Research Article

"I Can Never Be Too Comfortable": Race, Gender, and Emotion at the Hospital Bedside

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Abstract

In this article, we examine how race and gender shape nurses' emotion practice. Based on audio diaries collected from 48 nurses within two Midwestern hospital systems in the United States, we illustrate the disproportionate emotional labor that emerges among women nurses of color in the white institutional space of American health care. In this environment, women of color experience an emotional double shift as a result of negotiating patient, coworker, and supervisor interactions. In confronting racist encounters, nurses of color in our sample experience additional job-related stress, must perform disproportionate amounts of emotional labor, and experience depleted emotional resources that negatively influence patient care. Methodologically, the study extends prior research by using audio diaries collected from a racially diverse sample to capture emotion as a situationally emergent and complex feature of nursing practice. We also extend research on nursing by tracing both the sources and consequences of unequal emotion practices for nurse well-being and patient care.

Keywords

emotion practice; emotional capital; race; gender; nursing; patient care; audio diary method; United States

Recent scholarship has depicted emotion as both an outcome and a mechanism of inequitable social arrangements. Embodied feelings emerge from one's position within social hierarchies at the same time that emotional practices help to maintain those hierarchies (Scheer, 2012). While general processes of inequality work through social interaction (Schwalbe et al., 2000), black feminist scholars are critical of generic processes that fail to account for the situated mechanisms that simultaneously perpetuate gendered and racialized inequalities (P. H. Collins, 2000). Gender has long been a lens that illustrates the subtle ways that systems of stratification are embedded within the self and reproduced through interactions and emotions (Cottingham, Erickson, & Diefendorff, 2015; Erickson & Ritter, 2001; Hochschild, 1983; Meier, Mastracci, & Wilson, 2006; Pierce, 1995; Simpson & Stroh, 2004). Recently, scholars working in the area of emotion and race have begun to examine unique dimensions of racialized emotional labor, demonstrating the influence of race on emotion management within the context of historically identified white organizations and institutions (Evans & Moore, 2015; Mirchandani, 2003; Wingfield, 2010a).

We contribute to this scholarship by examining how overlapping race and gender hierarchies infuse physical bodies with structural inequalities. Consistent with the tenets of practice theory (Bourdieu, 1990; Rouse, 2007),

emotion emerges from the (mis)fit between the structured environment and the individual's internalized adaptive patterns (dispositions, tastes, values, etc.). We combine this emotion-as-practice framework (Cottingham, 2016, 2017; Erickson & Stacey, 2013; Scheer, 2012) with scholarship on the "emotional double shift" (Evans, 2013). By focusing on the embodied emotional practices that help to shape the emotional "double shift" (Evans, 2013, p. 12) demanded of nurses of color—that is, the additional emotional labor workers of color must perform to remain and succeed in white institutions—we extend earlier work by illustrating the effect this labor has on the emotional resources that nurses have available to spend in self and patient care. In using audio diaries as primary data, the current study also contributes a unique methodology that captures nurses' reflexive insights into their spontaneous emotional experiences (Rosenberg, 1990) and, in so doing, details their experience of microaggressions on the job (Sue, 2010).

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Background

Nursing as a White Institutional Space

Documenting racism within the nursing profession is made difficult by written histories of nursing that erase the "color-line" (Du Bois, 1903). In the 1990s, the existence of a racist health care system was either denied outright (Funkhouser & Moser, 1990) or "whited-out" (Jackson, 1993) through cultural analyses that attributed health care disparities to individual health behaviors while also attributing careworkers' experiences of systemic racism to individual bias (Porter & Barbee, 2004). However, ongoing research in the 21st century draws our attention to the ways that race operates as a barrier and an axis of inequality in both nursing education and nursing practice (Beard & Julion, 2016; Byrne, 2001; Doede, 2017; Gilliss, Powell, & Carter, 2010; J. M. Hall & Fields, 2013; Hamilton & Haozous, 2017; Hassouneh, 2013; Lancellotti, 2008; Mapedzahama, Rudge, West, & Perron, 2012; Moceri, 2012, 2014; Moore & Continelli, 2016; Robinson, 2014; Schroeder & DiAngelo, 2010).

Despite the growing evidence of racism within nursing education and practice, such processes remain "absolutely opposed to the images that nurses have of themselves as caring professionals" (Jackson, 1993, p. 373). Barbee (1993) concurs, noting that "[t]he contradictions between caring, a principle part of the identity of nursing, and racism make it difficult for nurses to acknowledge racial prejudice in the profession" (p. 346). As a result, nursing's emphasis on empathy (Dinkins, 2011; Leininger & Watson, 1990) is transformed into an identity that synthesizes caring with paid labor in ways that lead white nurses to adopt a "color-blind" (Bonilla-Silva, 2006) belief that all people's experiences of health care are the same (Malat, Clark-Hitt, Burgess, Friedemann-Sanchez, & Van Ryn, 2010). This orientation simultaneously reinforces routine practices that disadvantage nurses of color (Glenn, 1992), and reproduces an "institutionalized ideological frame that minimizes and denies the relevance of race and racism" (Evans & Moore, 2015, p. 440). Understanding *how* this process unfolds during nurses' daily work routines and how it comes to differentially impact the emotional resources available to nurses of color requires the use of three interrelated concepts: emotional labor, emotion practice, and the emotional double shift.

Expanding the Conceptualization of Gender, Race, and Emotion

A specific area where the effects of institutionalized racism might be visible among nurses, and disproportionately so for women nurses of color, is in their emotional experience and subsequent performance of "emotional labor" (Hochschild, 1983). Nurses typify "middle level workers" whose jobs primarily require the performance of interactional work (Wingfield & Alston, 2014, p. 276). Emotional labor includes the management of negative emotions and the cultivation/performance of positive emotions as determined by the nursing role (Bolton, 2001). In addition to the specialized, technical labor required of today's nurses, they are required to effectively manage their own and others' (e.g., patients, physicians, aides, coworkers) emotions, so patients and their families retain a sense that calm, confident, and effective care is being provided. As others have shown, however, the expectations surrounding the performance of such emotional labor—or the management of one's observed emotional displays for pay (Hochschild, 1983)—are not equally distributed across all occupational sectors or incumbents (Fixsen & Ridge, 2012; Wingfield, 2010a). Beginning with Hochschild's (1983) original study, for example, the performance of emotional labor has been framed as a gendered experience linked to sociocultural stereotypes of women as more emotionally competent and community-oriented (Ridgeway, 2008).

Nursing's feeling rules and emotional labor performances occur within not only a gendered space but also a racialized one. The feeling rules or emotion norms about what, when, and how much to feel and express when caring for others are structured around an unnamed white woman practitioner and mirror the expectations found in mid-20th-century white, middle-class households (Barbee, 1993; Daniels, 1987; Glenn, 1992; Seago & Spetz, 2005). Stemming from the sociohistorical construction of nursing as a profession best-suited for white, middle-class women (Bradley, 1989), these norms shape the experience and management of emotion *across* race and gender in ways that create differential working conditions, interactional expectations, and embodied selves for white workers and workers of color, men and women (Anderson, 1999; Evans, 2013; Evans & Moore, 2015; Feagin & Sikes, 1994; Pierce, 1995). Although the U.S. health care system positions itself as a color-blind institution promoting diversity, inclusion, and equal opportunity, the specter or "haunting" (Gordon, 1997) of racism and sexism within the American context remains (American Nurses Association, 1998; Barbee, 1993; Jackson, 1993; Lancellotti, 2008).

As such, in addition to the "naturalized" expectations that underlie women's emotional labor in professional spaces, women professionals of color experience biases and microaggressions that both demand and shape additional forms of emotional labor (Evans, 2013; Glenn, 1992; Harlow, 2003; Mirchandani, 2003; Wingfield, 2009, 2010a). Racial microaggressions, as Pérez Huber and Solorzano (2015) define them, are "a form of

systemic, everyday racism used to keep those at the racial margins in their place" (p. 298). Pérez Huber and Solorzano (2015) specify racial microaggressions in the following way:

> They are: (1) verbal and non-verbal assaults directed toward People of Color, often carried out in subtle, automatic, or unconscious forms; (2) layered assaults, based on race and its intersections with gender, class, sexuality, language, immigration status, phenotype, accent, or surname; and (3) cumulative assaults that take a psychological, physiological, and academic toll on People of Color. (p. 298)

These processes often remain outside the conscious awareness and empathic rules governing the professional experiences of white women. Thus, as Evans (2013) shows in differentiating the racialized emotional experiences of black pilots and flight attendants from those of their white colleagues, race and gender can shape the emotional labor of specific occupations within larger economic sectors (P. H. Collins, 2000; Crenshaw, 1991).

This is not to say professionals of color lack agency or the ability to divert from these sociocultural feeling rules within white institutional spaces. Women of color also engage in acts of "everyday micro-resistances" that enable them to "participate in racially oppressive institutions while maintaining and valuing their human dignity" (Evans & Moore, 2015, p. 441). For example, both M. Ong (2005) and Wingfield (2010a) found that black women in professional spaces sometimes adopted the persona of the "loud black girl" or "loud black woman." While this persona aligns with white coworkers' racist, stereotypical assumptions of black women's emotional demeanor, the authors observed that it also allowed black women to assert themselves and be taken more seriously within white institutional spaces.

As the preceding argument suggests, theorizing emotional processes must account for how emotions emerge from intersecting social locations or identity categories—as, in the current context, they are not merely gendered but also racialized. This requires scholars to move beyond seeing emotional experiences and management as primarily "cultural" processes (Thoits, 1989) and to elucidate how they operates in ways that can account for the complex interplay of structure and agency, reproduction, and change (Erickson & Grove, 2008). Here, the stability of self, culture, and structure is not outside history and interaction but, instead, requires confirmation within everyday practices, thus leaving room for agentive forms of repetitive practice that, over time, have the potential to subvert institutionalized scripts (Scheer, 2012; see also Butler, 1990; Gould, 2009). In what follows, we adopt an as-practice framework (Scheer, 2012) to examine not just the management of emotion but also the emotional resources that are situationally mobilized as individuals confront practical demands within nursing. Attending to emotion practice includes recognizing the labor and skill involved in aligning emotional experiences with situated expectations (i.e., emotional labor) as well as the ways that such practices and their outcomes tend toward the (re)production of inequalities as in Evans's (2013) portrayal of the double shift.

Building on Bourdieu's (1990) theory of practice, an emotion practice framework draws attention to the ways that emotion operates at both the micro and macro levels of analysis. As Erickson and Stacey (2013) suggest, the framework leads researchers to attend to emotion's physiological dimensions (Theodosius, 2008), the ways in which emotion management practices both reflect and influence the structural and cultural dimensions of organizational contexts (Bolton, 2005; Lopez, 2006), and the insights of caring labor scholars who point to the role of emotion in the reproduction of status-based inequalities (e.g., Gunaratnam & Lewis, 2001; Stacey, 2011; Wingfield, 2010b). Emotion practice enables a means of reenvisioning traditional emotional labor concepts such as feeling rules and acting strategies in relation to concepts such as "emotional capital" or the emotional resources and energy that are tied to social location but, as relations of power (Bourdieu, 1990), may operate quite differently depending on the social or organizational context under examination. Hochschild's (1979, 1983) emotion management theory has been foundational in scholarship on carework, but shifting to emotion practice moves us beyond moments of surface or deep acting to trace embodied feelings and their cumulative effects on self and patient care.

In the current study, we use an emotion-as-practice framework to explore how the intersection of gender and race becomes part of nurses' "mindful body" as they experience, manage, and reflect on their emotions (Scheper-Hughes & Lock, 1987). Using audio diaries to capture nurses' self-reflections, we illustrate the ways that emotion practice occurs in the everyday, situated doings of nurses—reflections and practices that can be difficult to capture through formal interviews or even in direct observation. These audio diaries thus enable us to explore the effects that nurses' social location of race and gender have on how emotions emerge from and help to shape events within white institutional spaces and the reverberating impact they have on the nurse and their patients.

Method

To investigate how race and gender intersect to shape the emotion practice of nurses, we draw on data from audio-recorded diaries completed by 48 nurses from two U.S.

Midwestern cities. Participants were part of a larger hospital-based study of nurses and emotional labor that included survey and interview data collected between 2011 and 2013. For the present study, we focus on audio diary data as a method through which participants could reflect on their nursing shifts in an open-ended and relatively unfiltered manner (Monrouxe, 2009; Worth, 2009). Diary data provide a window into processes of reflexivity (Rosenberg, 1990) and more "spontaneous" experiences of emotion (Theodosius, 2006, 2008) that are difficult to access with survey or interview instruments.

Nurses interested in the diary phase of the project met with a team member who provided an overview of the project. Each participant provided informed consent. Following consent, they were given a digital voice recorder and instructed to make a recording after each of six consecutive shifts. Participants were asked to reflect on how they felt during and after their shift, to describe who and what influenced their emotions, and how they responded to their emotions or the emotions of others. Participants were not asked to specifically reflect on experiences related to race—these reflections emerged from the data without prompting. Participants were compensated with a US$75 check for completing the diary recordings. Each shift recording was transcribed in its entirety, de-identified, and uploaded to a qualitative analysis program (Dedoose.com). The study received institutional review board (IRB) approval from the University of Akron (USA).

Sampling

Participants were first targeted through a request to complete a survey, distributed to all full-time registered nurses through the hospital's internal mail system. Those who returned completed surveys and consented to further contact with the researchers provided the pool of potential participants for the audio diary phase of the research. The research design sought to maximize the diversity of nurses in terms of age, race, gender, and range of emotional experiences on the job. Nationally, nurses of color make up approximately 17% of the workforce and men roughly 7% (Institute of Medicine, 2011). As numeric minorities in the profession, all nurses of color and men nurses who completed surveys were invited to participate in the audio diary phase. For white women, we targeted women born after 1980 to compare their experiences with baby-boomer nurses born in the 1950s and 1960s. Because our pool of white women was extensive, we further selected white nurses who reported a range of emotional responses to further diversify the sample in terms of emotional experiences.

Members of the research team were demographically paired with potential recruits to improve participants'

trust in the project. A white man contacted white men nurses; a white, millennial-aged woman contacted young, white women nurses; a white, baby-boomer woman contacted nurses of the same demographic; and a black woman contacted nurses of color. After several months of communication attempts, nurses of color, men nurses, and nurses born after 1980 were targeted at a second hospital in the same region for participation in the diary study. Audio diaries were elicited from a total of 48 nurses. Thirty-seven of the nurses are women; 11 are men. Thirty-eight nurses are white, eight black, and two identified as Asian American. All the nurses of color, except for one black man, are women. Ages of participants range from 25 to 66 years old, with a mean age of 44.

Analysis

The analysis used an abductive approach (B. K. Ong, 2012; Tavory & Timmermans, 2014; Timmermans & Tavory, 2012) and focused on the expression, experience, and management of emotion in tandem with nurses' reflections on race. Rather than a purely inductive process, abductive approaches combine deductive and inductive logics within the analysis (Timmermans & Tavory, 2012). Consistent with this analytical logic, prior theories on gender, race, emotion, and emotion management were incorporated into the coding process to extend our understanding of these issues. Codes related to emotion (including negative and positive), emotion management (self- and other-directed), race, and gender were used to capture excerpts from the diaries that dealt directly with these concepts. In addition, thematic memos were constructed during iterative readings of the transcripts to capture connections across different codes and the potential relevance of each transcript to the concepts of interest.

Our goal in analyzing the data was guided by our understanding of the theory of emotion practice and the role that gender/race may play in shaping work experiences. Within the entire sample, 10 nurses explicitly mention race. Given that race was not an explicit feature of the research design, this is not wholly surprising, yet the nature of this "race" talk is notable. Among white nurses, references to race were in relation to patients and/or coworkers, but never to themselves as white. Among the 10 nurses of color who completed an audio diary, three explicitly mention their own race as relevant to their work experiences during those shifts and five others make indirect statements related to race. These features of the sample suggest that whiteness continues to be an unmarked category among white people (Frankenberg, 1993) and racial privilege is often invisible to or denied by those who possess it (DiAngelo, 2011).

Beth, Andrea, and Melanie, three nurses of color, do not mention their own race despite the fact that they discussed uncooperative patients in a manner similar to Tamara (discussed below). In another case, Lianna, a young Asian American woman, never explicitly remarks on her race or that of others, but the nature of her conflict with a manager and the way in which she describes herself as nonconfrontational and treated differently by the manager are reminiscent of the tensions between deference and independence described in Pyke and Johnson's (2003) study of young, Asian American women. Jerome is the only black man in our sample. He does not explicitly mention his own race in his diaries, but he remarks on the need to continually prove himself to his patients in a way that mirrors the findings of Wingfield (2009) in her study of men of color in nursing. We mention some of the details of these particular cases to illustrate how an abductive approach proceeds. It does not bracket the theoretical and empirical insights of earlier scholarship out of the current analysis (Tavory & Timmermans, 2014; Timmermans & Tavory, 2012), but instead uses them to understand the implicit ways in which race might factor into current participants' experiences. Without knowledge of prior theory and research, these implicit references might be missed in the analysis.

While we could devote our findings to illuminating the case of Lianna and Jerome and contrast them with examples from white nurses, we instead chose to use theoretically relevant vignettes (see discussion below) because they allow us to focus in greater depth on the three nurses of color who explicitly reference their own race as significant in shaping their nursing experience. This does not mean that all nurses experience race similarly, but rather, these three provide an outline of the potential ways in which race can shape the emotional experiences of nurses of color. In addition, we turned to the diaries of white nurses (men and women) to look for similarities and contrasts between their work experiences—particularly in terms of interactions with patients and coworkers—to further identify the ways in which race and gender may shape the experiences of nurses of color.

Because of the largely unstructured nature of diary transcripts, we use ellipses to signify areas of edited text and we have removed verbal fillers for brevity and readability. All nurses are identified by pseudonyms. Italics are added for emphasis, while notes on context, tone, and other verbal cues such as sighs and laughter are placed in brackets.

Results

In presenting the results of our analysis, we focus on a selection of vignettes (Le Compte & Schensul, 1999; Miles & Huberman, 1994) that detail the possible forms of emotion practice that nurses of color might use in their interactions with patients and colleagues. Vignettes are useful in that they offer "'rich pockets' of representative and meaningful data that create a composite of people and events studied" (Stacey, Henderson, MacArthur, & Dohan, 2009, p. 732). In what follows, we use vignettes from three individual nurses—Nora, Tamara, and Joyce— to highlight possible forms of racialized emotional labor and its cumulative effects. While each individual nurse's experience is unique, their narratives reveal recurrent patterns of racial aggression and microaggression. For example, "difficult" patients and patient families are notorious among health care professionals for the negative emotions they draw out and the emotional labor they exact (Michaelsen, 2012). But nurse diaries reveal that this emotional toll varies by race as well as gender, as patient care can often include racial slurs, noncompliance with treatment, and delegitimation of authority for nurses of color. Certainly, white women nurses also confront a questioning of authority from certain patients, but we find a distinct racial component as patients question even a black woman's status as a registered nurse. Interactions with colleagues are also a site of racialized and gendered emotion practice, as women nurses of color face conflicts with their coworkers that cast doubt on their knowledge and skills and their claims to the same emotions as their white counterparts.

Contrasting the experiences of nurses of color with white nurses from our sample and the literature, the results of the analysis reveal the ways in which racial hierarchies intersect with gender to shape nurses' emotion practice. Interactions with patients, family members, and coworkers reveal how one's social location can result in additional emotional labor akin to Evans's "double shift," as well as a depletion of emotional resources leading to exhaustion and a compassion deficit (Brotheridge & Lee, 2002; Froyum, 2010). These structured effects can, in turn, negatively impact nursing care, creating a vicious cycle of "symbolic violence" (Bourdieu, 1996) that unintentionally perpetuates racial stereotypes as nurses of color work the double shift with double standards and feelings of heightened scrutiny in a white institutional space.

Racial Aggression From Patients: Nora

One of the more extreme ways in which race can influence the experiences of nurses of color, and consequently their emotion practice, is in interactions with racist and aggressive patients. Although overt racist aggression was rare, Nora's vignette highlights two important features of such aggression—the consequences of this aggression for her individually and the collective practices that her colleagues engage in to shield her and other nurses of color from these types of patients.

Nora is a black woman in her mid-50s who works primarily with psychiatric patients. Nora vividly describes a schizophrenic patient who was verbally abusive to her and others on the floor:

> This man has a diagnosis of schizophrenia and he was a very difficult patient in that he was *racially and sexually inappropriate with staff* . . . he called me a "nigger," a "humpbacked monkey" several times. He called one of the other nurses a "white nigger" and it just really it- it- it- it's *all we could do to not retaliate* and even if you- it started like my response was to start to sing a hymn under my- in an undertone and of course he caught on to that and said "you a Christian nigger?" . . . and it was just awful, awful things and when you have a patient like who's having a crisis, it is *very difficult on the staff emotionally* . . .

Nora in this example avoids personalizing the experience and instead diffuses it to the unit as a whole. However, as she was required to manage not only a difficult patient but also a racially aggressive patient, her emotional resources were being depleted and, as she stated, she found it difficult not to retaliate. Her initial attempt to suppress retaliation is to sing a hymn, but this backfires as the patient then uses her status as a Christian against her while also degrading her with racial slurs.

Nora tells us that this same patient also refers to another nurse as a "white nigger." Embrick and Henricks (2013) note in their research on racial epithets that the historic differential between whites and blacks renders racial slurs directed toward whites much less consequential than those directed at blacks and other racial minorities. While the patient aims to demean both black and white women nurses, his use of the term "nigger" calls up the overarching racial ideology that places people of color, particularly black people, at the bottom of the social hierarchy. In addition to sexist comments, racist slurs toward black women nurses serve as reminders of racial injustice that are absent when directed at white nurses.

Consider Nora's experiences in contrast to those of Frank—a white nurse who also works with mentally ill patients prone to anger. He describes himself as "a bigger guy" who worries about intimidating patients too much. He says, "Sometimes having a male tech and a male nurse helps—the patients are a little more respectful." His coworkers will often refer potentially violent patients to him saying, "maybe you just talking with them will calm them down." While he, like other men in nursing (Cottingham, 2015), talks about the work he does to de-escalate patients, his physique and embodied white, masculine privilege shield him from the aggressions that white women nurses and nurses of color confront. Past research suggests that patients are quick to grant men nurses respect (Floge & Merrill,

1986), yet such interactions point to race as well as gender as an important influence. As men, and white men in particular, are easily granted competence and respect, patient interactions can exact fewer emotional resources.

The contrast between Nora and Frank reveals how interactions with patients might lead to an emotional "double shift" for women nurses of color (Evans, 2013). Women nurses of color lack the embodied resources that command respect from patients. Over time, this additional emotional labor exacts a toll:

> Unfortunately we do get several patients who are racially inappropriate. And it is *very difficult*, especially since they're elderly [laughs], to *try and maintain an emotional distance* from that kind of thing. You remind yourself that they're psychiatrically compromised but the- the words still are painful things and sometimes what we do is to try to schedule so that there aren't any black staff members taking care of these people but that's not always possible and they are often times not any better with Caucasian staff members. So it makes for an *additional stress* on this unit.

The unit as a whole—white and black nurses—works collectively to manage the negative emotions that racially aggressive patients can cause by sheltering black staff members from overtly racist patients. This collective strategy is similar to the collective emotion management of the emergency health care workers in Henckes and Nurok's (2015) study. The fact that there is an unwritten policy about racist patients suggests the magnitude of the problem as well as the burden placed on individual nurses and unit managers to informally cope with racism in the absence of official, institutional policies.

In the quote above, Nora depersonalizes her stress by reference to the entire unit. Reflecting on her day at the end of the shift, however, we begin to see the effects of stress on her personally:

> It's *very frustrating* and you know you *add* that to the stress of trying to communicate with mentally ill people and not [deep exhale] take *too much offense about what they say* to you and it makes a very long day and a very exhausting day.

To be sure, this is not the only form of stress she encounters as a nurse, but her frustration, stress, and exhaustion are exacerbated as a result of the additional emotional labor she must perform due to her status as a black woman. A single event sets off a chain reaction of emotional harm, emotional labor to suppress retaliation or the feeling of offense, and culminating in emotional exhaustion as her resources, including emotional energy (R. Collins, 2004), are depleted. In her deep exhalation, we see the embodied aspects of Nora's emotion practice.

Microaggression From Patients: Tamara

Overt racial slurs, and racist aggression on the whole, were relatively rare in the diaries. Yet patient interactions also took their toll on women nurses of color in subtler ways. The women nurses of color in this study experienced racial microaggressions from patients, patient families, and coworkers, primarily in assumptions of their inferiority and incompetence and subsequent noncompliance. To be sure, these encounters take a toll on the nurses themselves, but they also potentially compromise the provision of care as emotional resources or capital (Cottingham, 2016; Erickson & Cottingham, 2014) are shifted away from giving care and instead used to manage feelings of frustration and shock. Using an emotion-as-practice framework rather than simply focusing on nurses' emotion management allows us to trace the effects of social location from instances of microaggression to patient care. The following vignette from Tamara's diary highlights the potential depletion of resources that can come from giving care as a black woman.

Tamara, a black woman in her late 30s, reports one instance of a larger pattern of interactions she has with patients and patients' family members that she links to her status as a black woman. After a patient tells her that a family member will be coming, she reports the following:

> So I knew somebody was coming, so I was trying to get her [the patient] done, and the lady came in, and, since the way she walked into the room, my back was to her, she couldn't see my badge the way I [was] standing because I was facing the patient. And she said, "Oh, what is she here to do? Give you your bath or something?" And, no, she said, "Who is this? What, is she here to do your bath?" And the patient said, "No, she's the one in charge of everybody else!" [Laughs]

Early in her diary, Tamara talks about all of the things that she does as a nurse and how she feels like the social worker, the patient's minister, best friend, as well as "the ringleader of the circus." Feeling like she does so much stands in stark contrast with how others (a patient's family member in this instance) can immediately see her at a "lower level" than how she sees herself:

> And initially, I got really PO'd [pissed off], because her [patient's family member] first assumption wasn't that I was her [the patient's] nurse, there helping her, her first assumption was that I was like, you know, other staff, and a lower level. [Laughs]

She later talks about the incident as a "little bleep in the morning, it really got me upset" and goes on to discuss the other frustrations with working with the pharmacist and other coworkers.

A single question from a patient's family member can lead to a chain reaction in which nurses of color must suppress their own emotions. In addition, such events can lead to self-doubt and rumination. Tamara reflects again on the event later in her diary recording:

> You know, I had to think about this for a while all day, so I was really ticked, because as I'm doing this, I am thinking about this [research] project and thinking about my day, and whatnot as things happen to me and I'm trying to think, *am I thinking too much into it?* Am I not giving people the benefit of the doubt? No, I think I feel that way because it's happened before. It's like before they can read the badge, or even *IF* they read the badge, they assume I'm a lower level staff, I'm not sure why [laughs], *maybe because I'm black*, I don't know. Why not go with the higher assumption first?

Tamara again tries to laugh off her anger—a strategy used by other health care workers (Cain, 2012) and an indication of the embodied practice of managing her emotions. But she identifies the event as part of a larger pattern in which she is assumed to be a lower level aide. Goffman remarked that "[w]hen they issue uniforms, they issue skins" to highlight the relationship between institutional role and the self (Goffman, 1974). Hochschild added "two inches of flesh" (Hochschild, 1979, p. 556) to suggest that embodied emotional experiences as well as visible forms of self-presentation are linked to institutional roles. Playing with the analogy further, Tamara's experience suggests that skin (color) can be its own uniform and that its effects are more than skin deep. Race, in Tamara's experience, supersedes her institutional role as a registered nurse.

Tamara's experiences appear in direct contrast to Judy, a white woman in her mid-60s. Judy's patients act surprised, *not* because she is an registered nurse, but rather when she is willing to help them with toileting and bathing, the work of a lower level aid. From her diary, Judy reports,

> . . . went in to see Mr. B first . . . I kind of tip-toed in because if he was sleeping, I was gonna let him sleep. But he opened his eyes and I told him who I was and he said, "I just pooped the bed." So I said, "Okay I'll get you cleaned up." He says, *"You're not going to go get [an] aide?"* And I says, "No [emphatically]." I says, "I'll clean you up. It'll give me time you know look at your skin and talk to you a minute or two." So that's what we did.

As a white woman in her 60s, there is no question that she is a registered nurse and not an aide who typically performs the "dirty work" (Stacey, 2005). This assumption leads to both surprise and respect from her patients when she does not call on a subordinate for such tasks (another patient, after requesting help to the bathroom, asks, "Are you going to wait for an aide to come?"). While Judy relays this information in passing, it illustrates how race,

and possibly age in this case, could confer privilege to her as a white, baby-boomer woman. In contrast to Tamara, who must insist on her status as a registered nurse, Judy must insist on her willingness to perform tasks typical of an aide. Notably, both mobilize emotional resources in response to patients' expectations, but Judy's efforts do not lead to the spiral of anger and self-doubt that Tamara experiences.

Women nurses of color also manage racial microaggressions surrounding patient noncompliance such as patients being uncooperative in basic care, including bathing and changing wound dressings. Here, race was not explicitly referenced. However, by contrasting their diaries with those of white nurses, our findings suggest that the type of patient matters here. Mentally ill patients may be more likely to be aggressive and uncooperative to all nurses regardless of race. But other types of patients may be selective in their cooperation. Tamara describes several examples of patients being uncooperative—refusing to remain on an oxygen tank despite her clear instructions, refusing to move around in the bed to prevent bed sores, and refusing to let her clean them after a bowel movement. She goes on to describe the emotional labor involved in trying to elicit patient cooperation. Following a patient's bowel movement, she says,

> I lay her down, and then I'm like, "Are you able to let me turn you, just so I can wipe off your bottom and make sure the pad is clean?" Nope! I had to leave her alone for ten minutes. And *she can get real snippy and snappy*, "Just leave me alone, get away from me." . . . "You might get mad at me, but I'm gonna do it, because I'm not gonna leave you on a dirty bed." I said, "I'll be back in 10 minutes, and then this is what we have [emphatically] to do. *We need to do what we have to do.*"

This particular patient is known to the nurse to become angry and "snippy" about basic care, but as the nurse she must ignore this to provide good care. She tries to diffuse the patient's anger by giving her 10 minutes to prepare for the task. After another shift later in the week, Tamara says again that patients can be uncooperative. In this example, her patient has refused to let her clean him after a bowel movement:

> But I was like, "OK, you know what? Fine. But I need to get to your wound. I need to change your wound." You know, he's like, "Well, I don't wanna do that now." So, you know, you goin' back and forth, and this- THAT is *emotionally draining*. Let me tell you. To, you know, you're trying to tell people, educate them, you know, "why are we doing what we doing?" They don't wanna hear it, you know.

In this instance, Tamara resists the additional labor—acknowledged as emotionally draining—of persuading

her patient to cooperate by saying "Ok, you know what? Fine." We might see this as an example of everyday resistance that reflects "well-considered actions taken to manage and minimize the necessary emotional labor of people of color navigating white spaces" (Evans & Moore 2015, p. 450). When it comes to the patient's wound, Tamara tries to take the route of patient education by telling this patient why it is important to clean him, but this strategy is ineffective and leads to emotional exhaustion.

This is in contrast to white men nurses whose perceived authority may make their use of patient education more successful (Cottingham, 2015) and whose conflict with patients is usually restricted to patients with psychiatric disorders. The diaries of white men provide examples of patients refusing nurse advice, but few examples of noncompliance outside the psychiatric ward. Relevant to racial dynamics, Russell, a white man in his mid 40s, notes the following observation:

> . . . another thing that I've noticed if, like I said I-I'm white, a lot of times when I work with black patients it seems like I have to prove myself [pause] to them, more than I do- like as a new nurse to them- more than I do to my white patients to win their trust over. And one- once a minority patient becomes comfortable with me, they do open up but it seems like there's a little bit bigger of a hurdle to go over . . .

Developing trust and rapport, as identified by Russell, is in contrast to the lack of respect and compliance with basic care that Tamara routinely confronts. Men nurses and nursing assistants may even be called into a situation to command the authority that patients are quick to grant them (as described by Ashley, a white woman in her 20s in our sample and in research by Floge & Merrill, 1986). White nurses do encounter uncooperative patients, but these are typically mentally ill patients who may lash out violently at everyone (recall the first example from Nora) rather than the type of patients that Tamara (and others like Lianna, an Asian American woman in her 20s) encounters on a medical respiratory floor unit.

Microaggression From Coworkers: Joyce

Sources of additional, race-related emotional labor do not just emerge from interactions with patients. Interactions with coworkers are another means through which race and gender can shape nurses' emotion practice. Conflict with coworkers of all races can create an added layer of self-doubt and frustration. The diary of Joyce, a black woman in her late 40s, provides an example of this type of conflict and vividly illustrates the impact it can have on patient care.

Joyce works as a nurse partner in an outpatient oncology unit. Handling paperwork, scheduling patients, and

patient education take up a considerable portion of her job and her reflections in her diary entries. Scheduling also led to a memorable conflict with a coworker that she describes in detail in her second shift. Joyce emails a secretary whenever she has a scheduling need for a patient. In this particular example, the secretary responds via email to tell her to instead take her concerns to someone else, leading to the following reflection from Joyce:

> . . . . what makes me *mad* is, one, that she [the secretary] would say this to me- emailed it to me as if it wasn't part of her job description, and, two, *I bet if it was a WHITE nurse she wouldn't say that.* She wouldn't tell me who else—as if I don't already know—who else I can go to- to get this scheduled. And I know this for a fact. And that's very *frustrating* to me, it makes me so *mad* that I got to struggle with some of [sighs] my co-workers. And *because I feel like I'm black*, if I asked for it, and this is white and black co-workers, if I say it, I *feel* like I got to cover my back, make sure I got everything- all i's dotted, t's crossed, because someone is gonna check behind me, doubt me, say that I'm wrong. It happens over and over and over again, and you know that hadn't happened in a little while until today. You know it just reminds me; *I can never be too comfortable.*

As a black woman, she feels that coworkers (including other black women) talk to her differently than they would if she were a white nurse and that coworkers will doubt her and scrutinize her work more than white nurses. This leads to feelings of frustration, anger, and like she can "never be too comfortable." Her quote points to a pervasive feeling of being on edge that is linked to her status as a black woman. Similar to stereotype threat (Steele, 1997), Joyce appears concerned that her performances will be harshly judged because of her race. This performance pressure can negatively impact performance, but it also points to a distinctly gendered and racialized emotion practice. Joyce's situated embodiment of emotion is characterized by a pervasive unease and self-doubt.

Later in the same shift, we see how the race-related emotional labor described above directly impacts Joyce's ability to activate compassion in an exchange with a patient. Talking about a breast cancer patient who appeared to be scared and hesitant to continue treatment, she says,

> And this patient, she came over. I don't know about what she wanted me to do but I was *already stressed* about thing 1 and thing 2 from this morning, those two emails, and I just *wasn't really feeling* [like] trying to baby-talk her into getting her- into getting her treatment. "You're grown! If you don't want treatment then, ok, you don't want treatment, so we'll reschedule you for another time."

Race-related emotional labor depletes her emotional reserves diminishing her ability to empathize with and comfort a scared patient. By seeing emotion-based skills

and capacities as resources shaped by structural inequalities and the compounding influence of time, we can better understand how racist microaggressions come to negatively impact nurses and their patient care. The stress from prior (racist) encounters leaves her unable to activate compassion for an ambivalent patient.

This act appears to be one of survival, but we see later that Joyce seems to experience some guilt about this event. She later asks a spiritual counselor to talk to the patient and follows up to find out how the patient was doing.

> I did though, instead of just totally dismissing her [the patient], *I didn't want to do* that, but I just didn't have time because I was starting into my other clinic with my other patients. I asked one of our spiritual counselors to go over and talk to her, which she did immediately, and I think she had a long conversation with her, so you know that was good.

In her original framing of the event, she suggests that her emotional resources during the shift are taken up by racially tinged interactions with coworkers. The stress of these prior interactions caused her to not "feel up to" the task of assuaging a patient's concerns about treatment. Yet in this second account of the event, her explanation shifts from not "feeling [like] trying to baby-talk her" to one of time constraints ("I just didn't have time"). Time constraints might provide a more objective and professionally legitimate rationale, but in this explanation, the distinctly racial antecedent is lost.

Discussion

Centering on the vignettes of Nora, Tamara, and Joyce, we explored the relationship between race, gender, and emotion practice in nursing care. Building on the work of other scholars of race and emotion (Evans, 2013; Evans & Moore, 2015; Kang, 2003; Wingfield, 2010a) and studies of emotion in nursing (Broom et al., 2015; Cricco-Lizza, 2014), we find that nurses of color experience an emotional double shift, similar to that reported by Evans's African American pilots and flight attendants. The stress of racial slurs, anger and frustration in having one's authority and status questioned, self-doubt in legitimating feelings of anger, and pervasive discomfort that comes from the threat of negative stereotypes all appear as race-related emotional experiences. Our combination of audio diaries with an emotion-as-practice approach allowed us to capture not simply isolated moments of aggression and microaggression and subsequent emotional labor, but also the additional effects of these events on nurses' emotional capital, and negative impact on patient- and self-care. Unlike other professions such as airline pilots or law students (Evans & Moore, 2015), nursing's emotional

demands make the implications of the racial double shift directly relevant to the quality of patient care nurses are able to provide. Such processes and their effects also show the structured and unequal practices that Du Bois's (1903) double consciousness requires and, in turn, how inequalities are reproduced both situationally and within the broader occupational context.

As an institutionalized hierarchy, racism is not merely a feature of racist white individuals (as the conflict between Joyce and a black secretary illustrates), but linked to institutional policies and cultures that may be internalized even by those stereotyped in negative ways. Such forms of internalized racism, or what hooks (2003) might call "mental colonization," illustrate one of the ways that working within institutions where whiteness operates as an unspoken normalized standard yields particular "hidden injuries" for employees of color (Dodson & Zincavage, 2007; Pyke, 2010; Wingfield & Alston, 2014). The cultural myth that embracing an ethic of care and empathy precludes nurses and other caring professionals from perpetuating racism (Barbee, 1993), creates an ideology of denial that circulates throughout institutionalized health care settings, and infiltrates routine interactional practices (S. Hall, 1986; Pyke, 2010). As Wingfield and Alston (2014) suggest, middle-level workers are charged with racial tasks that "involve the self-presentation, emotion work, and/or behaviors that are necessary for upholding the racialized power dynamics in predominantly White organizations" (p. 280). The costs of such unrecognized processes include the perpetuation of white privilege as well as reduced individual health, well-being, and job performance.

We conceptualize racialized emotional labor as one form of emotion practice, emerging from interactions with patients, patient family members, and coworkers of diverse races. This practice leaves traces, as emotional effects are embodied and "stored in the habitus" (Scheer, 2012, p. 211), while also affecting nurse well-being and the provision of patient care. Nurses of color can experience depleted emotional resources critical to the delivery of quality care (Stacey, 2011; Virkki, 2007) as a result of racist and sexist interactions on the job. In this way, racist encounters can have a reverberating and subtle effect. Using an emotion-as-practice framework and audio diary data enabled us to trace the intersection of racism and sexism and its effects on nurses' embodied comfort, activation of compassion, and depleted emotional energy (R. Collins, 2004). Overt and subtle racism is bad for nurses and, in exhausting emotional resources, bad for patients. On the practical side, hospitals and units might take a more proactive stance toward patients with a history of racial outbursts or noncompliance. The policy that Nora discusses of moving racist patients to different nurses might not be tenable in certain contexts, but explicit efforts to confront biases and subtle forms of prejudice among patients and staff could complement efforts to create generally equitable work environments.

Our use of diaries points to processes of emotion identification and legitimation that go beyond the mere management of emotion (Theodosius, 2006). Using audio diaries, we were able to capture situated events, often illustrative examples of patterns identified by the nurses themselves, as well as nurses' reflexive consideration of what they feel and why. Rather than see emotions as final products, easily reported in surveys and interviews, diary data suggest that emotions are processes through which participants make sense of their experiences—"the body's knowledge and memory . . . its appraisal of a situation" in an ongoing rather than static manner (Scheer, 2012, p. 206). Emotions are not mere products of social practice; rather, they themselves constitute "a practical engagement with the world" (Scheer, 2012, p. 193). This form of practical engagement moves beyond identifying or illustrating the conditions under which the performance of emotional labor and the double shift occur, to show the embodied and reflexive practices that constitute, reproduce, and potentially change such conditions and their effects. Diary methods such as the ones used in this study may be particularly useful for expanding how we understand the operation of such controversial practices as racism and sexism as well as providing unique insights into such seemingly ephemeral processes as emotion practice in nursing.

Our use of diaries also captured moments of self-reflexivity that might be missed in formal interviews. Tamara's vignette in particular highlights this type of reflexivity. Asking herself, "am I thinking too much into it?" Tamara's reflections reveal the ambivalence and self-doubt that can characterize the seemingly simple but complex practice of "naming" experienced emotion in white institutional spaces (Scheer, 2012). Such self-doubt can be seen in her reflexive efforts to identify and legitimate her anger (Rosenberg, 1990)—performative efforts not easily captured in analyses that focus on masking, repressing, or cultivating emotions. Self-doubt—a cognitive and emotional "mode of response" (Emirbayer & Goldberg, 2005, p. 482)— results from the friction between her position as a black nurse and the norms governing the hospital as a white institutional space as well as the resulting emotional labor that must be performed to maintain the semblance of "normal" interactional rules. This friction, and the resultant labor, expends emotional resources that might otherwise be channeled into patient- or self-care.

The diary method, though, is not without limitations. The open-ended nature of our instructions to nurses who participated in the study meant that we received diary entries of varying lengths and richness. Our inability to

probe participants at the moment of reflection on issues such as the race or gender of particular patients, family members, or coworkers, limits our ability to fully capture the racial dynamics of nursing. We are also limited to a short timeline of six consecutive nursing shifts. Longer periods of data collection might better capture the ebb and flow of nurses' emotion practice over time.

Historically, black women in the United States have moved from the "mammy work" of domestic care to the public realm of service work where they continue to disproportionately care for and nurture others (P. H. Collins, 2000, p. 45). In using an emotion-as-practice framework along with audio diary data, our hope is that the toll of embodied racialized and gendered history, as well as the accompanying unrecognized emotional labor it exacts, becomes more visible. Race continues to be a politically charged issue in the United States. Our findings shed further light on the intersecting importance of gender and race for understanding the nuances of caring labor.

Declaration of Conflicting Interests

Funding

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