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Chapter 13
The Emotionalization of Burnout in the Health Care Sector

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During the last forty years, the healthcare sector has gone through several major changes. An important positive change has been the introduction of patient-centered care. The increasing interest in the patient's perspective was part of a significant societal shift toward acknowledging structural patterns of injustice and oppression in society. However, it was also a specific reaction against the strongly authoritative and cold attitude toward patients, which was still influential among medical professionals in the 1950s. At that time, doctors and nurses were supposed not to get too emotionally involved in their patient's suffering. In the 1970s, this approach was beginning to be questioned. There was widespread public discussion concerning injustice, cruelty, and callousness in health care, and there was a growing awareness of the importance of understanding and respecting the individual patient's perspective and opinions concerning medical treatments. As a result, patient-centered care is today a central feature of nursing ethics.

However, in the 1990s, many countries were struck by a deep economic depression and consequently, there were large-scale cutbacks in staffing numbers. So-called New Public Management was also implemented in the healthcare sector. The main feature of New Public Management was that it adopted perspectives from the private business world and implemented these in the public sector. New Public Management is often described as a rationalization of institutions with cutbacks on staff, tighter working schedules, and stricter control of the production of service. However, New Public Management did not only lead to a rationalization but also a new kind of *emotionalization* of health care. While nurse work had previously primarily been

described in ethical terms, nurse work was increasingly described in emotional terms.

Because of the large-scale rationalizations in the healthcare sector, an increasing number of nurses suffer from stress and burnout. Though it is generally acknowledged that structural cutbacks cause these syndromes, burnout is today often described as an emotional reaction. It is also suggested that nurses should be trained in resilience to tackle the increasingly stressful working conditions in the healthcare sector. My aim in this paper is to discuss the meaning of burnout in the healthcare sector and what I will call an emotionalization of both nurse work and burnout.

The chapter proceeds in the following order: I begin by questioning the tendency to describe burnout among nurses as an emotional reaction. I argue that the stress that nurses describe often is ethical. Furthermore, I argue that one can see a tendency to "emotionalize" ethical situations in care work, which reflects the influence of emotional intelligence theory. Furthermore, I argue that the stress nurses experience, specifically in Nordic elderly care, deeply reflects structural changes due to New Public Management. These structural changes have led to a disintegration of the whole meaning of patient-centered care. The experience of stress and burnout among workers in Nordic elderly care is then not a mere emotional reaction but ought to be understood as an experience of the disintegration of ethical space in their work.

In the second part of the paper, I argue that one can see a gendered pattern in how nurses' stress and burnout are described as emotional. I compare how nurses working in the healthcare sector were affected by New Public Management in the 1990s with Sari Charpentier's[1] (2007) description of how middle-aged women in the banking sector were affected by New Public Management in the 1990s. In both cases, one can see a

[1] Sari Charpentier, "Ilska som klimakteriesymtom i arbetslivet" ["Anger as a symptom of menopause in working life"] in *Kvinnor, kropp och hälsa,* Elina Oinas and Jutta Ahlbeck-Rehn (Eds.) (Lund: Studentlitteratur, 2007).

tendency to emotionalize women's experiences of stress and exhaustion.

In the last part of the paper, I discuss Elianne Riska's[2] research on the historical development of stress research on male business executives. Riska suggests that one can today see a shift toward a neoliberal conception of "hardiness" that normalizes a certain male type that should be able to handle stress. I compare this normalizing of a male ability to cope with stress with the claim that nurses should be trained to be resilient and to be able to handle stress. I argue that one can see a gender and class pattern in how the ability to handle stress is described. The neoliberal concepts of hardiness and stress uphold a gendered division of labor where women are expected to endure stress in working conditions that lead neither to a career nor a well-paid job, while middle-class men are expected to endure stress in order to achieve both a career and a secure income.

Burnout – An Occupational Problem or an Emotional Reaction?

The concept of burnout was originally coined by Christina Maslach in the 1980s. According to Maslach, people-work with customers, clients, and patients puts workers at greater risk of burnout. Maslach interviewed people working in various customer or patient occupations. Based on these interviews, Maslach wrote the book *Burnout, the Cost of Caring*.[3] She describes how people working in the social sector tend to suffer from a certain kind of exhaustion caused by too much intensive work with customers, clients, and patients. Maslach argues that a major reason people become burned out is due to problematic structural patterns at work, such as a too high workload and reductions in staff numbers. Maslach also defined burnout as consisting of three syndromes: emotional exhaustion, depersonalization and de-professionalization. These syndromes are,

[2] Elianne Riska, "From Type A man to the hardy man: masculinity and health", in *Sociology of Health and Illness*, Vol. 24, No. 3, 2002, pp. 347–358.
[3] Christina Maslach, *Burnout, The Cost of Caring* (Los Altos: Malor, 1982).

according to Maslach, not expressive of personality traits but are caused by structural problems at work. In a later book, Maslach and Michael P. Leiter[4] conclude: "Burnout does not result from a genetic predisposition to grumpiness, a depressive personality, or general weakness. It is not caused by a failure of character or a lack of ambition. It is not a personality defect or a clinical syndrome. It is an occupational problem."[5]

However, even though Maslach emphasized structural problems at work as the major causes for burnout, burnout is today often described as an emotional problem expressive of personal weakness indicating a lack of emotional intelligence. For instance, Dorota Daniela Szczygiel and Moïra Mikolajczak[6] write: "Importantly, our findings show that NE [negative emotions] do not always lead to burnout, but that they particularly do for nurses who lack EI [Emotional Intelligence]."[7] According to Szczygiel and Mikolajczak, burnout in health care is caused by "negative emotions", "emotional exhaustion", and "emotional dissonance". Furthermore, they write: "…experiencing NE enhances one's level of physiological and psychological arousal, which, if long-drawn, can have a deleterious effect on affective and cognitive functioning. […]"[8] As a solution to this problem, Szczygiel and Mikolajczak argue that nurses should become more resilient and be trained in emotional intelligence.

This description may sound fine. One may assume that nurses who feel "negative emotions" or "emotional exhaustion" may also become burnout. However, if one looks at how nurses themselves describe situations that are difficult to bear, it is not

[4] Christina Maslach and Michael P. Leiter, The Truth about Burnout: How organizations cause personal stress and what to do about it (San Francisco: Jossey Bass. 1997).
[5] Maslach and Leiter, *The Truth about Burnout,* p. 34
[6] Dorota Daniela Szczygiel and Moïra Mikolajczak, "Emotional intelligence buffers the effects of negative emotions on job burnout in nursing" in *Frontiers in Psychology,* 9, Article 2649, 2018, pp. 1–10.
[7] Szczygiel and Mikolajczak, "Emotional intelligence buffers the effects of negative emotions on job burnout in nursing", p. 6.
[8] Szczygiel and Mikolajczak, "Emotional intelligence buffers the effects of negative emotions on job burnout in nursing", p. 6.

clear that they can be defined generally as experiences of "negative emotions" or "emotional exhaustion". For example, consider the following description by Ericson-Lidman et al.,[9] where a nurse working in municipal elderly care tells of situations that she finds especially difficult to bear.

> It is about pain relief at the end of life//I failed to persuade the doctor to give the large amounts of pain relief that the resident needed// It is our job. At the end of life, they should not have to sit in bed and scream out of pain, fear, and anxiety. We are obliged to provide relief. It is the law.[10]

In the case above, the nurse describes how a dying patient was mistreated by not being administered enough pain relief. This was a situation the nurse experienced as very difficult. From the perspective of EI, this might be defined as a "negative emotion" that eventually causes "emotional exhaustion". However, I think it would be problematic to describe this case in emotional terms. The nurse is not talking about emotions but describing a situation of *injustice* in health care. By talking about "negative emotions" or "emotional exhaustion", the ethical criticism in the nurse's words is ignored.

One thing I am trying to suggest so far is that there is a tendency to *emotionalize* ethical situations in nurse work. This tendency does not originate from nurses' own descriptions but from how researchers on emotional intelligence tend to describe nurse work. This tendency also obscures the essentially ethical meaning of care work, turning it into any kind of customer work. Instead of assuming that burnout among nurses essentially is an emotional problem, it would be important to acknowledge that nurses describe various *ethical* situations as exhaust-

[9] Eva Ericson-Lidman, Astrid Nordberg, Birgitta Persson, Gunilla Strandberg, "Healthcare personnel's experiences of situations in municipal elderly care that generate troubled conscience", in *Scandinavian Journal of Caring Science,* June; 27(2), 2013, pp. 215–23.

[10] Ericson-Lidman et al., "Healthcare personnel's experiences of situations in municipal elderly care that generate troubled conscience", p. 220.

ing. These kinds of experiences seem to be on the increase. Ann-Louise Glasberg writes about an increasing number of cases of what she calls "stress of conscience" among nurses, explaining that, due to New Public Management, this has to do with a shift in responsibility: "People are burdened by having to make *difficult prioritizations*, sometimes in conflict with integrated principles.[11] The responsibility for prioritization has been transferred from the organizational level onto the individual staff member."[12] My suggestion so far is that when Szczygiel and Mikolajczak tend to claim that burnout is centrally an *emotional* problem, they tend to disregard that what nurses often describe as exhausting are *ethical* experiences. By defining nurses' responses as emotional, they are assumed to be irrational overreactions rather than critical ethical appraisals. The concept of stress of conscience differs from the concept of emotional exhaustion in that the ethical aspect of the experience is acknowledged.

Emotional Dissonance or Emotional Labor?

Another emotional syndrome that, according to researchers on emotional intelligence, causes burnout among nurses is that nurses are often forced to hide their true feelings from patients and colleagues. Nurses are then often forced to be kind and calm in situations where they might be upset, feel grief or anger etc. These kinds of situations are described as causing "emotional dissonance". Szczygiel and Mikolajczak write:

> […] experiencing NE (negative emotions) creates a specific burden upon nurses who, despite their true feelings, must maintain professional and supportive demeanours. […] Thus, in many job situations nurses must conceal their true emotional reactions and express emotions that they do not feel.

[11] Ann-Louise Glasberg, *Stress of Conscience and Burnout in Healthcare* (Umeå: Umeå University, 2007.)
[12] Glasberg, Stress of Conscience and Burnout in Healthcare, p. 12.

> Which leads to emotional dissonance and feelings of inauthenticity […][13]

Szczygiel and Mikolajczak suggest that the problem of emotional dissonance is similar to what Arlie Russell Hochschild, in her book *The Managed Heart,*[14] calls *emotional labour*.[15] Hochschild interviewed flight attendants who described how they constantly had to keep a polite and kind appearance even though the mainly male customers were often rude and drunk. Hochschild describes how the demand for a certain kind of emotional behavior for flight attendants creates a system where people must accept being treated in unfair and suppressive ways. These repertoire of emotions upon which flight attendants must draw are classical "female" emotions such as kindness, warmth, empathy, and tolerance. Classically "male" emotions such as anger, courage or pride are not allowed. Emotional labor expresses a standardizing of classical female behavior at work. An emotional behavior that implies a constant acceptance of unequal and suppressive relationships prevails. This demand for a certain kind of emotional appearance is also often an integral part of low-status jobs, jobs that may be part-time and that are often poorly paid, i.e., in dominantly female working sectors.

Even though the concepts of emotional dissonance and emotional labor may seem similar, there are, I think, important differences between them. When Hochschild talks about emotional labor, her point is not to describe an inner psychological conflict where flight attendants are not able to express their innermost feelings to customers or passengers. Instead, she describes how the demand for a certain emotional appearance of constant politeness simultaneously means that flight attendants must accept demeaning and sexist working conditions. According to Hochschild, this is a gendered problem. When

[13] Szczygiel and Mikolajczak, "Emotional intelligence buffers the effects of negative emotions on job burnout in nursing", p. 6.
[14] Arlie Russell Hochschild, *The Managed Heart, Commercialization of Human Feeling* (California: University of California Press, 1985).
[15] Arlie Russell Hochschild, *The Managed Heart.*

researchers on emotional intelligence suggest that Hochschild's concept of emotional labor is similar to the concept of emotional dissonance, they misunderstand Hochschild's point. Hochschild is not arguing that flight attendants ought or want to be able to express their innermost feelings all the time. Rather, her point is that there is a systemic requirement for the use of certain emotional behavior that is integral to patterns of gender discrimination and injustice at work. The EI researchers use Hochschild's concept in a way that does not acknowledge sexism or oppression at work. Neither does their concept of emotional dissonance acknowledge how the experience of emotional labor may be an experience of injustice towards patients. Sharon Bolton[16] quotes a nurse who describes the situation in the following way:

> On fraught days when the ward or clinic is really busy and we get the 'complainers' going at it hammer and tongs I walk around with this stupid grin plastered on my face. This is what we have to do now, smile at customers and try not to let them go home unsatisfied. Well, if I was them I'd be unsatisfied. They are getting less than they used to. They used to get my time and attention. Even if we were a bit stern with the 'complainers' at least they knew where they stood and were made to understand that health service can only do so much. But now? We go around smiling at them like everything is alright when it isn't. And what is that smile worth? Nothing. I'm seething inside and can't wait to finish my shift.[17]

What the nurses are critical of here is *not* the need for care and attention toward patients. Neither are they saying that the problem is that they cannot reveal their negative emotions to the patients. Nor, for that matter, are they critical of the need to behave kindly and politely toward patients. Rather, they are criticizing a conception of patient-centered care that is being

[16] Sharon Bolton, "Changing faces: nurses as emotional jugglers", in *Sociology of Health and Illness,* Vol. 23, No. 1, 2001, pp. 85–100.
[17] Bolton, "Changing faces: nurses as emotional jugglers", p. 94.

hollowed out, where there is an increasing demand for *superficial* politeness, with less time to really talk with, listen to and care for patients.

Bolton's description reveals how there has been a systematic reduction of the meaning of patient-centered care since the 1990s, with less time to seriously attend to patients while a surface impression of good care is still being kept up. The problem that the nurses describe is not that they experience emotional dissonance. Rather they describe how they must be dishonest toward the patients about the bad quality of the care. Again, this is *not* essentially a personal emotional problem but an *ethical* problem reflecting how the fragmentation of work leads to a loss of space for honesty.

The Corrosion of Elderly Care

In his book *The Corrosion of Character*,[18] Richard Sennett describes how working life has changed during the late 20th century because of the tightening of neoliberalism's grip. According to Sennett, one great change concerns the meaning of time and an increasingly "flexible" working life. Today's working life has become more "flexible", meaning that people often are employed on short-term contracts and are also expected to be open to many job changes throughout their lives. However, according to Sennett, this increasingly flexible working life also profoundly affects who we are: "Perhaps the most confusing aspect of flexibility is its impact on personal character".[19] According to Sennett, character entails a capacity to see life, including work and personal relationships, as long-term commitments. The concept of character is thereby connected with trust and reliability. I think one can see a fragmentation of trust and reliability in the nurses' description in the quote from Bolton above. With today's working life emphasizing adaptability to a fast pace and constant change, there is no room for long-term commitments

[18] Richard Sennett, The Corrosion of Character, the Personal Consequences of Work in the New Capitalism (New York: W. W. Norton & Company, 1998.)
[19] Sennett, The Corrosion of Character, p. 10.

and trustful relationships. In this sense, the fragmentation of time in today's working life leads to a fragmentation character.

Sennett further argues that the concept of character gains its meaning through certain kinds of concrete patterns of living where time is itself narratively significant. When working life is cut up into pieces, our life narratives become fragmented. "The conditions of time in the new capitalism have created a conflict between character and experience, the experience of disjointed time threatening the ability of people to form their characters into sustained narratives."[20] Sennett describes this fragmentation of narrative as mainly affecting an individual's conception of life. However, I think a fragmentation of narrative also can be seen on an interpersonal level in elderly care provisions in the Nordic countries. A big change here is that the time to work with individual patients has been cut up into tiny parcels. These structural changes in the healthcare sector have been studied by Marta Szebehely,[21] professor in social work at Stockholm university, with specific focus on elderly care in the Nordic countries. She describes how work in elderly care has changed with respect to time. The change has not only to do with large-scale reductions of staff numbers, but also with the fragmentation of working time. The structure of care has changed so that care work has been cut up into small pockets of time. This means that care workers have to take care of more elderly persons per day, meaning they have less time for each visit. Szebehely describes this as "an assembly line mentality" influenced by work at hospitals that has now been introduced into elderly care. While care workers in what Szebehely calls the 'traditional home care district' cared for three elderly people per day, care workers at the more modern 'service house' cared for nine each day. While care workers in the traditional district had about 1.37 hours per patient, the care workers in the 'service house' generally had six

[20] Sennett, The Corrosion of Character, p. 31.

[21] Marta Szebehely, "Vårdbiträdets vardags vid traditionell hemtjänst och vid servicehus", in Rosmari Eliasson (Ed.), *Egenheter och allmänheter, en antologi om omsorg och omsorgens villkor* (Lund: Studentlitteratur, 1992.)

minutes per elderly client. This fragmentation in working time per client affects both the practical work as well as the relationship between the care worker and the elderly client. In a Finnish report on elderly care by Teppo Kröger et al.,[22] the authors note that between 2005 and 2015, the number of home care workers who go to the shop for their clients decreased from 20% to 4%, while the number of home care workers who cook food for their clients has decreased from 17% to 12%. What is more, the number of home care workers having time to drink a cup of coffee with their elderly clients has decreased from 25% in 2005 to 5% in 2015. That is, when time has been cut up into tiny parcels, there is no more time to do things in a way that creates room for social ways of being together. There is a big difference between cooking food for a person and bringing them a ready-made meal. When you cook food, there is room for talking with the client about daily matters. Likewise, the fact that there is no time to drink coffee with their elderly clients means less room for having a conversation with them. This is a fragmentation of narrative time in an interpersonal sense, in that there is no time to create personal bonds between client and care worker.

Some of the erosion of the caring profession also shows in the introduction of new forms of control. Today, home care workers are obliged to register the times of visits on their mobile phones once they have made their house call. Here one could assume that the increased control is a way of protecting the client's rights. However, strict control seems to be more about cost savings than safeguarding the rights of the client. As the Norwegian researcher Mia Vabö points out, this system results in the care worker not being able to stay and chat for a few minutes at the door with the elderly when leaving.[23] An important gesture of ordinary respect and concern is thus undermined. At the same time, as control is increasing, the care workers say they have

[22] Teppo Kröger, Lina van Aerschot, Jiby Mathew Puthemparambil, *Hoivatyö muutoksessa, Suomalainen vanhustyö pohjoismaisessa vertailussa* (Jyväskylän Yliopisto, YFI julkaisuja 6, 2018.)

[23] Mia Vabø. "Mellan traditioner och trender", in Marta Szebehely (Ed.), *Hemhjälp i Norden -illustrationer och reflektioner* (Lund: Studentlitteratur, 2003).

fewer possibilities for contact and communication with colleagues and foremen.

It is evident that homecare workers have ever diminishing time for social support and interpersonal relationships with the elderly. These changes in working time and increased control can be described, in Sennett's terms, as a corrosion of character, consisting of a loss of time for personal contact with the patients and a loss of narrative space. From the description above, one can also see that it is not "too much emotion" or too close contact with suffering patients that is the main problem here. The problem is rather that, there is no room left for any kind of personal relationship with clients in elderly care, nor is there any room left for treating elderly clients with respect and dignity.

De-professionalization of Women's Labor and Emotionalization of Women's Tiredness

In her article "Ilska som klimakteriesymtom i arbetslivet"[24] ["Anger as a symptom of menopause in working life"] Sari Charpentier discusses how middle-aged women working in the Finnish bank sector in the 1990s were affected by substantial cutbacks and structural changes. According to Charpentier, these women were subjected to increased pressure, stress, and insecure working conditions. While the women working in the banking sector before the 1990s had stable working conditions, many now had been placed on one-year contracts that were up for periodic renewal. This meant that the workers always felt pressured to work as effectively as possible. It also became increasingly difficult for the women to advance in their careers, with many experiencing a de-professionalization of their jobs, by having to work with tasks that were below their education. Charpentier notes that while also men working in the banking sector were placed under more insecure conditions, they still often tended to get an opportunity to advance in their careers. In this sense, there was a difference between how increased insecurity affected men and women.

[24] Charpentier, "Ilska som klimakteriesymtom i arbetslivet".

Despite women's working conditions becoming less secure, with a concomitant de-professionalization of their jobs, women's experiences of being tired and angry were explained away as emotional reactions related to the menopause. According to Charpentier, explaining tiredness as emotional and as having to do with the women's ageing and menopause individualized their experiences and ignored the fact that their working conditions had changed.

One can see a similarity between Charpentier's description of how women in the banking sector were described as emotional and how nurses who become tired at work are described as emotional. When women working in the banking sector became tired and angry because of increasingly insecure and stressful working conditions, their tiredness and anger were attributed to the onset of menopause. Somewhat similarly, when nurses are tired and angry because of significant cutbacks in staffing and due to a fragmentation in the available time to care for patients, these responses are defined as "emotional exhaustion", "negative emotions", or "emotional dissonance". Both in Charpentier's description of the banking sector and today's nurse work, one can also see a de-professionalization of their work. Charpentier describes a pattern of de-professionalization in the banking sector where the middle-aged women were put to work with fewer qualifying tasks than before. Similarly, nurses working in the elderly care in Finland describe how they now must work with tasks that are below their professional education. Since basic staffing has been reduced to a minimum at elderly care facilities, nurses now take care of cleaning, cooking, and laundry alongside caring for the elderly. A systematic degradation of the caring profession is ongoing. In both cases, one can see a pattern where tiredness and stress are defined as emotional reactions and thus as mere personal problems. Structural changes in workplaces are left unacknowledged.

Resilience and the Emotional Blurring of the Ethical Meaning of Care Work

At the beginning of this paper, I noted that researchers on emotional intelligence, such as Szczygiel and Moïra Mikolajczak, argue that nurses ought to be trained in emotional intelligence in order to become more resilient and cope better with stress. I have also suggested that there is a tendency to emotionalize the meaning of patient-centered care and to reduce and ignore the ethical meaning of nurse work. Talk about the need for resilience is part of this tendency to emotionalize ethical problems at work. For instance, one of the major figures in Emotional Intelligence research, Peter Salovey, writes:

> What distinguishes the resilient person from the person who seldom copes effectively? The answer, we believe, has to do with emotional competencies – individuals differ in how well they perceive, express, understand, and manage emotional phenomena. These emotional competencies are components of a broader construct we have termed *emotional intelligence.* […] emotional intelligence influences responses to emotional arousal and, as a result, plays a significant role in the coping process.[25]

Coping or being resilient is, according to Salovey, a matter of being able to handle one's own or other people's emotions. Also, consider the following description by Mary Harper and Jon Schenk[26]:

> Given the overall positive correlations established between EI and performance in nurses, knowledge of the EI of successful staff nurses may have widespread potential. First of all, establishing an EI profile of successful staff nurses provides a

[25] Peter Salovey, Brian T. Bedell, Jerusha B. Detweiler, John D. Mayer (1999). "Coping intelligently, emotional intelligence and the coping process", in *Coping, the psychology of what works* (New York: Oxford University Press, 1999.) p. 141.
[26] Mary G. Harper and Jan Jones Schenk (2012). "The Emotional Intelligence Profile of Successful Staff Nurses" in *The Journal of Continuing Education in Nursing,* Aug 43 (8), 2012, p. 354–362.

> descriptive profile that may support the creation of a predictive model of characteristics that are essential for success in nursing practice. This EI profile may form an organizing framework for employment selection and professional development throughout a nurse's career. In addition to employee selection, an EI profile of successful staff nurses may provide a basis for comparison that can be useful for nursing school selection.[27]

The above descriptions by Salovey and by Harper et al. may sound reasonable. Of course, one may assume it would be good if staff nurses were resilient and emotionally intelligent. But what does this mean? The problem is that by suggesting that nurses need to be emotionally intelligent and resilient, the systematic dismantling of the healthcare sector, which has been going on since the 1990s, is ignored. Ignored is also how the dismantling of the healthcare sector has seriously affected the meaning and possibilities of providing good care. When Harper et al. suggest that staff nurses should be trained in emotional intelligence and resilience in order to handle the increasing exhaustion and burnout among staff, they ignore that staff's experiences of exhaustion reflect serious ethical reactions such as, for instance, having to mistreat patients because of cutbacks in staffing. Instead, these experiences are seen as "emotional".

The Hardy Man and the Resilient Nurse

However, the problem is not only that the concept of resilience blurs an essentially ethical meaning of care work. There is also a problematic gendered dimension in the meaning of resilience. In her paper "From Type A man to the hardy man: masculinity and health,"[28] Elianne Riska discusses research on stress among middle-class male executives, from the 1950s up to the 1990s. According to Riska, during the 1950s, there existed a description of a certain type of stressed middle-class man working in the

[27] Harper et al., "The Emotional Intelligence Profile of Successful Staff Nurses", p. 355.
[28] Riska, "From Type A man to the hardy man: masculinity and health".

business sector described as the *type A man*. While the *type A man* was described as someone constantly working, they were also prone to having serious heart conditions. *The type A man* was considered as having a seriously problematic personality, running the risk of a premature death.

However, in the 1970s, a new, more positive description of the middle-class business executive appeared, namely *the hardy man*, a concept coined by Suzanne Kobasa[29] in 1979. Riska writes:

> A new generation of middle-class men can look forward to a new relation between their social position and health: men can be real men, succeed and still be healthy. In contrast to Type A man, who was driven by a seemingly irrational passion to reach extrinsic goals and rewards, the hardy man is constructed as one who is driven by intrinsic motivation.[30]

According to Kobasa, hardiness reflected a new healthy male personality trait that could endure stress better than before and that differed from the Type A man who tended to become ill from stress. Riska quotes Kobasa: "persons who experience high degrees of stress without falling ill have a personality structure differentiating them from persons who become sick under stress."[31]

However, Riska questions this rosy picture of the new hardy man. She points out that the fact that heart attacks are currently not as common among men than in the 1950s is on account of their healthier lifestyles. Middle-class men are today much more aware of the importance of eating well and exercising than middle-class men were in the 1950s, with the consequence that today's business executives do not die as much of heart attacks when compared to the 1950s. Furthermore, Riska argues that the concept of the hardy man normalizes a modern male ideal

[29] Suzanne Kobasa, "Stressful life events, personality, and health: an inquiry into hardiness", *Journal of Personality and social Psychology*, 37, 1979, pp. 1–11.
[30] Riska, "From Type A man to the hardy man: masculinity and health", p. 350.
[31] Kobasa, "Stressful life events, personality, and health: an inquiry into hardiness", p. 3.

type of neoliberal manhood where it is expected that men should see the constant pressure at work as a positive challenge and as a possible career move while they should also exercise and think about their health. Riska writes:

> The constitution of hardiness not only demedicalizes male behaviour but, more importantly, legitimizes traditional masculinity. Men can now have a comfortable sense of mastery of their stress level, or may reason that stress might even be good for them. Yet what the new construct of hardiness also did was to confirm that hard work, competitiveness, and self-control were core values of heterosexual masculinity. […] The concept of hardiness diffuses the social character of masculinity: masculine behaviour is captured as an individual characteristic and personality disposition rather than as an institution and a set of structures that privilege a certain type of white middle-class male behaviour.[32]

There are similarities between the research on hardiness and the research on emotional intelligence. Both research fields originally focused on a dominantly male, middle-class working sector. In a similar way, just as hardiness was described as defining especially modern male business executives and leading to a good career and healthy life, emotional intelligence was described in positive terms as leading to a good career and a happy life for businessmen. Central figures in the research on emotional intelligence were Daniel Goleman, Peter Salovey and John D. Mayer. Emotional intelligence was claimed to offer a fresh perspective on intelligence that contrasted with classical conceptions, such as IQ. In contrast to IQ, which was considered too rationalistic and racist, emotional intelligence was claimed to offer a more socially aware and democratic perspective on emotions. It was claimed that everyone could learn to be emotionally intelligent. However, even if researchers on emotional intelligence tended to claim that it was a democratic field of research, they primarily focused on business leadership in the private

[32] Riska, "From Type A man to the hardy man: masculinity and health", p. 355.

sector. Like hardiness, a central aspect of the definition of emotional intelligence was an emphasis on emotions as a personal strength connected with personal virtues in combination with health and getting rich. Peter Salovey[33] writes: "[…] the appropriate regulation of emotions is an important predictor of good health and a key to investing money wisely."[34]

However, as New Public Management began to affect healthcare in the 1990s, researchers on emotional intelligence shifted their focus from the business world to the public sector, specifically health care. Even though the concept remained the same, researchers shifted tone in how they described the connection between emotional intelligence and personality. The business vocabulary of 'emotions leading to success and wealth', which had been a central part of the theory of emotional intelligence when directed to business leadership, did not fit so well with working life at hospitals. Suggesting that nurses will become rich and healthy if they are emotionally intelligent would not persuade those in the public health sector of the importance of the theory of emotional intelligence. Instead, the most important words connected with emotional intelligence were not "wealth", "success", or "personal health" but "resilience". Thus, one can see a shift in the meaning of emotional intelligence when researchers on emotional intelligence shift their focus from the business world to health care. When emotional intelligence researchers shift their focus to health care, EI is no longer defined as having to do with one's capacity to live an economically secure life or to strive for promotion and eventually become a business leader because such aspects are generally non-existent for women working in the health care sector.

The concept of hardiness and the concepts of emotional intelligence, and resilience normalize a picture of the good worker as someone open for a modern working life that is fast-

[33] Peter Salovey, "Applied emotional intelligence: regulating emotions to become healthy, wealthy and wise" in J. Ciarrochi, J. P. Forgas & J. D. Mayer (Eds.), *Emotional intelligence in everyday life* (New York: Psychology Press, 2006.)

[34] Salovey, "Applied emotional intelligence: regulating emotions to become healthy, wealthy and wise", p. 229.

paced and shifting; a working life where one is constantly open for "challenges" at work. That these "challenges" for some mean opportunities for promotion while for others they are a product of continuously poorly paid short-term contracts is not acknowledged. From the 1990s onwards, with neoliberalism increasing its influence over society, these concepts have become increasingly popular. One can see a gender and class pattern in how these concepts are used to describe the personality of the good worker. The hardy man is a middle-class business executive, while the emotionally intelligent, resilient nurse has a low-paid job. The concepts of resilience, emotional intelligence and hardiness normalize a gendered division of labor, according to which women are expected to endure stress and uncertain working conditions that do not lead to a career or a well-paid job, while men are expected to endure stress in order to achieve both a career, a secure job and a good income.

Conclusion

In this chapter, I have critically discussed the tendency to describe burnout and exhaustion among care workers in the healthcare sector as an emotional reaction. One can see such a tendency, especially among researchers on emotional intelligence, where ethical situations in care work are described by emotionalized scientific concepts such as "emotional exhaustion", "negative emotions", and "emotional dissonance". In contrast, I have claimed that the stress and exhaustion nurses describe is often an ethical response. By coining these experiences as emotional, the ethical criticism expressed by the nurses is ignored. Furthermore, by discussing Sennett's notion of corrosion of character and Szebehely's description of the disintegration of time in Nordic elderly care, I have suggested that the stress and burnout among care workers reflect a disintegration of ethical and narrative space in care work.

The emotionalization of stress and burnout in the healthcare sector reflects a broader pattern of gendered fragmentation of work and tendencies to describe women's experiences of stress

and exhaustion in emotional terms. This can be seen if one compares how care work in Nordic elderly care has been restructured and fragmented from the 1990s until the present with Charpentier's description of the restructuring and fragmentation of the working conditions for middle-aged women working in the Finnish banking sector in the 1990s. By describing women's experiences of stress as emotional, the structural disintegration, uncertainty and de-professionalization of women's work are ignored.

As Charpentier suggests, even though neoliberal policies have affected both male and female working sectors through increasingly insecure working conditions, one can see differences in what this insecurity means for women and men. Furthermore, stress research individualizes stress differently depending on whether it is directed toward female or male working sectors. As Riska notes, stress research connected with the development of concepts like the *A type man* and the *hardy man* tended to focus on male business leadership, connecting stress with economic stability and positive career development. A similar male focus can be seen in how researchers on emotional intelligence have focused on business leadership. Furthermore, I have suggested that when researchers on EI in the 1990s started to take an interest in the female healthcare sector, the tone in how EI was described shifted. Health and wealth disappeared from the descriptions of EI, and instead, EI became a psychological strength connected with "resilience", implying an acceptance of working conditions that will not provide career opportunities or economic stability. In this sense, the neoliberal concepts of hardiness, emotional intelligence and resilience maintain a gendered division of labor where women are expected to endure stress under insecure working conditions that do not lead to a career or a well-paid job, while male business leaders are expected to endure stress in order to achieve a career and a secure income.[35]

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