which illustrates how male-associated acts and

identities are observed and performed by women in both their daily social lives and through more theatrical performances like the “drag king”, challenging the notion that the social features of “masculinity” are an exclusive feature of men. This also calls the exclusivity of “femininity” into question, as tendencies which are regarded as “feminine” (such as emotionality and caring) could equally be considered the product of performativity, and as such would not be at odds with men’s capacities.

In a related critique of exclusivity in gendered associations, Butler (1990) addresses the uses, limitations and implications of language by conveying how references to sex (like “masculine” and “feminine”) influence interpretations and attitudes towards actions. Butler argues that the use of words like “masculine” and “feminine” to describe actions and behaviours reinforces a binary way of thinking and insinuates that individuals’ behaviours (like emotional expression) *should* be aligned to either masculinity or femininity, and that such behaviours are determined by sex. This gendered discourse affects both actors and observers: for instance, the repeated association of violence with masculinity means that men are more likely to partake in violent acts as an affirmation of their masculine identity. Yet it also means an act of violence perpetrated by a man would be viewed as an exhibition of such masculinity, a conclusion which is unlikely to be drawn when similar violence is perpetrated by a woman. This binary paradigm of linguistic categorisation thus perpetuates assumptions that individual practices should/would significantly differ from members of the opposite gender and be like members of their own gender and could prejudice explanations to individual behaviours.

Butler’s approach to gender as radically socially constructed was useful in establishing the role of discourse in shaping social realities through its influence on individual actions, as well as the constraints of gendered conceptions and approaches to interpretation. However, its focus on discourse as being a powerful regulator of gender significantly undermined the role of individual agency in reshaping these practices by portraying individuals mostly as enactors of pre-existing gender narratives (McNay, 1999). In other words, if individuals were so discursively impelled by ideas,

language and narratives, then people would not be able to question and alter or redefine their gender. In this way, it fails to accommodate or explain the variety of practices and beliefs around gender as demonstrated in Connell's work (Connell, 1995). Still, it offers a valuable perspective for understanding how dominant discourses on masculinity can shape individual identities and practices as well as interpretations of practices, a feature which would be assessed in the context of this study.

The diversity of practices and identities related to gender – as well as contextually-dependent differences in what counts as masculine and feminine behaviour – thus presents a problem with the use of “masculinity” as an explanation for male emotionality (or lack thereof). References to masculinity in research are either based on descriptions of particular individuals' portrayed identities and interpretations of activities within specific contexts (which may have limited applicability in other contexts) or are based on presumed understandings by the researcher which may not necessarily reflect the outlooks or aspirations of the individuals described. To better understand how aspirational or discursive aspects of masculinity play a role in men's emotionality, it is important to investigate how men make sense of it in their own lives. This would be considered and addressed in this study's investigation of emotional labour within the specific research setting.

Emotional Labour in the Research Context

Available research on men engaged in female-predominated occupations has shed some light on the experiences and activities of these social actors when examined in comparison with female contemporaries (Cross and Bagilhole, 2002; Lupton, 2000; Simpson, 2004; Williams, 1993; 1995.). These examinations have largely focused on the conflicts between gender norms and occupational norms, as these are typically closely associated due to occupational stereotyping. However, an assumed separation of gender capacities still underpins these reported conflicts, and men's performances within these roles – including their engagement with emotional labour – have typically been analysed based on a conformity or rejection of prescribed gender norms (Pullen and Simpson, 2009; Simpson, 2007). This focus on gender as the origin of professional capacities rarely advances taken-for-

granted understandings of male workers and potentially obscures other aspects of the participants' experiences that could have shaped their actions or experiences.

With respect to men involved in care work, a few studies have examined how understandings of caring and emotionality as a feminine capability have shaped attitudes to (and by) male carers with respect to the roles they performed (Loughrey, 2008; O'Lynn and Tranbarger, 2007). In these studies, men who performed caring activities were depicted as either exhibiting "softened" masculinities or co-opting "feminine" attributes in a way that did not challenge normative masculinity. But given the multiple ways masculinity has been (and can be) constructed, these studies often fail to elaborate exactly what comprises the "masculinity" being softened/subverted, where this understanding of masculinity was derived, or why this version is expressed as relevant to the research participants in their specific context. If "masculinity" depicts what men do, then the actions of the men in the studies should be constitutive of masculinity. To maintain a descriptive position of these caring activities as "feminine" or as a "softening" of masculinity, researchers must presume that masculinity precludes these tendencies, and such a view would result in limited interpretations as it is more concerned with what men *should* do rather than what is practically done.

A study by Cottingham (2015) examined how male nurses in a Midwestern hospital in the US reported aspects of caring and emotional labour. Using a mixture of interview responses and participant-generated audio diaries, Cottingham analysed the reported strategies male nurses used when faced with emotionally demanding situations, such as "reframing" their role as nurses to be separate from their self-identities, emotional distancing, and relinquishing control, and linked such discourse to culturally entrenched masculine ideals. While these findings were useful in outlining the practical strategies employed to manage emotional labour in the care setting, they could not be considered exclusive to men – female nurses were just as likely to use them in daily practice. The study also did not elaborate on what form of masculinity was the basis of their practices, or why these performances of masculinity persisted considering their limited use in the occupational

context. Further investigation of professional male carers' perspectives is thus required to understand how these strategies for addressing emotional labour are rationalised by the individuals themselves as opposed to presumed alliances towards masculinity.

A quantitative study by Cottingham, Erickson and Diefendorff (2015) sought to evidence how male nurses were protected from the negative effects of emotional labour through their social position as men, suggesting that their gender served as a "status shield" against dissatisfaction with their roles. The explanation for this finding was that the practice of emotional repression during men's socialisation meant that they could engage with emotional labour in a more instrumental fashion and as such were protected from truly experiencing emotional disturbances created in their work environment. While highlighting a potential mechanism for reducing the impact of emotional labour, this conclusion was based on relatively small differences in reported measures of job satisfaction. This could be a misattribution as, job satisfaction can be influenced by other factors which were not assessed by the study, including nature of role, job security, social integration or work-life balance (Haar et al, 2014; Wilczyńska, Batorski, and Sellens, 2016). The conclusion also relied on assumption that members of both genders were similarly socialised and thus followed similar motives for emotional expression. These premises were not supported by the study as the other correlations between emotional labour and occupational outcomes showed no remarkable differences between genders (a finding consistent with Erickson and Ritter, 2001).

Though there is little evidence to support significantly different practices or effects of emotional labour, perceptions of masculinity have been reported to influence the activities of male nurses towards care provision. Whiteside and Butcher (2015), through a systematic review of eleven qualitative studies, showed how expectations of male sexuality (particularly the fear of sexual assault) influenced nurses' use of touch in both clinical and emotive care for patients. Similarly, Cottingham, Johnson and Taylor (2016) reported that assumptions of hypersexuality (a belief that men are overly eager to engage in sexual activity), particularly towards non-heterosexual identities, were

issues that male nurses had to navigate while performing their roles as carers. This additional strain on their occupational performance was described as “heteronormative labour”, and to continue providing care, male nurses employed several techniques such as verbally or implicitly reassuring patients of their heterosexuality and acting in ways aimed at reducing assumptions of homosexuality. These findings hint at other aspects of emotional labour yet to be explored.

Just like Hochschild’s pioneering work showed how expectations of femininity and mothering were utilised to shape the occupational role of air hostesses (Hochschild, 1983), these findings suggest the existence of other precedents and dimensions of the emotional labour that male carers undertake due to social expectations of masculinity. Existing studies on men involved in female-predominated professions like nursing and teaching have addressed the importance of performing (largely unacknowledged) emotional labour within such roles (Gray, 2009; 2010) as well as the impact of gender on emotionality in terms of how they sought to maintain their understandings of masculine identities within their occupations (Pullen and Simpson, 2009, Simpson, 2007). But given the variations in socialisation and motivations towards emotionality, the focus on interpreting emotional performances according to expectations of gender performances potentially obscures alternative explanations for behaviours and the ways in which individuals make sense of their practices. Further research is then required to uncover any additional aspects not demonstrated in available research, as well as to explicate the reasons and motives for these performances.

This study thus aims to investigate the issues that male carers associate with emotional labour, as well as the practical measures taken to address such issues and the justifications they have for these practices. This would help inform understandings of male care workers in the current mixed economy of care and the concerns around caring occupations as experienced by this demographic group.

Research Aims

From available literature, little has been done to investigate the specific circumstances men consider emotionally-demanding, or the rationale for their practices of emotional labour beyond conforming to/remodelling traditional understandings of masculine identities. With a focus on this gap in understanding, this study aims to examine the ways in which male healthcare workers perceive, represent and address emotional labour within their respective roles, with a focus on practical and subjective influences on their emotional performances (such as relations to other employees and patients, or their attitudes to work and effectiveness in the workplace). This investigation attempts to answer the following research questions (*with the rationale included in italics*):

1. **How do men perceive and respond to emotional labour within care roles?** *This question should yield accounts of various circumstances that male care workers associate with emotional labour, as well as the range of emotional resources/narratives they deploy for addressing these circumstances as they arise. This could give insight into men's' explanations of their emotional performances.*
2. **How do their understandings of emotional capacities as men affect emotional performances, considering the female-predominated nature of their occupations?** *This aims to assess how individuals' views on gender capacities and emotional expression influence their responses to emotional labour and division of labour by gender.*
3. **How do they adapt to/resolve any conflicts between expectations of their gender and occupations?** *This would explore how dominant discourses on gender and care work affect their experiences and behaviours, and how/why individuals accept/challenge these discourses. It also aims to examine how such conflicts influence care provision and other practices within and outside the working environment.*

Chapter Summary

This literature review considers the subject of emotional labour of male care workers through an examination of some existing research on the interconnected elements of emotions, gendered emotionality and male-gendered social identity: masculinity. While varying perspectives exist regarding each of these elements – including how emotions are to be defined or understood, the socially-mediated role of gender as an influence on identifiable emotional expressions, and contextually varied observations in the performance of masculinity – available knowledge both emphasises and constrains domains of understanding within the research area. For instance, ideals of masculinity proposed by different theorists describe observations of men’s behaviours in particular contexts, while simultaneously side-lining how these contexts shaped their observations and theorisations. This tendency has contributed to forms of essentialism in related research on men, as *a priori* understandings/rationalisations of behaviours observed from other contexts are used for interpretations in new contexts, despite evidence of significant variability across time and place. Similarly, understandings of emotions as socially mediated have been used to acknowledge differences in emotional expressions (or emotionality) between men and women, while also obscuring the socially mediated differences in interpretations of emotionality by observers, perpetuating preconceptions which influence understandings of emotional and care-related behaviours or activities. Informed by this existing research and its identified issues, this study was proposed to investigate the emotional labour of male care workers through a contextually driven approach that acknowledges both individual subjectivity and societal influences on behaviours, and domains of inquiry which were highlighted within three research questions. The details of this investigative approach are discussed in the subsequent chapter on *Research Design*.

Research Design

Introduction

This chapter discusses the approach and methods used to address the research gap identified through the literature review. This is done through a critical consideration of the philosophical positions regarding the forms of knowledge to be acquired and studied (epistemology), the selection and practical consideration of research methods and the ethical and contextual issues around the research process.

However, before considering the details of the research process, it is helpful to restate the research aims and sub-questions, as these help to rationalise the choice of methods. The study aims to investigate the issues that male carers associate with emotional labour, as well as the practical measures taken to address such issues and the justifications they have for these practices. This overarching aim is addressed by attempting to answer the following research questions:

1. **How do men perceive and respond to emotional labour within care roles?** *Examines various circumstances that male care workers associate with emotional labour, the range of emotional resources/narratives they deploy for addressing these circumstances as they arise, and their explanations/justifications of their emotional performances.*
2. **How do men's understandings of emotional capacities affect emotional performances, considering the female-predominated nature of their occupations?** *Assesses how individuals' views on gender capacities and emotional expression influence their responses to emotional labour and division of labour by gender.*
3. **How do men adapt to/resolve any conflicts between expectations of their gender and occupations?** *Explores how dominant discourses on gender and care work could affect experiences and behaviours, and how/why individuals accept/challenge these discourses. Also aims to examine how such conflicts influence care provision and other practices within and outside the working*

environment, as well as emotional resources deployed within their working and personal lives.

These questions were selected based on considerations of key aspects of the research focus as noted in existing literature, as well as my understandings of the research environment based on prior experiences as a healthcare worker. These experiences prompted my interest in the research area and are expected to influence the methodology in several ways, including the focus of investigation and interpretation of research data (further consideration of these influences on the research are discussed subsequently in the section on **Positionality**). An acknowledgement of this subjectivity and potential intersections with the experiences of others also influenced the selected approach to the topic, as discussed in the following section.

Epistemological Foundations

The study is intended to draw on *subjective* understandings and experiences of emotional labour by assessing the accounts of men engaged in caring work within the health industry. This is not to establish any incontestable “facts” regarding the nature of emotional labour, but to examine how situations are understood and represented as emotional labour by individuals and evaluate these understandings for commonalities, ambivalences/contradictions and conceptual associations. This approach to uncovering knowledge of the social world as rooted in subjectivities is thus aligned to interpretivist epistemology (Bryman, 2012).

This epistemology (which refers to ways of knowing about the world) of interpretivism recognises that knowledge of the social world cannot be separated from boundaries of the individual experience, the concepts individuals recognise and comprehend, and the ways in which their perceptions are communicated (Steedman, 1991). As such, the methods of investigating such knowledge examine the dimensions and meanings ascribed to individuals’ experiences of social phenomena (Denzin and Lincoln, 1998). These experiences are typically conveyed through language (a process which involves some degree of reduction depending on the foundations of the language itself, and an assumption of shared

understandings of meanings within the language), and these communicated experiences are subsequently interpreted and re-conveyed by the researcher, a process which is influenced by their subjectivity and other features of their social position. As such, the research process involves the interaction of two (or more) subjectivities through the mediums of language and/or other modes of communication, and thus produces a constructed approximation of the social realities being examined; an assumption of realistic representation would be erroneous as this would discount the influences of individual understandings and expression, and constraints of language itself (Denzin 2001).

Given that many elements of the research focus (like emotional labour and masculinity) are subjectively variable, and the aim of the study is exploratory (which requires the methods employed to be sufficiently flexible to identify and explain a range of variable and novel features), this interpretivist approach to enhancing knowledge of the research area is most suitable as it is based on communication of social realities. Furthermore, the interpretivist approach acknowledges both the nature of the foci of inquiry and the influences of individuals (participants *and* researcher) involved in the production of consequent knowledge, making it ideal for a critical examination of social realities *without* resorting to considering these representations as absolute truth.

However, this interpretivist approach should not be taken as just a reflection of participants' and/or researcher's prejudices, but one which takes the limitations of constructions of knowledge into account. As with all research endeavours, the aim is to capture aspects of the studied phenomena whose existence is independent of attempts to study them or any constructed representations (though these inevitably place some constraints on our understanding). Thus, while individual accounts assessed through this study cannot capture the studied phenomena in their entirety, they can however produce accurate and transferable representations of such phenomena within the limits posed by subjective understandings and translations through language (Hammersley, 2011). This awareness of the features and

limitations encountered in an exploration of subjective experiences were factored into the methods chosen, which are discussed below.

Methods

Given the research aims and epistemological position, the methods chosen for the study were based on key theoretical and practical considerations related to the research aims. These include the forms of sampling and recruitment, data collection methods and analytical framework, which are discussed below:

Sampling and Recruitment

Participants in this study were men (of ages ranging from 18 to 68, representing the age range of employees in the care sector) who worked in two settings of care provision: health/care institutions (including hospitals, hospice care, domiciliary care, et cetera) and the home. “Men” in this study refers to anyone who self-identifies as male (includes trans-men), not the biologically defined categorisation based on sexual characteristics. This definition was to allow for a variation of perspectives and support the examination of masculinity as a *social* performance, as this is relevant to assessing the potential effects of any masculine aspirations on emotional expression in the settings of care provision. Men caring in a non-professional capacity (like care for relatives) were not considered in this sample, as their experiences will not provide information regarding emotional *labour*, which operates in the setting of paid employment.

Participants were drawn from health and social care organisations in the north-west of England, and this limitation of recruitment area was meant to reduce costs associated with transportation to interview sites. While I recognise that this limited geographical area could confine certain aspects of findings produced, narratives were not expected to differ significantly by region but more by sector (private/public) or by social characteristics such as age, ethnicity, sexuality, class and education. Participants were nevertheless purposively selected (selected based on their variations in characteristics – Bryman, 2012), a decision taken to allow insight into different working contexts in the mixed economy of care. The aim of this sampling strategy

was not to achieve representativeness, but to assess a variation of contexts and working environments which could influence emotional labour, as well as the discourses which may be shared or subverted across these contexts.

Access to participants was sought through a diverse range of sources, including professional bodies and regional trade unions (such as the Royal College of Nursing North West branch, Unite, and the Care Providers Alliance, the latter of which coordinates several groups including Care England and the Registered Nursing Home Association), professional support groups (like *Men in Nursing Together*), volunteer groups (like Voluntary Organisations Disability Group) and using my own personal networks. Recruitment through unions/organisations was to enable access to participants from a range of care facilities, which consequently produces a variation of perspectives in the study sample. Email messages to organisations (usually with leaders or managing offices) were used to introduce and explain the purpose of the study, and where organisational interest was expressed, recruitment messages (with participant information sheets and contact information) were supplied for dissemination to potential participants. Organisations were not expected to actively recruit participants, only to help disseminate information. Participants were also sought through networks within the Faculty of Health, Social Care and Medicine, and through personal contacts who were involved in or had connections to others involved in the health/care industry. Where any such individuals expressed interest in the study, I sought their assistance with recruitment through their recommendations of other potential participants and/or dissemination of information about the study. This snowballing technique was used alongside recruitment through organisations as members of the study population are relatively uncommon in the care industry (Day, 2015).

However, due to the restrictions imposed to manage the COVID-19 pandemic (which occurred during the recruitment phase of the study), responses to recruitment – especially through professional bodies – were predominantly negative, in keeping with precautionary measures proposed by the public health regulatory body (Public Health England, 2020). Consequently, recruitment efforts were focused on social networks.

Introductions through these existing networks were noted to improve responses from potential participants by establishing some level of trust prior to the researcher-participant interaction, which was especially important considering the research focus on somewhat sensitive and emotional issues which may have discouraged some participants (Streeton, Cooke and Campbell, 2004).

Introductory meetings were arranged with selected interested participants to provide information about the study, build rapport and address questions and concerns about the research aims and process. Where participants were still willing to proceed, these meetings were also used to plan subsequent meeting dates and venues based on their availability and preferences. Dates for the first interview were set at least a week after the introductory meetings, and this period was expected to provide enough time for prospective participants to reconsider their decision to participate and potentially withdraw (this capacity for withdrawal was communicated at the meetings and through the participant information sheets provided – See **Appendix A**).

To encourage participation, I emphasized informed consent, participant anonymity and that individuals and their organisations will be portrayed in a way that recognizes their dignity (for instance, any potentially embarrassing or offensive stories which could be used to illustrate a key finding will be sanitized before presentation so as not to give negative associations to individuals or their professions). As the possibility of repeated contact sessions (due to the data collection methods, discussed in the subsequent section) was expected to be a barrier, I equally emphasized that participation was not mandatory for all aspects of the study, and all meetings were to be scheduled (and potentially rescheduled) based on their availability. Five participants agreed to be engaged in the proposed forms of data collection, as described below. This number was suitable for the selected analytic method – especially considering the reflexive approach to evaluating the interviews through dialogue with participants (discussed subsequently under the *Data Analysis* section) – and given the “information power” of the data collected (Malterud et al, 2016).

| Interviewee Pseudonym* | Number of Interview Sessions |
|-------------------------------|-------------------------------------|
| Trevor Keepsakes | 2 |
| Bob, Your Uncle | 1 |
| Manfred | 2 |
| Lawrence Nightingale | 1 |
| Patch Adams | 1 |

**Pseudonyms were selected by participants, to retain some level of ownership and recognition over their data. This is explained in the Ethics section.*

Data Collection

To meet the exploratory focus, this study used a combination of methods for data collection: audio-recorded interviews and two participatory visual methods (or “photo-methods”, which involve the use of images as prompts for discussions; Pauwels, 2015). The two forms of photo-methods used were *researcher-led photo-elicitation* – where discussions were based on the pre-selected images introduced by the researcher, and *participant-led photo-elicitation* – where participants produced images for discussion with the researcher, based on what they considered representative of, or relevant to, the research focus.

To utilise both methods, participants were invited to be engaged in two interviewing sessions, though participation in the second was optional. The first session featured the topic-guided interview followed by photo-elicitation, while the second (if consented to) was used for a participant-led photo-elicitation interview (often preceded by a discussion of any considerations or concerns the participant may have had after the previous session). These second interviews occurred after about three weeks, during which time the participants were asked to take about ten photographs which capture their emotional experiences in the workplace. Interviewing sessions lasted between thirty minutes and two hours, varying depending on the participant and nature of discussions.

The methods used within these sessions were selected for both specific and synergistic reasons, and are discussed in the following subsections:

Interviews

As the focus of the study is on subjective experiences, individual semi-structured interviews were deemed most suitable for capturing data as these allow for a more narrative format to responses and a subjective focus on aspects of emotional labour that the participants find noteworthy (Bryman, 2012). The individualised arrangement (as opposed to a dyad or focus group) was selected due to the potentially sensitive nature of the topic and possibility that confidential details related to care work could be disclosed as part of the conversation. It also provided greater flexibility for arranging interviews, which was particularly important given the nature of the participants' professions and the desire to reduce inconveniences or barriers to the interviewing process. The sensitivity of the topic also guided the choice of interviewing venues, and interviews were held in the participants' choice of location, where they felt comfortable and were assured some level of privacy (Herzog, 2012). However, this need for convenience, privacy and comfort had to be negotiated along with a need for clarity in conversation, and so any locations which were unsuitable (due to the possibility of externally generated noise) were avoided in favour of quieter (but convenient) meeting grounds as deemed suitable by the participant.

An approved interview guide consisting of open-ended questions derived from the research objectives was used to direct discussions (See **Appendix B**). A semi-structured approach to questioning (where any noteworthy topics that emerged from answers to the questions were followed up for further details) enabled a topical focus to the discussion which also suited the exploratory aims of the study. Questions used to elicit conversations (both from topic guide and from the responses prompting for additional investigation) were worded to reduce restriction to, or priming of, responses with value-laden affirmative or negative adjectives or presuppositions. This was intended to ensure that responses were directed by the participants' perspectives by reducing the influences of my viewpoint on the data obtained – as responses to questions could be affected by tendencies towards

agreement within the social interaction (Wang and Yan, 2012). Similarly, where the meanings of responses were not understood, or ambiguities of interpretation were noted, interviewees were asked for clarifications. After explanations were offered, I expressed my understandings of their statements in alternative ways to authenticate my interpretation and provide the opportunity for their correction of potential misunderstandings. This process of confirming meanings was another means of reducing potential differences of understanding between myself and the interviewees to improve the trustworthiness of the research findings (Denzin and Lincoln, 1998), which aligns with the research aims by privileging the participants' perspectives rather than my interpretations (especially considering the importance of subjective differences on aspects of the research topic).

However, despite these attempts at reducing personal biases, interviews are ultimately social interactions shaped by a host of influences from the interviewer, respondent and research context (Warren, 2012). As such, responses to the discussion prompts could have been influenced by other aspects of the interactions, such as my facial expressions, tone of voice and body language, or the interviewees' expectations of appropriate/socially acceptable responses, willingness to self-disclosure or even concerns about time and other commitments. While I did my best to minimise some of my potentially negative impacts on the process – such as keeping a neutral facial expression and an open and engaged poise (through actions such as keeping my arms unfolded and leaning towards the respondent) – my conversational style and experiential familiarity with the research topic meant that my interactions and behaviour during the process were not always disinterested, and varying degrees of self-disclosure and humour were employed through the process. These were often done to build rapport, break up the somewhat interrogative nature of the interaction and promote dialogue. This was informed by the adoption of a position as a “narrative partner” (Gubrium and Holstein, 2012 p.33), using active subjectivity in a co-production of accounts rather than attempting to uncover some pre-existing “unbiased” narrative. The potential value and impacts of these intersubjective dynamics are considered during the analytical and interpretive process.

In addition to this use of question-driven discussions, photographs were also selected as a suitable medium for eliciting conversations to explore participant perspectives. The use of photography is discussed in the following section.

Photo-methods

Photo-methods are a relatively new approach to data collection rooted in visual anthropology (Collier, Collier and Hall, 1986), and have been considered a potentially beneficial method for investigating concepts within the health services (Hansen-Ketchum and Myrick, 2008). This method was selected for this study as it assists with the generation of richer contextual data and can be used to better explore subjective interpretations and the meanings attached to scenarios. It was also intended to help draw out issues that are important to the individuals within their working environments, particularly when using participant-directed photography (Pink, 2001). Photo-methods are considered especially useful in research on men, as different aspects of the method help assuage some of the tendencies to limited self-disclosure that may be produced by male socialisation (further discussed below, and used in studies such as Creighton et al, 2017; Oliffe and Bottorff, 2007; Simpson and Richards, 2018; Wilde et al, 2020) The two photo-methods selected for this study – researcher-led photo-elicitation and participant-led photo-elicitation – are described below:

Researcher-led Photo-Elicitation

Photo-elicitation entails the use of imagery as prompts for discussion (Pauwels, 2015). These images assist data collection in several ways: first, they can provide indirect access into interviewees interpretations of situations which may otherwise be missed in a traditional interview (Collier, Collier and Hall, 1986). For this reason, photo-elicitation was done after the initial voice interview, as it provided the opportunity to contrast the nature of responses between both forms of data collection, and interviews alone could produce responses coherent with expectations of social identity (Creighton et al, 2017). Having interview discussions prior to the use of photo-methods also assisted with building understandings and familiarity with the research focus, which was expected to enable better responses to images. Similarly,

providing a tangible object of interest also helped mitigate the potentially confrontational nature of the interview setting by reducing focus on the respondent (Pauwels, 2015), and this helped improve participant engagement, advance the discussion by offering new foci for commentary, jolt memory through associations and refocus the conversation where digressions occurred (Olliffe and Bottorff, 2007).

Pictures for the photo-elicitation interviews were sourced based on my understandings of (and experiences with) the research object – emotional labour in the care setting. These images were collected from a variety of stock image websites such as *Alamy* and *Getty Images*, and the use of these images for research purposes is permissible under current copyright laws (as the study is for a non-commercial purpose – GOV.UK, 2004), and attribution of ownership will be included for any such images used in the final publication. Following consultation with a colleague (who worked as a male nurse), eleven pictures depicting male care workers in emotive scenes associated with their roles were selected for the study (See **Appendix C**). This consultation process was important as the responses generated by the photo-elicitation method are “anchored in an image that is understood, at least in part, by both parties” (Harper, 2002, p. 20), and as such images which were considered appropriate by *both* myself and the consultant colleague were deemed more likely to be understood by respondents and elicit responses.

However, this selection process was still limited in its scope: many of the pictures featured men engaged in more clinically oriented care work, a feature which was due to the nature of images available to choose from (which tended to focus on male nurses, who were easily identifiable as professional carers). Similarly, the occupational backgrounds of both myself and the consulted colleague (both medical professionals) potentially contributed towards this bias in the selection of pictures, as we were more likely to consider care work in clinical scenarios, which we found more familiar. These limitations were noted at the time of selection, considering that prospective participants were anticipated to work in a range of care environments. In response to this, participants were told that they were not

expected to comment on all the pictures and could skip any images they did not consider personally noteworthy.

As with interviews, questions around images were deliberately open-ended, phrased in a manner that avoid influencing interviewees responses, such as “What comes to mind when you look at this?” The emotive scenes depicted in the images were particularly important in the research context, given the capacity for photography to serve as a mitigating “third object” of focus in explorations of experiences which may be difficult to express in a direct conversation (Frogget, Manley and Roy, 2015). The pictures were intended to prompt affective associations with the participants’ experiences and produce an intersecting narrative – one both constrained by the details within the image that elicited the response but equally representative of their perspectives and experiences. Follow-up questions were used to clarify meanings and further explore statements generated through this process.

The same set of photographs were used across interviews to enable comparisons of individuals’ interpretations, and this contrast of responses enabled an interrogation and re-contextualization of differences in perspective. The use of photographs to drive discussion within the first interview session was also meant to familiarise respondents to the photo elicitation process, which was intended to ease the process for the participant-led photo-elicitation required in subsequent interviews, as discussed below.

Participant-led Photo-elicitation

Participants who agreed to further interviewing were asked to produce their own imagery – whether pre-existing, captured from directly their natural environment or composed to illustrate a message – which were to be used for subsequent discussions. Images from digital cameras (as can be found on most commonly available smartphones) were preferable, but disposable cameras were offered as well, in case participants did not have a digital camera or preferred not to use their own camera for the project (with the promise that photo films from these cameras were to be developed at no charge to participants). These second interview sessions were intended to

occur about three weeks after initial interviews, though the actual duration inevitably varied depending on participants' schedules. About ten pictures were requested, and instructions were given regarding the types of images that were appropriate (this is further explained in the subsequent section on *Ethical Concerns*), but the choice and number of photographs were ultimately based on the participants' discretions. Two participants consented to this process, producing a total of six images. However, neither of the participants who produced pictures for interviews offered them for publication, as they intended to keep these images private.

As with the initial interviews, respondent-generated images served as discussion points, as the images themselves offered no meaning without interpretation (Collier, Collier and Hall, 1986). This use of participant-generated images fit with the research aims as the photographs produced were directed by the participant's perspective, and as such a discussion of their photographs enabled insight into issues that are of importance to them by giving participants more control over the stories they chose to tell (Banks, 2000). The self-directed and personalised nature of the photographs used in this process was also expected to counter some of the limitations posed by the images used in the earlier photo-elicitation by grounding the discussions in scenarios familiar to the participant. The period between interviews and the process of creating images also provided some of the benefits of longitudinal interviewing, such as improving familiarity with the researcher and research topic and giving participants time to reflect on their practices and earlier discussions (Grinyer and Thomas, 2012). This prospect for reflection had the potential to provide additional perspectives on earlier accounts, as participants had the chance to discuss any issues or topics which were overlooked in initial interviews.

Yet while the benefits of photo-voice were acknowledged, it is equally valuable to note the limitations. Images taken by participants were guided by matters such as interpretations of the research aims (some pictures could only be tangentially related to what the researcher hopes to investigate), the scope of photography (which is limited to objects that can be captured, as well as the capacities of the camera itself – such as the frame of view and

ability to function in low light), appropriateness of photography (not all situations could be photographed due to personal and ethical reasons) and contextual practicalities (it would be difficult to capture a situation where it was physically impossible – such as while caring for a client – or where there are more important issues at hand). Similarly, the awareness that the photographs were to be viewed and remarked on could have influenced the choices made during and after the process of capturing the images. This means the final images provided for discussion were *contextually filtered* representations of the research object, and while they could provide some insight into the participants' perspectives on the research focus (emotional labour), they cannot be considered fully representative of lived realities. These considerations were factored into the process of data analysis, which is discussed in the following section.

Data Analysis

Audio data from interviews were transcribed verbatim in a semi-denaturalised format. "Semi-denaturalised" means that content of speech was maintained, but quirks such as stutters, pauses and other non-linguistic vocalisations were eliminated unless these affected the context of what is said. Contextual clues noted in the audio data (such as sarcasm or humour) were added to the text to guide interpretations. Transcripts were managed using a word processor and the Institution's digital cloud storage service (Microsoft Office and OneDrive) to enable safe storage, retrieval, and interrogation of data.

As the study aims to explore both subjective interpretations and discourse, the analytic approach selected to achieve the research objectives is Interpretative Phenomenological Analysis (IPA). IPA is premised on the belief that the elements and expressions of subjective experiences are interconnected, and both aspects should be assessed to gain insight into how these experiences affect individuals (Smith, 1996). For this reason, it holds a decidedly idiographic focus (though these individual narratives are inevitably situated in social contexts), and combines interpretative and narrative components, meaning that its analytical focus entails an interpretation of components of individual accounts as well as the unique ways in which individuals describe and make sense of their experiences

(Reid, Flowers and Larkin, 2005). This combined focus acknowledges both the participants' portrayal and interpretation of experiences through language as well as the researcher's interpretation of these accounts through critical analysis, engaging in the "double hermeneutic" (Giddens, 1987, p.20) as the individuals must first understand and interpret their experiences before they can be understood and interpreted by the researcher. In addition to an evaluation of ideas and concepts in narratives, participants' understandings are explored through an evaluation of the ways in which they express their stories, an approach which bears some similarities with discourse analysis. However, IPA differs from discourse analysis in that it is focused on how experiences are interpreted through discourse, while discourse analysis is focused on how the accounts are linguistically constructed (Smith, 2011).

The analytic process for IPA entails a close reading and interrogations of participant accounts to generate codes which summarise and produce insights into the participants' experiences and perspectives. Each case is handled independently, and codes must be produced *from* the data rather than from existing theoretical frameworks applied *to* the data. In this way, findings from this method are limited to only what can be demonstrated through participant accounts, which keeps the reported outcomes close to the source. This close and critical analysis of each case makes the method ideal for producing rich and complex insights from a small number of individual narratives, as is the case in this study – sufficiently detailed IPA studies have been conducted with as little as three to six cases (Smith et al, 2009). Emerging codes are related to both the *content* of the accounts and the *construction* of such accounts are then organised based on recurring patterns into themes. The analysis of constructions of language for meanings connected to experiences constitutes the hermeneutic dimension of IPA (which distinguishes it from thematic content analysis), and involves an appraisal of linguistic elements such as word choices, implied references and notable insertions and omissions, all of which are used to assess and situate the individual accounts in relation to popularised social narratives (discourses). Both the content- and construct-related themes identify concepts and issues that matter to the participants, as well as the meanings

they attach to these entities/ideas. These themes can be organised based on similarity (depending on whether they converge or diverge) and interrelationships into larger (superordinate) themes. Findings would subsequently be appraised using a “light touch” best-fit approach, highlighting correspondences and conflicts with available social theories rather than engage in more structured construction of theory (Bryman, 2012).

However, though the method aims to ground interpretations in the participants’ accounts, it would be wrong to say that IPA produces findings that directly reflect reality due to numerous limitations of the data collection process as earlier noted. Data used for analysis is shaped by several influences like the participants’ accuracy of recall, tendency to self-disclosure, capacity for self-reflection and words choices for representation of experiences (which are shaped by cultural environments that could differ from the researcher’s and thus affect understandings and inferences drawn). Still, given the nature of the research focus and the intention to assess individual perspectives, participants’ descriptions remain the most feasible means to access the required data, and the method is well suited to the study aims. The combination of this analytical method with repeated and reflexive dialogue between the researcher and interviewees – a consequence of circumstances that emerged over the course of fieldwork and prompted an ethical reflection on the analytical process, as explored in the next subsection – produced insights that were in keeping with the interviewees’ perspectives, further aligning the method to the research aims.

Ethical Concerns

Beyond the complying with legal requirements, maintaining ethical practices in this study refers to measures taken to respect the rights of all individuals involved throughout the course of investigation (Israel, 2014). These include, but are not limited to, acquiring informed consent, minimising harm to participants, maintaining anonymity and confidentiality (where appropriate), and avoiding invasion of privacy. Participation in this study was emphasized as voluntary, and all individuals were provided with information about the study (including the need for voice-recorded sessions) prior to data collection through information sheets and explanations by the primary researcher.

Considering the possibility for repeated contact with participants and the prospect that views on participation may change, informed consent taken at the first interview was considered provisional until interviewing was complete, and participants were provided with information on who to contact should they choose to withdraw from the study or retract information that was previously offered. There was no financial remuneration for participation, though complimentary refreshments were provided during the interview sessions.

In keeping with General Data Protection Regulations (2016), data and findings produced from this study were handled to minimise access to personal information and preserve anonymity. Pseudonyms were used in all transcripts and labels for data files, and only necessary identifying data was kept for analysis. Recordings of the sessions and other digitized information were kept confidential and stored in personal password-protected online data drives. Consent documents were digitised (after which hard copies were destroyed) and stored separately from all interview data in password-protected online data drive to reduce risk of connecting interviewees' identifiable information. Data from the study is to be held for a period of ten years, and further details on how data will be handled are outlined in the Data Management Plan (See **Appendix D**).

Ethical guidelines for use of photography in research as highlighted by Gross, Katz and Ruby (2003) were used to direct researcher and participants on what photographs can be captured and published. These included: avoiding images which could be potentially embarrassing to subjects, no images which intentionally portray others in scenarios that could be interpreted negatively or depict illegal activity (as this could lead to breach of confidentiality for the sake of safeguarding). These guidelines were given to participants through the information sheet and in discussions prior to commencing photography. However, because the guidelines cannot practically be enforced, the ethical principles were to be applied more stringently on any images volunteered for publication, with any identifiable subjects and information (such as patient records or addresses) to be

concealed. No photographs were ultimately volunteered for publication, so this considered ethical process was unrequired.

Participant-generated images for this project are considered the intellectual and creative property of the participants and were used if they opted in and provided written consent (a section for this was included in the consent form – See **Appendix E**). Any participants who chose to volunteer their photographs for publication were informed that images will only be published if they followed the ethical guidelines. However, even with the need for confidentiality and anonymisation, the use of participants' images without due recognition of authorship could be considered unethical (Coffey, Robinson and Heath, 2012). To balance both needs (authorship and anonymity), a compromise was reached where participants were asked to select unique pseudonyms for themselves, and these pseudonyms were used for labelling all data (including quotations and imagery) related to participants. This way, participants can recognise their contributions, and are given the choice on whether to maintain their anonymity.

On a related note to ownership and representation of participants' voices, an equally important ethical concern bears on the politics of knowledge (Reiken et al, 2005), that is: the power relationship between researcher and participants, and ensuring that participant's stories, once obtained, are portrayed fairly and without distortion. Though the design of this study was intended to illuminate the experiences of the participants by encouraging their production of the primary data, the analytic approach employed and existing differences in personal understandings of concepts and situations means that the final depiction of findings is determined by me, the researcher. To reduce the influences of my interpretation, participants were asked during interviewing and over the course of analysis to authenticate understandings of meanings through feedback statements and follow-up questions. Each participant was also offered a plain English summary of key findings from their individual interviews during the process of analysis to ensure that their stories and contributions are appropriately represented. This participant feedback process was only meant to explore interpretations of the initial interviews (it was not a source of additional data) and involved a

conscious use of theoretical tools to open out the richness of meanings. The interchange with participants' interpretative accounts also served as a reflexive strategy to inform and possibly contrast interpretations, extend the dialogic relationship between myself and respondents, and minimise inequalities of voice and representation.

Due to our introduction through social networks, this feedback process led to closer personal connections with participants, and these growing friendships enabled a depth of understandings of their lives beyond what would have been possible in a traditional interview arrangement with interpretative analysis. In this sense, the extended interactions and deepening interpersonal relationships contributed a semi-ethnographic dimension to the study, resulting in a "friendship as method" approach which Tillmann-Healy (2003) describes as "authentic engagement [where] the lines between researcher and researched blur, permitting each to explore the complex humanity of both self and other". A recognition of this shifted dynamic during the study prompted an awareness and commitment to an ethic of friendship, seeking deep understanding and just representation, and putting any "fieldwork relationships" (placed in quotes as some of these relationships developed and are expected to continue beyond the study contexts) on par with the project, rather than a means to an end.

This application of "friendship as method" supported an empathetic contextualised understanding and fairer representation of the interviewees' perspectives. However, this empathetic approach and "ethic of care" had to be balanced with self-awareness and a critical engagement with the interviews to avoid emotional vulnerabilities or "merging" perspectives between myself and interviewees (Owton and Allen-Collinson, 2014). For instance, while I could personally recognise and empathise with some of the difficulties that participants faced with relaying complex emotions as experienced in care work, I strived to maintain an outlook of ignorance which encouraged their elaboration of their emotional accounts while simultaneously de-emphasizing my focus on my emotions. This helped both to manage my emotional experience during the interviews and maintain a

distinction in perspectives captured in accounts, which was valuable and necessary for this research topic.

As the focus of the study on emotional experiences of participants and difficulties they may face in performing their roles, there was a possibility that discussions could have led to distress for some participants. To minimise any such negative impacts, I used listening skills to establish whether to continue the discussion and retained a list of helpful organizations which specialise in tackling mental distress (like Samaritans, LGBT groups etc) to offer to participants if needed. These actions were guided by a distress protocol (developed with the help of the supervisory team – See **Appendix F**) that suggests positive action and possible resolutions before, during and after interview. Yet while acknowledging the potential to cause distress, the interviews were also considered to provide an opportunity to air out issues and difficulties regarding emotionality in the workplace, which could be considered a therapeutic experience for participants (Creighton et al, 2018). Participants were reminded prior to each interview that they could pause or terminate the discussion at any point during the process and contact me (before findings are published) if they chose to retract statements or withdraw their participation.

Positionality

As acknowledged earlier in the preface, my interest in this topic was influenced by my medical background and experiences with the physical and emotional demands surrounding patient care. This gender similarity and familiarity with the research subject often served to facilitate conversations with other health workers, though it equally had the potential to complicate my perspective by obscuring certain "taken for granted" elements in health work. Whilst challenging, this double consciousness as a medical professional and researcher provided insights from within and outside the research setting. This was beneficial in the research context, as it enabled me to easily appreciate but also critically evaluate the participants' perspectives. Also, as I am a medical doctor and of African ethnicity, these factors may have affected the nature of data collected. For instance, my position as the primary investigator could have impacted on recruitment (if a

participant was unwilling to speak with a foreigner), and perceived differences in cultural background or social status (due to education or occupation) could have affected responses by interviewees. These factors, while unmodifiable, were factored into the collection and interpretation of all received data and emergent themes (Finlay and Gough, 2003). For instance, I withheld my identity as a medical professional in recruitment and early briefings with potential participants to avoid the impacts that this perceived identity may have on the interactions; I only introduced myself as a PhD student with some interest in the research topic. Any disclosures on my history as a medical professional were done during the interviews, typically to corroborate interviewees' experiences or highlight the limitations of my prior understandings, and these disclosures were regarded positively given the privileging of interviewees expertise on the research object.

It is also important to acknowledge the potential influence of my own views on gender and emotionality. As a relatively young bisexual man with a gender-free outlook on individual and social characteristics, I recognise that my personal standpoints could offer a different perspective to understandings of the concepts explored in this study. It is this subjectivity that sparked my interest in the research topic and is inevitably reflected in the utilisation of the chosen methods, including how I related to participants, conducted the fieldwork and interpreted narratives. I expect this viewpoint to lend to my critical appraisal of study data and did my best to avoid unhealthy and politically motivated biases that would manipulate data to 'prove' a desired outcome. I also worked to reduce the influence of personal biases in this study by confirming interpretations with the study participants (during and after the interviews, as previously discussed in the Ethics section) and through consultations and triangulation of themes with my supervisory team.

Chapter Summary

The approach and methods selected to meet the aims of the study have been informed by a dedication to exploring individual perspectives, considering practical and ethical issues which impact on the research process. While the selected methods of audio-recorded interviewing and photo-elicited discussion can offer particularly rich insights into the individual

experience of emotional labour, they nevertheless pose limitations to the scope of data that can be accessed and collected. Similarly, the interpretative approach to analysis, which would be influenced by elements of my inescapable subjectivity as a researcher, confines the interpretations and inferences that can be made from the research data. This means the outcomes of the study would, at best, be partial understandings of the research focus, filtered through the constraints of human perception and communication.

However, even with these limitations, the methods have been designed to grounding of the data in participants' perceptions through their direction of the research focus. Similarly, the integration of participant authentication in the analytical process – a decision taken to counterbalance the interpretive leanings of the researcher – lends a degree of trustworthiness to accomplishment of the research aims. As such, the subsequent outcomes can be taken to be credible representations of dimensions of emotional labour as experienced and communicated by male health/care workers.

The next chapters will each explore three key overarching themes from the research data, highlighting similarities and discrepancies between accounts, as well as nuances *within* accounts – in keeping with the idiographic focus of the analytical method. These findings are, due to the data sources, research focus and analytical method, constrained in their scope and represent concepts and contextual details identified by the researcher. Themes will be supported by extracts from interviews which exemplify the identified concept, along with a discussion on the intersections and dissonances between the findings and with other related research.

The themes identified, organised and discussed in the next chapters are:

- *Identity in Care Work*
- *Emotions in Context*
- *Policy in Care Work*

Identity in Care Work

This chapter presents and discusses the first dominant theme surmised from analysis of all accounts of emotional labour: an understanding and expression of individual identities as situated within the care environment. Yet before this can be explored, it helps to provide a working definition to ground the discussions. “Identity” is a complex concept with diverse and sometimes conflicting definitions and constructs in sociological and psychological studies (Bamberg, 2004; Brown, 2000; Burkitt, 2004; Cote, 2006; Kroger, 2007; Schwartz, 2002; Wetherell, 2010). However, within this study, the term “identity” relates to elements of interviewees’ accounts pertinent to their self-description, including understandings of personal characteristics, interpersonal interactions and relationships to significant others, affiliations with notions of social collectives, and even material artefacts (such as a house, which could produce the identity of a “home owner”; or contents of their bank account, which grants the identity of a “millionaire”), forming an integrated definition of interacting components (Vignoles et al, 2011). This self-defined focus positions identity as characteristics which the individual finds personally and socially meaningful to their concept of self.

The subsequent subheadings are named after each interviewee in this study and aim to explore interconnected elements of their identities which influence emotive expressivity and engagement with emotional labour within the care setting. This method of presentation was also chosen to provide a case-specific baseline for the discussions in subsequent chapters. The idiographic focus of the study’s analytical method (interpretative phenomenological analysis) was well suited to this form of exploration, and the analysis of narrative and discursive elements within accounts revealed connections and contentions between interviewees’ reported identities and the characteristic expectations of their roles. To retain this individualised focus, these findings on identity will be presented through biographical summaries of their accounts, to highlight and discuss the interactions between the personal and professional dimensions of their reported experiences. The details of these summaries are by no means wholly representative of the interviewees

described, and the extracts of their discussions are presented to shed light on features of their identities considered noteworthy in relation to the research focus.

Bob, Your Uncle

“Bob” was the chosen pseudonym for a liaison psychiatric nurse in his mid-forties who worked in the hospital setting, where his role centred on assessments, treatments and referrals of people considered to have mental health difficulties in the emergency setting. He had previously worked in other care-related roles, including support work for people with learning disabilities and geriatric psychology, before moving into liaison psychiatry because he “really wanted to... work **with** people” (emphasis captured from his word stress during the interview). He clarified this to mean work where the clients were more involved in the treatment process, as opposed to largely being recipients of actions dictated by the care worker.

This self-determined foray into his vocation forms the starting point from which connections between care work and his sense of identity are explored. In discussions around his role as a psychiatric nurse, the language used was often centred on distinctions between his care-related actions and those of other health professionals:

“I think on a Psychiatry side, we tend to be a lot flatter in our hierarchies in that, um, work alongside the consultants and the junior doctors and the psychiatrists and the psychologists and the OTs and the Physios, and the Social Workers. I think in- um- in the medical environment, it’s much more hierarchal construction, isn’t it? The consultant’s at the top, and everyone does what the consultant says, that’s it. Very structured, isn’t it? And I think, to some extent, particularly the medical colleagues find that quite difficult because we...we don’t mess about with challenging people. We’re not fazed by arguing with consultants and saying ‘no, I’m not going to do that, I don’t think that’s the right thing for the patients. And no, I don’t think that referral is appropriate because...this that and the other.’ So, it might be about giving a rationale.”

The use of the term “we” in this context was especially noteworthy, as it was used to frame how the values and expectation within his role as a psychiatric professional was both collaborative and conflictive when cast against other named roles within the healthcare service. While all were acknowledged as “colleagues”, the term “we” signalled his affiliation with only a subset of the health care industry and separated the norms of his role (such as a rejection of hierarchies of command) from those of other professionals. In this regard, his sense of identity within the wider health care service was both affiliative and exclusionary, based on the peculiarities of professional expectations within the role he identified with. In further discussions of how the norms of his profession shaped his view of emotional labour, a common reference to “the uniform” was used as a metaphorical representation of the expectations of caring behaviours and professionalism attributed to this role. For instance, in his response to one of the prompts for photo-elicitation (*Picture 5* in the **Appendix C**. All subsequently referenced pictures are also in this appendix):

“I think that’s a big part of what you see in this picture, that sort of... understand- saying ‘yes...you’re sad, I understand that. I can see that, I can see that...things are hard’... whatever’s going on, whether she lost somebody or had some bad news or whatever, um...{long pause} ... and sort of understanding the emotion...not just doing the job. You might have a uniform on, but you’re not just doing a job. You’re that- see, you got that connectedness, that- that...empathy, that humanness.”

This comment on the expectations of “the uniform” seem to be pitted against what it means to “do a job”; the act of care and treating clients with compassion could be considered part of the “job” of the uniformed professional – in effect, merely a manifestation of emotional labour. Yet, here, Bob challenges this notion by rooting the act of care within a more existential sense of interpersonal connection and what it means to be human, a perspective which challenges findings in other research which largely place acts of care and emotional labour (especially from men) as a means of establishing power or control (Cottingham, 2015). The recognition of the care worker through “the uniform” and the attribution of expectations around care

and professionalism were both also described as a potential source of contention in the relationship between the care worker and client:

“This is um...it’s interesting in psychiatry because often...my job is quite unusual for psychiatry in that I wear a uniform... whereas lots of people in psychiatry don’t like uniforms because it...they feel it produces a barrier. Um...and you want to be alongside somebody and...and...um... but I don’t- the uniforms have advantages and disadvantages, don’t they? And they um...it’s a... they do create expectations to some extent ...um but also they create opportunities as well. Um...because in reality, if I’m going to visit somebody at home and I’m in my own clothes, I’m still a nurse going to see somebody in their own home aren’t I? Whether I’ve got a uniform or not is- is...um... it does create- sometimes it creates opportunities, particularly in – in- what’s interesting is that we wear a uniform in liaison psychiatry because we work in...a general hospital, and so there is an expectation...of nurses to wear uniforms. And also the element of...the colour of your stripe (yes) Being a band six I have a white stripe, band sevens have a red stripe, and there’s that element of hierarchy...of um...of leadership or respect or whatever you want to call it, it’s that sort of...sometimes you need a bit of authority in your recommendation or decision-making to other professionals within the care professions, you know. Whereas if you entering in a pair of jeans and a t-shirt you...people will say “who are you? What are you doing on the wards” sort of thing. You haven’t got that rapport necessarily with the other- your other colleagues.”

In the first part of this quote, Bob mentions how the identification with a uniform could produce a barrier to emotional communication, based on the expectation that any acts of care from the care professional were potentially inauthentic or a mere manifestation of “doing a job”. He contrasts this expectation placed on the uniform with how he would be judged without it, showing through “*I am still a nurse*” that the care he would provide is independent of his attire, and that his identity and role as the care worker transcends his recognition as one. And yet, the expectations from being identified through the uniform could serve to legitimize his authority and facilitate communication with other professionals by indicating his level of

expertise within the organisational structure (as depicted through stripes). This sense of ambivalence around what it meant to be recognised as a professional – by both clients and other healthcare workers – showed how the interactions within the setting of care could be constrained or facilitated by his identity as a care worker.

The excerpt presented here also shows the interplay of two levels of recognition: from the person who encounters Bob as a care worker, and the Bob's own awareness of how he is recognised. While a clients' recognition of his identity as a care worker produces expectations and possible limitations, his own recognition of how this perception could affect his work (for instance, as a barrier to emotional connection with clients, or to legitimize his professionalism, as with the stripes) informs his knowledge of the advantages and disadvantages of "the uniform" as a marker of his identity. Further analysis of this segment raised questions around the nature and impact of recognition itself as a cognitive process. Within contemporary theories, recognition is understood to be predicated on several elements – the subject who recognises, the subject being recognised (we can call this the object, though in this sense, we are not limited to inanimate entities), a figure which the object can be identified with, and a relevant property which necessitates the identification of the object with the figure (Giorginni and Irrera, 2017). Taken together, this demonstrates that the recognition of any subject or object is bound on foreknowledge (from which the figure for comparison is derived) and the process of identification with the figure enables a unification or connection between multiple experiential phenomena (Ricoeur, 2005). For instance, to recognise a bird (the object), a subject must first hold prior knowledge of what a bird is, and this idea forms the figure against which the properties of a new exposure (like the presence of a beak, eyes, wings, etcetera) can be compared to achieve the recognition of the object. When applied to Bob's comments, it can be inferred that the figures which determine his recognition as a care worker are derived from clients' experiences with other care workers (alluded to in the phrase "*there is an expectation...of nurses to wear uniforms*"), which create the expectations that are applied to him through the identified property of the uniform. His

awareness of these expectations was then considered in his responses to the clients.

This acknowledgement of (and response to) expectations derived from other experiences and contexts applied to other aspects of his identity, notably in discussions around the impact of gender on care work. Much like his awareness of the recognition of his “uniformed” status as a nurse was seen to produce certain expectations, his recognition as a man was also regarded as a source of expectations (typically derived from other men) which he had to respond to while providing care:

*“Um... {long pause} ... I think sometimes, people...maybe aren't quite as open all the time with- with men (yeah) or with me. If then I was waiting with a female colleague, um, then I think sometimes people are more emotionally open...to a woman than a man. And um... where as they want **solutions** from me, I think. Sometimes that's my perception anyway. Um... they want- particularly because I'm a prescriber, I, um... my colleagues often say to me “well, I've done the emotional bit, what do you think we can do from a medication point of view?” I mean, there's something to- that's a skill, isn't it? I'm...I trained to do that so that's sort of my specialty to some extent. Um...but it is very interesting that, I think, particularly from working with one of my female colleagues, I think...they would often look for me for the sort of practical answers...as to what to do with... um, from sort of a treatment point of view. Yeah so that's um...{sighs}... But I think sometimes, um...{long pause}... But sometimes on a- a male to male point of view, you can...sort of come alongside somebody and say “listen, sometimes it would be- things would be sharp, mate. Life is sometimes rubbish.” Um...and that sort of empathy, like “listen, we've both got kids. We know how hard it is sometimes when they're all bickering in the background.” And sort of coming alongside someone and working alongside someone to look at... and show them to- that you understand where things are coming from and why they are feeling so distraught and what's going on in their lives. I think that often helps people. That sort of level of empathy helps people tune into...sort of what you're discussing and what sort of options you're coming up with, and where- where we can go from here. Um...and I think that's helpful sometimes. Um...*

So I think it does influence- I think sometimes you can... I think you need to be aware of how your gender influences how people see you, so you can then tailor what you're discussing and how you approach things so that it helps that person...with the best outcome. Um...and I think also, particularly, a lot of the people we deal with...particularly some- the women that we assess...have experienced quite a lot of trauma. Sometimes we'll choose who sees that person to reduce that sort of- well, someone's... you see the notes from A&E and they're talking about...maybe there was a sexual assault or a rape last week, then I'm not the person to see that person. You know, it's that sort of... um... sensitivity to the person's needs, really, and- and finding the person that fits that sort of role and...uh...it's helpful for the- for the person who's there that the patients has the best outcomes."

Within this relatively lengthy excerpt, there are several notable points on Bob's experiences with the perceptions of his gender, yet most point to how forms of recognition and affiliation with a preconceived male identity affected his experience of care work. The first part focused on how associations of emotionality with women and rationality with men (even among his colleagues) determined the activities he is expected to be good at, through the insinuation that the "*emotional bit*" was separate from the "*practical answers*" or "**solutions**" (which he stressed) of a care interaction, with each regarded as a differently gendered specialty. While he acknowledged that he was, in fact, trained to offer medical treatment, he found the relegation of his role capacities to this dimension to be "interesting" (a word choice I considered to be euphemistic for something more negative). The sighs and truncated sentences that followed seemed to reflect a difficult articulation on how his identification as a man was used as a limitation on his capacities for emotional communication and care. And yet, in the sentences that follow, he highlights the potential benefits of gendered identification by illustrating how gender or other aspects of male identity like fatherhood shared between himself and male clients could facilitate communication and empathy, and even inform the "solutions" to issues being addressed. And in the latter parts of the passage, he offers a contrast by referencing how his identification as a male figure could be detrimental to a patients' wellbeing through their

affiliations with negative experiences (like sexual assault), and this understanding informs his approach to care provision. All these dimensions could be surmised by the statement: *“I think you need to be aware of how your gender influences how people see you, so you can then tailor what you’re discussing and how you approach things.”* In this acknowledgement, Bob indicates that his forms of care and emotional labour are shaped by external understandings and perceptions of his gender within specific contexts, rather than dictated by performativity of internalised gender norms as highlighted in previous literature (Cross and Bagilhole, 2002; Cottingham, 2015; Simpson, 2004).

Beyond the activities within the care environment, Bob discussed how his identity and recognition as a care worker affected his other social relationships. At the time of interviewing, he had been married for fourteen years and had had two children, one of which was on the verge of going into high school. His references to his role as a parent and within his close social networks often featured in his accounts of how care activities shaped his identity in both a professional and personal sense. For instance, when commenting on *Picture 11* (where a worker serves tea to a woman with a neck brace), he said:

“Um...{long pause}... because although this person hasn’t got a uniform on, they’re still offering care, aren’t they? Might be a relative, it might be...a friend, it might be a visitor...but they’re still offering that level of...intimacy and care. Um... she’s got a neck brace on, hasn’t she? I suppose maybe she’s injured her neck or something in uh...whatever. Um...so you’re still offering that care to- and compassion, aren’t you? On a personal basis, it’s-it’s... and that’s the other thing is whatever environment you’re in, you’re still offering that care to- to somebody else, aren’t you? With my kids at home, with my wife, my friends, wherever I am, you’re still offering that level of...relationship and care, aren’t you, to other people and...because a lot of the skills we use in nursing...are skills of life, aren’t they? Like sort of...how to talk to people, how to listen, how to...empathize, how to be in a relationship, all those sorts of things are parts of being human, aren’t they?”

These dimensions of identity, though discussed separately, interacted across relational contexts and were all considered facets of a unified identity as a care worker. While the separation of roles was made tangible through wearing the uniform (which was used to highlight the situated nature of emotional labour), Bob also acknowledged that emotional demands and expectations placed on his recognition as a care worker often transcended the work environment (such as through his roles as a parent or friend). As such, within the unification of his identity through engagement with care activities, the lines between emotion labour and emotion work are both identified and blurred:

*“Um...but there is- is always that tension, isn't there, the uniforms do create...sometimes a good expectation but sometimes a barrier. Sometimes, uh... a helpful re-cognition of what- what the roles are... and... and- also sometimes you're wary that if you put on that role, and if you take the uniform off then you're **not** in that role. That sort of element, isn't it, that you can... 'I'm a nurse now. I've got my uniform on, I'm a nurse. I'll go and do my nursing job, and then I'll go home, and I'll be a dad and a husband, I'll be a friend.' Um... {laughs} But you'll still get lots of people asking you 'Um...oh my Dad's got dementia, what can we do, x, y, z' so you're- although you're- people know that you're a nurse, people know you're- you work in psychiatry, so people...still seek out that advice even though you haven't got the uniform on... because they... they expect that certain element of...knowledge and experience and whatever.”*

This excerpt presents how differing dimensions of his identity intersected, based on roles and expectations associated with each. First was his reference to “the uniform”, where the act of putting on or taking off the attire was construed as adopting or relinquishing the expectations of the nursing role. However, even though there was an attempt to separate this professional identity (“*take the uniform off then you're **not** in that role*”- he emphatically stressed the “not”) while trying to adopt other social roles/identities (“*be a dad and a husband...a friend*”) the identification as a nurse still impacted his interactions and relationships. In effect, his recognition as a nurse affected his sense of identity both within the care

environment (where understandings of nurses shaped expectations placed on him) and outside the care role where the awareness of his nursing role and the qualities associated with it shaped social expectations. These dimensions of identity as interacting within the institutional and personal settings were further explored in the accounts of other interviewees, as highlighted and discussed below.

Lawrence Nightingale

“Lawrence Nightingale” is the pseudonym selected by a nurse who worked in a paediatric surgical ward, where he helped prepare children and teenagers for surgery and manage their post-operative recovery. His role necessitated extended contact with the patients (lasting weeks to months, depending on the procedure), and demanded a highly flexible “person-centred approach” to care provision due to the widely varying needs of the patients based on their personal characteristics, as depicted in this interview segment:

“You can never go in there with a set approach, even if you know information beforehand about the patient, you need to have a conversation with them first. You need to get to know them and- and judge what it is. And then of course you've got...the difference between the genders as well because at such a young age it's quite pronounced. But then you've also got to be careful that you don't go in that and call this five-year-old girl “princess” because she might not like princesses and she might be into, I don't know, boy things (Interviewer: Transformers {laughs}) Transformers. Who doesn't like transformers? (Interviewer: Exactly, who don't like transformers, like, I mean) Yeah. So yeah, there's a lot of um...there's a lot of subconscious assessment going on most of the time.”

These statements, taken together, highlighted how characteristics identified between people shaped communication and the approach to care work, and was the central theme to most of Lawrence's conversations around the influence of identity in his practice. However, the contrast between the earlier and latter parts of the extracted quote paint a complex and somewhat contradictory picture. At first, Lawrence advocates an individualised approach to patient care rather than a “set approach” based on generalised

stereotypes. However, despite the suggestion of distancing from stereotypes, the language used also implies a compartmentalisation and designation of characteristics based on gendered beliefs (like “*boy things*”) and an indication that these distinctions hold some sway over behaviours – notably with children. These “subconscious assessments” indicate that pre-formed notions of individual characteristics influence the approach to care work, through an attempt to unify individuals through categorical recognitions (such as establishing commonalities in traits between those recognised as “boys” and “girls”, as referenced in the earlier section on the cognitive process of recognition). This cognitive imposition of expectations based on idealised commonalities and stereotypes, naturally, creates tensions with the more individualised ideal of a “person-centred” approach to care.

These contentions on the properties attributed to gender were encountered in latter remarks on the influence of gender on care work. For instance, when asked to comment further on how he and colleagues coped with the stressors of care work (as explored in the *Personal Dimensions* section of the next chapter on *Emotions in Context*), he said:

“Um...probably, if you were to do a study on the amount of...alcohol consumed by nurses {laughs} that- I imagine that might be quite a popular one. A lot of people, they're all ‘Oh, I'll have a bottle of wine tonight’. A lot of boozing is probably what um... {pause} a lot of my colleagues are also women, and majority of them are- and a lot of them have families. And so, they- I don't...the honest answer is I don't know how they do it, because they'll finish doing the thing that can sometimes break me, and then they'll go home, and then they'll look after and support and raise a whole family. I'd- I don't do that. So I don't know, maybe speak to them guys and- because I would also like to know how they do it because it astounds me. The- some days I finish work, it's take- it's took everything out of me, and I go home and I'm fit for nothing but just sleeping or just being mindless somewhere. But yeah, they go home and they've still got people relying on them and they...you know, they're still- they don't let them down and they're always there for them.”

Here, Lawrence contrasts his capabilities against his female colleagues. The key point of highlighting their gender in this comparison was that the women have families and dependents, but the process of handling the difficulties and consequences of emotional labour was not assumed to be improved by their gender. This challenged, or at least subverted, traditional notions of naturalised caring ability in women and female nurses (Davies, 1995; Thurer, 1995), which has typically been the premise against which male capacities for care are contrasted and questioned. And yet, psychosocial research on how care activities are adopted by women support the idea that caring is more likened to a skill developed in the appropriate context (Chodorow, 1999; Reveley, 2019), rather than a manifestation of their gender. In effect, the caring attitude associated with women is only produced through the demands of childcare and familial responsibilities. This is supported by Lawrence's further comments on how the demands of care work could be detrimental to his other social relationships, and a further example he offered on how gendered expectations played a role on understandings and assumptions of care-related activities:

*"It- It is something that plagues my mind a bit because I do want to have a family one day, and I think...it's knackered me out now, how am I going to do it then {laughs} But then, people **do** do it, and when you ask them, they say 'It's because I've got to do it'. I think that comes up quite a lot. I've got another friend who works in- so she's a learning disability nurse working on a medical ward in a mental health hospital which I would say is probably one of the most difficult nursing environments to be in. she goes to about this big {indicates height}. If you're talking about clichés and stereotypes, if we were standing next to each other, you would assume that I do her job and she does my job, because she's this little sweet-looking girl and I'm this big, you know, scary-looking dude {laughs}. But no, um, so [what] she does- she- It's incredibly physical, uh, a lot of restraints and...very emotional as well, because a lot of the patients that are coming through have got horrific stories and histories and stuff and these are things that you- that you have to deal with, or the results of these- these horrible stories are- um, the patient's presenting with challenging behaviours and stuff like that so the two are*

linked. Um, and when I asked her, like, how she does it, she just says 'It's because I have to do it', Like, it's part of the job and that- that seems to come up quite a lot. You just have to do it, because it's what- it's what you have to do."

The first part of this reinforces the notion that caring behaviours are developed and improved by necessity – that is, to meet the demands of others for care – rather than some inherent physical ability that exists *a priori*. In the middle portions of the quote, Lawrence challenges the notion of stereotypes and their associations by comparing his role with children's nursing (which demands nurturing behaviours and emotionally flexibility) with the role of his colleague who is a woman in a role associated with more physical ability "restraints" and custodian behaviour. These roles are each associated with the feminine and masculine genders respectively, based largely on how these activities are commonly executed in other contexts, such as mothers with their children (Thurer, 1995), or policemen whose roles demand physical handling and restraints of people (Pinizzotto et al., 2012). These prior associations support such expectations and produce categorical impositions of gender, which is highlighted by the remark "*you would assume that I do her job and she does my job*". And yet, by the end of the quote, Lawrence affirms that the common consensus among those in care roles supports the notion of caring aptitudes (and related activities) as contextually determined – "*you just have to do it*". As such, it is the decontextualized and popularised attributions of gendered capacities (mediated through the process of identification and categorical impositions) that create tensions between what exists in care practice and what is expected from the care workers. Lawrence stated that these associations permeated even the ideals of those who should have a different perspective:

"So I'm talking...if I mention...if someone tells me about their friend who's a nurse, I'll say "what's her name?" When that's a terrible th- you shouldn't say that, should you? Well, I definitely shouldn't say that. But it's just something that comes out, it's in the- kind of ingrained in the social consciousness of everybody. Um...so yeah, there is a very definite...gendered...view. But...nowadays, I think it's...but we might- our first thought might be "what's

her name?" I'll then think "shit, I shouldn't have said that." At least now we're kind of getting to the point where we're questioning it, and it's not just...it is the first thing that comes out of our mouth, but then we're saying "oh, hang on a minute, maybe I should question that." So it's- it's- there's some progress, I think."

The focus here is on how stereotypes around the female-predominated nature of nursing (Loughrey, 2008; Macdonald and Sirianni, 1996) shape ideals and associations "ingrained in the social consciousness". Yet, even with this acknowledgement of dominant ideals, Lawrence's emphasis on "*I definitely shouldn't say that*" seems to serve a point of reflection based on his gender identity as an exception to the norm (as a man in care work who defies the expectation), even though he counterintuitively holds the same expectations as others. His self-reflective statements are also tied to shifts in the social consciousness, based on shifting demographics around service occupations (Kerfoot and Korczynski, 2005) which could prompt reconsiderations on the gender of care worker. However, in his experience, the expectations around his gender identity still impacted on his experience of care work, as described here:

"So I- I try not to think about it too much. Because then you can get kind of- you can get bogged down in it and...they you will then maybe be getting a bit more paranoid and a bit more...um...susceptible to- to these sort of invasive thoughts. So people thinking "is he a weirdo because he's a man doing this job?" You know, "Is he..." {sighs} So I try not to think about it, I just go in, do what I need to do, like I was saying before, just do what I need to do and...and then afterwards think on it. There is, sometimes, when I'll go in to the bedside and...I can see the parent- It's never the patient, the kids are never...they haven't got this...this ingrained into them yet, they're a bit too young, depending on the age of the patient. But most of them- most of the kids seem me and think "Ah, that's a big brightly-coloured, weird-looking strange-looking fella", (Interviewer: Yeah {laughs}) and that interests them. It gives me an advantage in that because I'm not like everybody else that's coming in there. Quite a few times, I've felt that it's given me the advantage of- say I've been able to make that connection with that patient quicker and

got them to take their meds, whereas everyone else hasn't been able to. Or...someone needs to take bloods, and they get- they're getting nowhere, but that change of face and that...shock to the system that my appearance can provide can sort of jolt them out of it, and then I- it's- yes, there's those advantages, if you- if you're careful with it. But sometimes, I can see that parents are looking at me, thinking... "Who- what are you doing here? Who are you?" Even- and also another one I get quite a lot is...um, a parent would say "do what the doctor says", and I'm stood there in my nursing uniform, like the same uniform as all the other nurses, very clearly- if you- it's one of the most recognisable uniforms going, isn't it? And I know a lot of doctors wear scrubs now, but they- they don't wear the blue ones, they purposely have the nurse in blue scrubs for that reason. And I don't- I don't even correct them anymore, I just- [think] "yeah, just do what I say" {laughs} because it's easier. But I suppose I should challenge them on it. Yeah, it is- it is something that exists."

The first part highlights a coping mechanism for dealing with potential negative perceptions around being a man in the nursing role. His reference to "invasive thoughts" and being "paranoid" align with the idea of "stereotype threat" (Tollinson, 2018) where known negative stereotypes against a person's identified group (in this case, being a man caring for children in a female-associated field – a "weirdo") created a psychological discomfort around potentially confirming stereotypes. Following this, he appears to wrestle between the advantages and disadvantages of his atypical appearance and/or being male in a female-predominated space; first, with managing the contrast between suspicion from the parents and apathy from the children who are yet to follow the "ingrained" modes of thinking; then the use of this contrast to serve as a psychologically-persuasive tool for building rapport based on his unusual appearance. By the end, he depicts how the assumption of authority/care responsibility (the reference that he is a doctor, based on his gender), reflects the expectations around women (being nurturing) and men (being authoritative) in care roles. Of note is the refusal to challenge the notion as it appears to serve a care function in the work environment by presenting him with an ideal of greater authority which

appeals to the client. The final statement on potentially challenging the idea seems to stem from concerns around perpetuating the stereotype around gender and care roles, even though he takes advantage of its associated benefits.

This acknowledgements on how attributions his male identity influenced his position and activities within the care context were also the key focus in discussions on how he interacted with colleagues and patients, and how “feeling rules” applied disparately. For instance, when discussing the use of humour within care work:

“I will not say half of the things that a female nurse would say. For fear of, like, sexual misconduct, that kind of thing. Like, they would make a lot more um boundary-crossing jokes, in certain areas, usually around su- like, a lot of the elderly staff- uh, the elderly women, would flirt with me. And it’s just a joke, and I don’t take offence to it, and I- you know, I- I play along with the joke, but I- sometimes, when you think if I was to say the same thing to them, that would be- it would be a whole different thing. Completely different thing. {sigh} But I don’t think that’s necessarily a bad thing about gender, I think they just need to {laughs} be a bit more professional. But I also understand the- the reason that they’re doing it is, you know, to have a bit of a [laugh?]- I don’t take it personally.”

This excerpt shows a complicated interaction between contextual norms and gender norms. For instance, the use of dark and “boundary-crossing” humour is a contextual norm, one which accepted within the care environment both as a means of interaction and as a coping mechanism for the stressors of the care role (this is explored again in the subsequent chapter on *Emotions in Context*). However, this gets overlaid with decontextualized or naturalised gendered expectations of male hyper-sexuality (as explored in Cottingham, Johnson and Taylor, 2016), producing a setting where his engagement in the same behaviour as female counterparts has the potential to create negative reactions due to differences in interpretation. Lawrence constructs this as an issue with the behaviour itself, rather than a critique on a double-standard of

expectations applied to him due to gendered identification. Yet shortly after this, he said:

“I would add the caveat that I don’t know where them expectations come from. If it’s me that’s putting them on myself. Because I’ve not actually...no one has ever...called me up on it because I do...adhere to it. I try to be extremely professional in work {sighs} so I don’t know if that’s just me thinking that or if there’s a...an outside influence making me feel like that. But it is just how I am, regardless. But yeah, that is...there is a certain element of...expectations that are put on by ourselves, or by...the outside.”

This was an important note, given the contrast between the norms developed within the professional context and those imposed from understandings developed outside this context. Lawrence admits that these understandings – inaccurate as they might be - shaped his conduct regardless of the origin of these expectations. This was further cemented in his response to *Picture 5* during photo-elicitation:

“She’s had the broken news- she’s had the news broken to her and- sh- he’s just giving her a hand to hold, isn’t he? This is something that...I struggle with. Um, the physical-ness of it. Because a lot of...so if a patient is upset, I- your instinct is to go and give them a hug, isn’t it? It’s what- what you do just to comfort them, just to give them that contact. And it’s what a lot of my colleagues do, and it’s what- it’s my first instinct as well, but I need to check myself when I’m doing it because... {exhales} I don’t know. Maybe it’s- again, it’s just...you know, what we were saying about the...expectations we- we’re putting on ourselves. But I feel less comfortable to be able to go and...just give them a cuddle. I don’t- I know...I don’t feel less comfortable, I feel like it would make them less comfortable. On both genders, men and women. With women, I feel...especially as well, because I’m big, normally when I’m cuddling them, their face is like...in my crotch {laughs} kind of thing. But then comforting a- a dad as well... I have to be a lot more...um...measured with how I would do it. Which I- it doesn’t make me feel very good. Because I should be able to go and just give this guy a hug if he needs one. But...I’ve got a- normally, I’ve got a worry about his uh his um perception of me being a

male in this position, but I've also got to try and juggle what his perception of his masculinity is, and is he going to be offended if I hug him? All this kind of thing. Yeah, that can be a bit of a challenge sometimes.

Here, Lawrence comments on the use of touch to provide emotional comfort to patients, which is limited by expectations placed on himself as well as expectations of the discomfort it could induce in the recipient. While not rooting the source of this inhibition to internalised gendered expectations, there are references to sexual inappropriateness (*"their face is, like, in my crotch"*), external perceptions of his gender and potentially infringing on other people's expectations of their gender. This juggling of internal desire to provide comfort and the external misinterpretations/consequences of any such actions added a challenge to his performance of emotional labour in this circumstance, which he claims is not typically experienced by female colleagues. Furthermore, the understanding that his sense of masculinity and the actions he considered acceptable (such as hugging) could be different from those of other men served to limit his use of physical contact as a means of showing support. These comments align with findings by Whiteside and Butcher (2015) on the limitations of use of touch by male care workers, as well as Cottingham et al (2016) who presented "heteronormative labour" as an additional strain on male care workers who presented themselves as heterosexual to avoid stigma associated with homosexuality and possible homophobic reactions. Both could explain Lawrence's reluctance to engage in any action that could be misconstrued as sexual intent (whether heterosexual or homosexual). An awareness of how his acts of care could be construed by others based on attributions to his identity modified his perspective and approach towards care work. Yet while his recognition of these identity-dependent expectations largely produces constraints to care in his accounts, an individual sense of identity could also serve to challenge these expectations, as will be explored in the next sections.

Manfred

"Manfred" was the chosen name for a support worker, whose role involved assisting people with diagnosed mental health conditions living within a domiciliary facility. He described the purpose of his role as facilitating clients'

abilities to live independently, and considered this to be different from care work in the sense that it “deals with a different range of issues” and because the clients were at liberty to engage with the workers’ support to any degree they chose, including not at all. This variable engagement of the support worker took a range of forms, such as helping with grocery shopping, assisting with hospital visits, or interfacing with NHS Services, and while congenial interactions with between staff and clients were encouraged, permissible activities were guided by protocols and limitations to maintain clear lines of responsibility between the different members of the multidisciplinary care service. As a result, in Manfred’s view, the value of his role centred on building and sustaining relationships with the clients:

“It’s usually tenants minding their own business, literally doing their own thing. Uh, interacting with us...like, um, literally passing the time with us, which is...still...an important part of our work. Because it’s um establishing a healthy day to day life even if it’s basically downtime but having relaxed relationships and building trust can be done even through uh really uh mundane things such as watching TV together or preparing a dish.”

This comment frames the engagement in social interactions with clients – during which emotional regulation is expected – as essential to helping establish regular beneficial habits and dispositions which helped develop the clients’ ability towards self-sufficiency. As such, the successful engagement with emotional labour was considered crucial to the success of his role as a support worker, and offered unique privileges within the professional setting:

“...there is some kind of...uh... social expectation whenever, say, you see the social worker, you are kind of expected to say some things? You might think that you are expected to say something so you would say specific things to the social worker or you might omit certain things if you think that the social worker is not working right. This doesn’t happen to some of us because we are there every day and we do not have...um... we do have a clear role but this role being very limited in some ways, like we cannot prescribe medication, we cannot freely administer medication, puts us more...closer to their level. So in a way we look more normal to them. So it’s

easier for them to trust us and tell us things that they might not tell to the manager or to the social worker or to the doctor. And by establishing a relationship on a more- on more friendly terms, this...is what we can actually [have] access to, and it's a resource."

This placement of the support worker "closer to level" with the client references the power dynamics between care recipients and providers who are seen to hold certain forms of authority within the care industry. Yet while acknowledging the relatively limited role of the support worker, Manfred considers this perception of the worker by the clients as leading a more "normal" form of interaction, which is considered a resource as it facilitated more open conversations. However, as this relationship was built on a sense of companionship which differed from those with other care professionals, it was equally considered separate from the rules of engagement which guided other professional interactions. This meant that the support worker had to navigate a unique set of "feeling rules" (Hochschild, 1979) based on the perceived personalities of care recipient *and* the discretion of the worker:

"...Every uh support worker tends to respond in a personal way. So not th- not being the- some uh uniform and clear boundaries, clear processes, clear procedures to follow {sigh} the personal dimension, the personal aspect...uh, comes a bit more into play and you...you can see that sometimes...uh, someone might be a bit more helpful taking care of things that...shouldn't really be taken care of by the support worker, and this doesn't mean that we uh {huffs} uh, I don't know, um...because it hasn't got to that point where we actually ... um... put it this way, um... Not being a clear response might...make the workers...see the people they have in front of them...more as regular people rather than people than need care, and this makes the responses they have – since they're not codified – more personal and...being the perception of the person who has personality disorder, more normal, more of a normal person, more like uh...one of your children or uh...one of your um uh I don't know, school mates. The response comes out as more spontaneous, so you might get...to see...frustration or friendliness to levels that might potentially lead to unprofessional behaviour."

An interesting note here is Manfred's reference to a "uniform", which – as seen in Bob's accounts – served as marker for recognising the professional identity. In the absence of this marker and clear procedures for interactions, Manfred seems to describe – with difficulty, given the multiple pauses – a setting where the regulated expectations of interaction and emotional displays (in the form of codified behaviours) were abandoned for a more "normal" form of emotion work. This perception contributed to the workers' framing of the recipients of such emotional displays in the context of familiar social contacts (*one of your children or...school mates*), which is consistent with the premise of deep acting (Hochschild, 1983). However, while these familiar forms of interaction could be a resource, they were also seen as potentially producing negative outcomes such as frustration or "unprofessional behaviour" as the boundaries of permissible actions were unclear. This blurred boundary of expectations produced tensions between expected familiarity and professional distance. The complexities of this unclear position, further complicated by the potential unpredictability of the manifestations of his clients' mental health issues, thus placed the task of navigating the different rules of engagement on the support workers who were expected to manage the situation:

"...Not all of...the staff members are...uh...skilled enough from that point of view, I think. That's my opinion. So you might see people getting a bit more involved when someone has a crisis rather than waiting out for the right moment to intervene. And you could get more frustrated, or you could get aggressive...towards the person that is being aggressive or um uh...crying for- uh quote 'no reason' unquote."

This explicit reference to acts of emotional labour as a skill ties to Lawrence's comments on how care aptitudes are developed within the settings where they are demanded. Similarly, as noted with Lawrence's accounts, Manfred's comments on this skill of managing emotions and situations around care were largely rooted in the aptitudes of individual workers rather than any gendered notions. Yet gendered ideals still played a role in clients' evaluations of the workers. This was especially poignant in Manfred's discussion of one of his photographs which he presented for the participant-

led photo-elicitation aspect of the interview (these were not offered for publication, and so the contents are described). The picture he produced was a gift, a drawing made of him by a client who had previously refused support from male staff. Speaking of how he established a relationship with this client, he said:

“It was...sorry- it was actually kind of natural because it’s probably...um...probably the male staff he had to deal with were mostly nurses of- or agency workers acting as nurses and they had just to put him down. Or maybe they weren’t uh- maybe social workers or psychiatrists, not really listening to him, not really picking up on his needs. So maybe empathy was not getting through, and...we could say that...men might be less empathetic? I’m not sure, but the thing is men can still show empathy, can still be empathetic and uh turns out- I think I am quite a bit. And...it’s not like something that he had to...realise, that me, despite being a man, I could be trusted. It was just natural because I was being empathetic, and he just felt like he could talk to me, and that there was- there wasn’t like um any specific moment where we realised it could be working out. It just went along- we went along, started talking bit by bit and then he just, like, realised that he liked talking to me.”

In this extract, Manfred acknowledges a tendency for male care workers to be in roles which use restraint (typically in response to aggression, as noted in Martin and Daffren, 2006) and a dominant narrative of men being less empathetic and less emotionally-responsive (Flannery, 2000), both of which he deems to have influenced the client’s initial attitudes towards him. And yet, he directly refutes these claims with his own understandings and experience (*“men can still show empathy”*), a counterpoint which was supported by the client’s interactions and developed relationship with him despite earlier reservations. This, again, casts a critical light on how understandings of identities formed in other contexts are applied due to figurative identification, and how these processes of categorical impositions affect perceptions of care workers based on the identities and traits they are assumed to hold. It also challenges the assumption that gendered attributions are predictably and consistently enacted by those who identify

themselves with the gender labels, an assumption which has permeated other studies on the influence of gender on care roles (Krosnberg et al, 2017; Loughrey, 2008; Cottingham, 2015). Rather, Manfred's perspective supports the idea of an *individual's* suitable emotionality in establishing relationships, as referenced in the next chapter (*Emotions in Context*) and evidenced in other research on male care workers (Arreciado Marañón et al, 2019). This premise of suitability for caring and emotionality (which has been referenced in several studies on care work and emotional labour, Badolamenti et al, 2017) formed part of his identity (*"I think I am, quite a bit"*), and is further explored through the accounts of the next interviewee.

Patch Adams

Choosing the title of his favourite movie as a moniker (based on the life and work of American physician Hunter Doherty "Patch" Adams who advocated caring for patients through humour and emotionally uplifting acts – Patch Adams, 2014), "Patch" was man in his mid-20s who provided care services for people in the home setting, assigned through an agency. He had previously worked in the food service industry, and was introduced to the role after he attended a job fair where most of the stations were focused on recruiting care workers, and went into it with the belief that it was suited to his nature:

"So I've decided basically I'm- that what I found out, really, that- because I've been this agency, in this job I found me forte with looking after people, I've just got that natural instinct, but not only that, I'm getting taken care of myself."

This reference to a *"natural instinct"* and to care-related behaviours as a manifestation of personal character formed the focus for most of Patch's discussions on care work. With this perspective, the act of providing care was a natural extension of his proficiencies, which were applied to others in a care setting:

"I did look after my uncles and that, and like other vulnerable adults that were in my family and ...I've worked with kids, you know, with autism and stuff like

that. So...I sort of had that...experience and that criteria but not in where it's a complete stranger {laughs}...

"...At the end of the day, I'm a carer and...that's not just me saying I'm a job, it's a job, I'm a carer. No. In life, I'm a carer. I'll care for anyone and that's a law. If I see someone drop on the road, I'll run over straight away and help them out, that's just me. You know. And...I've been put on this planet to help people. That's what I believe. So for me to find a job that I can do that naturally is...so comforting, and amazing, and, you know, it's great."

Much like in the quotes by the previous participants, Patch makes a distinction between care as "a job" with set expectations/requirements and as something that transcends the domain of employment into being a manifestation of the self. As such, acting in a caring manner was presented as congruent with his sense of identity and purpose. This position aligns with more recent propositions of "Caring Masculinities" (Elliot, 2016), which critiques how ideals of masculinity have been theorised as rooted in dominance and defined by an avoidance of emotions, as opposed to positions where positive emotions are valued on a practical level, informed by acts of interrelation and interdependence. Yet Patch also acknowledged how external expectations of a carer's identity (rooted in stereotypes of gender capacities and caring as a feminine trait) often contravened his sense of self and recognised natural ability, presenting such conflicts from a position of indignation:

"I found that- I find that really offensive because...with being in like a room or something like that and there's a child, the person who has the kid always gives the kid to a female, and never um a male. It's like...WHY? It's like...there's- there's no...there's no difference, really. Like you...are we known to be someone that's uneducated about kids? Sometimes that's not true; males have more knowledge about kids than women sometimes you know? And it's- It's that...bias and sexism where it's...it's sort of like, they've requested females, why? What- what are we going to do? You know? Um...is it to do with, like there being a personal reflection on where they've- they don't want a male to view them? You know? Um, what's it called,

like...like their dignity, you know, their dignity. Is it that, or have they been abused by a male or? You know, if it all falls into that. But...it's sort of like classing every male as not acceptable or applicable. You know "Oh, we all want females". Well, you're sort of like...divert- it's sort of reducing it and making us feel more unwanted or...you know. We're all...th- there's males that are all capable of doing nursing, that have gone into the nursing and that know the same as a female. But therefore, people requesting for more females and- I don't understand why. You know, it's sad really because...you know, we're capable of doing it."

While Patch counters the narrative of male ineptitude towards care and the consequent biases this stereotype produces in the discriminatory selection of care workers (Kouta and Kaite, 2011), he also attempts to justify why these negative attitudes towards men could exist, considering fears of sexual objectification/assault as potential explanations. These concerns have been referenced in other studies (Cottingham et al, 2016; Zhang and Liu, 2016). Yet, like other interviewees, Patch maintains that any capacities for care are more attributable to individual traits and skills developed through experience, rather than a manifestation of gender which dominates the social narrative (a similar finding seen in Colby, 2012):

"It's- It's weird isn't it because it's sort of like being implant- being implanted into people's brains and it's...it...people need to start realising that... the- there's- obviously there's two genders, but it doesn't mean that one's capable of doing something better than the other. We're all different, no matter what. A male to a female, male to a male, female to a female, we're all different, you know. As I say about experience as well, like a male could have more experience than a female but they're still wanting a female. It's like...well, you know, it's- it should go off who's better rather than who's male or female, you know..."

When reflecting on these gendered biases existed, he added:

"I think it all derives from...military. Because it- um...going into, like, the military and stuff like that, men were supposed to go to war, while females done the nursing. I think it's more to do with that as well, it just carried on

over time and over time it stuck with that stereotypical uh state. Um...Obviously the world's changing, you know."

This acknowledgement of the effect of historicity on the persistent stereotypes around caring and gender links to earlier references and comments on the role of foreknowledge in shaping recognition and identification. Since most understandings of men are developed outside the care setting (especially considering occupational segregation around care work; MacDonald and Sirianni, 1996), the expectations of gendered capacities applied to men in care work are linked to the qualities of men who had little to no incentive to develop the skills required for care. By identifying male carers with pre-formed figurative ideals of men through the process of recognition, the traits which are expected of them are similarly decontextualized. Patch's awareness of these expectations evoked a desire to compensate:

"I just go in with confidence, and basically...be a person that shows off about what you know. With medical, the more you show off about what you know, the more ins- intrigued and the more they go 'maybe he actually knows what he- he's doing', you know. Just show off. Do what- do what you can to- to inform them that you've learned the stuff that you'd needed to learn to be in that industry anyway, you know. It's- and it's all tied up in that social interaction with being civil and being um...not only professional but having a laugh, you know, being positive, bright, you know."

In, this segment, Patch describes his intentional engagement with emotional labour through projecting a sense of confidence and positivity as response to a "stereotype threat" towards his identity as a young man in the care role (a concept earlier referenced in Lawrence's remarks about being a "weirdo"). In effect, his approach to emotional labour served to legitimise and authenticate his professional identity by countering potential judgements about his incompetence. This response towards potential adversity also aligned his actions in the care setting with his personal sense of a caring identity, as earlier mentioned. As with other interviewees, his navigation of these tensions around dimensions of identity played out in accordance with his

impressions of others' judgments on dimensions of his identity, like age, gender or level of knowledge/education. These issues and their intersections were central to the accounts of the final participant in this study, as described below.

Trevor Keepsakes

Trevor “wandered into” (his words) care work through a summer camp he attended after his university education, where he helped care for people with special needs. Following an inspiring experience with a passionate worker at the camp, he committed to working in the care sector where he had been employed for close to a decade at the time of interviewing. He had worked in several care settings, including institutions for palliative care and a day centre for special needs, and eventually was employed through several agencies through which he provided at-home care services. Yet, like other interviewees, he made references to how aspects of his perceived identity influenced his experiences within the care industry. For instance, when he discussed his period of work within care institutions, he observed that his educational status was often used to judge his abilities, commitment or interest in the role:

“Whenever I talked to people about ‘hey, I went to University, it was like this this this’, I know- it didn’t...it wasn’t because I wanted to promote that I went to University but it became something that people focused on. And I got a weird...reverse snobbery. And...because I was a young chap, I suppose, everyone kept using the word ‘stop gap’, and there wasn’t as much cooperation from certain people because they thought ‘why bother? He’s not gonna be here for long’.”

Here, Trevor discusses the impact of his colleague’s perceptions of his tertiary-level education and how this was used to imply that he was ill-suited for the role or likely to be a temporary worker (that he used care work as a “stop gap” while seeking other employment). Trevor remarked that the role is largely associated with those who have low levels of education, which may have created a collective identity with traits held in contrast to those considered to lack “real world” practical skills. Compounding the impact of

this perception of his poor suitability for care work on his workplace relationships, his level of education and other life experiences built around his identity made communication with colleagues difficult:

“I suppose, you know, I was a- I’m an out and out dork so it’s not like...me and, say, Barbara or whatever their name was {laughs} could talk about Coronation Street or grandkids or anything like that. So, you know, on a personal level, I - there were no frames of reference, really. And...I think, you know, I might as well carry the sign saying ‘I was a uni student’. And...a few – quite a lot of – the people I had the hardest time with were the people who couldn’t really see past that.”

In the first line, he relayed how being a “dork” – that is, a social misfit often considered to have unpopular interests – impacted on his “frames of reference” and ability to converse with colleagues, who were typified as usually older women (“Barbara”) who had children or grandchildren and other more typical interests (like the long-running show “Coronation Street”; Jones, 2016). These attitudes towards him based on a perceived sense of difference ultimately contributed to his decision to leave the institutional care environment and work one-to-one with clients in their homes:

“I knew that I couldn’t stay there forever because it was quite soul-crushing, you know, the fact that...it wasn’t the fact that it was these people were passing away and in terrible conditions, that are going that was difficult. It’s the fact that I was trying my best and...I was never one of them.

“...It didn’t matter so much about who I was looking after, or what I was expected to do, it was who I was working with. And while I’m always looking out for a career in care with a community feel about it, feel about it, you know, I can see why I’d – there was a lot of pressure relieved in being one-to-one to going to people homes. And it’s- it’s probably why I didn’t seek that for a good while after. It’s something I decided I want to do – the community feeling - but it’s not something I’ve hunted for. You know, I haven’t sought it as much as I might have if I didn’t have such a negative experience there.”

The judgements made regarding his education and perceived ability on being “one of them” came into the conversation around care work, as Trevor believed perceptions of his educational status led to his ostracization. This sense of alienation from peers contributed to leaving the communal workplace. However, even while relieved to work in a one-to-one setting with clients and away from the judgement of peers, he showed an ambivalence around his working conditions, seeking the sense of collective identity among colleagues (in line with the “relatedness need” to feel connected to others within an in-group; Ryan and Deci, 2000) while also rejecting it based on the negative experiences he endured due to responses to intersecting facets of his identity. These intersections were further implicated in subsequent parts of Trevor’s interview. Much like his educational status and identity as a “dork”, he also considered gender to be a key aspect of this difficulty with assimilation:

“It’s rare for many young men in particular, that I’ve seen...going to- go into the community setting. Because it’s um...I don’t know. I... there’s a bit of otherness, you know. There aren’t many- (Interviewer: You mean, like, otherness in, like, in what sense?) In, like, a young bloke isn’t going to be able to talk with a fifty-year-old woman about playing Call of Duty, you know. Or... you know, they might be able to talk about football, but they have life experiences that are very different, you know.”

The explicit reference to “*otherness*” was tied to the position of men as a minority group within Trevor’s working environment and produced through differences in their experiences and expectations when compared to the dominant group (women, particularly older women). This notion of emphasized separation or dissimilarity contributes to a working environment considered unfriendly towards men and has been the subject of research considering ways to diminish barriers to men’s involvement in care (O’Lynn, 2004). Trevor illustrated this dissimilarity using archetypes to represent differences in interests produced by life experiences and socialisation (like an interest in video games such as *Call of Duty*, a war-based franchise commonly marketed towards and played by young men, with characters based on historical masculine ideals and the expectation of men to engage in

violence; Wills, 2019, pp. 149 - 157). While a potential for common interests was acknowledged (“*they might be able to talk about football*”), the gendered experiences were seen to compound the dissimilarities produced by age. Beyond the effect of these identity features on the worker’s perspectives of interests and capacity for social interactions, they were also considered to influence workers’ understandings and assumptions of *each other*. For instance, while Trevor believed that more younger people working in his sector could provide more common ground for building workplace relationships – as age and gender proved to be a barrier to communication with older colleagues – reactions to his perceived identity still had the potential to impede communication with *younger* colleagues:

“It’s a bit difficult, it- you know, like, younger people would probably get my perspective, my interests, but at the same time, you know, it’s not... {exhales} It’s not something I feel at ease with, spend- you know, talking a lot to younger people who...{sighs} who it may appear that I’m hitting on, you know. I...I like to appear...like I’m acting in propriety, you know, sort of thing. So... {ugh} no- you don’t want to wake up one day and find you’re this sleazy old man who’s...getting a little too engaged with a younger person, who’s probably very politely listening to you {laughs} you know. So...yeah, I think, you know, while a lot of people see me as a kid, I kind of see myself, with younger people, as somebody... I should be above board with. Um... I mean, thankfully I’ve never had an attraction to a younger person, but then again, it’s probably because I can never see past their age. And... that’s for the best. I’m glad about that, you know, I’m glad I don’t have to think ‘well, I shouldn’t do that, but then again this person’s very pretty’, you know. I’m, I’ve kind of... you know. Of all the folly that I could be accused of, I’ve been quite sensible of being appropriate with people’s age.”

The insinuation that his gender and age differences could potentially produce accusations of sexual intent with female co-workers or inappropriate behaviour (being a “*sleazy old man*”) represents an awareness of impositions of external understandings on his identity. Like other interviewees, such impositions around his identity influenced his interactions with colleagues and produced another dimension of self-management in addition to the emotional

labour of the care role (and links with heteronormative labour from Cottingham, 2016). The comment on “*all the folly that I could be accused of*” tied these difficulties to judgements on his competence and suitability for care work based on perceptions of his identity. Yet despite these difficulties and the sense of otherness he experienced within the working environment, Trevor still considered his role as central to his identity:

“A carer is the core of who I am. So if I was told that, you know, go and have a job in an office or...in a store for the rest of my life, I’d walk under a bus, really. If I knew I was going to be a number for the rest of my life, rather than a vulnerable person’s best friend, you know... Couldn’t do it, you know? I want to do something that matters. And I know there’ll never be a thirty-foot marble statue of me, of Trevor the Great who, you know, or Trevor the Kind, but, you know, if the people who have me in their lives aren’t the better for it, then I might not even- I might not have bothered to exist.”

These connections between his role as a care worker and his reason for existence or sense of purpose were interesting to note, considering his entry into the role was largely incidental (much like with Patch). This highlights the role of familiarisation in forming a sense of identity – in effect, what people do repeatedly within a working environment often becomes associated with who they are through a process of “Identity Work” to establish a sense of coherence (Brown, 2015). The framing of being the “best friend” to a client highlights an interpersonal dimension of care work, as it positioned his relationships as authentic social bonds formed between individuals as opposed to the product of workplace expectations for emotional performance. These frames of understanding could be related to the context of their care practices, which were within the clients’ homes as opposed to regulated institutions (this environmental dimension is further explored in the next chapter on *Emotions in Context*). These interpretations of the nature and value of emotional connections and emotional labour (providing “*something that matters*”) reflected an internalisation of caring as part of their identity formed through repeated performance and consequently enacted as an affirmation of this adopted identity. This was reflected in his sense of individuality within an occupational role (being more than “*just a number*”).

The hyperbolic comment on being recognised for his role (“*a thirty-foot marble statue of me*”) also highlighted his awareness of the devaluation of care work (Dill et al, 2016), a finding which would be considered in the later chapter on *Policy in Care Work*.

Chapter Summary

These intersections of perceptions of age, education, gender and even personal interests present a complex picture on the different ways of identity shapes engagement (or, more commonly, disengagement) within care work, a finding which resonated through all accounts. “Identity” in this regard extended beyond how individual workers understood themselves, and integrated their beliefs on how they were perceived by others, including clients and colleagues. The interactions between individual attributes both by the self and others, and perceptions around care both within and without the working environment create an intricate web of interacting facets which shape the caring identity. Yet from the perspectives of the male care workers, the common ideological impositions around their identities – mostly tied to beliefs undermining their competence or assumptions of sexual intent – were concerns which refashioned their understandings of and approach to emotional labour.

This domain of *Identity in Care Work* highlights a reciprocal relationship between an individual’s sense of their identity and the external influences which affect their participation in care work – notably *perceptions* of their identity. This means that while an individual can enact certain ways of signalling or affirming their sense of identity through care work (as with Manfred and his position on being empathetic), the participation in care work equally shaped their ideals of their identity (as with Patch and Trevor who regarded the care activities they had routinely engaged in as a key part of their character). These understandings of identity formed a key influence in their engagement with care-related activities and emotional expressions while working, both of which are the focus of examination in the next chapter: *Emotions in Context*.

Emotions in Context

This chapter presents the second main theme from analysis of interviewees accounts: depictions of how emotions were expressed and appreciated during care work. Though there have been debates on how emotions are to be defined in a sociological sense (mostly rooted in where boundaries should be drawn on what constitutes an emotion; Bericat, 2016; Turner, 2009), this study depicts “emotions” based on the multiplex construction as proposed by Burkitt (1997; 2002) as described in the *Literature Review*. By this, it acknowledges the subjective feelings of the individual created by biological processes *and* the socially constructed elements related to normative understandings, recognised affective displays, linguistic depictions, modes of presentation/interaction, and power dimensions which shape emotional responses. These multiple dimensions of emotions are required to understand the dynamics which shape “emotion work” and “emotional labour” (Hochschild, 1979; 1983), terms that describe the management of emotional experience and expressivity (emotionality) within the context of social interaction and paid employment respectively.

In discussions around emotional labour, all interviewees’ accounts presented emotionality in a variety of ways, usually through anecdotes or as responses to prompts in both interviews and photo-elicitation. These descriptions of expressions of emotions were analysed through comparisons within and between individual narratives to produce three recurring and interrelated facets of contextualised emotional expression within the working environment: the personal, relational and environmental dimensions. Due to the reliance on reported accounts within this study (as opposed to direct observation in the field), the findings presented here are limited to what interviewees were willing and able to express during the discussions. As such, the deliberations around these findings can best be considered partial representations of their emotional experiences. The extent to which each of these features influenced their emotions was also beyond the scope of exploration within this study, yet all three facets were deemed influential on the final acts of care and will each be explored in the subsequent subheadings.

Personal Dimensions

This subtheme relates to interviewees' perspectives on the influences of the care worker as an emotional actor on the care relationship, surmised through their accounts of themselves and their elicited comments on the care workers depicted in the photographs. All interviewees alluded to a sort of emotional baseline which underlaid their affective expressions and subsequently shaped their ability and reactions to engaging in emotional labour. The baseline could be considered a subjectively experienced embodied dominant feeling (of varying intensity) produced by and understood in the context of the social environment (Burkitt, 2018). This affective baseline was typically influenced by several factors existing beyond the setting of care provision (including the individual's sense of self as explored in the previous chapter), which nevertheless positioned the care worker in a given emotional state prior to their interactions with the clients. Where this initial emotional state was considered negative, the care worker often resorted to some form of abnegation to produce the desired emotional display for their role, as expressed in the following interviewees descriptions of how they prepared for work:

"You know, we've got our personal lives, we might have shit going on in that personal life, but when you're in work... you can say that- say that you're sad when you're out or if you're particularly down that day. You go in, you pretend to be jokey and cheery and- and what not. {sigh}." – Lawrence

"Well, if I ever have like an uncomfortable experience, like um... some prat on the bus or you miss your bus, sort of thing, it does take a little bit of willpower just to kind of...submerge that and grumble about it with somebody else later on. Um...arriving late, when it's not your fault, and someone being agitated when you arrived, you know, being quite impatient and... you know, I suppose a- a good deal of this job is learning how to react when someone is rude to you without... without justification, you know..." – Trevor

For Lawrence (who worked in a children's surgical ward, as described in the previous chapter), presenting a "jokey and cheery" disposition was deemed necessary to assuage the fears of his physically and emotionally vulnerable

patients. Yet he also acknowledged the need to address the existing feelings outside of the working environment (*“you can say that- say that you’re sad when you’re out”*), bracketing off the emotional labour as an act which may not necessarily influence the initial baseline. Trevor’s story exemplified how existing negative emotions produced by social interactions before going into the care setting had to be *“submerged”*, as they could be exacerbated by interactions within the care setting (*“someone being agitated when you arrived”*). Like Lawrence, he also considered the need to address these existing emotions after the care interaction (*“grumble about it with somebody else later on”*), and how such acts of emotional suppression were a learned skill required for his role. These accounts thus situated the demands for emotional labour within the ongoing social encounters and emotional experiences of their daily lives, meaning that interactions with clients could exacerbate or alleviate their pre-existing emotions. The recognised distinction between the authentically felt emotional experience and the managed emotional expression was considered by all interviewees to be a cardinal element of the care role, in keeping with existing literature on emotional labour in service professions (Adelman, 1995; Hochschild, 1983; Van Dijk and Andrea, 2006). The dissonance created by emotional abnegation within the work environment (Hochschild, 1983) – coupled with the responsibility they assumed for crafting favourable interactions with care recipients – created an emotional “stress/load”, which workers had to manage through several strategies. For instance, Manfred, a social support worker, discussed the emotional interactions with clients who had terminal diagnoses (first through a personal anecdote, and again in response to a photograph where a male worker is consoling a crying woman):

“I was really feeling gutted and...my eyes were really burning, trying not to uh let out emotion. I had to take a break afterwards.”

“...the workers, I mean, they do have preferences, they do have their own feelings, their own problems as well that they might not show what they’re bringing them- with them, at work because they might have problems at home and...they’re just not in the mood to do- to get this kind of...load on them because when you have to sit down with somebody that is suffering, it

actually...you're responsible in a way, for them, not to let them escalate. It gets taxing.” – Manfred

In these extracts, Manfred acknowledges the need to manage the difficult emotions produced in response to unfortunate events, as well as the highly subjective nature of how individuals may respond to such events given their initial feelings and personal predispositions. In this way, the impacts of emotional labour are personally contextualised. Similarly, the ways in which such difficult emotions are handled were also personally contextualised, as expressed here by Lawrence who described how he coped with negative feelings that had been previously suppressed:

“I don't know how I handle it {laughs} I actually just...I just do. Well, you just have to, don't you? It's a part of the job and you just have to do it. Afterwards, then there's all sort of...unhealthy coping mechanisms. St- I'm about to roll another cigarette ({laughs}) that's- that's one of them. There is a lot of coping mechanisms going on. Um...and everyone's different on what it is that helps them get through. I smoke, I- well, I do exercise as well to balance it out. It's good for dealing with...um emotional stress and whatnot, isn't it? Um...I do- also...reflection helps as well. Um, in that it can help you get some...um...make some sense of some of the more senseless things that happen” – Lawrence

Lawrence considers the different actions taken to address the feelings of stress, including “unhealthy” ones like tobacco smoking (which has been known to produce momentary feelings of relaxation despite its negative long-term effects – Jarvik, 1991). The indication that “*it's part of the job*” also re-emphasizes an understanding of this dimension of coping with the impacts of emotional labour as inextricable from the role of caring. In a similar discussion of coping strategies among colleagues in the hospital setting, Bob discussed found the use of humour (a strategy reported in Bolton and Boyd, 2003, and referenced in the previous chapter) to be helpful in managing the negative impacts of interactions at the workplace:

“Because sometimes you come back from assessment, and it hasn't been an easy assessment or...a client or a patient you've been working with maybe

has been...quite irritated with what you suggested, not happy with what you've advised. Um...so having that chance to offload those sort of emotions. Uh...and sometimes dealing with it with some humour...helps defuse those situations. I think is- is how I often deal with it." – Bob

By contrast, Trevor, who often worked alone in the home-care setting, relied on his family members to "offload" his negative emotions after work:

"I think a lot of how I got by was just saying, you know, to my little brother 'Hey, Travis, I'm with this guy, and...just, I'm not getting it. And... you know, the effort I'm putting isn't being appreciated. The little things I'm getting wrong are jumped on', you know, and just...just moaning. {laughs} Because, really, there's very few people I know...who actually do care work. Actually, there's no one outside of work that I know who does care work. So...talking to somebody about my- my job, it's quite alien for a lot of people." – Trevor

This recognition of the wider personal context served to frame participants' workplace experiences. From this perspective, failing to address any issues created by emotional labour contributed to negative mental health outcomes which had potential impacts on other social relationships. As such, the awareness of the impact of emotional labour and the ability to manage it was considered essential to professional, personal and social wellbeing:

"I think a lot of my family bore the brunt of, you know... because I'm pushing all this good will and enthusiasm and, you know, effort into helping in this one location, um... I went home, and I just didn't have the energy for anything." – Trevor

"I think that's the hardest bit, isn't it really as the professional is that you don't...you're able to let go of that emotion as you maybe get changed or whatever, coming out of the work environment, on the drive home or whatever. Um... because if you- if you let all those emotions sit on you, you never get- you never process them or...or work through them, then... they're then- you take them home. And that affects your home life, isn't it? It affects your relationship with your wife or your family or whatever." – Bob

The success of these procedures of emotional management were often connected to perspectives on individual characteristics considered to affect one's ability to display, respond to, and manage emotions in a healthy way. The explicit references to the impact of emotional labour on their emotional lives and relationships stood in contrast with dominant ideals of men's awareness of, and attitudes towards, emotions which are rooted in maintaining power and control (like in Cottingham, 2005; or Timmers, Fischer and Manstead, 1998). Such studies of male emotionality have typically relied on assumptions of biological imperatives and/or identical socialisation to explain why men developed such attitudes towards emotions. Interviewees in this study instead took a more nuanced and individualised approach in considerations of emotionality within the caregiving experience, emphasizing emotional dispositions towards others in their considerations of suitability for care roles and the value these roles could create for clients through emotional labour:

"Because...{sigh} if you don't care, you shouldn't be a carer. You should stack shelves, you should be in an office, you should be anywhere but here. If you're not good at your job, then you're filling the spot for somebody who would be. And... sometimes the- what's expected of you in the job, it's quite low. You just kind of prepare tea, you help them up and down the stairs, you bung something in the microwave, blablabla. So what you're actually doing isn't that difficult, but if you care, it makes all the difference." – Trevor

"...it's not just what you physically need to do but also the approach you have that...helps, uh, quite a bit." – Manfred

Similarly, in responses to a photograph of a smiling nurse who seemed to be greeting an old patient:

"All that nurse is doing is giving him a smile. He's supporting him a bit on his arm here. But the main thing I take away from it is the smile. Um...which, again, I suppose is one of the little things, isn't it? It's that little smile that can...give motivation, give some strength...it can...inspire courage. Of course this old fella is not thinking any of that (Interviewer: {laughs}) He's just

thinking ‘ah, what a nice smile that man’s got’ and he’s just- he’s going about, but, like it’s...it’s these little things, isn’t it?” – Lawrence

“...you know, greeting with a smile. That’s- that’s all I’d want in the caring industry if I was ill, you know, someone that’s really relaxed, comfortable with me.” – Patch

In this regard, the capacity to provide value in care work was attached to the individual’s predispositions to emotional engagement and the willingness/ability to provide care effortlessly, a finding which has been addressed in other literature (Kammeyer-Mueller et al, 2013) and in the previous chapter on *Identity in Care Work*. However, this recognition of individual emotionality as influencing the care relationship extended beyond interviewees’ appraisals of their positions as care workers towards others within the care environment, such as colleagues and clients. For instance, in response to a photograph of nurse smiling at a young girl in bed who seemed distraught, Manfred described the tensions or difficulties in how a care worker could recognise the emotional state of the care recipient and modulate their own emotional displays to influence the other:

“Anyway, um...it’s um...it is really like this though. It’s um...it’s a constant...not struggle, but...act of balancing? And...when you are really emotionally aware, you can see the person...going further- further away from you or getting closer to you and you know how much force you have to put into the situation.” – Manfred

Manfred’s discussion of “balancing” described the emotional labour as an iterative process which relied on the care worker’s awareness as well as the care recipient’s responsiveness. As such, achieving a desired emotional response from a client or patient was a reflexive process of modulation determined by the emotional states of both individuals. Similarly, Trevor considered that his clients’ own baseline emotional states – similarly shaped by their circumstances such as suffering from chronic illnesses – as well as his colleagues’ dispositions towards him as a care worker (as explored in the previous chapter on *Identity in Care Work*) influenced many of the interactions which demanded his emotional labour:

“I hadn’t worked with people who needed the level of personal care that was expected from some people. So I... I made the tea, you know, which ran cold with a lot of people. Um... I helped where I could, but there was some sense of ‘there are people who are going to do it better, there are people who are going to do it quicker’, you know. So... make the tea, make the meals, help people where I can, [help them use the] toilet, that kind of thing. But I didn’t do the morning clean up, sort of thing. And that happened quite regularly. I do think... you know, in a tough job where a lot of people are miserable, I think I got the brunt of the, you know, disgruntled behaviour.” – Trevor

This understanding and positioning of other agents within their social interactions modulated their understandings and responses to emotionally-laborious situations, often evoking a sense of empathy which enabled a rationalisation of their emotional experiences. These responses to the subjectivities of others further shaped the relationships developed through the care setting, which influenced the interactive dynamics of emotional labour as explored in the next subsection.

Relational Dimension

The second dominant theme summarised from interviewee accounts of emotional labour was the relational or interpersonal dimension of the emotional experience. Much like the personal dimension, the nature of the relationship between the care worker and the recipient of care was emphasized in their discussions around care work and often served to determine, undermine or complicate their adherence to “professional” conduct – that is, the nature of language and emotional communication deemed acceptable by employers. This was often relayed as an effect of *time* on the carer-client relationship dynamic, and this was especially noted in the professions where the care worker had prolonged and repeated contact with the clients leading to the formation of social bonds. For instance, Patch who worked in the home care setting, described his interactions with clients in ways that subverted the expected professional relationship:

“...the clients I had, they treated me like I was part of the family, done me Sunday roast..., you know, when it was my birthday, they’d get me stuff for my birthday, vice versa.” – Patch

Likewise, Trevor (who also worked in the home care setting) described his relationship with a client for whom he had regularly provided care for over three years and fondly called the “little old man”.

“I think I knew I was- you know, I was told I was getting through to him when he just reached over and gave my ear a little tug and it’s that kind of playground shenanigans that... you know, it was kind of like, we’re playing, we’re mates. And to see that change, you know. And I’m at home and...sorry, I’m at his home, and the family are there, you know.” – Trevor

Manfred’s relationships with the boarders at his domiciliary care home had similarly evolved over time, often defying the limits of interactions expected from his role as a support worker:

“Having to see and meet these people every day, it just comes naturally to be friendly towards the ones that are friendlier and more communicative. Uh...so at some point, you can see that some of them might...uh, come to you and talk to you as they would talk to...if not a family member or a friend, someone that they uh do not feel um...[distant from]” – Manfred

By contrast, for Lawrence who worked in the hospital setting, the interactions with clients tended to be brief or short-lived, and this limitation diminished the impact of any close bonds on their emotional performances and kept their focus more inclined towards meeting role expectations:

“...It’d be a lot more difficult to remain unattached when you’re in their environment and you get a sense of who they are more so than...{exhales} you know, just chatting to them. And also, presumably, this is longer term care as well. Mine’s acute setting, so they come in, I’m only with them for a couple of weeks, tops, and then they’re off. Whereas here you’re with them for years, aren’t you?” – Lawrence

These allusions to kinship, friendship and familiarity were echoed through all accounts, and the extents to which these friendships were forged depended on the nature and duration of the interactions with their clients. An interesting note was Trevor's seeming Freudian slip of "I'm at home" which suggested the level of closeness in his interactions with and attitude towards the client referenced in the earlier quote of "playground shenanigans". His accounts provided an excellent reflection on the extent to which these bonds factored into the care relationship and the worker's emotional experience:

"I mean, we started this thing, me and the little old man, and I'd- maybe it was wrong to start off with but he doesn't even think about it now. I don't even think about it now – but I kind of... we hold hands. He likes holding hands. I mean, one time... there was a time where I had to get him out of bed and he wouldn't. You know, he would sit up and he'd lie back down, kind of thing. And I'll be trying to coax him out, trying to hold his hand. And even though he wasn't getting up, he wasn't letting go of my hand. So even though he wasn't doing what I was trying to enc- prompt him to do, he still wanted me to be there. It was still 'I want you' which, you know, meant a lot to me. I mean, it annoyed his sister who had to come up and get him down, but, you know. So we hold hands quite regularly. You know, he's a fifty-five-year-old man, and I'm a young bloke... but, you know, feels like a little brother to me. And one time I just lifted his arm up and let him place it- So I wasn't like 'you must fit into there' I kind of like, gave him the area where he could sit like that with his arm on my shoulders and my arm on his, and I'd have to- because he's only a little fella, I'd have to slouch halfway down the sofa so that it's level for him. And... we did that at the respite place, and a few of the workers saw it, and one went 'Aww let's get a camera' and obviously she realised she can't take a picture of him without his consent. But, you know, we were buddies and it was plain to see."

These contrasts between perspectives developed in different contexts of care revealed how interpersonal relationships subverted some of the expected dynamics of the carer-client relationship and the degrees to which norms of "professional behaviour" were maintained (note Trevor's reflection on "maybe it was wrong to start off with", which was an acknowledgement of a potential

infringement on his role expectations). Yet even for the care workers who had developed deeper bonds with their clients, their subversions of their expected professional relationships were framed as a potential source of conflicts which could negatively impact on their work. For instance, immediately after Trevor's "camera" moment earlier described, he added:

"But one person said {dark tone shift} 'You have to be careful', you know, 'you can't take that familiarity for granted. You- some people might see it as unprofessional, that kind of thing.' And she said it in the most supportive kindly way, as though to say 'it would be a stupid way to see it but it would be a way that some people might.' So she...she wasn't seeing it as a credible accusation, but she said it was one that, you know, if it flings, it could cause me, you know, trouble. Trouble sounds harsh, it makes it sound like I'm already, you know, like I'm already doing something wrong that I could get caught for. But it's something- I guess it could be misinterpreted. Because, you know, if I'm not trying to be his mate, am I actually doing my job?"

This showed how the rules around professional interactions encoded in policy (further explored in the next chapter) conflicted with his own understandings of the care role, which was to offer a feeling of closeness and bonding with the clients on a level comparable to a friend. The interpersonal dimension of the care relationship often raised questions around what it meant to "do the job" and was echoed through all the participants' accounts. Where this issue was raised, a common perspective was that the essence of the care role centred on providing emotional interactions for clients, rather than instrumental or "clinical" acts like giving medication, feeding, or providing intimate care such as bathing or dressing up the clients. For Patch, this was the emphasis of his relationship with a certain client (whose name was anonymized to "Donovan/Donnie" depending on how it was expressed by Patch):

"He knew someone was there, and anytime he'd drift off, he'd wake back up, and I'd go 'alright Donnie, I'm here, I'm here for you, I won't leave you,' you know. And he'd go 'okay' and go back to bed. And um, just that alone makes me a lot better, I'm doing my job, you know. Donnie's m- Donnie's my mate,

you know, he's not just a client. Even if he was just a client, it doesn't matter, you know. You need that professionalism, you're a carer for god's sake. Be a carer, you know." – Patch

Similarly, in response to prompts for photo-elicitation, other interviewees said:

"When you're...a caregiver, it's making that person you're working with think 'well actually this person is giving ME time. It's not just they're doing a job. They're actually giving ME time, and ME focus'...um... rather than just coming in and changing a cannula or giving a pill or...answering a question or...or whatever. It's about that- that sort of... ..one on one, that sort of relationship, isn't it?" – Bob

"...you kind of have to be a professional friend to them, in a way. So a friend without benefits, without a lot of benefits, but a friend nonetheless." - Manfred

The ideal of the "professional friend" seems a succinct representation of the main issue reported in the relational dimension of the care role, as each element of that ideal – *professional* and *friend* – demands a different set of "feeling rules" during interpersonal interaction (Hochschild, 1979). This perspective of the care role means the care worker must manage the dissonance between their personal emotionality and professional expectations (the process of emotional labour, as earlier acknowledged) along with the dissonance between complying with professional expectations (performing emotional labour) and displaying emotions appropriate to the social context of their relationship with the client (Hochschild's concept of "emotion work", *ibid*). The expectation of growing closeness expected within a friendship stood in conflict with the expectation of emotional distance needed to carry out professional duties, and these contrasting dimensions of the relationship framed the interactions in such a way that some elements of friendship were offered, but only to a limit dictated by the workers' recognition of professional sanctions. This limitation was captured in Manfred's remark that the form of friendship was often without the "benefits" – such as respect, security, generosity, devotion and support that would be received in a typical social context (Rubin, 1985). Most interviewees expressed this tension

between the two dimensions of feeling rules as another facet of emotionality to be managed as part of the care relationship, especially where the interactions with care recipients were prolonged and intensified by growing social bonds:

“People, I think, expect [that] if you’re in a uniform or you’re in a- a caring professional, they expect... you have a little bit [of] detachment and a little bit of... they don’t expect you to be their best mate. Sometimes, I think sometimes they do. There’s always that sort of... tension, a little bit, again, isn’t it? Um... Because there’s always a bit of a...flux isn’t, these sort of uh – sort of relationships, isn’t it?” – Bob

“...in a way you have to be detached, but still you have to be there and show that you’d be there and they have to feel you...that you’re there.” - Manfred

“...you need to be able to...love them deeply on a level where you can give a lot of yourself to them. And, you know, there’s sometimes when...I’m going without, like, basic human needs, like, you know, I’m skipping my dinner, or I’m not going for a wee or I’m, you know, I’m literally...kind of forgoing these things for their benefit. So you need to be- love someone to do that. But they’re strangers {laughs} so that’s quite...you know, everyone goes on about loving...everyone, and the world would be a better place but in actual practicality, it’s quite difficult to do. But there’s another layer on it, in that...you got- also got to be...strict consummate professional at all times, which is a complete contradiction to being...loving someone and giving yourself to them {laughs}. That is quite a difficult...line to straddle. It’s not-like, it’s one of the ones that kind of goes on in my head without me thinking about it. But when I stop and think about it, there’s a bit of a...like, the engine stalls, and I’m like ‘hang on a minute, what- how- how do I behave in this situation?’ So I find normally, it’s best to just be, and then question if it was right or wrong later.” - Lawrence

Lawrence’s framing of professional care relationships as an act of “love” was especially poignant and highlighted an idea of a bestowal of value and respect on the care recipient which motivated acts of care - even to the detriment of the care worker (Djicic and Oatley, 2004). This understanding of

a strong relational emotional component drove the care relationship and often blurred the lines between professional instrumentality and personal investment. Yet the ability to manage this tension between interpersonal and professional expectations required ongoing self-reflection and situational awareness and was considered indicative of the care worker's competence or maturity. A failure to maintain this distinction between roles was considered to have potential negative consequences:

“And...it's easier to not just be friendly but feel like you're a friend to them. And it's easier- and I think if someone is not really mature enough, might end up...um...like, bringing work back home. Like um...either disclosing personal details or uh let's say, giving out the phone number just to keep in touch or not feel alone or whatever. Or, um, bring the frustration home, and not come the next day with a clean slate, which would lead to problems.” – Manfred

“I mean, it's- it's like... it's offering help that you can do and that won't affect you too much, affect your work, affect your lifestyle too much but, you know, sort of still making them comfortable at the end of the day. You're still in their residence, they're a part of my family, I'm a part of theirs, you know? It's hard- it's- it's one of them as well, you can't get too...too attached. Um...because it can affect your life, you know.” - Patch

The “problems” included the potential for negative emotional impact of these long-term care relationships, potential conflicts which could lead to loss of reputation and termination of employment. This finding extends and complicates the popular understanding of emotional labour, which was originally appreciated in the context of short-term interactions with service users where the rules of engagement were monitored and largely served the interests of the service industry (Hochschild, 1983). Instead, care workers navigated both the expectations of the service industry and those of the social interaction, with an understanding of compounded consequences from failing at either or both obligations. This awareness of the complicated “feeling rules” were further addressed through connections between emotions and spaces of social interaction, as explored in the next section.

Environmental dimension

The environment of care provision was considered to play a role on the emotional experiences of both clients and carers, and this relationship between place and affectation was considered influential to the practice of emotional management. These considerations of space as a determinant of emotional labour were especially noteworthy in comparisons of accounts between different working contexts and applied in both the physical and metaphorical sense. In the physical sense, the tangible elements of the environment were seen to directly influence the carer and clients' emotions, and as such could be managed to produce a desired emotional reaction, serving as an alternative means to achieve the ends of emotional labour. For instance, Trevor saw the home care environment where he worked as a space where the client could be made comfortable through modifications in the outlay:

"I think you need to do the utmost for the people that you're with, and if the first they wake up to is a lovely, airy, bright, you know, room, then, you know, it puts them in a state of ease, you know? It's not just about physically handling people in the right way. It's just...you know, letting them feel at home. Letting them feel welcome, that's the main thing." - Trevor

By contrast, Bob and Lawrence who worked in the hospital setting framed the environment – due to its associations with illness and death – as a negative impact on the patient's emotions, for which their acts of care were designed to alleviate:

"I think what's important is making it very personal even though it's in a very...non-personal environment, but making it that... 'this is about you this is about what's good things for YOU' and it might be sharing the memories, sharing the happy times and the past...um...looking at what's good now, and just making that moment special. Because I think that's what's important, isn't it, really?" – Bob

Yet beyond these connection between environment and emotions, interviewees made metaphorical references to different spaces as locations for emotional performances, where their permissible actions were influenced

by understandings of ownership and authority. For example, for Bob and Lawrence who worked in the hospital setting, their work environment was considered in opposition to the patients' home environment where patients had greater authority, and so a care workers' emotional expressions were expected to reflect an acknowledgement of this sovereignty:

"...it's about that relationship isn't it and that connection and...and working alongside, particularly if you're going into someone else's environment, someone else's home...um...you're the guest. You- that power relationship changes, doesn't it? And the fact that you're not... this isn't your environment, this is somebody else's home, this is someone else's...life." – Bob

"I've not done any community care. Um...but I can see that it'd be a difficult...because in the- in...my role, they're coming to my...my territory, my environment, and it's a place that I feel comfortable in. But you're going into their home, and I think you- it'd be a lot more difficult to remain unattached when you're in their environment and you get a sense of who they are more so than...{exhales} you know, just chatting to them." –Lawrence

The delineation of "environments" or "territories" for emotional framed the notion of being a "guest" when outside the usual environments of their professional practice, which introduced different social expectations and placed the worker in a position of deference to the client. This power dimension was only complicated where a long-term relationship had been established, as reflected here in Lawrence's description of the difficulties associated with the more personalised relationships that resulted from providing care in the home setting:

"When I was saying that patients can be dicks, when you're in their home environment and they're being dicks, they're more, um...justified in being dicks. But then you are, also, sort of, part of the family, and... I think it'd make it worse, when they're being dicks to you, when you're in- that close to them. And it'd be diff- yeah, like, on an emotional management, it'd be difficult to bite your tongue sometimes, I think. Mm, yeah, it's- it's not my type of caring that I- I don't think I could do that." – Lawrence

The choice of words by Lawrence *“It’s not my type of caring”* reflected the juxtaposition against the nature of care in the hospital environment where he worked, in which the care worker was held in a higher position of authority which dictated the dynamic of the relationship. This belief in a justified abuse of power and the expected tolerance of negative behaviours from clients due to being in their home environment was thus considered a “type” of caring – as opposed to a violation of expectations. When interviewee accounts were compared, it was interesting to note that these impressions were provided by those who worked in the hospital environment (Bob and Lawrence) who were more accustomed to being regarded in positions of authority as medical professionals. Patch and Trevor, who worked in these home care settings, instead reflected on how these power dynamics complicated the interactions with their “hosts”, the care recipients and employment agencies, especially considering their more personable relationships with these people (as highlighted in the previous subsection on the relational dimensions of care):

“With my client Donovan, he was from Kirkby, he loved football, he loved- he was a lad (yeah) you know. Me and him used to have a joke like s- we used to go out like that and swear and- and take the piss and- we- our language was...like, it wasn’t professional language but...it was a language where...it was acceptable in that house. Because they- they were all okay with that and um...obviously it was a different, um, area, a different place than- you know, you’ve got to be careful.” – Patch

“I saw the...the family of the person I’m caring for as the masters of that universe when you work, when you say you’re supposed to um... you know, Well, they don’t say ‘you have to come in’, you know, ‘four hours earlier’ or ‘you have to come in tomorrow instead’ but as long as, you know, you’re kind of flexible towards them, that’s fine because they can always say ‘actually you’re being a pain in the ass, I’ll get another company’. So you just...you know, you give and take because you never know when – not that I’ll ever do this – but if you’re a bit late on the bus {laughs} and you turn up late and you stay a little bit late, you know, there’s- you never know when they have to be patient for you, you never know when they might ha- you might have to wait

an extra fifteen minutes because they're picking up the kids and there's traffic so... - Trevor

The contextual and power-laden nature of emotional management in respect to different “feeling rules” – as seen in Patch’s expression of *“It was acceptable in that house”* or Trevor’s comment on the *“masters of that universe”* – is indicative of the position of power which the employers (in this case, the family members) occupy within the space of care provision. Their power over the carer lay in their capacity to make decisions which could positively or negatively impact on their employment, such as leniency or punishment (like termination of contract) for perceived infractions. As such, the care worker negotiates a position of appropriate behaviours leveraged on their social attachments within the working environment (as earlier described) as well as the given permissions and prohibitions of the employer. These pressures to abide by acceptable modes of conduct are related to the precarious nature of employment within the sector, a feature further discussed in the next chapter on *Policy in Care Work*.

Beyond influencing their modes emotional regulation through power dynamics, the associations of emotional labour and the spaces of care provision were articulated to directly shape the care worker’s attitudes and emotional displays by serving as a prompt to assume certain modes of interaction. For instance, where Trevor explained his approach to managing relationships with difficult clients:

“I think when I went through the front door, utmost politeness and friendliness, regardless of whether it was reciprocated was like my default.” – Trevor

For Lawrence, the environment served to help compartmentalise emotions between his personal and professional lives:

“[I] just try and spend time with my friends as well, the normal thing I do, which is because they’re not- they’re very...they’re not medical, they’re not in that environment. When I’m there [with them] I’m a different kind of person, I’m not the person I am in work. I can be silly and re- well, I’m quite silly in

work but I mean...I can NOT be serious, I can just...chat shit and...talk bollocks and what not.” – Lawrence

These allusions to the how emotions are managed in recognition of differing environmental contexts and acknowledged the power dimensions are in keeping with Hochschild’s description of “feeling rules” as shared ideals which “guide emotion work by establishing the sense of entitlement or obligation that governs emotional exchanges” (ibid. 1983, p. 56). In effect, the environment of care work served as a proxy to prompt these understandings of entitlement and obligation, and the care worker’s emotions were managed accordingly. However, a recognition of these ideals seemed to apply in alignment with the care workers’ own sense of identity, as was considered in the previous chapter. For instance, in the previous example, Lawrence’s aside of “*well, I’m quite silly in work*” reflected his preferred mode of interaction which was maintained despite some adoption of professional expectations. These intersections and potential tensions between individual and professional desires formed the final major dimension of the research findings and will be explored in the next chapter on *Policy in Care Work*.

Chapter Summary

This chapter examined interviewees’ descriptions of their emotional experiences through three dimensions which were observed to influence these accounts. The recognition of emotional labour as situated within the wider contexts of the individual’s emotional experiences offered some appreciation for how the approach to and impacts of such labour varied based on circumstances. This personalised focus of emotional expression also connected with earlier discussions of identity in care work, as interviewees’ responses to care demands were influenced by personal understandings (and external perceptions) of their identities. In a similar vein, individuals drew upon available resources in their unique personal context to manage the impacts of emotional labour, including peer and familial relationships. These differences in individual coping strategies affected their abilities to adequately manage the negative impacts of emotional labour,

which affected their ability to continuously engage with care work and potentially affected other relationships outside the occupational setting.

The second key subtheme emphasised the relational dimension of emotional labour, one which has typically been overlooked in existing literature (due to the focus on other sites of emotional labour). Within the health and care setting of prolonged contact with service users, interviewees relayed the emotional demands as influenced or complicated by their developing social attachments, often framing their relationships to clients using expressions of affection, familiarity and kinship such as friends or family. Their awareness of different “feeling rules” expected in social and professional relationships introduced a form of tension to their emotional labour, and they described some difficulties in their attempts to manage their emotional displays between what was appropriate for the interpersonal dynamic with the clients or patients, and what was deemed acceptable for their role as a care worker.

The management of the conflicts around these rules of emotional engagement was further explored in the environmental dimension of contextualised emotions, where the physical setting of care work – and the inhabitants of that setting – influenced the directions of their negotiations on suitable emotionality. This environmental dimension considered how the settings of care work served as prompts to adopt certain modes of emotional communication. It also highlighted the power dynamics that govern emotional expressions; in effect, how the “feeling rules” were obeyed depended on who was in the position to enforce them and the impacts that any rule infringements could have on the care worker. An exploration of how such rules of engagement are applied and navigated, along with other influences on emotions - forms the focus of the final key theme discussed in the next chapter: *Policy in Care Work*.

Policy in Care Work

This chapter discusses the third and final key theme surmised from analysis of interviewees' accounts, and its title pertains to the "labour" aspect of emotional labour; that is, the working conditions which influenced interviewees' emotional experiences, forms of communication and acts of care. While the study's focus and small number of interviewees limited the range of information that could be accessed and explored, the accounts from differing settings of work offered some insights into the interactions between the wider circumstances of employment and performances of emotional labour. However, before discussing how participants' perspectives were influenced by working conditions, it is useful to provide some context on the wider socio-political circumstances that have shaped the nature of care work.

The National Health Service (NHS) remains a publicly funded body which delivers most health and care needs (Dolton et al, 2018), and operates along with private services and agencies, the latter of which typically operate based on incentives to secure profits and persist within a wider competitive market (Foubister et al, 2006). Yet, whether in the private or public domains, these health services are shaped by social, political and economic forces, and thus contend with the issues of *price* and *value* for services offered (Donaldson, 2011). For instance, the state of the NHS was one of the key priorities in the Brexit negotiations (Conservative Party, 2017) and concerns around security of the workforce post-Brexit led to massive reductions in registrations of foreign nurses who make up a good proportion of the workforce and have been essential to meeting the shortfall in service needs (Baker, 2021; Boffey, 2017). Such wider socio-political issues affect many of the processes around which the health and care services are organised and delivered, including how workers are recruited, retained, compensated and evaluated (Anderson et al, 2021; Charlesworth et al, 2021).

Since the care industry is largely service-oriented – unlike industries which cater to material demands where outputs can be standardised through forms of automation – the value provided is strongly interwoven with the skills and characteristics of service personnel. Due to this intense interdependence

between care workers and the “product” of care, the regulation of the characteristics and activities of these personnel are a key incentive for the regulation of value produced through the service industry. This premise creates the “feeling rules” guiding emotional labour (Hochschild, 1983), among other indicators of service quality. These forms of regulation can further be influenced by dominant ideals shaping the approach to employability and industrial organisation, such as neoliberal ideologies which historically led to increasing marketization of health and social care-related institutions and remain influential in current managerial practices in the care sector, especially in the private care sector (Brown and Baker, 2013; Harvey, 2007). For instance, under the premise of encouraged competition, the extensive measurements of Key Performance Indicators (KPIs) as markers of quality of a service often serve as evidence to support funding of services, though the awareness of these consequences by workers equally produce unintended effects such as manipulation of data and increased pressures to achieve performance targets which lead to detrimental effects in the standard of care (Atherton et al, 2015). These interactions between the care workers’ working experiences and their employment-related policies or imperatives featured within interviewees’ accounts of emotional labour, and are explored under three interrelated subthemes: *Boundaries*, *Contests* and *Values* of care and emotions.

Boundaries to Emotion:

The first subtheme to be discussed pertains to the occupational expectations of care work and the limits or constraints on acceptable forms of care-related expressions. These influences of policies and sanctions within the workplace were key in Hochschild’s (1983) original elaborations of emotional labour and were acknowledged in several dimensions within interviewees’ accounts. For instance, in Manfred’s accounts of working in a domiciliary establishment, he discussed how the specific responsibilities of the support worker role within the larger service structure confined both their physical and emotional labour:

“...We are bound to do just specific things, so even in these cases, we know there is a procedure and this procedure helps me keep emotions in check

because I don't need to take more responsibility than I have to and I know who- who can take the responsibility that- that needs to be taken.

"...since we have clear procedures, and a clear hierarchy and structure, I don't feel alarmed. So, uh...at the moment this stops being in place, this stops existing, that's the moment where you don't know what to do, when it's easy even for well-structured people to make mistakes." – Manfred

In these quoted segments which were connected from different parts of the interview, Manfred relays that the professional expectations expressly codified as rules functioned as a protective measure for limiting emotional involvement – with rules in place, actions can be taken impersonally, thus reducing the toll on the worker's emotions. This almost stands in contrast to the ideal that rules mostly have a negative impact on the emotions of the worker. In this instance, the constraints are beneficial, especially to the inexperienced worker who may be more concerned about making mistakes and required clear guidance to validate their competence. By contrast, Trevor, who worked in the home care setting without direct supervision, relayed how the unclear and often inconsistent enforcement of policies around acceptable care behaviours often meant that new workers who relied on their own initiative often found themselves infringing policy constraints on emotional communication:

*"It's just... so many things that aren't about your behaviour, aren't about, I would argue-~~{~trail noise}~~ arguably~ your conduct, it's- you know, it's the policy that you don't consider. When you're trying to be... you know, what you consider to be a good person and good employee, sort of thing, and... you know, there's- there's... {sighs} protocol that... maybe- you know what, I do think I was told about it, that- years [ago], in another job... you know? And maybe they thought people wouldn't think about it or something like that, but I suppose it's... you know- the thing that might be second-nature to do, that you **mustn't**, that's more important to underline, I think." – Trevor*

While the tangents obscure the message to some degree – which were in line with Trevor's typical mode of speaking, yet could indicate some internal conflicts or anxieties regarding the subject matter – Trevor discussed how his

work policies restrained even the taken-for-granted responses that would otherwise be “second nature” or expected in the typical care relationship, often emphasizing things that must **not** be done (the bold emphasis represents the word stress in the audio recording). While workers were expected to bear these policy limits in mind – as they typically could not directly be supervised – any such infringements of these policies were used to judge the conduct and competence of the care worker which, in his setting of agency work which relied on zero-hour contracts, added a layer of risk to his employability.

However, beyond the effects of compliance with the “feeling rules” – which have usually been the focus in previous studies, such as with how perceptions of fairness in these rules contributed to emotional exhaustion (Grandey and Fisk, 2005), or how sanctions were complicated by gendered expectations (Cain, 2017) – interviewees focused on how their emotions and care-related activities were expected to be geared towards achieving outcomes dictated by established or evolving health/care policies. For instance, Bob, who worked in a hospital’s psychiatric unit, described how the nature of interactions with patients were impacted by demands to reach rapid diagnoses as a measure of a successful treatment:

“And there is a lot of pressure to do that quickly. Because you’ve got the targets and all that sort of stuff. That sort of culture, isn’t it? That sort of- you’ve got four hours, then you got to get them out by four hours otherwise you’ve- you’ve lost! {laughs} This sort of idea that you’ve got to treat everyone within four hours... Whereas in psychiatry, it often takes an hour just to see people, never mind to then plan and organise what you’re going to do next. Um...and after you’ve sat there for two or three hours in A&E. And then there’s this expectation that- {voice change~} “Well, you’ve just seen them, can you go and see them [other patients] as well?”~ No, actually I can’t, because I’ve got to work out what I’m doing with this person first and organise that and make sure it’s all documented correctly and all those sort of things which is frustrating {sighs} and- and labour intensive and things. Yeah, so that conflict and that- again, it’s a bit of conflict in culture as well, isn’t it in that there this culture of “see, treat and do, and get up.” And

sometimes in psychiatry, there's more... there's a more lengthy process." -
Bob

Here, Bob describes the policy demands around rapid treatment in A&E (the targets, pressure, etc) as being a constraint on his ability to work, as his role requires a more personable interaction with the patients and cannot readily be completed in the allotted time. These demands added to the difficulties involved in the role, and was described as a source of conflict since the success of his role was frustrated by the same metrics used as markers of a successful treatment process within the acute care setting. This conflict was described as placing him in a difficult position where he was torn between fulfilling the obligations of employers and colleagues to attend to patients quickly, and the expectation to deliver comprehensive personalised care based on deep engagement with the patient – which was often a *"more lengthy process"* in psychiatry. The failure to account for the time-dependent nature of establishing connections with clients as part of the treatment process thus produced an unrealistic expectation of how care was to be delivered, an expectation which was then to make a judgement of success or failure (*"you've lost!"*) on the care worker. This verdict affected both their performance and potentially the employability of the care worker based on the quality-monitoring arrangements.

From Bob's accounts, this side-lining of the realities of emotional labour within workplace policies were a potential source of aggravation, as they added an additional strain to the performance of the care role. Yet even where the emotional labour was acknowledged in policy, the duty was still placed on the care worker to handle the impacts, as seen in this response by Lawrence on how he managed his emotions when confronted with tragic situations:

"I do- also...reflection helps as well. Um, in that it can help you get some...um...make some sense of some of the more senseless things that happen. {sighs} Um...so yeah, you have to be quite reflective. Also, as a practitioner, they drum it into- the reflection – into you, when you're training. Not just for the emotional...support side of it, but also for, like, professional

growth as well. So obviously if you- like with all the situation management, and sometimes we are just human. Sometimes we make the wrong call, and you need to be able to recognise that you've made the wrong call, so that next time, your actions will be informed by that previous... um, previous thing you did."

In this quote, Lawrence acknowledges the institutionally-mandated measures for emotional management ("*they drum...the reflection – into you*"), likely informed by the large body of research surrounding burnout and high turnover rates in nursing based on responses to emotional labour (Badalamenti et al, 2017; Elliot, 2017; Kammeyer-Mueller et al, 2013; Peate, 2014). The connection between self-reflection as a tool for both good emotional self-management and professionalism was an interesting note; in his estimation, the ideal of well-managed professional who expertly navigated situations was unrealistic ("*sometimes, we are just human*"), though the process of self-reflection was considered beneficial to learning from previous mistakes to avoid repeating harmful practices. This focus on reflective practice has been critiqued for being a reactive skill which is more beneficial for established practitioners than new nurses, who would benefit from antecedent-focused strategies like developing sufficient emotional intelligence *before* the care interaction (Botha et al, 2015; van Zyl and Noonan, 2018). In a similar vein, Lawrence also critiqued this policy-endorsed normalisation of emotional labour and the expectation that the worker would manage its impacts:

"Yeah, it's like...you- 'why would you get into- you know what this job entails, so why would you get into it if you weren't ready for it?' Which isn't particularly healthy because...you know, it's like- like we were saying before, people doing things just because they've been done before. Just because it is very- like, surely, we should be making ways- thinking of ways to make it easier {laugh} Well, not easy, but, less...less difficult." – Lawrence

In the first part of this comment, Lawrence – using a personified voice – criticised how institutional expectations of routinised emotional labour had formed a mandate for self-selection of care workers; that is, prospective care

workers were expected to consider their own willingness to engage in the difficulties of emotional labour before seeking employment in the sector. He regarded this view as unhealthy, as it perpetuated existing issues within the care sector through an unwillingness to change working practices by placing the onus on workers to self-manage. Considered within the frame of wider socio-political ideologies, this framing of emotional labour as a personal responsibility also shifts the blame for such issues from employment conditions towards the workers' preparedness for such labour – a stance which echoes the individualistic ideals of neoliberalism (Brown and Baker, 2012; Harvey, 2007). In the final statement, punctuated with wry laughter, Lawrence considered how the difficulties around emotional labour were inescapable (making things “*not easy, but...less difficult*”) yet could be minimised through potential reforms.

A final consideration on policy as a limitation to care expressions was offered in a remark by Lawrence where he considered how the ideals of detached professionalism constrained the care relationship within the institutional setting – despite how the expression of emotions within such roles had an emphatically interpersonal dimension (as presented in the earlier chapter and considered in Martinez-Inigo et al, 2007):

“That’s a pretty shitty part of the job as well, in that once you send someone home, it’s highly unprofessional and definitely looked down upon to then follow up, and say- just go ‘well, I know where they live, because we’ve got all their records, I’ll just pop around and see how they’re doing’. You can’t do that. You may want to do that because you want to know that they’re doing well. But you- you never get that closure and you- you have to kind of, like, assume, like, that kind of thing. Because, like, ‘because they’ve not come back in, I’m assuming that they’re well’. But, yeah... {Sniffs} That can be quite, uh...quite an emot- because you’ve...like we said, you’ve loved this person enough to give them your time and your energy and then they’re just gone and that’s it then, you know, it’s the end of your relationship with them and you’ll never...hopefully, never see them again (Interviewer: {laughs}) Hopefully, in the nicest way possible. That’s why I normally s- when I’m discharging a patient, that’s my line that I normally use. ‘It’s been a pleasure

to meet you but hopefully I'll never see you again.' In the nicest way possible." – Lawrence

Here, Lawrence discusses the emotive conflicts embedded in the contrast between having a personable relationship with patients (which requires "love" and fosters some degree of attachment in the process of performing caring behaviours) and a detached "professional" one where the involvement is limited to only the point of care. This juxtaposition emphasized the complementary facet of the interpersonal dimension of emotional labour discussed in the previous chapter; the boundaries of acceptable emotional involvement dictated by occupational policies constrain any organic expressions of care from the care worker, meaning that any attachments formed during the care relationship are to be nullified as soon as the patient leaves the care service. This, naturally, produces a sense of loss (in keeping with expected psychological distress, based on well-established literature on attachment - Hazan and Shaver, 1994) which the care worker is also expected to manage. Lawrence relays this feeling in a bittersweet manner, as having patients leave the care setting signifies both the loss of the relationship and the success of the care process. This act of coping with repeated loss forms a potentially underappreciated dimension of emotional labour in the care setting. It also exemplifies the care workers' navigations of differing priorities around their care behaviours (like loyalty to the relationship with the client versus the demands of the institution), a dimension which is further explored in the next subsection on *Contests in Care*.

Contests in care

This second subtheme of 'contests in care' was surmised from accounts which described how occupational characteristics and policies created contests or conflicts in priorities for the care workers, which in turn influenced their performance of their roles. Much like with the previous subtheme, these influences on care work were shaped by the expectations created within the specific environments, and – as highlighted in the previous chapter on *Emotions* – complicated by the relationships with the care recipient.

Considering care work in the hospital environment, Lawrence reflected on how policies on care shaped the carer-client relationship:

“...everything I mention is all...everything we do is all person centred, again, I’m going to say that word a hundred million times. Everything is child-centred. So even something as simple as giving some meds to a sixteen-year-old, normal typical kid, you could just say ‘here’s some paracetamol’ and [they’d] take the paracetamol. But for a young kid who’s scared, you have to...build up a relationship with them first. You need to kind of...you- there’s different approaches taken to absolutely everything we do. So not only is it dependent on the procedure but dependent on the patient, depending on what it is. Yeah, there’s a lot of um... of bespoke kind of...tailoring going on.” – Lawrence

Within this quote, the policy-driven ideal of patient-centred care means that the nature of the relationship created through care interaction becomes part of the process aimed to achieve equity (Ortiz, 2018). However, while beneficial outcomes are intended through this person-centred approach, this “tailoring” of care produces an issue with regards to how the end is to be reached, given the numerous influences on the carer-client relationship; in effect if outcomes are expected to be the equitable, but the procedures are expected to be different, then the onus is placed on the care worker to navigate and orchestrate the process. In essence, the emotional labour of the care worker can be considered a means to an end of clinical care – in line with the ideas originally portrayed by Hochschild (1983) – yet also as an end by itself, given that the customised care relationships offered to meet the service policies inherently demand the performance of such labour. The care worker is thus placed in a position where their emotional labour is both instrumental to reaching measurable ends of care work (such as providing timely medication) and providing an experience of care that is suitable to the recipient.

This ideal of care work as both instrumental to the service ends and tailored to the care recipients was mirrored in other settings of care. For Manfred, whose domiciliary care service was intended to support the clients’

autonomy, these contests of priorities were navigated as a part of daily experience within the sector:

“So we do go and help them with practical things that they might be able to do on their own but in some occasions, they might need a bit more prodding or a bit more ...support, because they can’t do them on their own. And...for us...since it’s a supported living, they’re perfectly- supposedly perfectly capable of managing on their own. It’s a fine balance between serving and remembering- reminding yourself that your kind of service is having them realise that they can do them on their own.” – Manfred

Drawing on his own experience, Manfred noted the impact of the nature of the care context on the extent of care and emotional involvement provided. While the care worker was expected to offer support to the clients, the act of offering support (described as “serving” the client) was seen to potentially interfere with the aims of the service to encourage autonomy. The support workers in his facility were thus expected to manage and “*balance*” these divergent end points, since the measure of the success of their support lay in helping clients’ achieve a state of independence which rendered the support workers’ further involvement unnecessary. This awareness of dissonant aims produced conflicts in how much care and support was to be offered and complicated the workers’ performance of emotional labour. For Manfred, these conflicts around meeting institutional demands for emotional labour were further aggravated by unclear rules of engagement and the circumstances around the care interactions:

“...being a temporary service, it’s not an easy thing to do, because you don’t have the time to get to know the person well enough to be able to uh form plans and responses for all the um...really um...inconsistent behaviours they might...they might uh display...[or] show, yeah. So um...this puts you in a situation where you know you have to respond in some way, but there are no clear instructions to do- to follow. So you see that every uh support worker tends to respond in a personal way. So not th- not being the- some uh uniform and clear boundaries, clear processes, clear procedures to follow {sigh} the personal dimension, the personal aspect...uh, comes a bit more

into play and you...you can see that sometimes...uh, someone might be a bit more helpful taking care of things that...shouldn't really be taken care of by the support worker.” – Manfred

The conflicts between the demands of the employer and care recipient were often resolved through judgements based on the personal capacities of the care worker (as referenced in the previous chapters on *Identity in Care Work* and *Emotions in Context*). For Manfred, this additional responsibility and reliance on individual discretions often meant that responses to care demands were inconsistent and expected professional boundaries could be crossed as the personal dimension of their relationships with clients became the basis of situational judgements. This potentially placed his and other support workers' actions in conflict with the (unstated) expectations of the service, a situation which could produce repercussions for them. While his descriptions are specific to his care institution, these issues are likely to be seen in comparable contexts where the rules of engagement are similarly unclear.

The contests in priorities around care were further complicated when there were third parties in the mix, such as family members whose responses to the care worker dictated several parts of the care interaction, especially in environments where care was negotiated between the demands of the family and the institution. For instance, Lawrence's work in paediatric surgical unit often demanded that – since family members were considered custodians of the patients and were involved in monitoring his interactions – his behaviours had to appease both the care recipients and the family, which sometimes produced conflicts of interests as highlighted in this story about caring for an older child with a terminal diagnosis:

“...when I was going in there, and doing by obs or whatever it is I had to do, it was a strange dynamic...in that I had to behave...one way with him, and with them, simultaneously. I had to be really...uh, like, supportive, and gentle around them, but I had to also act like nothing was wrong, and had to be a bit- because we had a bit of a...relationship at this point, when I was...maybe a bit more boisterous than I would be with other...other patients, because of,

you know, how he responded to it. So yeah, I had to- had to- uh wear both these hats at the same time. One [for] dealing with the parents, and one dealing with...with the patient. Which is something you wouldn't get in...in adults.” – Lawrence

Lawrence considered the issues of autonomy and custodianship in the paediatric care relationship – here, parents are custodians of their children and thus had the final say over any care to be delivered to their child. In such a setting, the emotional labour of the care worker was morphed to suit another dimension, which is the expectations of others beyond the individual to whom the care relationship has been established. The case made here of having to perform two modes of emotional labour to meet the expectations of both the client (based on the openness of preceding relationship) and the parents (based on their desire for maintaining a secretive façade) placed additional demands on him as a care worker. This contextual nuance was more applicable in his care setting where the client has other caregivers than in situations where the relationship was mostly between the carer and client as in adult medicine. It also bore parallels to accounts on caring for people with in the home setting, where the rules of care were largely dictated by the home owners – as referenced in the subsection of the *Environmental dimension* in the *Emotions in Context* chapter.

Considering the home environment, the participants' accounts of managing emotions often reported contests between the expectations of the clients' primary caregivers (who dictated the appropriate forms of interaction) and workplace policies (which were difficult to enforce in the absence of institutional monitors). This prioritization of the families' needs sometimes could place the care worker in a difficult position, given that both the families and care institutions could make decisions that impacted their employment. For Patch, these issues were most apparent where problems arose during the job:

“There's an understanding, there's a fine line, you know, and...uh there's a bit of...thingy with...with problems, who'd you go to? The family or do you phone up your office? Like, everyone knows you're supposed to phone up

the office, but sometimes it's like the little things or anything like that, whereas it was more respectful to go and talk to the- the household, to the person that's, you know, they're here rather than the office. Um...and it- with the family as well, it was sort of like...um...you've- you've got to have an understanding of... it's your- it's a job..." – Patch

While the agency employers were acknowledged, the immediate presence of the family members gave some priority to considerations on how issues were to be communicated and resolved ("*they're here rather than the office*"). Patch's example emphasized the power dimensions within the care relationship, especially with respect to the dual authority figures involved in his employment - the clients/families and the care agency. The potential for conflicts between demands of both authority figures highlighted the precarious nature of the role, where the worker was torn between loyalties to both parties who dictated their employability. The last line especially seemed to indicate a mental reframing of how these issues were to be approached ("*...it's your- it's a job.*") – an impersonal approach to consider these conflicts as part of the role, though the conflicts could strain relationships with both the family members and employers at "the office".

A final related consideration of these contests in priorities was highlighted in Trevor's accounts of maintaining relationships with both the families of his clients and his employers while performing care work in the home setting. The two quotes below – the first of which was also referenced in the previous chapter on the *Environmental dimension* of emotional labour – formed a continuing narrative on how conflicting priorities and loyalties had different impacts on his experience of care:

"I saw the...the family of the person I'm caring for as the masters of that universe (hmm) when you work, when you say you're supposed to um... you know, Well, they don't say 'you have to come in', you know, 'four hours earlier' or 'you have to come in tomorrow instead' but as long as, you know, you're kind of flexible towards them, that's fine because they can always say 'actually you're being a pain in the ass, I'll get another company'. So you just...you know, you give and take because you never know when – not that

I'll ever do this – but if you're a bit late on the bus {laughs} and you turn up late and you stay a little bit late, you know, there's- you never know when they have to be patient for you, you never know when they might ha- you might have to wait an extra fifteen minutes because they're picking up the kids and there's traffic so..." – Trevor

Following this, Trevor described a situation where the clients' family requested a different arrangement for care, which went against the scheduled arrangements with his manager, and his reaction to the situation:

*"She [My manager] knows I was in communications with the family, you know, that were cutting her out... and...I just kept thinking 'Well she's [the client's sister] paying for it. So, if she asks me to come at a certain time and I can facilitate it, why not?' So... I didn't... I should have, and I regret it now, I should have seen the office as where **everything** happens. That if I got that text, I should have said 'look, I can probably do that, but you need the okay from – what's it called – first, my manager first'..."*

These comments, taken together, show the intersections between the relational dimension of emotional labour – that is, the tendency to resort to more organic emotional interactions with clients given a prolonged duration of contact – and the more stringent demands of workplace policies. In effect, the prolonged emotional labour in the care setting, through its transformation towards more typical emotion work of social interactions (as in Hochschild 1979) complicated the workplace relationships and hierarchal structures/chains of command. The implications of the “masters of that universe” framing of the clients' families again highlighted their power over the care worker through their capacity to make decisions which could positively or negatively impact on their employment, such as leniency or punishment (like termination of contract) for perceived infractions. This awareness confined the care worker into a negotiating position on how to deliver care, which was in part leveraged on their social attachments within the working environment. The reference to financial compensation offered for these negotiated acts (“*Well, she's paying for it*”) also connected with Trevor's sense of value around the care role, which was further highlighted at

a subsequent part of the interview where he explained his decisions to go against the official rules/policies:

*“Yeah, it’s not written down, but it’s one of those things where, like, you know {laughs} It’d be like, okay, a policeman has to go there and he has to speak to certain people that way or this way. But at the end of the day, his job is to stop crime. And if there was something where... it was by the book but it allowed trouble to take place, then he’s not doing his job. He might be technically correct, but it’s not the **spirit** of the job. And so... companionship, if it’s possible, should be sought out. I ...that’s my opinion, but then I suppose after this kind of, you know, give and take relationship I’ve had with one family that has caused, you know- {huffs} to be honest, that whole thing with, you know, going to a different place at a different time, I was told by my manager ‘I considered firing you’. And... in hindsight she was right but it was something I never- I never considered it was **wrong**, um...let alone fireable. So it...it is so naïve. But at the same time, I’d have done things differently. I’d have still said ‘sure, I can do this at this time, but I need approval from dot dot dot’. You know, um... you know, this kind of um... {sighs} I’d say bartering, um... this kind of agreement between, you know, a service provider and a service user.” – Trevor*

Here, while there was an attempt to offer a rationale for his decisions (all words in bold reflect emphatic stresses in voice as noted in the audio recording), Trevor considered his position as a mediator to resolve issues between the service provider and user, mediating the tensions between his professional and personal relationships. The reference to “*bartering*” indicates an awareness of the transactional nature of the care relationship (much like previous remark on what he is paid for), even while it is situated in more complexly interwoven personal and professional contexts. While the prioritisation of personal relationships formed with clients served as justification for his decisions (as seen in the emphasis on companionship as the spirit of the job), his awareness of the consequences of defying workplace policies served to underpin his approach to managing these conflicts. These considerations of how employability and financial compensation guided the approach and performance of emotional labour

were reflected in other accounts as well and were the premise for the final subtheme to be considered: *Values of Care*.

Values of Care

The final subtheme to be considered relates to interviewees' accounts of the value of emotional labour and care expressions within the context of their employment. Beyond the capacity for complicating emotional labour as highlighted in the previous subthemes, interviewees often framed their workplace policies and other employability demands as the end to which emotional labour was engaged – in keeping with Hochschild's original work (ibid, 1983). For instance, Trevor's work in the home care setting through an agency with zero-hour contracts meant that the incentive to earn a wage limited his freedom of choice around his relationships with clients, even in cases of negative treatment:

"...you have to be quite forgiving, and- and especially forgiving to someone who isn't at all forgiving to you, um... you know, you really have to kind of, um... take the knocks on the chin and carry on. Because you can't just work with people when you like them, you know. I mean, heck its... you know, you'd have to be in a fairly okay financial position to do that, which... you- isn't exactly likely, doing the job I do, you know." – Trevor

In this acknowledgement, Trevor emphasizes the financial constraints which compelled his performance of emotional labour; the capacity to be forgiving in response to antagonistic behaviour and "take the knocks on the chin" was phrased more as a necessity than a virtue. Though Trevor acknowledged the value that was provided through acts of care, the low monetary compensation and competitive market for care services placed an additional incentive to provide a level of care that exceeded expectations and appealed to clients:

"...it's not just what's on paper that tells you who you are, you have to be a person who makes a positive influence, you know. You have to- if you're not, then how is anyone going to trust you? If you're just doing what you're required to and nothing else, then...why wouldn't they get somebody else {laughs} You know?" – Trevor

Trevor gives conflicting accounts between emotional displays from a place of authenticity that is meant to foster trust, and emotional labour which conforms to expectations “*on paper*”. However, all of this is framed within the context of employability – in effect, the emotional expressions and “*positive influence*” produced by the care context are acknowledged to influence who is hired for the role. This justification showcases the complicated position in which the care worker is placed, between delivering a service in line with professional expectations, and providing some form of added value beyond “*what you are required to*”, which builds trust and appreciation from clients and leads to continued employment. A failure to demonstrate this added value was seen to pose a risk, as the client could choose to terminate their contract and employ another. This emphasized precariousness of care work was especially a concern to Trevor, who discussed the difficulties of his role here:

*“I really don’t know where I’m going to be by this time next year, [or in] five years. I’ve got a client I care about but, you know, he’s...he has Downs syndrome and is considered quite elderly for someone with that condition. So...there’s a lot of... {sigh} I know I’m in a very fluid situation. And I don’t know if that’s...I’ve probably- I have made what people would consider **unwise** career decisions based on my, you know, commitment to clients, you know, that... they aren’t good long-term decisions. But I kind of figured, if at the moment I can afford to make these choices, I’m going to, you know. For as long as I’m able to look after people I care about and pay the bills, I’m gonna do it. Because one time I did give up a job that I got something out of, very meaningful. But I had to leave it because no way could I get my own place, you know? It was only because I was living with a relative [that] I was able to do a job that at one point gave me just eleven hours a week, you know. And at one point I was doing maybe {huffs} twenty-one or twenty-seven [hours], I don’t know, something paltry. But the amount of travel required meant it was {laughs} it was a bit of a long week, even if it didn’t pay...that way. But I left it...and the clients who ended up leaving that care provider because they just weren’t given support”. – Trevor*

The above quote strongly highlights the instability that Trevor considered to be part of his role – the poor job security made it difficult to plan, and this was further complicated by the unstable health status of his clients and additional costs incurred while performing his role. While he emphasised many of the actions and sacrifices made for the role as “*unwise*” in terms of career advancement and compensation (his emphasis), his justification for these choices lay in his capacity to provide some physical and emotional support for those he cared about. However, this motive to provide care was still impeded by the financial insufficiencies of his employment which provided inadequate hours and a low base pay which was further diminished by transportation costs (both in terms of money and available time to work). These difficulties led to his decision to leave the place of employment which – through staff shortages – also led to a loss of clients. The situation Trevor described here closely aligns with the notion of the “precariat” (Standing, 2014), a working position characterised by “so-called ‘flexible’ labour contracts; temporary jobs; labour as casuals, part-timers, or intermittently for labour brokers or employment agencies”. The time costs of labour, irregularities in working times and conditions, lack of capital and employment benefits all contribute to a sense of anxiety over the future and struggles to maintain a stable occupation (and related occupational identity). These stressors, naturally, affected his emotional baseline as a care-worker required to engage in emotional labour to maintain the precarious employment – a form of labour complicated by growing emotional attachments to clients given the duration of contact and intimate contexts of the care role as highlighted in the previous chapter.

These contrasting dimensions of professional instrumentality and genuine personal interest expressed in the value of emotional labour were similarly highlighted by Patch, who also worked in the home care environment through contractual “care packages” offered by a care agency to clients. For Patch, the close interpersonal relationship established with a client “Donovan/Donnie” was an important motivator to work, and yet the financial dimension of his employment and time demands of providing care produced conflicts with his desire to help Donovan:

“Donnie’s always seen so many people you know, and it- they weren’t always the same people that were there, it was...always people getting trained up and leave and all, and that took a toll on Donnie. And us as well, because we have to...get to know new people. And we were there twelve hours a day with them people. So, we’d have to share personal information with them, our emotions with them, what we went through, what other people in that in- that industry have gone through before us and we’d learn off that. You know, we’d learn off each other. So, we sort of have to build that rapport and trust with our...staff, um and- it was, for us, like...if people didn’t turn up on shifts, they’d have to phone us. And...that’s when it becomes a bit of an annoyance because...we- although we could say yeah or no, it’s sort of that worry on the- if someone’s not there, there’s no one to look after Donnie. I’ve got a life as well, and I’m an- I’m enjoy- I- I’ve billed something for this time and they phone us and [say] ‘can you do that’ and it’s like...now... ‘I can’t do it’ and that plays on your mind... like [I] wonder if Donnie’s alright, wonder if they got someone else for Donnie’ you know. So that was- uh- horrible going through that.” – Patch

Here, Patch describes the impact of the high turnover of staff on both the clients’ experiences and organisational arrangements, producing forms of instability that were detrimental to both sides of the care relationship. His consideration of the wider consequences of this turnover also highlights the conflicts between the emotional demands of the care interaction and the occupational demands of adequate compensation for time spent, as well as the impacts of this conflict on other aspects of the worker’s life. This exemplifies the argument offered by Frase (2013) who, in his critique of the concept of the precariat as a class rather than a condition produced by evolving labour demands, considers how “privileging of the workplace as the key site of labor struggle neglects all the ways in which the struggles of workers extend out into the community and the home”. This blurring of the lines between personal and professional spaces mirrors the blurring of emotional demands which serve as an act of labour and personal care – while Patch acknowledges that his decisions around engaging in additional work are based on his considerations of other time demands (“I’ve got a life

as well”), the emotional attachment to the client still produced worries and doubts regarding his decision and the situation.

These dissonances between the desire to engage authentically with clients who had physical and emotional care needs, and the awareness of the commercialisation of their emotions as a valued commodity was captured quite well in this quote by Trevor:

“Nobody likes...to be told they’re getting worse or anything like that. But...even though it might not change the facts of the matter, improving somebody’s quality of life, lifting up their morale... {sighs} It helps... it helps give just that little- little bit of brightness in a very dark time. And it’s- it’s... {exhales} That’s why people keep saying ‘oh, robots, robots, they’re going to take care of the hospitality thing, they’re going to be the new nurses’... like...a screen with as smiley emoticon will never be a human being who wants to take the time to listen to you and smile and just try and brighten your day.” – Trevor

Trevor’s reflections on the value of authentic emotional engagement touched on the increasing reach of technology in creating redundancies within precarious contemporary working environments (Larsson and Teigland, 2020). While he considered the care role as protected largely due to the inability for artificial intelligence to replicate the emotional nuances of people, the threat of loss of employment remains prominent in his considerations. Trevor’s positioning of emotional labour as produced for, and beneficial to, the human experience also signifies an alternative ideal of value to emotional engagement in care work: the workers’ appreciation and identification with the clients’ circumstances and the intentional desire to produce some sense of comfort or joy. This consideration of the value of care work to clients *and* carers – divorced from financial compensation –was noted in other interviewees’ perspectives. For instance, in Lawrence’s response to *Picture 3* (in which a young care worker sharing cupcakes with an elderly woman), he discussed how nurses engaged in activities with the sick children in their care to elicit positive emotions:

“We can’t bring cakes in anymore because it’s not- not a healthy diet, but, you know, we’d do some colouring in or we’d do some...s- something that makes them happy. That’s probably one of my favourite [moments]. I got to make Lego... not last week, the week before. And I was- as I was building it, I was thinking ‘this is my job. I’m getting paid to do this.’ Like, ‘the more I’m into this, the better I am at my job.’ Which is a good feeling. Yeah, it’s nice.” – Lawrence

While there is a clear emphasis on the commercial context of these actions (*“I’m getting paid to do this”*), Lawrence described this with a sense of incredulity as the “job” he performed was, technically, playing with children. In his latter statements, he remarked on the positive emotional impact of care work on the clients, shifting the sense of value beyond the financial incentive for engaging in emotional labour. This additional dimension of value and reward was often cited as the reason for engaging in care work, especially where the monetary compensations were inadequate, as exemplified in these quotes from Patch and Trevor:

“You’ve still got to earn money and stuff. I think the difference is as well, is that someone goes into the industry just for money and someone goes into the industry to not only gain money but to- to um...look after and to make sure people are doing well, and to learn and to understand people a bit more, you know. That’s- that’s my sense on it, you know.” – Patch

“If you can’t tell yourself that you’re making a difference, then... well, for me anyway – it takes the wind out my sails, because this job doesn’t pay well. Um... I’m probably gonna have to keep doing it for years because the pension ain’t anything. Em...so...if I’m gonna be working my entire adult life, I want it to be doing something where the last thought I have in my head is... I made a positive change.” – Trevor

In these statements, the emotive impact of the job on the care worker – a sense of making a positive impact on clients’ lives or developing their understanding of others – is described as a motivator/justifier for engaging in care work, despite any issues faced with regards to adequate payment or financial security. So, for these workers, the emotional connections

developed in their roles through interactions with their clients were considered sufficiently valuable to overshadow these other concerns (within reason, where important personal needs were met, as earlier described). These accounts highlight some of the complexities of emotional labour within the setting of long-term care and extend prior understandings of such labour as driven by professional instrumentality or gendered performativity (as stated in Cottingham, 2015; Cottingham et al, 2016). Their emphasis on the value they hope to create for clients and themselves also raise questions on the extents to which commodification serves as the driving force behind engagement in care work; the financial incentives were framed as more of a dissatisfier/demotivator than a source of satisfaction (a finding seen in other studies like Chikoko and Akintola, 2016 and Jamieson et al, 2015). Where the monetary compensation and additional benefits from employment were insufficient, it was these personal and emotive ideals of value that served to maintain their engagement with their emotionally-laborious roles. Given the emphasis on trust and affection built over time on the quality of the care interactions (as discussed in the previous chapter on *Emotions in Context*), it stands to reason that measures taken to diminish dissatisfactions should improve the workers' ability to engage in the care setting and provide a greater sense of value for both carers and clients.

A final notable reference to workplace arrangements and occupational policies – which ties their influence on emotional labour to the foci of the previous chapters on emotions and identity – was highlighted in Trevor's participant-led photo-elicitation session (as with Manfred, these pictures were also withheld from publication and so are described). Here, he presented a picture of a medicine tray to discuss his anxieties and difficulties with administering medication, a skill which he considered to be “*a clinical part in a job that mostly requires you to be personable*”. While he discussed how these anxieties impacted on his emotional state while at work, he re-iterated his perspective on care work as a facet of his identity, though one that had to be managed within the confines of occupational policies which could terminate his employment in the event of mishaps performed even while engaging in care work:

“[If] I didn’t have care work, {huff-hiss} I’d be buggered. Because it’s- it’s part of who I am, you know. It’s probably – I say being a care worker, being a carer, besides being – I don’t know- a bit of a nerd, is like the biggest part of who I am... and the idea that it could be gone {snaps fingers} for- from something, you know, whether I wasn’t paying attention or whether I thought I was doing something nice, you know, that’s...that’s...terrifying, you know. So, yeah, that’s why I took that picture...”

“There’s little things that you can get wrong, but you can walk away knowing you did a good job because you cared. Because you did things that...if somebody was doing it for the money, they wouldn’t have done it, you know.”

Trevor emphasises how his deep engagement with his care role is done despite the low pay (“*you did things that...if somebody was doing it for the money, they wouldn’t have done it*”), as his emotional engagements within the role affirms a facet of his identity (“*being a carer...is like the biggest part of who I am*”). This connection of care work to his identity contributes to his anxieties around losing his role, especially as acts done in negligence or error are a potential reason for terminations of employment in healthcare. Additionally, the idea that this termination of his employment could also be due to “*doing something nice*” connects with the previous statements made around the contests in care, where actions he had performed for the benefit of the clients could be considered in violation of workplace policies by his employers. Yet even with these concerns around his precarious situation – the low wages, unsteady hours, lack of employee benefits like pension schemes, and even the potential to lose clients for any number of reasons, including death, as many are old and/or otherwise unstable – he places greater value in the achievement of doing “*a good job*” (an ideal earlier established to involve emotional support rather than physical support). This alternative sense of value around care work adds to understandings of how care workers navigate the difficulties of their roles, and how care activities considered to be emotional labour serve as more than just a source of difficulty and dissatisfaction, but potentially provide a sense of meaning. This desire for meaning in the face of other difficulties could serve as a potential

avenue for understanding and promoting care work, and form a focal point in policies designed to address emotional labour in health and care settings.

Chapter Summary

The theme of *Policy in Care Work* aimed to examine the influences of policy arrangements on interviewees' experiences of emotional labour and care work within the current context of service delivery in the health and care sector. Though parts of their accounts emphasized the dimension of instrumentality of emotions – that is, using emotional displays to meet employability demands, including receiving benefits and avoiding termination (a finding aligns with existing literature on emotional labour) – interviewees also emphasized the reverse relationship of this commercialisation of feelings, where workplace expectations were viewed to stifle or conflict with other personal and professional desires. These tensions in priorities were addressed in different ways based on individual agency and circumstances, yet their adverse impacts on the carers' emotions and experiences of work were noted. Furthermore, some accounts also considered the value that emotional labour produced in the care setting beyond achieving financial compensation, further challenging ideas of instrumentality and career-related motivations. Simply put, the interviewees were not just using emotions to work, but also – to varying degrees – working for the emotions.

These findings prompt a reconsideration of the applications of care-related policies and the differing values attributed to emotional labour within care work. For one, the focus on set procedures and measurable criteria for understanding and managing the care interactions undermines the impacts of agency and situational variability. Such policies which neglect those dimensions of the care experience are likely to produce additional difficulties for workers hoping to meet their unrealistic metrics of performance. Furthermore, the varying impacts of relationships formed while delivering care should be considered in workplace policies. If care workers are expected to follow a person-centred ideal of care delivery – which naturally requires a good understanding of the care recipient formed through interpersonal interactions – then the formation of these relationships should

be prioritised in policy arrangements. The capacity for workers to maintain these relationships within the working environment should also be considered in policies; the impact of issues like job dissatisfaction and adequate compensation on their emotional states should be matters to address if people are to continually engage in emotionally-demanding roles. The exact form such policies could take would vary based on the working arrangements, yet a commitment to understanding managing the impacts of emotional labour is essential to improve and sustain arrangements for care provision.

Research Outcomes and Impact: Recommendations, Limitations and Conclusions

This study set out to investigate the experiences and contexts of emotional labour by men in care professions, using a combination of traditional and photography-driven interviewing approaches to elicit in-depth discussions of personal experiences. While the range of considerations produced through both the data collection and analysis of the interviews had to be limited for practical reasons, three dominant and interconnected themes were highlighted to help understand how emotional labour and care work operated within and influenced these men's lives. This chapter aims to summarise the outcomes of this research endeavour and highlight the contributions to knowledge, including lessons to be taken from the research method and its findings (discussed in accordance with the key themes), and propositions for potential applications of this knowledge.

Methodological Strengths and Weaknesses

The first focus of contributions to knowledge highlighted by this study pertains to the processes through which its findings were realised. Though difficulties with approval processes from health/care institutions placed limitations the range of perspectives that could be explored (these were further exacerbated by lockdowns during the COVID-19 pandemic, where health and care workers were expected to remain shielded from members of the public to control the spread of infections), the chosen methods of data collection and analysis, and the continuous discussions with interviewees beyond the interview setting, offered rich insights into their lived experiences and the contexts and constraints that shaped their emotional expressions and care-related actions while at work. The use of photography following interviews was invaluable to this project – most interviewees were somewhat hesitant and reserved during direct discussions of their experiences yet seemed more at ease with using personal anecdotes to substantiate their perspectives on emotional labour when commenting on photographs. Thus, the selected method provided an indirect approach into discussing their experiences (a benefit considered by Buckingham, 2009). While, at the time of the research proposal, I considered the possibility that images may prime

responses in a similar manner to leading questions in an interview, the experience of using photographs showed no such biases. Rather, conversations were directed largely through interviewees' ability to identify with the contents of the photographs of emotive displays and caring contexts, and this provided valuable insights into their perspectives and the experiences which shaped their attitudes. It is possible that these insights may have been gained through other forms of data collection such as written diaries or ethnographic observation, yet the introduction of photography within an interview setting helped to elicit rich and explorative personal accounts while maintaining a phenomenological focus on the research object of emotional labour among male care workers, both of which were ideal for the research aims and analytical approach.

The choice of Interpretative Phenomenological Analysis (IPA) was indispensable given the limited sample size and the aim of contextual exploration; the idiographic focus enabled an in-depth exploration to appreciate interconnections of biographical and situational elements within individuals' perspectives on emotional labour. Yet this idiographic focus can also be argued to be a weakness of the approach: the small numbers needed for feasible detailed analyses make it difficult to provide generalisations or highlight which elements of individuals' biographies are most important contributors to the reported experiences of studied phenomena (Smith et al, 2009). However, despite limitations of "generalisability" (which is used to reflect applicability of findings when using quantitative methods or a larger number of participants), knowledge derived from assessment of individual accounts still sheds light on wider issues and should be transferable to similar contexts – though the extents of similarity between individuals *and* contexts would naturally vary (Yardley, 2000). Furthermore, a counterargument could be that individual experiences cannot (and should not) be reduced to "key elements", as each interviewee demonstrates the complexity of interacting elements in their experiences when considering the broader contexts. The convergences and divergences observed within and between accounts problematise the focus on commonalities in descriptions to establish understandings of phenomena (as considered in Giorgi and Giorgi,

2003), assumes a primacy of the commonalities and potentially obscures the roles of other phenomena. For instance, though navigating perceptions of and prejudices associated with masculinity influenced the emotional labour of all participants, other dimensions of identity such as experiencing othering due to educational attainment (for Trevor), being a parent (for Bob) or having an unusual physical appearance and humorous disposition (for Lawrence) were discussed more significantly in accounts of emotive interactions. The focus on assessing commonalities in accounts also assumes a similarity in how individuals prioritise or communicate elements of their experience, which could be a pitfall of interpretative qualitative methods (including IPA) given the hermeneutic dimension of assessing meanings and the often-overlooked influences of the researcher's lens of interpretation. This aspect was mitigated to some degree through dialogue with interviewees during the analytical process, and the frequent conversations blurred the conventional lines between my role as a researcher and the interviewees, and consequently led to the realisation of a "friendship as method" approach (Tillmann-Healy, 2003). This approach further served the research intentions, as it reduced the privileging of my voice as a researcher and situated phenomenological understandings closer to the sources of the accounts.

The use of "friendship as method" and dialogue with participants – a process of narrative co-production and interpretative contextualisation – offered a critical reflection on the process of knowledge production and can be considered the key strength of the research process. In particular, the process of mutual exploration impacted on the findings from the analytical approach by highlighting blind spots, errors, and limitations in my interpretations, which further supported the value of situated understandings regarding the experiences of others. For example, early in my analysis of Trevor's transcripts, I interpreted a few of his statements as reflective of his perspective on gender and care work. It was through later conversations that I discovered his penchant for slipping into communicating imagined or memorised impressions of other people's views and comments. This meant that my interpretations were of his perspective *of other people's perspectives*, and when I reflected on other transcripts, I realised this quirk of

communication was shared by Lawrence – which led to changes in my analysis of his interview as well. This reflexive interrogation and reappraisal of ideas and considerations to accommodate new understandings occurred over the course of analysis and increased my confidence in the veracity and relevance of the findings. However, even this ethic of friendship and commitment to fair representation could not eliminate the influences of my understandings or any blind spots which escaped identification, and as such the findings from this study can best be considered a credible set of understandings rather than *the* credible understanding of the studied phenomena (Smith et al, 2009).

Recommendations from Findings

Reconsidering Emotional Identities

The first major theme of *Identity in Care Work* considered how ideas built around social and occupational roles intersected with or influenced the interviewees' sense of identity. These intersections were naturally expressed in individually distinctive ways, ranging from accounts of how care work was an expression of a sense of self and purpose to how it interfered with other dimensions of their identities. The theme of identity also brought into focus how interviewees were perceived by others, and how associations with certain ways of being (such as a nurse, or a man) often intruded upon their identities in ways they sought to manage within the care interaction. This issue was traced back to the workings of the human capacity for recognition, through which understandings of new encounters are phenomenally grounded in ideas extracted from previous encounters. The findings within this theme helped highlight the limitations of gendered conceptualisations – the separation of the characteristics of gender from the individuals and the contexts in which they are observed creates a sort of cross-contamination or imposition of attributions when other individuals are considered to belong to the pre-composed categories (though the process of recognition).

This categorical imposition is the basis of both the stereotyping that interviewees reportedly encountered while at work, and the decontextualized rationales ascribed to the activities of male care workers in previously published research. It also highlights why care work itself is considered

“feminine”; most initial exposures to care-related behaviours occur in the familial context, where mothers are the usual caregivers. Yet this identification of caring with women overlooks the realities of how these care-related behaviours are formed – in both interviewees’ accounts and other research (like in Reveley, 2019), care-related behaviours are developed and practiced in response to a demand for care, rather than expressed as a pre-existing natural ability. These repeated practices of care can consequently become integrated into the caregiver’s sense of identity despite pre-held ideals or external assumptions of personal abilities, as was seen in accounts by Patch and Trevor. This notion of identity produced and refined by contextual practices challenges some of the existing literature on how male engagement with care and emotions is directed by personal aspirations towards hegemonic ideals of masculinity (as seen in Cottingham, 2015; Cottingham et al, 2016) which are largely irrelevant to the settings and expectations of their care practices. In effect, the repeated associations of care with women and control (amongst other characteristics) with the men – while ignoring the origins and contexts of these association – produced issues for male care workers who identified with care behaviours through their exposure to similar care-demanding contexts as women, yet often could not be reconciled with the figurative ideals present in common understandings of care and emotionality due to foreknowledge produced in their social environments.

This finding holds important consequences for both care work and future research. An awareness of the capacity to misinterpret new observations (like people or situations) based on associations to pre-constructed understandings is valuable for challenging these categorical impositions. Within care work, this could mean taking measures to tackle issues around carer’s identities by explicitly addressing biases or intentionally reframing categories to be more inclusive and diminish extraneous affiliations. In essence, an intentionally *agender* approach may help to appropriately understand, discuss, and evaluate nursing practices in defiance of existing decontextualised associations. For example, referring to men in care work as “male nurses” or “male carers” in conversations or other forms of

communication with clients and the public potentially insinuates that associations to the category of “male” are important to how they are to be understood as “nurses” or “carers”. Similarly, within research endeavours, it prompts a re-evaluation of the origins of ideas around categories which may be used for interpretations – researchers may unintentionally perpetuate categorical impositions through an assumed relevance of their foreknowledge. Within this study, the process of continued conversation, feedback, and authentication with interviewees beyond the original interviews helped challenge my established ideas around aspects of their identities and the meanings I had attached to certain words or associations which were less relevant to the individuals themselves. While it may not be possible to perform similar authentication processes within other studies due to the nature of research design, it is important to recognise and highlight how these limitations and differences in conceptualisation can reproduce existing biases and potentially obfuscate understandings of phenomena.

Expanding Emotional Labour

The second major theme of *Emotions in Context* explored how the interviewees communicated the influences on their emotional expressions both within and outside the care environment. These influences were considered in several dimensions observed within and between accounts. The personal dimension centred on how care workers were predisposed to certain forms of emotional expression, which were based on individual and circumstantial factors which existed outside the working environment. These fed into the relational dimensions of emotional expression within the occupational setting, which were influenced by the nature of the interpersonal relationships they had formed with clients, a relationship often intensified by the duration of the care interactions. The interpersonal dimension served to both facilitate care expressions and occasionally subvert ideals of “professionalism” as the imperatives of emotional engagement became complicated with time, prompting the care workers to juggle expectations of emotion work (following the “feeling rules” of normalised social interactions) and emotional labour (the sanctioned rules of emotional expression as determined by employers). The interviewees’ understandings of how these

rules around emotional expression could be enforced were reflected in the final subtheme of the environmental dimension, where the settings of care and the power dynamics within them served as a prompt for assuming certain modes of emotional expressivity.

The domains in this theme extend understandings of concept of emotional labour in several ways. The personal and interpersonal dimensions complicate the distinction between emotional labour and emotion work as proposed by Hochschild (1979; 1983). The personal dimension of emotional labour – as embedded within the individual’s emotional and social milieu – expands the unidirectional way the issue has typically been considered; there has been a greater focus on how emotional labour negatively affects emotions and relationships outside the workplace, and less attention given to how life outside the workplace influences both the capacity for and consequent impacts of emotional labour. Furthermore, while Hochschild’s seminal works and subsequent studies (like Badolamenti et al, 2017; Van Dijk and Andrea, 2006) have highlighted the issues produced by regulations on emotional expression, the features of the working contexts under study (in which workers typically engaged in repeated and relatively short-term interactions) produced limited understandings of how emotional labour is experienced in other settings. The associations of emotional distress and burnout with continual emotional labour (as in Adelman, 1995, Martinez-Inigo et al, 2007, and other studies) have largely been based on studies of *repeated* engagement with different service users in relatively brief interactions, shrouding the dynamics and consequences of *sustained* engagement with a few service users where there are interpersonal attachments and social expectations, as is the context of long-term care interactions.

In some ways, the use of conceptualisations of emotional labour produced from other settings gave rise to a similar issue of misrecognition as cited earlier on issues with Identity, where foreknowledge obfuscates understandings of new situations due to operationalisations of pre-formed ideas and their associated features. Similarly, theorisations on the features of “masculinity” in relation to emotionality observed in other contexts – including

avoidance of emotional expressions, disengagement from the emotions of others, or instrumental use of emotions to seek control – have been used insensitively as explanations and motivations for men’s activities within care work (as in Cottingham, 2015). Yet even within the relatively limited scope of this study, the cross-comparisons of individual biographies and working environments illustrate how the nuances of situations emphasize or undermine certain influences on emotional expression – for example, the social expectations of a “guest” when delivering care within the home, or the complex dynamics of managing emotions for family members whose expectations differ from the client. This means that subsequent studies on emotions and emotional labour would benefit from giving special attention to the contexts in which observations are made, which would provide a critical consideration of the applicability of dominant definitions/ideas on emotions.

For the employment contexts, the findings highlight the importance of understanding the unique pressures on workers created by personal circumstances and/or interpersonal dynamics and making provisions to help appropriately navigate potential problem areas. For instance, lone workers who may be under greater pressure to comply with the needs of clients and lack avenues for collegiality (which was said to help the interviewees within institutional settings) could benefit from professional arbitration of conflicts or avenues to communicate with colleagues, “offload” their emotions, foster a sense of identity and potentially improve their mental wellbeing. Furthermore, an acknowledgement of the interpersonal dimension of emotional labour, especially in settings where care workers have prolonged contact with clients, serves to challenge the dominant ideals of detached professionalism, and a reconsideration of how these relationships influence the wellbeing of the workers. For example, grief counselling for workers following the death of their long-term clients would be appropriate given the personal attachments that are likely to be formed in these “working relationships”. Such grounded and contextually responsive approaches to emotional experiences of care work could serve to minimise the impacts of emotional labour, improve workplace satisfaction and create a better experience for both care workers and service users.

Reworking Labour for Emotions

The final major theme, *Policy in Care Work*, examined how occupational policies and other dimensions of employability influenced experiences of emotional labour. Here, the wider contexts of care services, such as neoliberal ideals of competitive free markets and individual choices, the “gig economy” which produces precarious settings of work, and the rise in automation were considered as the background against which interviewees understood their engagement in care work. Though the limitations in the sample size and research approach made it difficult to offer generalisations or comments on the state of care policies, the impact of these policies were nevertheless present in interviewees’ accounts of emotional labour, prompting a consideration of their effects on emotional engagement within the workplace. The policies and circumstances around care work were largely considered to produce boundaries to emotional expression (especially given the close relationships often formed in the setting of long-term care), create contests in priorities, or prompt interviewees to contemplate the value of their work considering the strains produced by inadequate financial compensation. These identified issues generally undermined care workers’ abilities to engage satisfactorily with clients.

The problems created by policies often reflected a poor understanding of the realities of working in the care setting, such as the use of key performance indicators which set impractical targets for care provision by ignoring the time required to establish a good working relationship with clients, or penalties applied based on unrealistic expectations of professionalism while navigating the complexities of human emotion. Similarly, the pressures produced by precarious and unpredictable bids for employment – which serve commercial interests – also weakened the workers’ capacity to remain in their roles as it negatively affected their usual emotional states (which changes attitudes towards, and impacts of, emotional labour) and contributed to high turnover rates which in turn had negative impacts on clients due to loss of established relationships. These issues with retention tempered the potential benefits and value produced by sustained care relationships, which are essential to supporting an ideal of “patient-centred care” (Ortiz, 2018). For care workers

to gain adequate understanding of a person's needs to provide this individualised approach to care, they require significant and continuous engagement with the "patient" to understand and navigate the interpersonal dynamics (an important aspect of the care relationship, as earlier discussed) and accommodate the individual, familial and professional expectations. This naturally entails a significant degree of emotional engagement and management, a reality which seemed to be unrecognised in interviewees' accounts of their workplace policy arrangements and added an additional layer of strain to their emotional experiences besides the emotional labour itself.

These issues reflect a long-standing, yet slowly shifting, approach to healthcare service delivery, where paternalistic ideals of care provided *to* patients/clients by knowledgeable professionals are being revised to consider care arrangements as designed *with* patients/clients, recognising and integrating individual preferences into the care relationship (Rodriguez-Osorio and Dominguez-Cherit, 2008). These shifting expectations of care reflect both shifting cultural and political norms (as seen in Murgic et al, 2015 in a study of patient expectations in Croatia during its transition from communism) and concerns around patient/client satisfaction with services in the face of increasing competition (Karaca and Durna, 2019). In essence, personal and emotional engagement is increasingly required as a contributor to service quality. However, as the accounts of interviewees suggest, it is unrealistic to adopt a service model that relies on emotional labour to achieve its aims, while simultaneously disregarding the actors, processes and impacts of such labour. Furthermore, some care workers considered the emotional engagement with clients as a strong motivator for continued engagement in care work, despite difficulties they faced with compensation or other policy-related limitations. Health/care institutions would be better served where the value of emotional labour was recognised, used to shape employment policies, and make provisions for adequate support and compensation. For instance, the time required to form good relationships with clients, the influences of these interpersonal connections on professional dynamics between carers and clients, as well as the potential impacts of

these relationships on staff should be integrated within workplace expectations. Such contextually reflective integrations of emotional labour in workplace policies would minimise the adverse effects of such labour on the care workers and consequently improve the care offered to patients/clients.

Directions for future research

The insights produced by this study have helped to recontextualise some aspects of emotional labour and the developing role of male caregivers in current mixed economy of healthcare provision. As an academic initiative, they contribute to existing knowledge on gendered emotions and emotional labour, particularly with respect to men who are a less studied demographic. For male health/care workers and wider population, it also holds several potential benefits. Using this improved understanding of the concerns and pressures on male workers in these non-traditional care roles would help in the development of appropriate schemes to address the role demands of staff and plan measures to prevent and manage stress/burnout among employees. This could help to reshape expectations and management of role responsibilities, improve work experience, and enhance employee and service-user satisfaction.

Yet given the limitations of scope in this study, future research could consider alternative ways to evaluate emotional labour, such as larger-scale or contextually-specific surveys to assess the extent of the problem and guide potential policy reforms. Additionally, it would be beneficial to assess policymakers' understandings and integrations of emotional labour into the guidelines and expectations for workers in the care sector, to assess how service-related priorities may influence policy design. Following on from the findings of this study, I would consider subsequent participatory studies focused particularly on long-term care roles to assess the nature and impacts of sustained and complicated emotional labour – that is, the forms of professional emotional management forged during longstanding care relationships, which are under-researched and differ from the experiences of repeated short-term interactions which have been the focus of most studies (as in Badolamenti et al, 2017). An improvement to understandings of professional experiences and working conditions would help to advance and

normalise expectations of men (and women) in care roles, which should impact on male participation in care responsibilities, improve gender distribution and equality within the health/care industry, and enhance access to and quality of care.

Postface: What happens now?

In the final week of October 2021, while riding on the escalators in Liverpool Central station, I observed a recruitment poster for people to participate in the care sector as support workers.



Given the focus and methods of my study, I was immediately drawn to the images of the men in the poster; the expressions of joy, physical closeness between the workers and clients - especially notable in the middle picture where the carer has his arm around the client's shoulder, reminding me of Trevor's stories about the "little old man". I also noted the absence of language that made any suggestions of a preferred sex for the potential support workers. I considered this feature positively, given how interviewees

in this study conveyed that recognised gendered categories supported a myriad of suppositions regarding their capacity as care workers (based on prior understandings and exposures to people identified with these categories). This positive consideration also prompted a reflection on how *my* understandings had changed over the course of the thesis; while I had questioned the extent to which gender affected care-related behaviours from the outset based on personal experiences in healthcare, the unique features of my own history (such as being a less engaged medical professional and having an agender approach to social interactions) meant I nevertheless held limited or erroneous ideas on the motivations and rationales for these behaviours from others considered to be different from me, as were reflected in my initial interpretations of interviewees' statements. The process of continuous dialogue with participants – using “friendship as method” to engage closely with their perspectives while maintaining and refining a critical approach to avoid “merging” viewpoints (as in Owton and Allen-Collinson, 2014) – challenged my understandings, both around the research topic and other topics of consideration where I had previously assumed some sense of understanding. I consider the reflexive effect of this dialogic engagement, using interactions with others to scrutinize and interrogate my own interpretations (see Tillmann-Healy, 2003, p 735) as the most personally significant impact of this project, an effect which I expect to carry forward into all future endeavours.

As I examined this poster from a more critical perspective, as refined through my conversations with interviewees during this study, I considered how engagement in Support Work would affect those who responded to the call for recruitment, especially considering the experiences of Patch and Trevor who worked in similar settings of agency work with hourly pay rates. While the second point of emphasis in the advertisement stated that the worker would have the opportunity to “make a real difference to someone’s life”, a sentiment shared by many of the participants in the study as a motivator to engage in care work, I could not help but consider the first point – the “Real Living Wage of £9.50”. While this rate is above the current legal National Minimum Wage of £8.91 (Low Pay Commission, 2021), the idea that this was

a “living wage” could be contested given that workers may not be offered an actual number of working hours to produce a wage that they could reasonably live on. Also, given some of the prejudices that exist against men in care work (based on assumptions of their capabilities or tendencies), male recruits may face disadvantages due to client choices, a limitation which further reduces their employability and impairs their satisfactory engagement within the industry.

The recruitment poster also prompted my reflection on issues around entry and retention within the social care sector, based on what I had learned through this study. While the advertisement aimed to attract people into care work, this was no guarantee of sustainable employment. In the months since I began writing up this thesis, two interviewees (Trevor and Manfred) left the care sector. Trevor made this decision with difficulty; while he felt compelled to remain in care industry based on his loyalties to clients and sense of identity, the low prospects for collegiality, workplace advancement or greater compensation as well as an increase in his childcare and social demands prompted him to consider other career options. Manfred’s decision to leave seemed more related to frustrations around organisational management, such as biased employee reviews and unfair applications of rules. I wondered if their participation in this study may have influenced these decisions, as the conversations we had both for the recorded interviews and over the course of analysis may have encouraged a reflection on their working circumstances and prompted or expedited their choice to leave their care roles.

While the nature of this study was far from representative of all experiences in the care sector, I can only hope that the understandings it has produced and emphasized can help to improve the circumstances of male health/care workers. Yet that hopeful optimism is tempered by more cynical understandings of living and working in our rapidly changing society with evolving expectations of healthcare services, shifting ideals and demographics of employment, and market pressures on adequate compensation. In the face of such uncertainties, only time will tell how things unfold.

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Appendix A: Participant Information Sheet

Study title

An Exploration of Emotional Labour of Male Healthcare Workers.

Principal researcher

Dr Imo Emah
Graduate Teaching Assistant,
Faculty of Health, Social Care and
Medicine.
Edge Hill University
St. Helens Road
Ormskirk
L39 4QP
Email: emahi@edgehill.ac.uk

Director of Studies:

Dr Paul Simpson
Senior Lecturer, Applied Health
and Social Care
H209, Edge Hill University
Phone: 01695 657066
Email: simpsonp@edgehill.ac.uk

Invitation

You are being invited to take part in a research study examining the emotional experiences of male professional health care workers. Please take time to read the information that follows carefully. If you would like more information or if anything is unclear, please contact the researcher, Imo, on the telephone number or email address provided above. He should be able to answer your questions and if not will direct you to his Director of Studies.

What is the purpose of the study?

The aim of this study is to find out about how male professional health care workers manage their emotions to meet expectations of the workplace (what is referred to as “emotional labour”). As only 11% of professional care workers are male, there may be unique challenges when working in a field which has predominantly female gender expectations. This research seeks to go some way to understand these challenges.

Why have I been invited?

You have been invited as you fit within the focus of the study: you identify as male and work in a professional care role with significant personal contact with service users. This study focuses on registered nurses and staff in care homes.

Do I have to take part?

No. Once you have read this information sheet, it is up to you to decide whether to take part in this study. You will be asked to sign a consent form to show that you've agreed to participate.

What will I be asked to do?

There are two stages to the study. You don't need to be involved in both stages, though it will be most beneficial to the study if you are.

The first stage is an interview where you will be asked a few questions about how you manage your emotions while on the job. This interview will also involve a discussion using pictures related to care work that have been selected by the researcher. This is to help further understand your experiences and explore aspects which may not have come up earlier in the conversation. Interviews are expected to last about an hour but could be longer if you want to say more.

The second stage is optional and occurs over the following three weeks or so. In this time, you will take up to ten photographs (or more, if you choose) which you feel capture something about your emotional experiences with while providing care. This could be a picture of a location associated with managing emotions, or an arrangement of objects to symbolise the experience. Please do not take pictures of others without their consent, or of anything which could be considered inappropriate or illegal. After these pictures are taken, the researcher will arrange to discuss them with you like in the first interview. Digital photographs are suitable, but a disposable film camera will be provided by the researcher if you do not have (or would prefer not to use) your own camera. The researcher will collect and develop any photographs from film cameras and return them to you for the second interview. Photographs will only be used for publication with your consent.

Can I withdraw consent?

Yes, you can withdraw your consent without giving a reason before or during an interview if you begin to feel uncomfortable, though the researcher might ask why this is to see if help can be offered or to avoid any practice that might put others off from continuing with participation. If you withdraw consent, all data taken from you (including consent forms) will be destroyed and not included in the study findings.

You can also withdraw your contribution **within 28 days** after the interview. This limited time is given because it will be difficult to locate and remove your data once it has been added to the rest of the study. You can discuss with the researcher or Director of Studies and they will try to resolve any concern

you have or address any upset you might be experiencing. Please think about this carefully before agreeing to take part.

Will my participation be confidential?

Yes. Your name and other details (like geographical area and workplace) will be changed so that your identity cannot be recognised. Any photographs you may take will not be used without your written consent. If you would like your photographs to be published, you need to indicate this in the consent form and accept that the images will not be attributed to you. Your photographs will only be used if they fit with ethical guidelines determined by the researcher. Any identifying features in the photos you take will be obscured for the sake of protecting the identities of people captured.

However, there are limits to confidentiality. The researcher has an obligation to act if a disclosure is made that suggests, either directly or indirectly, harm is being done to you or to others, including criminal activity or bad practice. This is a legal requirement to safeguard any individuals identified as being at risk of harm.

All data from this study will be handled to ensuring compliance with data protection legislation. The researcher confirms that all data collected will be used fairly, stored safely, and not disclosed to any other person unlawfully. Data will be kept and stored on the University servers and by the researcher on secure password-protected online data drives.

Edge Hill University is committed to respecting and protecting your personal information. To find ways in which we use your data, please see edgehill.ac.uk/about/legal/privacy.

What will happen to the results of the research study?

Within a month or so after your interview, the researcher will send a basic summary of your contributions back to you to ensure that what you say during the discussions is represented as you had intended.

Once the study has been completed, the findings will be presented through a doctoral thesis in Edge Hill University, as well as at conference presentations, journal articles, and for other educational purposes. Any data used will be anonymised, except in the case of a legal challenge where the researcher may be compelled to disclose certain information to the authorities.

Data from this study will be retained in the Edge Hill University archives for a period of ten years.

What are the possible benefits of taking part?

Your participation would provide the opportunity to share your experiences which would help to better understand the working environment for male health care workers and potentially improve services. There is no financial compensation for taking part.

What are the possible disadvantages and risks of taking part?

There are no expected disadvantages of taking part, although there is the possibility that some matters raised during discussions could be sensitive, embarrassing, or potentially upsetting. The researcher will try to be supportive in any such instances, and you can halt or stop the interview if you feel unable to continue. For any significantly distressing situations which require professional care or assistance, a list of useful agencies will be provided to you. This will be informed by a distress protocol (used in previous research and adapted for this study) which is based on active listening and trying to resolve any concern to your satisfaction before, during and after the interview.

Is there someone independent I can talk to about the research?

If you have any feedback, concerns or queries that you do not want to share with the researcher, you may contact Dr Paul Simpson (see top for contact details) or Professor Clare Austin, Associate Dean, Faculty of Health, Social Care and Medicine, Edge Hill University, Ormskirk, Lancashire, L39 4QP, Tel. 01695 650722 or austinc@edgehill.ac.uk.

Who has reviewed the study?

The study has been reviewed by the Ethics committee at the Faculty of Health, Social Care and Medicine, Edge Hill University.

Appendix B: Interview Topic Guide

Interview Schedule

Preamble: Thank you for kindly agreeing to talk to me about your experience as a professional care provider.

- 1) Some background information: Could you tell me a bit about yourself and the work you do?
- 2) How do you manage your feelings while working?
 - Prompts: how workplace demands affect emotions, how techniques for managing emotions (may) have changed over time and reasons for such changes, impacts on occupational skills, confidence, collegiality and support
 - Explore significant incidents and situations, understandings of personal capacities, comparisons to male and female colleagues (might reveal discourses), impact on social and psychological wellbeing.
- 3) Now we are going to look at some pictures I've brought along. [*Stock images of male nurses in situations including caring for patients (with happy vs concerned expressions), stressed, etc*]
 - What do you think about this?
 - Lines of questioning on researcher-generated photographs (to be used to prompt discussion on emotional responses), will include:
 - Any similarities to or related stories from own practice
 - Influences of situational differences and socialization
 - Further exploration and explanation of any unique observations
- 4) Is there anything you would like to add?
- 5) Invitation to further interviewing (if they have not already agreed to this)
 - I'd like to have another discussion like this, but this time using pictures that you've taken which say something about your personal experiences. Will you be willing to take a few pictures – about ten should be fine - we can use for this? You can use a disposable camera (which I will provide) or one of your own. You don't have to do a second interview, but it will really help me to better understand your own views on this.

Appendix C: Images Selected for Photo-elicitation



Picture 1



Picture 2



Picture 3



Picture 4



Picture 5



Picture 6



Picture 7



Picture 8



Picture 9



Picture 10



Picture 11

Appendix D: Data Management Plan

Danger: Men at Work? An Exploration of Emotional Labour of Male Healthcare Workers

A proposed qualitative study for an application to register for a research programme leading to the award of Doctor of Philosophy at Edge Hill University

Principal Investigator/Researcher: Imo-Obong Emah

Institution: Edge Hill University

Project abstract:

Men's emotional labour in health care occupations has been comparatively neglected in research, and available studies largely describe these emotional performances as directed by aspirations to masculinity. The dominant model is that men are estranged from their emotions and that this results in an inability to fully or satisfactorily engage in care practices. Such reductive thinking side-lines nuances of individual practices, and this study aims to explore the variety of men's emotional experiences in the care setting. This study will use individual in-depth interviews featuring photo-elicitation and participant-generated photographs to explore: 1) the emotional labour performed by men working in care roles in hospitals and care facilities; and 2) the interactions between their emotional performances at work and dominant discourses on gender and masculinity. Its findings should improve understandings of men working within these roles, which would help improve working conditions and service delivery, and assist in the recruitment and retention of men in the care industry.

Last modified: 04-02-2019

Data Management Plan created using DMPonline

Data Collection

What data will you collect or create?

Data will be collected from about 20 participants. These will include:

Raw data:

- Digitally recorded audio data

- Researcher-curated Photographs.
- Participant-generated photographs
- Interview notes
- Participant contact details

Reduced data:

- Anonymised transcripts from audio recordings

Other:

- Participant information sheets (which will include the purpose, aims and objectives of the research and how it will be undertaken, issues of anonymity and confidentiality and the expected benefits and risks)
- Consent forms
- Interview topic guide

Audio data will be rendered in AAC format, with file sizes expected to range from 40 to 100 MB (corresponding to about 1 to 2.5 hours of voice recording).

Researcher-generated photographs will be rendered in digital picture formats (JPG and PNG) for ease of storage and accessibility across multiple devices, with total file size not expected to exceed 100MB.

Participant-generated photographs will include digital and printed formats. Printed formats will be developed from film cameras and will be given to the participants. Digital photographs will be stored on the participants' camera devices.

Interview notes will be hand-written at point of interviewing and transferred into digital text files to enable accessibility and storage along with other digital data. Digital transcripts from these recordings and other documents will be in Microsoft Word (.DOC) format for easy transfer between word-processor and data analysis programmes.

All digital data will be stored on the Edge Hill University network, which is encrypted and password protected, or the researcher's own password-protected online cloud service (Microsoft OneDrive and Google Drive). The maximum overall file size anticipated for this project is about 2GB, which is within capacity of available storage services.

How will the data be collected or created?

Participant data (names, signatures and date of participation) will be collected through consent forms provided prior to interviews. These will subsequently be digitized to enable storage with other data, with hard copies destroyed (shredded) and disposed with confidential waste.

Contact information will be collected directly for follow-up interviews and stored on the researcher's password-protected mobile device. These will be deleted following the study.

Audio data would be recorded during semi-structured interviews on digital audio recording device and files will be transferred for secure storage as earlier described. Audio will be transcribed verbatim (and proof-read) by the researcher, with assistance of Google voice-recognition text-to-speech services to facilitate transcription process. Both digital audio files and corresponding transcripts would be titled with the pseudonyms given to the participants.

The researcher's photographs will be curated from publicly accessible online sources following consultation with members of the study demographic. Selected pictures will be stored in an online drive and printed prior to interviews.

Participants photographs will be produced either through digital devices or disposable film cameras (provided by the researcher). Hard-copy photographs will be developed by the researcher, but digital files will not be handled by the researcher. All participant-generated photographs remain the property of the respective participants and will not be collected or stored by the researcher except with their permission.

Documentation and Metadata

What documentation and metadata will accompany the data?

Metadata provided for study data would follow the Data Documentation Initiative (DDI) standards to facilitate retrieval, and include:

- Data properties such as creator, title, language of publication, date of creation, geographical location, etc.
- Attributes relevant to the study like key themes ("emotional labour", "men", etc) and methodological details (like "qualitative" and "photo-elicitation").

Ethics and Legal Compliance

How will you manage any ethical issues?

All participants will be given information about the study, the type of information required and the need for audio recordings, and written consent would be obtained prior to any data collection. Participants will be given pseudonyms to protect their identities, and potentially identifiable information (such as workplaces, addresses, names of friends and family members, etc) will be redacted or renamed in all transcripts. Pseudonyms will also be used to label all generated data. A separate document will be created to connect

these pseudonyms to the original participants, and this will be stored separately from research data to protect personal information.

With regards to photographic data, participants will be instructed on the types of photographs needed for the study and will be given guidelines on what photographs will be inappropriate and/or unethical. These include photographs which breach the privacy of others (including photographs taken in a public space but without the consent of the individuals in it), pictures which intentionally depict others in a negative way and pictures which show illegal or inappropriate activity (which may compromise confidentiality as the researcher could choose to report such activity in order to safeguard others). Photographs created by participants are not intended to be used in the final report to preserve participants' identities, and will not be published or distributed in any format without a participant's permission and if their contents violate ethical guidelines.

For any issues that may arise, participants will be provided with the investigator's contact information (included in the information sheet) to enable them to address any questions or problems they may have with the study, including retraction of information or withdrawal from participation.

Participant's identifiable data will only be accessible to the primary investigator. Reduced or anonymised data will be made available to other investigators through sharing arrangements and in research-related documents like progression forms and publications.

How will you manage copyright and Intellectual Property Rights (IPR) issues?

As the Principal Investigator, I will own the data. Photographs curated for the purpose of the study will follow author's copyright rules for attribution and sharing if used in any publications. Participants' photographs will not be used except with express consent (such consent will include the need for anonymisation in any publications).

Transcript data will be considered the property of the University and its distribution to/reuse by third parties will follow due permissions.

Storage and Backup

How will the data be stored and backed up during the research?

All research-related data would be stored in the Edge Hill University's password-protected online data drives. Back up of such information will be the responsibility of the primary researcher, and automatic cloud back up services would be used during data handling to preserve any changes to data. Research data will be rendered in a format that reduces storage space required, which will facilitate back up and retrieval.

How will you manage access and security?

All research data will be stored on password protected data drives only accessible to the principal investigator. These will include the University's secure network drives and investigator's personal computer and online drives (hosted by Microsoft services).

Consent forms which bear identifiable information will be digitised for storage and the hard copies will be shredded and disposed as confidential waste.

The document connecting pseudonyms to participants will be stored in a separate personal data drive (Google Drive) to prevent decryption of anonymised information in the event of any breach in security.

Selection and Preservation

Which data are of long-term value and should be retained, shared, and/or preserved?

Researcher-curated photographs and anonymized transcript data will be retained following the study for reuse and sharing. Participant-generated photographs will only be retained for sharing following consent and if contents do not violate ethical principles or compromise anonymity.

Digitized consent forms and other related documents (like Ethical Approvals, study proposals, interview guides, information sheets etc) will be preserved following the study for legal purposes but will only be directly accessible to the primary investigator.

What is the long-term preservation plan for the dataset?

Study data will be preserved in the Edge Hill University archives and held for the institutionally-determined duration (currently ten years).

Digitized consent forms and other study data would be preserved in the Edge Hill University password-protected online drives (currently hosted by the Microsoft Corporation's servers). Documents created in Microsoft are future-proofed in the sense that future Microsoft versions are backward compatible.

In accordance with Data Protection legislation, the data that will be collected and processed should only be used for the purpose for which it was created - that is, the data collected for this project can only be used for this project.

Data Sharing

How will you share the data?

Data will be accessible from the Edge Hill University archives following project completion, and will remain intellectual property of the University subject to its policies for authorised access and distribution. Data used in research findings will be published in the thesis and research journals, and with copies of the thesis (printed and digital) held in the university repository.

Are any restrictions on data sharing required?

There are no restrictions on data sharing, as archived data should not contain identifiable information.

Responsibilities and Resources

Who will be responsible for data management?

The principal researcher (Imo-Obong Emah).

What resources will you require to deliver your plan?

Access to the University's and personal computing facilities for data analysis, storage and retrieval. This includes ongoing access to NVivo, Microsoft Windows and cloud storage services (all licensed by the university).

Appendix E: Participant Consent Form

Title of Project: An Exploration of Emotional Labour of Male Healthcare Workers

Name of Researcher: Imo Emah

I, _____, confirm by providing my initials in the boxes below, that:

| | | |
|-----|--|--|
| 1. | I have read and understood the Participant Information Sheet dated [6 July 2019] for the above project. | |
| 2. | I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily where applicable | |
| 3. | I understand that this study involves being interviewed and examining photographs, and that this interview will be audio recorded. | |
| 4. | I agree to my words being used as quotes in publications or presentations and that these will be anonymised so I won't be identifiable. | |
| 5. | I understand that my participation is voluntary and that I am free to stop the interview at any time and withdraw from the study. | |
| 6. | I understand that if I withdraw from the study, it is only possible to withdraw my research data (i.e. the information I have given in interview) within 28 days of the interview. | |
| 7. | I understand that data collected during the study, may be reviewed by individuals from Edge Hill University or from regulatory authorities for audit purposes where it is relevant to my taking part in this research. I give permission for these individuals to have access to my anonymised data. | |
| 8. | I understand that this consent form will be stored as per the detail given in the Participant Information Sheet dated [6 July 2019] | |
| 9. | I understand that the information collected from me may be used to support other research in the future, and I agree for my research data to be shared anonymously with other researchers. | |
| 10 | (Optional) I agree to take pictures which would be discussed with the researcher in a subsequent second interview. | |
| 11 | (Optional) I agree to have my pictures published with the study, and I accept that these pictures will not be attributed to me. | |
| 12. | I agree to take part in the above study | |

Name of participant

Date

Signature

Appendix F: Distress Protocol for: “Danger: Men at Work”?

An Exploration of the Emotional Labour of Male Health Care Workers

This document sets out guidance that the researcher will observe and should apply according to circumstances in the event of distress expressed by study participants during the research process.

Before the research encounter: attempting to prevent distress

While adult males should not be constructed as generally fragile and overly vulnerable, men too experience distress and may try to hide it by drawing on a masculine coping ethic. As far as possible, conditions causing distress to any participant should be avoided or minimized in research. Even though a participant might have consented to take part in the process, consent is not once-and-for-all and will need negotiating at the first briefing meeting and subsequently just before the interview discussions. The researcher will need to be alert to participants’ facial expression and body language to check for genuine signs of consent on the day. If any individual discloses that he is feeling raw and vulnerable, the researcher will negotiate with that person to determine whether he is emotionally ready for the experience and, if necessary, ask that the individual withdraw participation.

During the research: briefing to prevent distress and reacting to distress

As the researcher asking people to photograph aspects of their lives, participants will be asked to avoid photographing anything illegal (which the researcher may be duty bound to report as professionals or concerned citizens) or identifiable subjects/information related to their work (like patients or their personal information). They will also be asked to avoid photographing anything that might cause anxiety to themselves or others. Whilst a participant is free to film/photograph within the above parameters, they will be informed that, although the researcher may refer to contents of images, the pictures will not be published unless specifically consented to. Images would have to fit guidelines to be accepted for publishing due to possibilities for wider/general identification.

Some distress is immediate and obvious. If it is noted before an interview begins i.e. the person appears distraught, close to or expresses tears, then any discussion should not be started. If this level of distress becomes apparent during the interview process, the researcher will stop any questioning or discussion immediately and see whether the person recovers and wishes to continue. However, though the researcher has experience with providing counselling, there will be no attempt to ‘counsel’ the person. Rather, he will carry details of appropriate counselling and support services to which any person could be referred if they express some concern, regardless of whether they show signs of distress (see below).

If the researcher senses, through observing a mismatch between what is said and body language or facial expression, that any participant is uncomfortable

about a *specific* question, he will check whether to move onto another question. He will reassure and remind any participant that they are free to refuse to answer any question and to stop the discussion at any time without having to justify this. However, if this were to happen, he might check diplomatically if there is anything he can do to address any concerns the individual has.

Much distress and even lack of genuine consent is not obvious. Participants can deny or understate any felt discomfort. Again, it is vital to remain alert to contradictions between spoken word and participants' facial expression/body language. Any mixed messages could be important indicators of pressure to take part through felt obligation rather than genuine free choice. In such instances, the researcher will ask whether the person concerned would like more information before starting any discussion and reassure them that there is no obligation to continue and that it would be wrong/unethical for the study to continue.

It is good practice to check out how participants are feeling at the end of a research encounter, especially as they will have shared visual data about their lives. If the researcher detects distress of any level at the end of or immediately following an interview, he will listen carefully to what the person has to say. If anyone asks us to keep a confidence, he will be honest and say that it depends on what the person wants to disclose, and if anything serious is communicated, he may be duty bound to inform any relevant authorities. In the event of any individual being in immediate danger, the researcher would contact the police and will also abide by the University's researcher safety policy – principles of which the researcher would extend as far as possible to study participants.

After the Interview: responding to participant concerns

As part of good policy on the ethics and politics of research, the researcher hopes to prevent any subsequent distress by asking participants to comment on brief descriptions of how their data is being used and how they are being portrayed. If anyone is unhappy with how they are being represented, he will negotiate with them how to rectify this before proceeding to further analysis of the data. As a matter of good practice, the researcher would highlight any differences in interpretation and recognize the reflexive value of a participant's different interpretation, which would also add to our analysis.

However, despite the above precautions, if any participant(s) contacts us and expresses distress sometime after the initial meeting and/or second interview, the researcher will follow the same kind of guidance as given above (relating to the running of interviews). If any participant regrets sharing something or wants to withdraw their contribution in part or whole after any interview, the researcher would remind and reassure them that any disclosure will be excised from any reports. However, participants will be reminded that the **deadline for such excise will be 28 days after the final interview.**

In the event of encountering participant distress sometime after the interview, at the very least, the researcher would empathize, listen carefully, take an individual's concerns seriously and note them down. These will be discussed

with the director of studies and project supervisors for advice. He would also ask the person how they think the issue could be resolved and, if they are unsure, offer them some suggestions and the chance to come back for further negotiations regarding issue. If what the person requests is impossible - e.g. because an article has been submitted or published – the researcher will explain why this is the case and suggest and discuss any possible alternative resolution. If the individual is still not happy, they would be reminded of their right to take the matter up with Clare Austin, Associate Dean, Faculty of Health and Social Care, Edge Hill University Ormskirk, Lancashire, L39 4QP, Tel. 01695 650722 or austinc@edgehill.ac.uk.

Researchers’ emotional safety and need for support

If the researcher witness or experience anything significantly upsetting in connection with the study before, during or after fieldwork, he can seek the support of the research supervisors or, if need be, make use of support from his line manager and EHU staff counselling services.

Support/Information

Taking part in research where people are asked to talk about your experiences always carries the possibility that unanticipated issues can arise. Participants may wish to discuss these issues with a professional or may simply want to find out more information. The following external agencies can offer support and guidance.

| Service | Contact information |
|---------------------------------|---|
| CALM (for Men 15 to 35) | 0800 58 58 58 |
| Men’s Health Forum | https://www.menshealthforum.org.uk/beatstress.uk |
| Samaritans | 116 123 |
| Support U LGBT+ Helpline | 0118 321 9111 |
| Switchboard LGBT | 0300 330 0630 |