

# Strategies of emotion management: not just on, but off the job

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## Strategies of emotion management: not just on, but off the job

Intensive care nurses, like professionals in other intense occupations characterized by high degrees of uncertainty, manage the emotions that result from their work both on and off the job. We focus on the job strategies – calling-in, sharing their experiences with others and engaging in a range of activities oriented to emotional recovery – that 37 intensive care nurses use to manage their emotions off the job. These strategies show how the social organization and division of labor in intensive care units influences nurses' emotional management outside of them and how organizational troubles for hospitals becomes personal ones for staff. They further support theoretical approaches that view emotions as dynamic elements belonging to individuals rather than aspects of people that can be fully appropriated by organizations.

**Key words:** critical care, emotion management, emotional labor, emotions, intensive care unit, nurses, nursing practice.

Intensive care nurses, like members of other emotionally intense professions characterized by a high degree of uncertainty, negotiate their emotions as standard parts of their job. In medical workplaces characterized by norms of detached concern, staff learn to express sensitivity to patients they keep at emotional distances (Fox 1957; Cadge and Hammonds 2012). From their experiences with cadaver dissection to their first interactions with patients, healthcare professionals learn to have short memories, use humor and focus on the technical aspects of work as ways to manage their emotions (Coombs and Goldman 1973; Lawler 1993; Feldstein and Gemma 1995; Lewis 2005).

Much of the research that considers how healthcare providers manage their emotions developed from Arlie Hochschild's *The Managed Heart* (1983 [2003]). Hochschild's study of airline stewardesses, and the scholarship that follows from it, utilizes a social constructionist approach to argue that people's emotional experiences in workplaces and their strategies of emotion management reflect status hierarchies

in the organization best understood in terms of structural, organizational and economic factors (Smith 1992; Martin 1999; Pierce 1999; Bolton 2000).

We agree with much in this line of research and aim to further it here in two ways by applying it to the case of intensive care unit (ICU) nurses. First, scholars tend to describe people's emotional experiences at work as static rather than embodied experiences they carry between life domains. As a result, studies tend to focus on how people manage emotions at work rather than work-related emotions outside workplaces. In so doing, scholars often fail to recognize the breadth and depth of workers' emotional experiences and the different management strategies they employ on and off the job. Second, by relying on Hochschild's distinction between public emotional labor made in service of employers and private emotion work carried out away from job sites, some studies conceal how the social organization of workplaces structures and how workers manage their emotions away from the job. This question inverts the classic relationship between personal troubles and public issues by asking how organizational troubles or issues – in this case for hospitals and intensive care units – become personal ones for staff.

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We investigate here the emotional strategies used by 37 nurses working in a neonatal and a medical intensive care unit at one large academic hospital in the United States. Understanding the approach to emotion management employed by nurses is particularly important given that emotional competence is often considered essential to successful nursing practice (Bellack 1999). We briefly describe how the nurses approach emotion management at work generally and on the job more specifically. We then focus primarily on the strategies they employ to manage work-related emotions off the job. While intensive care nurses rarely bring work home in briefcases or on laptops, the social organization and division of labor in these two intensive care units leads them to bring emotional experiences home and negotiate them there. Many of the nurses interviewed describe dreaming, thinking and behaving toward their patients when they are not at work. Off the job, they engage in practices that include calling-in to check on patients, sharing their work experiences with people who help them cope and participating in a range of activities oriented to emotional recovery.

Intensive care nurses, like other professionals, are 'multi-skilled emotion managers' in the words of Sharon Bolton (2001) utilizing different emotional strategies on and off the job. We show that their emotion management strategies are best explored as they experience them in multiple life domains. As they attempt to limit the impact of workplace emotions outside of work, these nurses show that their emotional experiences are fluid and what happens on the job is intimately linked to their experiences and management strategies off. Such emotional linkages are likely not only limited to nurses but also shared by others including police and emergency medical technicians who work in intense environments with high degrees of uncertainty.

## EMOTIONS IN HEALTH-CARE

Attention to how workers manage their emotions came to the forefront with the publication of Arlie Hochschild's now-famous 1983 book, *The Managed Heart*. Hochschild's insights about the content and process of emotion management informed many studies about how employees manage their emotions and the emotions of others in workplaces. This scholarship emphasizes how the structure and organization of occupations and workplaces influences the emotional content of work and the specific emotions workers manage on the job (Wharton 2009). In this social constructionist framework, emotion management occurring off the job is seen as distinct from processes that occur at work where emotions are appropriated by organizations. Much of the

research building on this framework views workplaces as having emotionally distinct and bounded cultures that lead people to have emotional experiences that are separate from other life domains (Lively and Powell 2006).

Hospitals – and intensive care units more specifically – are one site of emotionally intense, often uncertain, work that includes contradictory norms about emotion management. This is particularly the case for nurses who are trained to embody cultural imperatives of empathetic care *and* professional mandates of detached concern (Reverby 1987; Lawler 1993; Halpern 2001; Lewis 2005). The existing studies of how nurses – in intensive care units and more generally – manage their emotions tend to emphasize cognitive strategies through which they suppress them (Menzies 1960; Froggatt 1998; Maunder 2008). Nurses are encouraged to deal with the uncertainty and emotionality of their work while maintaining neutrality and orienting to organizational imperatives of efficiency (Smith 1992; Wilkinson 1995). In a study of hospice nurses, for example, Froggatt found them employing distancing strategies – switching emotions on and off, 'hardening' so that the emotions of others would have no effect on them and 'stepping back' or mentally distancing themselves from the work – to create a barrier between themselves and ongoing losses in the work (1998). Other studies illustrate how nurses create emotional barriers by emphasizing tasks rather than individual patients (Menzies 1960; Maunder 2008). Institutional context matters as some hospice volunteers have recently been encouraged by volunteer coordinators to push against medical norms of detached concern to 'notice how they feel' (Fox 2006).

Few studies of healthcare professionals explore the extent and ways individuals take their emotions home from work and manage them there. Most studies, instead, focus exclusively on emotions in workplaces where scholars view them as organizationally constructed (Mann 1999). Most scholars do not see emotions in workplaces as embodied in individuals or traveling between life domains but as aspects of people appropriated by organizations (James 1992; Phillips 1996). This approach conceals the depth of workers' emotional experiences and the specific strategies they engage in to manage their emotions off the job. Scholars writing about the sociology of emotions more generally consider how emotions operate for people in multiple domains (Wharton and Erickson 1993; Lively and Powell 2006; Turner 2009). We adopt this theoretical approach to emotions here. At home, where intensive care nurses lack both the norms of their workplaces and the supports for emotion management present in them, they develop other ways to manage the work-related emotions they experience.

Before outlining these strategies, we first describe how nurses working in two intensive care units at one large hospital experience the norms of emotion management on the job. We briefly consider how they manage their emotions at work and then devote most of our attention to the strategies they employ for managing work-related emotions off the job – while at home, with their families and in other spheres. Many of the nurses interviewed describe dreaming, thinking and acting around their patients when they are not at work. This approach to understanding how nurses manage work-related emotions are off-the-job models and encourages other scholars to overcome the split between public and private emotional work evident in much current literature.

## RESEARCH METHODS

The data we analyzed were gathered in interviews the second author conducted between October 2005 and June 2006 with 37 intensive care nurses who work at City Hospital, a large academic hospital. Our use of interview data in this study heeded Savage's (2004) call for more coherence between the theoretical approach to emotions and the methodological approach used to study them. In this case, our perspective that emotions are primarily social experiences necessitated an approach that would provide us with specific information about how the nurses themselves describe their emotions.

City Hospital, where the interviews were conducted, is located in a major northeastern metropolitan area in the United States and is regularly ranked as one of the country's best hospitals. The nurses work in the neonatal intensive care unit (NICU) ( $N = 20$ ) or medical intensive care unit (MICU) ( $N = 17$ ) at City Hospital, each with beds for eighteen patients. Work on each unit is fast paced, intense and unpredictable. Staff members see medically and ethically complex cases daily, often requiring them to work with families to make difficult decisions. Death is common. Each unit practices primary nursing through which nurses are assigned to specific patients they stay with throughout their time in intensive care (Manthey 1992). Unlike in hospitals where nurses are granted little autonomy, the nurses in both of these units were empowered educationally and by their nurse managers and leaders to work directly with physicians. We focus on nurses rather than other staff in the intensive care unit because they are numerically dominant and spend the most time with patients and families.

When this research was conducted, the neonatal intensive care unit employed a total of 60 nurses and the medical

intensive care unit 65. All of the staff nurses were invited, by e-mail and signs posted in the unit, to participate in this research project about 'personal beliefs and work.' They were offered two free movie tickets or \$10 gift certificates to the hospital coffee shop in exchange for a thirty-minute interview. Individual nurses suggested others, and reminder e-mails were sent until no further nurses came forward to be interviewed. We obtained approval from the Institutional Review Board at the second author's university before beginning this research.

The interviews included questions about each respondent's personal background, experience in the intensive care, memorable patients, self-care and personal beliefs. Most of the interviews took place in a private conference room in the intensive care either during or immediately before or after a shift. The data analyzed here were primarily shared in response to questions about whether individuals think about their patients when they are not at the hospital, how they make sense of the difficult parts of their work and how they take care of themselves while doing this work. All interviews were recorded and transcribed. Using a grounded theory approach, the interviews were systematically coded for related themes. This analytic approach was well suited to our research question as there is little prior research on how intensive care nurses or other professionals establish emotional boundaries off the job (Strauss and Corbin 1990).

Demographically, all but three of the nurses interviewed were women, almost exclusively white women, reflecting the demographics of nurses in these units. All were licensed registered nurses and had either a B.A. or B.S. in nursing. About one-fifth also had or were working on masters degrees. All had experience in nursing before starting in the intensive care, sometimes after completing intense hospital-based training programs. Some nurses had worked in other units at City Hospital before starting to work in the intensive care unit. Each nurse worked 8- or 12-hour shift, often alternating between days and nights, for 40 hours per week on average. Nurses ranged in age from their early 20s to their mid-60s with the medical ICU nurses in their mid-30s and the neonatal ICU nurses in their mid-40s on average. Likely as a result of their ages, the nurses in the neonatal ICU had been nurses, had worked at City Hospital and had worked in the neonatal ICU for longer than the nurses in the medical ICU. Nurses in the neonatal ICU had almost twice as many years of experience in intensive care (13.8 years) as did those in the medical ICU (7.5 years). Pseudonyms are used to present our findings to protect the confidentiality and anonymity of the research participants.

## FINDINGS

### *Negotiating emotional boundaries generally*

Intensive care units are emotionally intense environments in which the threat and presence of death is constant. In such contexts, the nurses interviewed spoke about the challenges of maintaining the emotional distance needed to buffer the stress associated with their work. Judy describing this dilemma explained:

I think it's definitely like emotionally tiresome sometimes. I go home and it's like nothing seems that important sometimes and it's like...you had a traumatic death or something...you go home and you're like, 'All right.' Everyone else is having normal day at the office, but I had to witness the most horrible thing, but you know.

Hannah, a nurse in the NICU, echoed similar sentiments about the difficulties of leaving work emotions behind at the end of a shift:

So sometimes I come home...and I'm still like pumped up, you know, like adrenalin-wise. And sometimes I even hear like the monitors beeping in my head. I know that sounds crazy, but I've expressed that to other peers, other co-workers, and they say the same thing.

Almost all of the nurses interviewed described – at least sometimes – thinking about their patients outside of work hours. As they think about patients, they continue to negotiate emotional boundaries between work and home. A few think about patients' medical conditions while most think about how they and their families are doing following the emphasis the units and hospital more generally puts on holistic care for families. 'I think about them a lot when I'm home,' said Karen. Marilyn thinks about them while she is 'doing the dishes.' Nurses think especially about their primary patients when they have been working with them for a long time or when the patients are not doing well. The close bonds nurses often develop with primary patients develop directly from the hospital's emphasis on primary nursing care.

Some nurses think about patients and families 'all the time...wherever I am' while others are triggered by certain things. When Kimberly, a neonatal nurse, was out shopping, she saw and purchased small slippers for one of her primary patients because something about them reminded her of the patient. 'She [the patient] can't wear clothes right now so I thought she should wear some slippers.' Dottie tries to build up an emotional wall at work to help her get through the day. It is outside of work, she explained, that:

Certain things will trigger like you might be in a grocery store or in Mass or something like that and there's

something that kind of clicks in and you start thinking about something that happened and it just brings back...it sets off a cascade [of emotion].

Other nurses have photographs of their primary patients in their homes that are themselves triggers. Peggy shows her children photographs of her primary patients saying they become 'characters just like your co-workers,' and Jamie has hung photographs of a long-term primary patient on her refrigerator. She explains:

Sometimes I just take it home with me...my whole family knows him [a long term primary patient]...His picture is still hanging on my refrigerator, and my kids still ask about him...Two of my girls [daughters] actually met him when they came in...one day when he was here.

In addition to consciously thinking about patients and families, a number of nurses dream about them. 'I dream about them constantly,' said Judy. When she is working many days in a row, she says, 'I feel like I never leave work, 'cause I go home and I dream about them and I come back [laugh].' Penny similarly dreams about patients 'all the time...I wake up at night, thinking, I have to check the blood sugar on the...you know.' Her dreams are not simply about taking care of her patients but about being connected to them. In another dream, 'I woke up one morning at like 6 am saying, "I don't see Jonathan [a patient]..." I thought I took him home with me. I had a dream that I took him home with me. Yeah, crazy.' Marilyn explains, 'I'm always dreaming about them at night, you know. I wake up in the morning and go, "Wow that was really a good dream. I hope she [a patient] is still okay [laugh]":' The kind of easy laughter that accompanies nurses' stories about these dreams suggests that they are common enough to have become part of the job. As much as nurses think about patients and families when they are awake but not work at work, patients and families enter their unconscious worlds through their dreams.

While most of the nurses interviewed negotiated emotional boundaries between work and home that had varying degrees of permeability, a few nurses negotiated this balance by seeking to create strict emotional boundaries around work experiences. Peggy has worked in the neonatal ICU at City Hospital for more than 20 years. She feels strongly about not being in touch with patients once they leave the intensive care unit. In her words, 'I don't make contact with my patients outside'. She thinks this emotional distance is necessary so she can move on and care for other patients, and so patients and families can better connect with future healthcare providers. 'I think when they leave me, they need to form a bond with their pediatrician....I don't want to set up a struggle between coming back and asking me if it's the

right thing or not.' She also feels like this distance is in part mandated by her profession as a nurse, 'I try not to become like an intimate friend. I want to be the nurse, but I'm not their best friend.' Parents sometimes e-mail Peggy photographs of former patients as they grow up, which she is always happy to see, but feels strongly that this communication be kept to a minimum and not initiated by her. Rob in the medical ICU aims to create similar space between himself and his patients once they leave the unit, for professional reasons and reasons of emotional self-protection. He, in his words, 'tries not to be in touch with or hear from former patients' aiming to 'leave work at work.' He is not sure how exactly he learned to do this but said he had to in order to continue working on this unit so that 'now it's pretty much ok.' In the words of Hannah, this kind of separation and distance from patients once they leave the unit is essential, 'in order to be able to function and not get overly involved...you have to know that cut off point,' a point she thinks comes with 'time and maturity.'

### *Strategies of emotion management on the job*

The nurses put their ideas about emotion management into practice in several ways at work drawing on resources available in the workplace. In so doing, they aim to protect their own psychological and emotional well-being. They draw on the support of colleagues, talk with patients' families and adopt several cognitive strategies including those aimed at changing their perception of a situation.

The most common way nurses described negotiating emotions on the job was by 'venting' to colleagues. Martha remarked, 'I think we cope a lot...with each other, and that makes it a lot easier because everyone kind of feels the same way and understands how the other person feels.' She explained, 'Usually I vent...to my coworkers, or, you know...we have a really good rapport with each other.' NICU nurse Christina similarly stated:

It always makes you feel better when you sit down with other people that day and kind of go over the whole thing right then and there – rather than go home and kind of hash it out in your own head...to kind of generate conversation about it is better than not.

The use of collegial relationships to process difficult emotional states was a theme that came up frequently and is very much in line with Lewis' conclusion that:

...the very difficult emotional situations that the nurses regularly face, allied to the fact that it is expected that they deal with their own emotions professionally (i.e. suppress them), mean that they are likely to turn to each other to cope when pain and distress is experienced (2005, 525).

While relying on colleagues to help manage emotions on the job was certainly a dominant strategy, other nurses spoke about how patients' families helped them cope with difficult situations. Nancy captured the importance of these relationships when she remarked, 'Well, you talk with each other. You talk with the staff and...I guess some days you just cry with the family and you know...it's sad, there's sadness when people – some people die at 21.' Tamara also spoke of how family connections helped her manage emotions on the job. The death of a baby on the unit shortly after the birth of her own child had prompted feelings of great sadness. In response, Tamara explained, 'I sat over in that bed space over there...and I bawled my eyes out with that father'.

In addition to relying on other colleagues to manage emotions, some nurses rely on cognitive approaches. One approach was to emphasize the work that the nurse had done to help the patient. NICU nurse Kosta for example, explained that:

And you know, a young person dying – it hits you very hard. How do I deal with that? I just do. It's sad. You do the best you can, and again that's a gratification knowing that you're just doing everything you know how to do, and you are just working 110%.

Similarly MICU nurse, Dottie remarked, 'Of course, like taking care of the dying patient...can sometimes be emotionally wrenching, but also can give you a great sense of pride in where you work and helping out in that respect.' Both Kosta and Dottie managed difficult emotions on the job by reframing the death of a patient. No longer was the focus on the difficult experience of the patients' death, but rather on the work the nurse did to help that patient.

Another way nurses described managing emotions at work was by reconstructing the situation as a positive. This was particularly true in instances where a patient had passed away. Often, nurses would reframe the loss in terms of relief because the suffering was over. Angela expressing this strategy saying:

And you feel bad for the family and the people that are left behind, but you know that they really eventually move on, and you know, sort of get over it, and like part of them is maybe relieved of their suffering is over, and their long, drawn-out hospital stay or something.

### *Strategies of emotion management off the job*

While some of the nurses sought to manage their emotions by creating impermeable boundaries around their work emotions and experiences, most aim to negotiate a balance, trying to create some, but not too much, emotional space

from patients and families not just at work but also in other life domains. As they individually and collectively sort through their work-related thoughts and dreams off the job, the nurses interviewed developed three sets of off the job strategies for managing their emotions. They rely on coworkers as they called-in to obtain information about patients, share experiences with people who help them cope and engage in activities oriented to emotional recovery. They utilize these strategies at homes, in restaurants, in gyms and in other venues. Some use the commute or physical transition away from work as one way to manage their emotions. Some spoke about using the commute to 'decompress' by thinking through things that just happened or sometimes just crying. Kosta lives a distance from the hospital and explains:

My rule is that when I finish a shift I have until my garage door goes up to process whatever it is that has happened on that shift. And when the garage door goes up, my family is not to bear the brunt of a bad shift.

Tamara has learned over time to 'detach' herself until she finishes work when difficult things happen, like a patient dies, which then leads her to, 'bawl my eyes out all the way home.' Laura also explains the importance of this transition period in her process of emotion management stating, 'Well, taking the train home, or driving home, sometimes I'm able to just kind of think through my day.'

## CALLING-IN

Nurses we interviewed call-in to work from home to check on patients or visit patients on days off as one strategy of managing their emotions. Most of the nurses reported calling-in from home, at least occasionally, to check on the status of a particular patient. In the words of Lillian:

You know, I just had a patient who...it was someone that I took care of for a long time and I went on vacation for a week. But I was wondering what happened with Koo. I kind of called to check in and see. And he had passed away, which I kind of expected....

As Barbara stated, 'We've all at one point called off-shift to see how so and so's doing.'

In talking about calling-in, many nurses are aware of the frequency of their calls and even set guidelines for themselves about how often they allow themselves to call, with less being better than more. Marie explains:

I have called back many times...I have woken up in the middle of the night – not every day – and called in and said 'how's this one doing? I do call back but I try not to make a big habit of it.

For Martha, 'There are times when you get very involved and I will actually call like once or twice a week and ask how the person's doing. But rarely. I really try not to.' Others talk about limiting their calls to once a day as a way of managing their thoughts about a certain patient. Tamara explains:

Occasionally there'll be a baby in the back of my mind that I'll really be worried about, and I will allow myself to call once a day to check on the baby, if that's something that I feel like I absolutely have to do. Rather than stewing about it, I will call and ask.

The examples of Martha and Tamara illustrate how nurses call-in as a way to address the emotions that result from not having information about a patients' health status. The goal of calling-in here seems to be to gain enough information to allow the nurses to comfortably limit the extent to which they are thinking about particular patients off the job. In doing so, calling-in is a strategy for helping nurses construct emotional boundaries between home and work.

In addition to calling-in as a personal strategy of emotion management off the job, several nurses spoke about calling-in as a collective strategy. Nurses at home rely on nurses currently working to call them at home if something upsetting happened to one of their patients. This suggests that phone calls are not just an individual strategy used to manage their own thoughts and emotions off the job but a strategy they use collectively to warn and help colleagues be emotionally prepared to return to the unit. Marilyn said she often thinks about her patients at home. Describing a certain patient who had surgery a few weeks earlier, she says she asked herself, 'Should I call, should I find out...but then...you try to separate yourself but it's not easy.' Then she thought 'If something really bad had happened to her [the patient], they [other nurses] would have called me because they know to call the primary nurse.' She concluded, 'So I'm like, "She must be fine, 'cause nobody called me".' Following a similar logic, Susan would sometimes call to check-in on a patient while also being aware that 'people [nurses] would call if something was going wrong. Because there were a few times when we didn't think he [a patient] was going to make it. They called me at home.'

In addition to calling-in, some nurses stated that they actually went to visit particular patients on their days off. Angela explained 'There've been a few that I've called on my days off, and my...cystic fibrosis patient I even went in to visit him a few times on my day off.' While this was certainly not an approach adopted by most of the nurses interviewed, this does highlight another way in which nurses try to manage work-related tensions off the job, by creating bridges back to the workplace to gain information about patients.

## SOCIAL SUPPORT

In addition to calling-in, many nurses described how they managed emotions off the job by talking through their work experiences with friends and family who helped them cope. Penny, explaining how she dealt with work emotions off the job said:

My fiancé...I'll just call him and say, "I had a rough day." And we'll go out and get something to eat and you know, he'll ask me about it and you talk about it, and that's sort of when you get to relieve the tension that you didn't get to relieve in front of the parents... A lot of talking though.

Jennifer similarly explains, 'Sometimes just talking about your own feelings...even talking about it with sometimes like family members that have no idea what you're really talking about. Just to like get it out and voice those words and get it out of your system.'

While Penny and Jennifer spoke about talking to their family members in general, other nurses were more specific, explaining that friends and family who were not healthcare providers were less useful social supports than those who were apt to understand the demands and emotions of the job. Jean remarked, 'My husband doesn't get it, so I don't even bother to talk to him about it.' Joanne on the other hand explained, 'Yeah, I think – well, my spouse is a nurse, too, so it helps that, you know we both kind of – we know where each other's coming from.' Similar to this, Kosta also expressed that it was people with experience in this type of work that were able to provide the social support necessary for emotional recovery. She says:

I don't really talk to my friends about it. People who aren't in nursing or don't do this kind of thing – I know from a fact they don't want to hear about it. It's too hard, it's too painful. I know my sister doesn't like to hear about it. She doesn't even like to hear when I've got a really sick kid going. My mom will listen to anything. Like I said, she's a nurse.

Penny also described drawing on the support of family members who worked in health-care. 'My mother's also a nurse,' she said, 'so if we've had a particularly difficult day' we talk about it and maybe 'sit down with a glass of Bailey's...what are you going to do?' Among nurses who described having other healthcare providers in their immediate networks, these people became central to nurses' efforts to manage emotions off the job.

## ACTIVITIES AS AN EMOTIONAL DISTRACTION

In addition to strategies nurses used to directly sort through their emotions off the job, some also described engaging in

practices primarily aimed at creating a distraction from their work emotions. They spoke about exercising, watching TV, listening to music, crying and/or praying as other personal strategies that give them some distance from work. In the words of Christina, 'There are times where I just need to watch TV or listen to music and forget about the day...' Dottie echoed this point claiming, 'You try to distract yourself.'

While the specific activities nurses engaged in varied, they were all aimed at pulling their attention away from the emotional strains of their work and allowing them to create and maintain emotional boundaries. For some nurses, these activities were more social. Lillian explained:

Yeah, you know, like it's nice if you can meet up with friends and go to watch a baseball game and have a beer, or I'm a big gym person and going running and stuff like that. So just getting out and not just going straight home and sitting there before coming back the next day.

For other nurses like Joanne, the activities were more solitary ones. 'I try to stay pretty balanced outside of work with exercising and just doing stuff for me,' she said. Similarly, Abby described the emotional relief and renewal she experienced off the job by spending time alone outdoors. She says:

I'm a big nature person. And I have a home near a lake that is an unbelievably renewal for me. It's...on an island. It's extremely quiet. We have tons of wildlife. Beautiful mountains, beautiful lake and that – just every moment that I'm there enriches me. That is my home.

Despite the differences in the type of activity, using distractions was an important way that nurses managed their emotions off the job.

## DISCUSSION

On the job, intensive care nurses manage their emotions and those of the patients and families with whom they work. The intensive nature of ICU work, with its low patient–nurse ratios and regular family contact, leads nurses to continue to manage work-related emotions when their shifts end as they think and dream about patients. The division of labor in the hospital encourages this emotional investment by assigning nurses primary patients and encouraging them to care for family members. It is at home, where nurses lack colleagues and other work structures, that they develop their own strategies. As they call-in, share their experiences with others and engage in a range of activities, nurses continually negotiate their emotional boundaries trying to obtain the right amount of distance from patients and families.

Both on and off the job, social support is a central way nurses manage emotions. At work, they draw on colleagues

in a process sociologist Peggy Thoits (1986, 417) would describe as 'emotion-focused coping'. Off the job, they rely on coworkers in a different way as they call-in to check on patients. Rather than participating in 'emotion-focused' strategies these strategies are 'problem focused' as they help nurses manage emotions resulting from a lack of information. Some nurses also rely on families and friends. On the job, it was the patients' families who often shared a nurse's grief or sadness. In their absence, some nurses looked to their own families. This confirms Thoits's finding that, '... others who share similar perceptions of and emotional reactions to an individual's circumstances (or can do so vicariously due to previous experience) are the most likely sources of efficacious coping assistance' (1986, 421). Some nurses also relied on cognitive emotional management strategies. On the job, they reframed difficult situations to emphasize their work or to see loss in more positive terms. Away from work, they often aimed to distract themselves through exercising, watching TV or praying to create space for emotional recovery. The nurses we interviewed combined these strategies in ways not clearly related to demographic factors, the length of time they had been on the unit or the specific ICU in which they worked.

The strategies nurses use to manage their emotions off the job illustrate the importance of expanding the examination of nurses' emotion management to specifically consider approaches to 'self-directed' emotion management and how these practices are in turn impacted by the domain and place in which they occur. Certainly, existing studies of emotion among critical care nurses have emphasized the important therapeutic value of 'other-directed' emotion management (O'Connell 2008). Beyond this however, there has been considerably less attention paid to how nurses manage their own emotions outside of the patient-provider relationship.

Our findings have implications for the future study of emotion in nursing practice, suggesting that there is significant emotion work that continues to go on among nurses when they leave the worksite. This is particularly important to consider given a growing recognition of the impact emotional distress has on the psychological health of the provider. ICU nurses in particular are at an increased risk of developing problems like post-traumatic stress disorder (Mealer, Jones, and Moss 2012). On the basis of the findings of our interviews, we suggest that nurses and nursing education programs should focus on developing an understanding of the kind of coping strategies that are employed by nurses when they leave the work site, and institutions should consider how they might provide support resources to nurses when they are off the job.

In addition to the implications our findings have for the study of nursing practice, our analysis may also support the development of a more integrated theoretical framework to study emotions more generally. These findings support theoretical approaches that view emotions as dynamic elements belonging to individuals rather than aspects of people that can be fully appropriated by organizations. We encourage future researchers to develop frameworks that do not rely on distinctions between public and private – between emotions managed in work contexts and those managed at home – when both sets of emotions results from organizational aspects of work. Studies in this vein might move analysis away from particular worksites or occupations, to instead focus on individual workers. Such an approach can also provide insight into factors that account for individual variation in emotion management strategies off the job, such as years of employment or home situation, coupled with general features and standards of the job, the organization and the industry. This case study suggests that self-focused emotional labor will be most ongoing among professionals working in industries and/or workplaces, like ICU nursing, characterized by high degrees of uncertainty and the continued presence of death. If this is the case, we would expect to see evidence of the off the job strategies of emotion management evident among intensive care nurses also among firefighters, police officers, ambulance drivers, members of the military and others who have worked in similarly characterized environments. To the degree that similar strategies are evident in professions dominated by men, future studies can also consider the gendered dimension of emotional labor off the job that we could not address here in a profession dominated by women.

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