CHAPTER 9

"IT COMES WITH THE TERRITORY": A FLUOROSCOPY OF EMOTIONAL LABOR

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ABSTRACT

Purpose: *While the main emotional labor strategies are well-documented, the manner in which professionals navigate emotional rules within the workplace and effectively perform emotional labor is less understood. With this contribution, I aim to unveil "the good, the bad and the ugly" of emotional labor as a dynamic theatrical performance.*

Methodology/Approach: *Focusing on three geriatric long-term care units within a French public hospital, this qualitative study relies on two sets of data (observation and interviews). Deeply rooted within the field of study, the chosen methodological approach substantializes the subtle hues of the emotional experience at work and targets resonance rather than generalization.*

Findings: *Using the theatrical metaphor, this research underlines the role of space in the practice of emotional labor in a unique way. It identifies the main emotionalized zones or emotional regions (front, back, transitional, mixed) and details their characteristics, before unearthing the nonlinearity and polyphonic quality of emotional labor performance and the versatility needed to that effect. Indeed, this research shows how health-care professionals juggle with the specificities of each region, as well as how space generates both constraints and resources. By combining static and dynamic prisms, diverse*

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instantiations of hybridity and spatial in-betweens, anchored in liminality and trajectories, are revealed.

Originality/Value: *This research adds to the current body of literature on the concept of emotional labor by shedding light on its highly dynamic and interactional nature, revealing different levels of porosity between emotional regions and how the characteristics of each type of area can taint others and increase/decrease the occupational health costs of emotional labor. The study also raises questions about the interplay of emotional labor performance with the level of humanization/dehumanization of elderly people. Given the global demographics about an aging population, this gives food for thought at a social level.*

Keywords: Emotional labor; emotionalized zones; space; liminality; in-betweens; health-care; public hospital

INTRODUCTION

In her pioneering book *The Managed Heart*, sociologist Arlie Russell Hochschild developed the concept of emotional labor. Initially defined as "the management of feeling to create a publicly observable facial and bodily display" (Hochschild, 2012/1983, p. 7), it was later expanded to include "knowing about, and assessing as well as managing emotions, other people's as well as one's own" (Hochschild, 1993, p. x). The most recent definition to date has it construed as "the regulation of feelings and expressions to fulfil interpersonal role expectations at work" (Gabriel et al., 2023, p. 517). Various definitions have been given over the years in a bid to refine and develop the concept (Fineman, 1996) though, as it is still expanding in the wake of abundant and fast-growing new research, its contours are, in some parts, uncertain (Gabriel et al., 2023).

The intrapsychic approach to emotional labor is dominant in the literature, with few or no incursions into temporal and spatial issues. Efforts have been made to capture intrapersonal emotion regulation variability and dynamics, exclusively over time (and not according to space), including through self-monitoring (Scott et al., 2012), through the analysis of the fluctuations within an emotional regulation episode (Beal & Trougakos, 2013) and through a momentary approach relying on a simulation experiment (Gabriel & Diefendorff, 2015). While this body of literature is commendable in its attempts to emphasize the significance of a dynamic perspective, its scope is restricted to an intrapersonal analytical level. In effect, "broadening [the] focus to the unit [. . .] within which emotional labor is enacted" could prove "fruitful" (Niven et al., 2013, p. 119), and outlining dynamics pertaining to spatial aspects (and not only temporal ones) could pave the way to future studies of emotional labor within this framework.

In this chapter, I will focus on the spatial dynamics underlying the practice of emotional labor, building on fieldwork conducted in three geriatric long-term care units (LTCUs) in a French hospital. Emotional labor has previously been described as "an umbrella term for an integrated process represented by job emotional requirements (environmental stimulus), emotion regulation (intrapsychic response),

and emotion performance (interpersonal behavior)" (Grandey & Gabriel, 2015, p. 327). Here, I examine how professionals *adapt* to the environmental stimuli and *perform* emotional labor while navigating through specific regions or "emotionalized zones" (Fineman, 1996, p. 557) within a hospital unit (I do not explore the intrapsychic aspects). Although the collective dimension is crucial to the performance of emotional labor, I concur with Grandey et al. (2013) in that the practice of emotion management targeted toward colleagues falls outside the scope of emotional labor. In this research and within the perimeter of the field of study, the targets of the emotional labor performance are third parties or organizational *outsiders*, i.e., residents and their entourage.

In line with the nature of the field of investigation, it seemed only fitting that the title of this research should be inspired by a medical procedure. Fluoroscopy provides a unique look inside internal body structures by capturing real-time movements within the tissues under scrutiny. It thus informs the functioning of specific body parts or systems (organs, bones, joints, etc.) and their mutual interactions (i.e., how one component can hamper another's functionality). Weaving the metaphor, I strive to showcase emotional labor dynamics in a circumscribed setting (each LTCU), both the dynamics happening *within* a specific zone and those emerging *across* zones, through interactions and spatial trajectories. This implies mapping each LTCU's layout and emotionalized zones but also adopting a *situated* approach to go beyond the view of the workplace as a static and purely "topographical" location. Moving from a vision of space as a mere backdrop or "neutral container" (Taylor & Spicer, 2007, pp. 334–335) to one where organizational actors go back and forth, creating meaning and navigating emotional rules, breathes life into the lived experience of the practice of emotional labor.

In the following pages, after a review aiming to bridge space and emotional labor literature, the qualitative methodology is detailed, before a narrative presentation of the results is provided, which is prolonged by a discussion of the implications of this research.

LITERATURE REVIEW: ARTICULATING SPACE AND EMOTIONAL LABOR

> Let us consider this waiter in the café. [...] He is playing, he is amusing himself. But what is he playing? We need not watch long before we can explain it: he is playing at being a waiter in a café. (Sartre, 1943, p. 94, as quoted by Goffman, 1959, pp. 75–76)

Performing Emotional Labor in Health-care Settings

A cross-disciplinary examination of emotional labor research reveals discussions on its boundaries (Gabriel et al., 2023; Grandey et al., 2013; Grandey & Gabriel, 2015), notably in noncommercial organizations and in the care sector (Bolton, 2005; Erickson & Stacey, 2013; Theodosius, 2008).

Indeed, Erickson and Stacey (2013) suggested forgoing the concept of emotional labor, in carework, in favor of that of *emotion practice*. This

perspective is interesting because it underlines the highly complex nature of emotional labor in health-care settings and the interrelations with the all-encompassing concept of care and how it is embodied and translated into practice. Bolton (2005), for her part, advocated using the term *emotion management* to cover the multifaceted quality of the concept, thus including dimensions that are absent from Hochschildian emotional labor. While I prefer to keep the term emotional labor, I consider that Bolton's typology is part and parcel of the concept. This comprises (a) *pecuniary* emotional labor (rooted in commercial feeling rules, controlled by the organization), (b) *prescriptive* emotional labor (associated with professional and organizational feeling rules), (c) *presentational*, and (d) *philanthropic* emotional labor (the latter being a subtype of presentational emotional labor, both follow social feeling rules). Bolton (2005) also underlines how employees juggle with these forms of emotional labor, either simultaneously or sequentially.

Theodosius (2008) proposed another, yet complementary, approach by distinguishing between instrumental, therapeutic and collegial emotional labor. *Instrumental* emotional labor is mainly a means to convey competency, to facilitate patient cooperation and to minimize discomfort around potentially invasive procedures while *therapeutic* emotional labor is considered as an integral part of care, from a holistic perspective (this builds on Hildegard Peplau's (1952) view of the relationship between nurse and patient within mental health facilities as one that should be therapeutic and not custodial). Therapeutic emotional labor fosters the establishment of a privileged relationship between patient and nurse, the latter listening to patients' confidences and fears while empowering them and encouraging them to cooperate with the care strategies and therapeutic paths offered.

With the *collegial* emotional labor subtype, Theodosius acknowledges the crucial role of the team. Hochschild (2012/1983, pp. 114–115) herself explored the *collective* emotional labor of flight attendants, mainly underlining the mechanics of team solidarity, and how "the job is partly an 'emotional tone' road show," where "the proper tone is kept up in large part by friendly conversation, banter, and joking, as ice cubes, trays, and plastic cups are passed from aisle to aisle to the galley, down to the kitchen, and up again" – team behavioral facets that Goffman (1959) also mentioned. Theodosius delves deeper into the way the team contributes to the overall emotional labor performance by illustrating its intricacies through verbatims and a detailed vignette on shame. For her, collegial emotional labor endeavors to "facilitate effective communication between colleagues in order to promote effective nursing care" (Theodosius, 2008, p. 182) and also plays a role in asserting status rights and acknowledging each nurse's place within the team.

While not exhaustive, the elements put forth by Sharon Bolton and Catherine Theodosius aptly characterize the central specificities of emotional labor within hospital settings. Each working environment has its own emotional texture and subtexts which impact the very nature of emotional labor and how it can be performed, with some workplaces showcasing a significant range of intense emotions and distressing encounters – hospitals are a case in point (Fineman,

1993a). The unique emotional culture and "social arrangements" of hospitals, which are "hierarchically, temporally and spatially structured" (Locke, 1996, p. 84), have been diversely explored, notably from the perspective of norms. Emotional rules have been, for example, envisaged through a multilevel approach ranging from the institutional to the ward/unit level, including reflections on the professional level and on socialization (Dickason, 2022). In a quantitative study focusing on nurses, Diefendorff and his colleagues have targeted the unit level, shedding light on how employees adopt and adapt organizational rules and norms through socialization and showing that emotional rules are shared at the unit level (Diefendorff et al., 2011).

Further research has built on this view, thus moving from a strict dyadic perception of emotional labor performance and interpersonal emotion regulation (Côté, 2005) because interactions within organizations are rarely "confined to just two parties" and "even episodes that are initially dyadic may draw other parties" (Niven et al., 2013, p. 110). In other words, "even in cases where a single agent performs emotional labor for the benefit of a single target, other individuals within as well as outside the work unit, and even whole units, may become involved in and affected by emotional labor" (idem). This suggests both the key role of the team and that, more broadly, the working environment may play a part in the performance of emotional labor. That being said, and although a diverse body of literature has blossomed in the 40 years since the emergence of the concept, space has remained somewhat of a blind spot in the study of emotional labor. If time has been identified as a relevant factor influencing its performance and mitigating its potentially deleterious effects on occupational health (Dickason, 2018), it is not too much of a stretch to expect space to play a similar role as it is the actual setting where emotional labor is done.

Space in Organization Studies

Environment, surroundings, premises, topography, topology, geography, territory, terrain, place, site, location, area, zone, region, spot, distance, trajectory, dimension, perimeter, boundary, setting, layout, map, blueprint, plan, design, architecture, working conditions, ergonomics... When thinking about space, a variety of words come to mind. However, this myriad of instantiations and adjacent notions is not matched by an equally dense body of research in organization studies. Although "[s]pace has always been a fundamental dimension of living beings and, of course, of the human experience," a "locus of biological survival, psychological existence and sociability," thus "a key issue for human organization," and "[d]espite its existential importance," it has only recently started to become "a central issue in management thinking" (Chanlat, 2006, p. 17).

In fact, space was important at the inception of management science (with ideas related to architecture and engineering) but then "became increasingly marginal to its concerns" (Clegg & Kornberger, 2006a, p. 16). It never completely disappeared though, and interest in it resurfaced fleetingly, with different incarnations, in the 1970s, 1980s, and 1990s (Chanlat, 2006), followed by a

mid-noughties call to bring space back (Kornberger & Clegg, 2004) and initiate a "spatial turn" in organization research (Taylor & Spicer, 2007, p. 341). Marked by its "topographical nature," the "spatial turn" (a term first coined in 1989, in the field of critical theory) invites researchers to "think spatially," i.e., "to consider how boundaries" (including "no-go zones" and "back-rooms") "are being instituted and transgressed," but also to see how organizing is constructed *through* and *with* "emotional sensitivity" (Beyes & Holt, 2020, p. 2). In a rare incursion into spatial considerations, in the field of emotional labor research, Bolton (2005) discusses the importance of seven types of spaces as social and organizational features and arrangements, in the context of presentational and philanthropic emotional labor, in effect illustrating the aforementioned instituted and transgressed zones: "spaces for being human" (p. 133), "spaces for resistance and misbehaviour" (p. 135), "spaces for a gift exchange" (p. 139), "spaces for a bit of a laugh" (p. 142), "spaces for occupational communities" (p. 144), "spaces for violations" (p. 147), and "spaces for the maintenance and creation of identity" (p. 149).

In their narrative review of the literature, Taylor and Spicer (2007) outline three forms of organizational space (space as distance, as materialization of power relations, and as lived experience) and three scales or levels, consistent with previous theorization (Lefebvre, 1991): *micro*, i.e., within the organization, *meso*, i.e., at its boundaries, and *macro*, i.e., the level within which the organization is nested. At the *micro* level, researchers in ergonomics have studied how to adapt the environment to workers to prevent or limit occupational health issues, and, in health-care settings, envisaged the impact of the spatial structure on care delivery. In geriatrics, in particular, professionals report musculoskeletal disorders and lower back pain linked to the provision of care itself, and to suboptimal or inadequate working environments (Estryn-Béhar et al., 2013) with a lack of tools that may alleviate the physical load of daily work such as patient hoisting equipment.

Interestingly, the history of hospital architecture emphasizes both the interplay between various typologies of structures, patients and care, and the challenges coming from space itself; these include the physical strain caused by going back and forth within the unit (Estryn-Béhar, 2011). In a bid to ensure future design flexibility in line with new medical standards, without engaging unmanageable costs, numerous hospitals have in effect adopted layouts that tend to be conducive to fragmented work for nurses and nursing assistants. Although the nurse station/treatment room is generally localized in the middle of the unit, it is a sole entity, which means that staff have to cover a lot of ground, walking through long corridors (which are never wide enough) to this functional area. Estryn-Béhar (2011) emphasizes this in the French context while Theodosius (2008, p. 127) displays the layout of a British ward which shares similar characteristics.

In the wake of Lefebvre's work (1991), space has been conceptualized as more than just a geographical, material, or physical reality. The focus has shifted to framing it as a relational and social phenomenon, allowing for nonlinear perspectives on spatial (and social) arrangements (Kornberger & Clegg, 2004). Space can be created and recreated, produced and reproduced, can shape action and

interactions and be shaped by them (Hernes et al., 2006), or even be (re)constituted through the daily work practices within organizations (Clegg & Kornberger, 2006b).

This is what Orvain and Gentil (2019) witnessed in their cross-observation of two emergency services: health-care professionals adapt their work according to the layout (see, p. 343, their two comparative schematics) and use voids or "dead space" creatively by adding surveillance areas in previously empty zones, thus introducing much needed flexibility. In this case, organizing happens through experimentation, breaching topological standards, and falling outside of the realm of clear institutional framing, thus creating what have been qualified as "white spaces" (O'Doherty et al., 2013). Space then becomes a mode of management, and corridors act as management tools (Orvain & Gentil, 2019), an evolution echoing the principles of generative building (Kornberger & Clegg, 2004) in that the interrelation between space and practices reconciles malleability and order by generating greater fluidity which, in turn, facilitates care provision in a relevant and meaningful way.

Spatial analysis reveals that "some building plans are deep, some shallow," their differences in structure imply "quite different relations between users, degrees of freedom in the choice of routes [. . .] solidarities and possibilities for control and surveillance" (Markus, 2002, p. 20). Social relations are, therefore, *mapped* by space in complex ways. Hospitals, like most institutional buildings, fit into the category of "reversed buildings" where "the most controlled people are in the deepest space" (Markus, 2002, p. 20). Here, "inhabitants" (i.e., health-care professionals) are "near the surface" (i.e., the entrance/exit), while "visitors (hospital patients)" are "deep" (idem, p. 20). This suggests both that each space, each area is occupied by a specific type of individual, and that what happens within each zone may differ, including from an emotional standpoint, which is what I explore in the following pages.

Emotions and Space in the Organizational Theater of Performance

More than 30 years ago, in the 1993 first edition of *Emotion in Organizations*, Stephen Fineman coined the term "*emotional arenas* to capture the intense activity of lived emotions in organizational life" (Fineman, 2000, p. 1). The understanding of these arenas draws on dramaturgy as emotion "is acted-out through vocal and bodily postures aligned to the micro-structure of the situation" and modulates "micro-social orders" (Fineman, 2008, p. 4). Each arena is the stage for the performance of emotions to fit the *context* and the *audience* (the latter being the *target* of what I would describe as an organizationally *situated* rendition). This vision helps to clarify how language, gestures, and "socially acceptable masks" are at the core of the emotional role played by the employee who is, in effect, a *performing actor* on the organizational *stage* (Fineman, 1993a, p. 13).

Within hospitals, construed as emotional arenas, health-care professionals are performing actors, the audience being patients, residents, visitors, families, taken individually (for a "one-to-one representation") or collectively. Emotional labor

is deeply connected to this "drama of emotions," to quote Fineman's (1993a, p. 18) turn of phrase. Indeed, Hochschild (2012/1983) builds on insights from Russian theater practitioner Constantin Stanislavski at various points in her development to explain the emotional make-believe process that takes place on the personal and organizational stage. Following the example of the actor who "displays [. . .] to the spectators the social signs of the emotion he temporarily embodies, whatever his state of mind [. . .]," who "blends in with the conventions of his character's conduct" (Le Breton, 2004, pp. 286–287), the individual shows suitable emotions in a given social or organizational context.

By introducing the notion of space, the essence of how to structure and articulate the transient subtleties and overarching cultural dimensions of the "emotion architecture" (Fineman, 1993a, p. 21) is unveiled, the topological mechanisms of emotional labor revealed. In his groundbreaking work on the presentation of self, Erving Goffman (1959) crafts different *regions* where specific behaviors manifest themselves. For him, a region "may be defined as any place that is bounded to some degree by barriers to perception" (p. 106). Taking inspiration from Sartre's well-known image of the waiter (see the epigraph at the start of this literature review), Goffman stresses that "[a] status, a position, a social place [. . .] is a pattern of appropriate conduct" that "must be enacted and portrayed," in other words "realized" (p. 75), but notes that the degree of authenticity varies from a "real, sincere, or honest performance" to a false one (p. 70). He also acknowledges the fact that "expectations regarding conduct come to be associated with particular places," and that the "space-time manifold" within which the representation occurs fosters certain impressions and behaviors (p. 106).

Using a theatrical metaphor, two areas are distinguished: the "front region" (Goffman, 1959, p. 107) and the "back region" (p. 112). In the front region, the social actor evolves in a *setting*, a set of *scenic elements* (the furniture and its layout, the props or accessories used). Inseparable from the actor is his "personal front," i.e., a set of elements ranging from the distinctive signs of his function, to his clothing (or "costume"), to his physical and behavioral characteristics (Goffman, 1959, p. 112). The *front* region (stage) and the *back* region (backstage), each have their own particularities: in the front region, the individual makes the effort to present a certain appearance, to maintain and embody certain standards, while in the back region, the actor can relax, "drop his front," and "step out of character" (idem, p. 112). In other words, the activity in the front region is based on rules or norms of politeness and decorum and a "tone of formality," whereas the back region (inaccessible to the public) is a regulatory space where it is possible to exchange with other members of the team, to question one's personal façade, but also to release the pressure, to take off the mask and express shared "familiarity" (idem, p. 128).

Fineman (1993a) mused on the variability of emotion rules and organizational culture according to space. Like Goffman, he underlined the regulatory function of back regions or offstage settings, cathartic for the individual, and conducive to the creation of a subculture of emotional bonding stemming from the social sharing of emotion (Rimé et al., 2004). To a certain extent, backstage is a *safe*

place (Goffman, 1959); however, it is no "emotion free-por[t]" as, even with colleagues, the need to keep up appearances remains, so as not to reveal potential insecurities, related to self-perceived competence, for instance (Fineman, 1993a, p. 21). In sum, in everyday occupational life, employees navigate between sets of explicit or implicit emotional rules (Dickason, 2022), and this observation holds good for back regions.

By thinking of the possibility of creating "a cultural map of an organization which charts the various settings and locations, or *zones*, which have come to 'permit' different types of emotional expression," Fineman (1996, p. 556) conceptualized "emotionalized zones" (p. 555). As he explains, these zones "are not randomly distributed but exist in relation to each other, sometimes counter-balancing, sometimes complementing" (p. 556). Organizations are a "mosaic of *emotionalized zones*," and while some are clearly and "formally demarcated" (Fineman, 2003, p. 37), others (back regions, in particular) are not necessarily "physically delineated areas" (Bolton, 2005, p. 134). Testament to the complexities of understanding organizational emotionality is the fact that both "the emotions that define and maintain 'proper' professional conduct" and "regulatory peculiarities" differ from one emotional arena to another (Fineman, 2008, p. 4).

In the case of hospitals, aside from the description of various types of emotional labor (Theodosius, 2008) happening onstage, backstage has spiked interest (Bolton, 2005; Tanner & Timmons, 2000). Conversely, other analytical prisms can be envisaged, for instance, by further clarifying the various zones where emotions are performed. Boyle does this in her study of the Department of Paramedical Service (DPS), which provides its subscribers with "prehospital emergency care," thanks to "on-road staff," and is an organization "literally saturated with emotions" (2005, p. 64). She outlines three "emotional regions" (p. 45): "front- or onstage, backstage, and offstage" (p. 47). The first two are localized within the workplace (and fit with Goffman's front and back regions), while the last is a nonwork region. Boyle compellingly highlights the techniques used to perform emotional labor (onstage), and discusses at length the regulatory role of offstage support. She also cites the "range of practices, including rapid speech patterns, the telling of 'war' stories, and the use of black humor" and, sometimes, "formal critical incident debriefing" (p. 59) happening backstage (e.g., base stations, truck stops, gas stations) and underlines the constant switch "from frontstage to back regions" (p. 58).

However, this account does not explore in detail the linkage or *transitions* between regions and the *potential* – spatially located – *turning points* in the performance of emotional labor, aspects that I intend to uncover in this study. By labeling emotionalized zones, Fineman (1996) frames emotional labor as socially *situated*. His view that the universe in which the actor experiences emotions and attends to his tasks should be considered opens the door for in-context research and fieldwork rooted in comprehensive approaches. This is the methodological perspective I have used to complete my study, as I will now explain.

A QUALITATIVE METHODOLOGY TO CAPTURE EMOTIONAL DYNAMICS

The purpose of this section is to explain the methodological approach I relied on to "take the pulse" of the "emotional beating heart" of the field of study and to shed light on the dynamics of emotional labor within a specific work setting, spanning various areas. After outlining broad characteristics of the research site, I share some musings about the consonance between *what* I intended to understand (i.e., the purpose of this study), on the one hand, and, on the other hand, *how* and *to what extent* the qualitative methods I used could help reveal the subtleties and intricacies of the performance of emotional labor across different areas or emotionalized zones, in an insightful and relevant way. I then explain in more detail the way I collected and analyzed the data.

The LTCUs: Living Spaces at Death's Door

The research presented here is part of a larger study on emotional labor as performed by (medical and nonmedical) health-care professionals (pre-Covid). In this account, I focus on three LTCUs, within a French public hospital, each accommodating 40 residents for an indefinite period of time. Intended for elderly people who have specific needs that care homes or nursing homes alone cannot meet, LTCUs are a hybrid structure: they are hospital services but also living spaces. Thus, it is *residents* rather than *patients* who are cared for, albeit residents without "their own independence of life" and benefitting from "constant medical supervision and maintenance treatment" (French Code of Public Health) due to their health status (pathologies and comorbidities) and loss of autonomy.

As has been made abundantly clear to me by the nursing supervisors, working in the LTCU is "far from glamorous," and both nurses and nursing assistants generally try their upmost to avoid working there, firstly because they fear that they will "lose their technical know-how" and, secondly, because they deem it "almost impossible to find work outside of a geriatric unit once you are assigned to one." In fact, such is the difficulty of attracting health-care professionals to geriatrics (acute geriatric care, follow-up care and rehabilitation, and LTCUs are considered as "Cinderella services," with the latter topping the "most unappealing" list) that the hospital has instituted a fast-track tenure scheme for those who have newly qualified... if, that is, they agree to work in geriatrics for a set period of time. The limited attractiveness of geriatrics is an issue felt widely across France, with a possible explanation connected to the way we, as a society, perceive our more senior members (Dickason, 2020). Each of the LTCUs under study has teams of a mixed level of work experience, with one unit more challenging to manage (according to the nursing supervisors) because of a higher proportion of young, less experienced, professionals who are there only reluctantly.

Diving Into the Field of Study: The Qualitative Researcher in the White Coat

Nurses and nursing assistants work side by side, attending to residents within the respective perimeters of their competency (the latter work "in collaboration and under the responsibility of the nurse," Dickason, 2022, p. 122). This includes, for

nursing assistants, "basic observations" (Theodosius, 2008, p. 126) as well as ensuring hygiene, comfort, and nutritional care: bed making, simple toileting needs, bathing, dressing patients, helping them into chairs or beds, etc. Along with "monitoring and evaluations," nurses "are expected to perform many tasks requiring technical knowledge and skills, such as taking vitals," administering treatment, "oxygen, changing dressings, starting the patient on an intravenous drip or enteral feeding" (Dickason, 2022, pp. 122–123). Nurses and nursing assistants are thus the health-care professionals that residents (and their entourage) see the most.

They are also used to welcoming students or temp staff, showing them the ropes of day-to-day work life, mentoring them. This is part of a culture deeply ingrained within the profession. The newcomers follow their more experienced counterparts or mentors for a few hours, days, or weeks (depending on the case), witnessing their nous in a diversity of situations: while dealing with residents and visitors, while improvising to provide adequate care when faced with shortages of specific medication or sanitary supplies, while finding strategies to compensate for the absence of colleagues. The fact that nurses and nursing assistants are, to a certain extent, "used to" being followed and/or watched during their daily activities makes it easier for a qualitative researcher to conduct *in situ* work. That being said, the theoretical prerequisite of building rapport and progressively earning the trust of the team still stands in the context of LTCUs. At my request, I had been introduced to the teams, by the nursing supervisors, as someone "conducting research on the work of health-care professionals and their emotions, within the context of an academic project," but I still had to dispel concerns from a few nurses and nursing assistants about me being "sent by the Direction" to subsequently "rat on them."

As a primary data gathering method, I opted for a form of participant observation known as "peripheral participant belonging," a posture that allows the researcher to "keep sufficient distance to maintain an analysis" while being immersed in the field of study, thus reflecting "methodological caution" (Chanlat, 2005, p. 166). Although it comes with its challenges, such as finding ways of mitigating the effects of the researcher on the site and vice versa (Miles et al., 2019) – in my case, being conscious of that caveat and opting for reflectivity (Cunliffe, 2022) – observation offers a unique way to "conceptualize in action" and to obtain an "original corpus" (Wacheux, 2005, p. 13).

Given that space is at the crux of this study, and that I wanted to capture the versatile nature of emotional labor across various zones, observing "real time" and *situated* activities, tracking "events-in-context" (Fineman, 2000, p. 14) was paramount. Through observation, I was able to "loo[k] *onto* organizational life while being *into* or *part* of it," to experience a "blend of distance and reflexive closeness," to witness and/or be part of "[d]irect, emotionalized accounts (stories, confessions, explanations, gossip)," thus gaining "access to how [organizational] actors express and represent their feelings" (Fineman, 2000, p. 14).

Aside from the obvious contextual richness of the material I gathered that way, my regular presence on-site also prompted some nurses and nursing assistants to volunteer for formal interviews. As interpersonal encounters conducted

in an empty room, either in the work setting or just outside of it, formal interviews do not always elicit *felt* accounts (Sturdy, 2003). To a certain extent, whether consciously or unconsciously, interviewees choose *what* to share or *how much* to divulge. Their recollections can either showcase raw testimonies with powerful illustrations, reframed specific emotional experiences, or rationalized, generalized, intellectualized accounts... Thus, using observation, shadowing (McDonald, 2005), field diary accounts of live dialogue – in other words, "capturing emotion in process" (Fineman, 1993b, p. 222) – proves to be invaluable to inject further *breadth* and *depth* into the realities of emotional experience at work, compared with what interviews alone could have yielded.

Data Collection and Analysis

The current work relies on two sources of data collected in the context of a larger study: observation (primarily) and interviews (secondarily). Fig. 9.1 presents a detailed account of the data sets (descriptive elements: number of hours of observation, number of interviews, etc.) as well as the steps undertaken for data collection and analysis.

Formal semi-directed interviews with nursing supervisors were aimed mainly at understanding the context of the LTCUs and relevant information on emotional rules and practices. Formal semi-directive interviews and informal interviews, with nurses and nursing assistants, focused on daily work and emotional labor. On-site data gathering pertaining to formal interviews included note taking during the interviews with details of *what* was said and *how* it was said. This echoes Shotter's (2008, p. 97) concept of "gestural meaning." The "spontaneously expressed, unique, bodily activities" (Shotter, 2008, p. iv), the "poetic nature of utterances that arrest us or strike us" (p. 97), as well as the "choice of words, their pacing, intoning, their intertwining in with other activities" (p. 8) point to or *gesture* toward *meaning*. During interviews, whenever possible, I included notes on the "poetic and gestural forms of talk" (Cunliffe, 2002, p. 135) (the notes were completed immediately after the interview, while the interaction was "still fresh" in my memory and vivid in my mind's eye). I prioritized visual clues (such as facial expressions, shrugging, pointing, making wide movements, thumping the table), as well as auditory ones (intonation, emphasis, rhythm, variability in sound level) and, obviously, those related to emotions (the emotions expressed while recounting an event, and the potential divergence with what was recounted, e.g., laughing despite the seriousness/sadness of the specific situation remembered). These elements were added to the full transcripts of the interviews. During analysis, I also paid attention to these facets of the interviews.

I used a field diary to meticulously record each observation sequence (which focused on key moments – observing handovers between teams, meetings with the mobile palliative care team, break times – as well as observing work routines and practices, shadowing some professionals in their work, engaging in informal discussions during and after shadowing). The various entries, as well as the very process of creating this field diary, facilitated introspection and stepping back

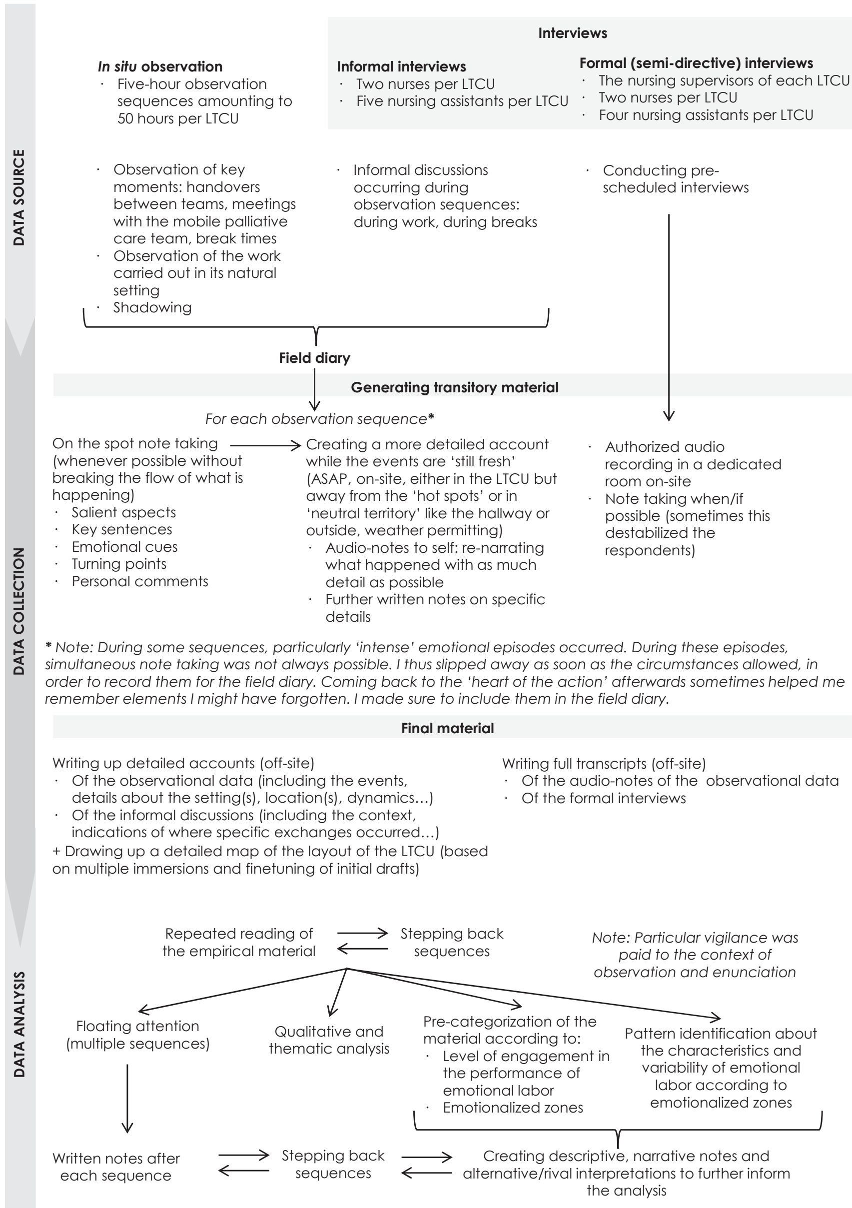


Fig. 9.1. Data Source, Collection, and Analysis.

processes. I also sketched, then refined, a map of the layout of each LTCU which was included in the field diary and served the dual purpose of making the structuring of space tangible and helping to assign emotional episodes and additional personal comments to specific areas. The field diary also included

notes about my impressions, emotions, questions, ideas, etc. Field diary entries were completed through various phases: on the spot note taking, followed by the creation of a more detailed account on-site (written and/or audio-notes), then writing up a detailed account off-site (including full transcripts of the audio-notes).

Data analysis and interpretation took place in several phases. To avoid (or, at least, limit) the epistemological risk of circularity, I relied on floating attention (Dumez, 2016). I took notes after each reading sequence in floating attention, set them aside, then looked at them again later in the process. The next steps involved qualitative and thematic content analysis (Bardin, 2013), immersion in the empirical material through repeated reading in order to proceed to a pre-categorization of the material according to the level of engagement in the performance of emotional labor and to the emotionalized zones, pattern identification about the characteristics, and variability of emotional labor according to emotionalized zones. Between each phase, there occurred stepping back sequences and re-reading of the notes made while in "floating attention mode." I also created descriptive and narrative notes related to each interview and specific situation observed (Dumez, 2016), including a summary of salient aspects and/or quotes deemed pertinent to the aim of the study. This helped inform the alternative or rival explanations of the interpretation(s) of the data that were considered during the various phases of the analysis (Dumez, 2016; Miles et al., 2019). Special attention was paid to the context of observation and enunciation, which also convey meaning (Miles et al., 2019; Shotter, 2008). Data saturation and consistency of analysis were verified by further stepping back sequences. Emotional labor and emotionalized zones constituted the focal prism through which the empirical content was interpreted, following back-and-forth movements with the literature. The alternative/rival explanations of the interpretation(s) of the data were confronted with the literature, while allowing for possible conceptual broadenings (indispensable for producing an accurate analysis of the reality under scrutiny).

RESULTS: UNTANGLING EMOTIONAL LABOR AND REGIONS

In the following pages, the results of the study are shared in a way that strives to elicit *resonance*, by "presenting insights that may connect, reverberate and provoke others into reflecting on [the] issue" (Cunliffe, 2022, p. 7). In accordance with the aim of this research and the methodological approach chosen, I deliver an account of my observations and analyses in a narrative style, with illustrations coming from participant quotes and extracts from the field diary, both laden with evocative language. These elements are completed by analytical figures elaborated to better showcase the spatiality and *polyphonic* nature of emotional labor performance within LTCUs.

A Broad Overview of Emotional Labor in the Front and Back Regions

The manifold complexities and intricacies of emotional labor performance and space in LTCUs call for the drawing of a first outline, a seminal stratum, that will be enriched by further analytical strata as the argument is woven. The layout of each LTCU follows the same blueprint, bar rare marginal inversion between rooms for the staff and/or cupboards. The building follows a Fontenoy design with two wings (Estryn-Béhar, 2011), and the functional areas related to the logistics of care delivery are localized at the junction of the two wings. Fig. 9.2 provides a general overview of the layout of a LTCU, charting its zones from a

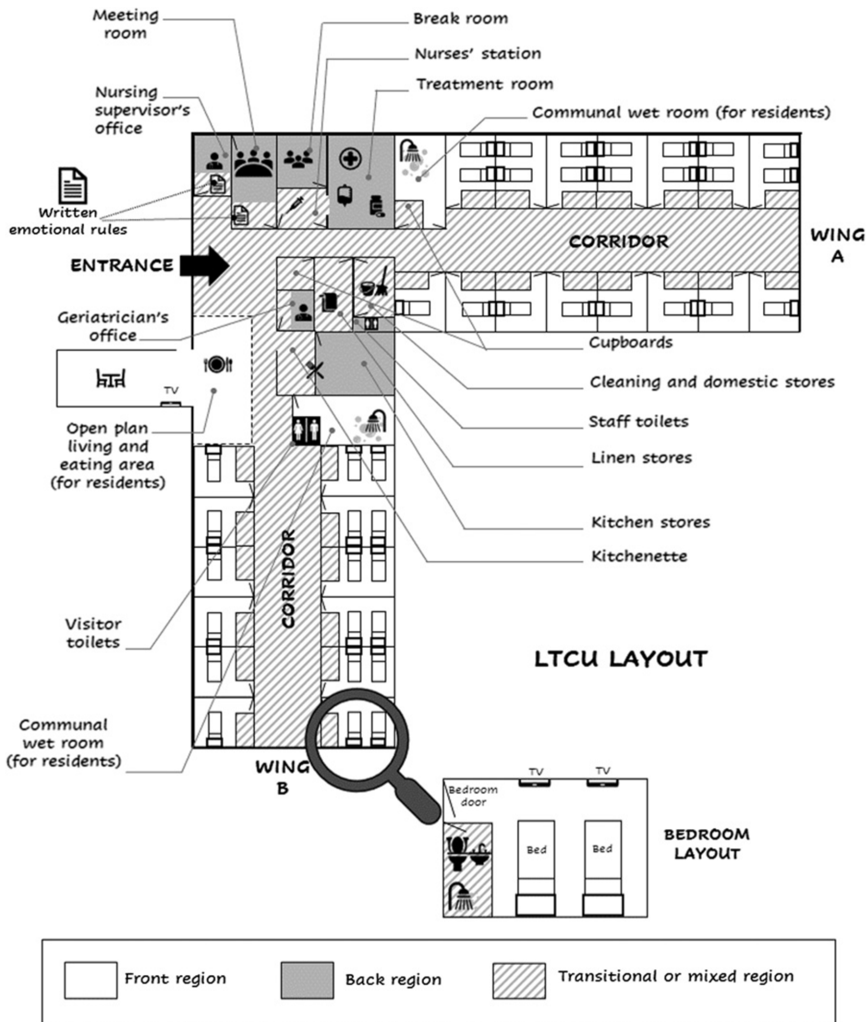


Fig. 9.2. Spatial Analysis of the LTCU [1/2]: Layout and Static Perspective.

static perspective. Depending on the location and the associated emotional norms, the expression of all or part of the range of emotions is allowed and/or expected from nurses and nursing assistants.

In the LTCU, the front region comprises the residents' rooms and the open plan living and eating area, but also the communal wet room (for residents). The offices of the nursing supervisor and geriatrician along with the meeting room and the nurses' station are part of the back region, as are break and treatment rooms and, incidentally, staff toilets (emotion regulation is, obviously, more personal there).

The front region is the place where it is important to comply with organizational requirements (emanating from the institution, the cluster, the service, or the ward) and professional emotional requirements (Dickason, 2022). Local sets of written emotional rules can be found in the nursing supervisor's office (e.g., job descriptions) and in the meeting room (e.g., advice and guidance when caring for residents with Alzheimer's disease). The "on scene presence" supposes that the nurse or nursing assistant gives the image of a professional with all the attitudinal and behavioral expectations that this engenders (calm, efficiency...). As I previously implied, like the actor personifying a character (sartorially and in all the facets of the role embodied) by putting on a costume, the health-care professional puts on a white coat, thus embodying the role of a health professional (nurse, nursing assistant):

> You are a caregiver, you have to listen to the person, be patient with the person, but sometimes you have to control yourself too... sometimes you have problems outside... I always remember at the nursing school, they always told us, anyway: "Once you wear your blouse, you keep your identity, but all your problems at home stay at home, you mustn't think about them anymore and the same goes for problems at work when you come home, you don't have to think about it anymore..." (nursing assistant)

Health-care professionals also have "props" for their "representation": computers on trolleys to access the records of the residents, food trays, incontinence pads, etc. According to the situation, I witnessed nurses and nursing assistants performing instrumental, therapeutic, or collegial emotional labor (Theodosius, 2008). What was also apparent was prescriptive and presentational emotional labor, with marginal instances of the philanthropic subtype (Bolton, 2005).

Back regions, meanwhile, are unique zones where emotions are released more freely, where confidences are exchanged, where tensions generated by the emotional burden of the activity are managed. Behind the scenes, the health-care professional may thus "take off the mask" and abandon the practice of emotional labor. These places, which are outlets for tension, allow the professionals to vent their feelings, mainly during handovers or breaks, so that they can later refocus on their practice. However, these areas are not devoid of (mainly *implicit*) social emotional rules, with a real variability that depends not on the wards as such but on the people or groups of people present, on affinities that allow for more or less authenticity and emotional sharing, more or less cathartic intensity in the exchanges. I was able to notice this during my immersions. As I wrote in my field diary as a personal note, "it comes with the territory"; in other words, the

nuanced performance of emotional labor is embodied diversely across the unit (this comment is included in the title of this research).

Back regions share properties with the "carnivalesque," qualities conceptualized by Russian literary theorist Mikhail Bakhtin who considers the carnival as "a time where the conventional world is turned upside down, and a second world is constructed" (Tanner & Timmons, 2000, p. 978). Here, touches of "carnival familiarity" may be expressed (Bakhtin, 1984/1968, p. 16) through "the 'unmasking' and disclosing of the unvarnished truth" (p. x), thanks to a "temporary suspension" of "certain norms" (p. 15) leading to "a special type of communication" (p. 10) laden with laughter and specific "speech patterns," consistent with the relaxing of "[v]erbal etiquette and discipline" (p. 16), at times bordering on the indecent or the abusive. Not all back regions allow for the uncensored rendition of the carnivalesque in all its glory, with its distinctive features – such as "travesty, unseemly behavior and familiar [...] contact," the "confounding of all forms of stylistic decorum" (Locke, 1996, p. 83), and the joyful and festive tone imbued with laughter, tainted with scatological humor, disparaging comments or parodies – being generally muted in the LTCU and consigned to the break room. Still, in keeping with Goffman's theatrical metaphor, carnival is "not a performance witnessed by an audience"; it favors social arrangements that are "fluid" and conducive to "expressing communality" (idem, p. 83).

Variability in the Performance of Emotional Labor Within Each Region

Front and back regions appear to be clearly demarcated areas but, in fact, straightforward spatial delimitation is complex to establish. One explanation stems from how space is actually *inhabited*. If this is compatible with the general health status of residents, they may go outside their rooms, to take an assisted shower (either on a wall-mounted stretcher or on a chair) in the communal wet room or to spend time in the open plan living and eating area. Apart from taking their meals and/or participating in collective activities, this is also a place where residents can meet their relatives. In the case of a single room, if it is empty because the resident is absent for the aforementioned reasons or because he/she has sadly passed, is it still *entirely* a front region? It could be reasoned that if only health-care professionals enter this room, it might – at least for a limited time – become a back region. And what happens in the case of double rooms, if only one resident is present? Does it "transform" into a front-cum-back region? The answer depends, in part, on who is actually present in this area at a specific moment.

Indeed, another explanation for why ambiguities arise in defining zones is that each LTCU is home to two sets of social worlds (Strauss, 1978) which interact diversely, and this has consequences for the practice of emotional labor. Acknowledging previous conceptual considerations on social worlds, his own and those of Tomatsu Shibutani (in the 1950s), and building on the latter's arguments, Anselm Strauss stresses their main characteristics: namely that "[e]ach social world is a 'universe of regularized *mutual response*'," each is "an *arena* in which

there is a kind of organization," each "is a '*cultural area*'" (Strauss, 1978, p. 119). Applying this conceptualization to LTCUs, one could make the case that two main social worlds emerge, each with its codes and norms: the social world of those performing emotional labor (health-care professionals) and the social world comprising the targets of this performance (residents and, potentially, their entourage and visitors).

Being in one zone or another does not imply strictly respecting the codes expected in what might be understood as the *distinctive territory* of each social world. For instance, in the social world of residents/entourage/visitors, it can be said that health-care staff should, at all times, be professional and fully engaged in the practice of emotional labor, behaviors that are consistent with the front region. Conversely, in the social world of health-care professionals, staff adhere to partially different codes: they are still professionals but may reinforce team solidarity, social support, and a sense of community by using a shared language in the back region, at times bordering on the carnivalesque. As Bolton (2005, p. 134) puts it while referring to presentational and philanthropic emotional labor: "it is possible to be many things to many people" in the front region.

An illustration from fieldwork brings this statement to life. This immersion sequence focuses on two nursing assistants caring for residents who share the same bedroom (in each LTCU, two thirds of residents are in double rooms, which entails a more complex and flexible emotional labor performance): one resident is communicative, the other is not. At one point in time, one can witness a nursing assistant performing therapeutic emotional labor with the communicative resident, while the other nursing assistant largely ignores the uncommunicative resident she is attending to, preferring to try to banter with her colleague (regardless of the needs of both residents). At first, the colleague resists falling into the joking mood of the other nursing assistant before caving in and succumbing to facetiousness. In this example, where/when does the front region actually stop being a scene? Is it still a front region if behaviors typical of the back region insinuate themselves here? Is the scene in fact cut in two for a certain period with a typical front region relationship on one side and a back region attitude on the other side? What is happening here could be construed as a *liminal episode* (Turner, 1969) "between formally structured events" (i.e., caring for residents) with a change of language and behavior from nursing assistants turning to the playful (Fineman, 1996, p. 556).

On the contrary, expectations from the front region can burst into the back region. A vibrant example coming from fieldwork is that of a nurse answering a phone call while in the treatment room. Before the phone call, she is focusing on her work: checking medical prescriptions and preparing the treatments for each resident, "prepping herself" for her round. This activity is halted for a fleeting joyful exchange with a passing nursing assistant just back from vacation. Another interruption happens when the nurse has to assure another nursing assistant that she will indeed go and see the resident who is supposedly suffering from fecal impaction and attempt to relieve her. On the phone, the nurse performs therapeutic emotional labor to answer the queries and alleviate the anxiety of the entourage of a resident receiving end-of-life care. Thus, is this back region truly

and only a back region? It is highly debatable. The same could be argued for the break room where the ringing of residents' call bells can be heard and/or health-care professionals may also need to answer the phone and the worried pleas of families.

Even when health-care professionals are in the front region with every intention of acting accordingly, performing emotional labor is by no means "plain sailing" and sometimes things go awry. LTCUs have, by definition, residents with dementia who (legitimately) perceive their hospitalization as a violent uprooting. Their behavior can lead to certain situations escalating and getting out of hand. During an interview, a nursing assistant mentions a case in which an angry and aggressive resident is forcibly restrained by several health-care professionals in front of the resident's relatives. Sharing her discomfort, she admits that "they had seen something of us that we didn't want to show them and I felt embarrassed toward them," and in doing so lays bare a failed emotional labor performance profoundly altering future interactions. She systematically avoided these family members afterward.

Going back to the concept of social worlds, Strauss (1978) insists on the fact that "social worlds *intersect*, and do so under a variety of conditions" (p. 122) and puts forth "a second important process, the *segmenting* of social worlds" (p. 123) which "leads to the intersecting of *specifiable subworlds*" (Strauss, 1978). He further explains that "[i]ntersecting [...] occurs usually not between global worlds but between segments," and that this "subworld formation signifies [...] new universes of discourse" (Strauss, 1978, p. 123). The dual phenomena of intersection and segmentation reflect the "tremendous fluidity" of a universe that "won't and can't stand still" (idem). By applying these thoughts to the context of LTCUs, the social world of those performing emotional labor (health-care professionals) can, for instance, be segmented into the subworld of nurses, and that of nursing assistants. The social world composed of the targets of emotional labor reveals the subworld of the residents who have kept a certain level of autonomy, that of the most clinically vulnerable ones (cognitively and/or physically impaired to various degrees), the subworld of the relatives, etc. In fact, each subworld could also be segmented, which shows the highly versatile nature of emotional labor performance.

Expanding on the reversed buildings perspective (Markus, 2002), where the deeper the space, the higher the control, fieldwork shows that the degree of effort required to perform emotional labor varies *across* set areas of the front region and also *within* one area, depending on the tasks realized. By and large, and although there are obviously exceptions, emotional labor is generally less intense in the open plan living and eating area than in the bedrooms or communal wet rooms. Several nursing assistants have told me, individually, that they feel uncomfortable while attending to intimate hygiene care (I noted telltale signs of this during observation sequences), stressing how demanding emotional labor is in such circumstances and how much engagement is therefore needed to perform it. Furthermore, taking care of uncommunicative residents can prove particularly testing as "there is little to no feedback," a nursing assistant told me during an interview, adding that "sometimes you have zero eye contact, sometimes they

look at you in a vague way, it's like you don't really know if they see you, it's like they're in a world of their own, innit?" She stressed that when she started out in the unit, she "didn't know how to deal with uncommunicative residents" and initially "didn't really take the person into account," or at least not at the level that might be expected. She credits experience with helping her better adjust to the unique emotional labor techniques that need to be deployed in such interactions, modulating the choice of words, the pace of speech, combining verbal communication with nonverbal cues, such as gently stroking the arm of the resident, etc.

The challenges of emotional labor performance with particularly clinically vulnerable residents are all but veiled by the agility health-care professionals demonstrate while providing care. Fieldwork revealed that when confronted with residents suffering from Alzheimer's or other forms of dementia, and/or multiple impairments, health-care professionals tended to disengage themselves from therapeutic emotional labor, adopting a more distant approach. In extreme cases, I witnessed staff behaving as though the resident was not there, chatting away about their own personal lives, as if they were in the back region, raising once more the question of where/when/how the front region ceases to be one. As before, the attitude of health-care professionals is paramount to understanding this spatial reconfiguration. This very much resonates with Goffman's (1959) observations: "by invoking a backstage style, individuals can transform any region into a backstage. Thus [. . .] the performers will appropriate a section of the front region and by acting there in a familiar fashion symbolically cut it off from the rest of the region" (pp. 128–129).

In fact, during each observation sequence, "different enactments of organizational geographies" (Beyes & Steyaert, 2012, p. 47) can be noted. What fieldwork revealed *in vivo* were occurrences of phenomena akin, to a certain extent, to "spacing" (p. 45) which entails "moving the thinking of space toward the thresholds of the material, the embodied, the affective and the minor" (p. 53). The concept of spacing is an invitation to rethink "space as processual and performative, open-ended and multiple, practiced and of the everyday" (p. 47). It encompasses composition and reconfiguration experiences where "the body and embodiment" are "an always-already spatialized set of relations," where "the spatial swirls of affective intensities and forces that sweep through the human body" contribute to "spacing organization" (p. 56) in order to revisit the boundaries of front and back regions.

Transitional and Mixed Regions as "In-Betweens"

Weinfurtner and Seidl's (2019) integrative review of research on organizational space identified four overarching themes: *distribution* in space (i.e., "how does positioning within a space [. . .] shape the activities taking place within it," p. 5), *isolation* of space (i.e., "what happens inside a space in relation to outside," i.e., outside the organization, p. 5), *differentiation* of spaces (i.e., "different characteristics and structures" are associated with "different spaces," which begs the question of "how boundaries alter a space's identity," p. 5), and *intersection* of

spaces (i.e., "[s]paces can overlap: what happens between spaces?," p. 5). The second theme falls outside the scope of this research, but the other themes are relevant to the investigation of emotional labor performance within LTCUs. I have tackled the distribution and differentiation of spaces, but, up to this point, I have yet to discuss the full intricacies of the overlaps and in-betweens.

The zoning proposed in Fig. 9.2 matches what is the *dominant configuration* for each area between front and back regions. As previously illustrated, each region sees changes in emotional labor performance, whether this is conscious or not, deliberate or not. Aside from the analytical strata provided by the perspective of social worlds and liminal episodes, another interpretative level can be added by investigating what I label as "spatial in-betweens." In common parlance, an in-between either denotes an intermediate stage/state or shares the properties of two different elements. Here I distinguish two sets of spatial in-betweens, transitional and mixed regions (also sketched in Fig. 9.2), which came to light through the exploration of boundaries, movement, and directionality.

By coining the term "mixed regions," I refer to hybrid areas without one dominant function as a front or back region (they share the properties of both). They can be one or the other in equal proportions and/or with comparable frequency, which means that mixed regions can adopt a *scene configuration* or a *backstage configuration*, depending on circumstances. In LTCUs, the shower and WC of each bedroom can be considered as a mixed region: if the resident has his/her hygiene care there and/or uses the WC there, then it is a front region, but if the resident is bedridden and hygiene care is done at his/her bed, with nursing assistants being alone in the shower room to get water from the tap, for example, it becomes a back region. The entrance to the meeting room and the nurses' station are mixed regions at the threshold of back regions as health-care professionals may interact here with residents and/or relatives, thanks to the doors remaining open at all times. Part or all of the offices of the nursing supervisor and the geriatrician may transform into front regions when there is a need to discuss with relatives, although these areas are dominantly back regions. Being semi-open, the kitchenette is dual, thus part of the mixed region. The size of rooms also has an impact: as cupboards, cleaning and domestic stores are cramped, the doors are generally left open which means that they share both the properties of the back region (when health-care professionals are alone) and of the front region (when a resident or relative interrupts them with a question). Here exiguity creates *de facto* mixed regions.

It is interesting to note that academic literature on in-betweens inherently includes movement, an aspect that is less visible in LTCUs' mixed regions where the distance and amplitude associated with movement is relatively limited, at least by comparison with transitional regions. The view expressed by Weinfurtner and Seidl (2019, p. 18) is that "the space that is located at the intersection of different spaces is not fully part of either of these spaces." In fact, the "characteristic 'in-betweenness'" of "an interspace" comes from "blurred boundaries" and the influence of "at least two spaces between which movement occurs" (idem). The authors invoke *liminality* rising from the blurring of boundaries,

which they consider as part and parcel of the in-betweens, with liminal spaces being "located where boundaries intersect and [...] therefore not fully part of either of the abutting or overlapping settings" (Weinfurtner & Seidl, 2019, p. 4). With the occurrence of liminal episodes previously mentioned, one can see how the characteristics of one type of region can *momentarily* imbue the other. And, to a certain extent, instances of blurred boundaries, where a front/back region is no longer uniquely one, could be construed as temporal and/or spatial liminality.

Liminality is multifaceted as it can also be unveiled in the outer space of each LTCU, within the building: the stairs and lifts, the entrance hall, etc., are other in-betweens where brief cathartic exchanges can take place and social sharing of emotion help to recuperate from the emotional demands of the job. One could add to this list the outdoor spaces just in front or behind the building where staff may smoke a cigarette together. Liminal spaces "often imply the suspension of known norms, behaviours, social positions or identities and involve some degree of uncertainty" (Weinfurtner & Seidl, 2019, p. 4). This is, in a way, what Fineman (1996, p. 556) suggests by listing corridors and washrooms as "places where confidences are exchanged, formal stances dropped, 'real feelings' expressed," giving substance to his previous affirmation that the *temporary* definition of some emotionalized zones made them no less "significant in the patchwork of emotional cultures." However, fieldwork puts these assertions into perspective as I will now explain. Indeed, observation has made it possible to delimit a specific region, the transitional region, in which the (aforementioned) strict suspension of norms and behaviors does not completely apply.

The corridors are transitional spaces between front and back regions. As relatives, friends and other people from the resident's entourage are only allowed in during visiting hours, which are restricted to the afternoons, in the mornings, and at night, corridors are exclusively frequented by staff (there are exceptions, obviously: in the case of end-of-life care and death, relatives are permitted to come outside of visiting hours). In the afternoons, as residents and/or relatives sometimes walk through the corridors, this transitional space echoes the front region. Most of the time, corridors are only used by health-care professionals, and in this case, this space echoes the back region. In transitional regions, health-care professionals can talk to each other about care, and sometimes, share more informal moments.

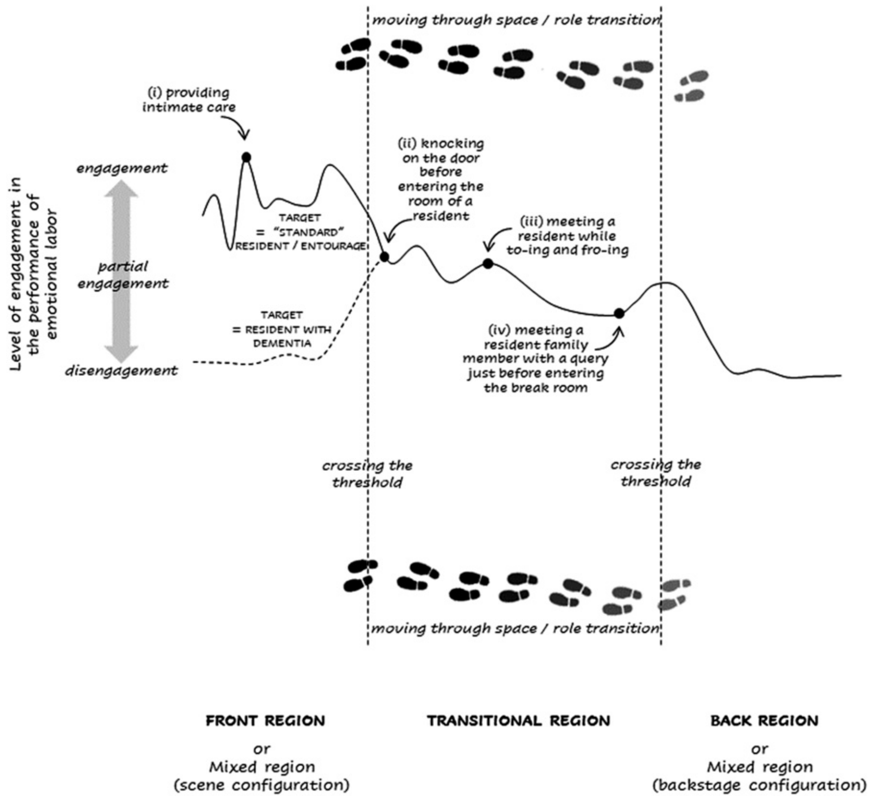
Although for Kociatkiewicz and Kostera (2015, p. 58), "[t]ransitional spaces are the physical manifestations of liminality: the state betwixt and between more stable states and realities," Shortt (2015, p. 655) contends that "simply defin[ing] these spaces as liminal [...] suggests they are abstract or conceived spaces and denies the fact that individuals *experience* them" (my emphasis). Taking inspiration from an interpretivist study conducted with hairdressers, she posits that, because "[s]paces like these are used and made meaningful" (p. 654), because they encompass "temporary and transitory characteristics" while being "simultaneously [...] 'lived' and re-constructed as dwellings" (p. 655), they should be described as "transitory dwelling places" (idem) for "privacy, for creating informal staffrooms and territories" (p. 654). LTCUs are living spaces; thus, this idea of in-betweens combining the ephemeral with more stable facets seems

relevant. Indeed, unlike standard hospitalization units, LTCUs welcome residents for (supposedly) months to years. Therefore, there may be more enduring qualities in the front and back regions, as well as in transitional and mixed regions. In effect, corridors are, admittedly, transitional regions, but also the antechamber of what is in fact a bed-cum-living room for residents, with for "veteran residents," personal artefacts and objects.

Boundaries, distance, and movement are at the nexus of the multidimensional concept of space (Weinfurtner & Seidl, 2019). Thus far, I have illustrated boundaries (between regions) and envisaged distance (space deepness) but evoked movement only sporadically. Yet, movement is a crucial component in understanding the interrelations between emotional labor and space as it is "associated with connection and change" (Weinfurtner & Seidl, 2019, p. 25). Geographer Doreen Massey (2005) focuses on the notion of *trajectory* to stress the "process of change in a phenomenon" (p. 12). She points to the "contemporaneous existence of a plurality of trajectories" (idem), implying potential crossings/intersections between them. Applying this to the case of LTCUs, transitional zones mark an intermediate area that is being crossed to get from a front to a back region (and vice versa) and/or a mixed region. If the directionality is toward a back region, health-care professionals can begin a semblance of relaxation (if their workload and the situation allow). If the directionality is reversed, professionals prep themselves for their emotional labor performance. They may need to perform emotional labor in transitional and mixed regions as these are potential meeting places with families and residents wandering around.

Remarkably, Goffman (1959) presented backstage as adjacent to the scene and did not develop the potential need to *transit* from one to another. The same person may embody several specific roles according to contexts and circumstances, both in the workplace and at home (Wharton & Erickson, 1993). Even if the "role we are to play, and how, in various organizational encounters, is not always clear" (Fineman, 1993a, p. 13), what is striking is that by moving across the unit, LTCU health-care professionals are in effect *experiencing role transition* (Ashforth, 2000): the transitional region anchors this role transition spatially. As part of their work role, they express and/or embody a diversity of emotions (Rafaeli & Sutton, 1987), with variabilities within the front region and between the front and back regions. Depending on situations and health-care professionals, preparing for the delivery of the emotional labor performance can happen in the transitional region or even start in the back region (or in a front region by thinking beforehand of the next resident who needs to be attended to). The nurse prepping up for her round (as previously mentioned) uses "anticipatory appraisal strategies" (Beal & Trougakos, 2013, p. 39) and visualization techniques. Fieldwork revealed various instances of health-care professionals in effect doing anticipatory emotional labor to help their upcoming performance with a specific resident or relative.

Fig. 9.3 introduces dynamic analytical elements by encompassing movement, trajectories, directionality, and the variability in the level of engagement in the performance of emotional labor within and across zones. It takes inspiration from the schematization of fluctuations around emotion regulation episodes (Beal



Note: This figure can be read from left to right and *vice versa*.
Examples of turning points are given:
(i) is within a front region
(ii) is associated with a trajectory from back to front region
(iii) is within a transitional region (regardless of the trajectory)
(iv) is to be understood as part of a trajectory from front to back region

Fig. 9.3. Spatial Analysis of the LTCU [2/2]: Trajectories and Dynamics.

& Trougakos, 2013, p. 36) and incorporates examples of turning points in the practice of emotional labor. These turning points showcase anticipatory emotional labor (e.g., before crossing the threshold of the bedroom of a resident) and the fluctuating level of engagement in the performance of emotional labor.

With this figure, I materialize the continuum between regions, and the variability in intensity *between* each of them, as health-care professionals move to deeper space, as well as *within* a type of area, depending on the target of the emotional labor performance.

Emotional Labor Performance in Motion

As I have shown, space interferes diversely with the performance of emotional labor. It generates obvious constraints within the perimeter of the front region, but it can also provide health-care professionals with resources, by the social sharing of emotions that happens in the back region, for instance. This is of paramount importance if one considers the particularities of emotional labor in LTCUs. Owing to the methodological approach I used, I have been in direct contact with the emotional texture that emanates from these units. Let me share an example of the atmosphere at a point in time during an immersion sequence taken from the field diary:

> From a sensory perspective, the sounds are multifarious: the curious mix of loud discordant voices and music coming from TV sets in residents' rooms, the insistent ringing of call bells, the discreet moans of certain residents, the vociferous cries of others, the steps of health-care professionals alternatively traipsing, trudging, treading through one place to the other. The air is stuffy in transitional regions, a whiff of urine and feces comes from various rooms, blending strangely with the lingering smell of food from the last hot meal. This contrasts with the fresh air coming from the open window in the break room. The whole unit could benefit from a lick of paint and the floor has what the nursing supervisor calls "*clean stains*," which means that it is washed every day but that the stains are ingrained in the material. This leads to regular tense encounters with families about hygiene. Corridors are encumbered by trolleys, one for the computers and medication, one for the incontinence pads, with bags of linen on the floor. (day 3 entry)

What fieldwork revealed in LTCUs is, in some respects, not a far cry from what Sharon Bolton (2008, p. 15) witnessed in her "nine-day stay" in a "British National Health Service orthopaedic ward" (p. 19). She insists on the fact that "caring professionals will work hard on the presentation of self, particularly with clients, in order to create a stable emotional climate and maintain poise for the carrying out of 'dirty work' such as body care, disturbing behaviour, or imparting bad news" (p. 24), elements that were also evident in LTCUs. The body is at the core of the relationship between the health-care professional and the resident (Mercadier, 2002). Immersions displayed a diversity of corporeal realities: being obese or emaciated, suffering from bad ulcers with necrosis and a protruding bone, etc. The daily work of nursing assistants revolves around "dignity work" which "centres on containing, controlling and concealing residents' incontinence to keep them clean, comfortable and well groomed" (Ostaszkiewicz et al., 2016, p. 2537). This is no simple feat as not all residents are cooperative for these tasks, sometimes consciously as they struggle with intrusion into their intimate sphere, sometimes unconsciously. An observation sequence showed the case of a resident continuing to sleep (and snore) while the nursing assistant changed his incontinence pad and cleaned him up... only for him to defecate again on the gloved hands of the nursing assistant. Turning toward me with a wry smile, she tells me "that's that, it happens with fresh water...," waits for the resident to finish and has "to do it all again."

The repetitiveness of what, at times, feels "pointless" for some nursing assistants, as it has to be reiterated "again and again," takes its toll and taints the performance of emotional labor. During an afternoon round, a resident rings her

call bell. The nursing assistant, who had changed her soiled pad a few minutes earlier, comes to see her: the resident tells her that she could not "stop herself" and that she had "peed" in her incontinence pad. After complaining that she had already changed the resident, she exclaims "you're disgusting!," "you're dirty!" She then tells her that she is not going to "change her again" and that the resident will have to "wait for the next round." In this example, the level of engagement in the performance of emotional labor is clearly debatable, the resident is dehumanized. Another illustration of this dehumanization of residents emerged from fieldwork with a nursing assistant calling uncommunicative residents "vegetables" in the back region much to the shock of the nursing supervisor and other health-care professionals. And what of the level of engagement associated with completely ignoring a resident because "he has dementia, he doesn't understand nothin' anyways"? Of course, some health-care professionals are overworked, some feel a lack of appreciation for their work by the hospital, others are burned out (depersonalization being a symptom), others simply do not realize the impact of their words and how it interferes with their behaviors, etc. There are probably other reasons, but these elements shed light on the underlying processes leading to this alteration of the emotional labor performance.

I regularly observed the marks of respect shown toward patients and/or their relatives during interactions, even if the subsequent confidences of the professionals led me to conclude that this was sometimes "superficial respect," not necessarily felt. Away from the residents, comments about them are not always complimentary, ranging from "she is a real cry baby" to "he is a real perve' that one" to "Alzheimer's in [room] 4 window"... Counterbalancing these marks of disengagement in the performance of emotional labor and dehumanization, and mirroring Bolton's (2008, p. 23) experience, "small moments that express our humanity" and "interconnectedness of social ties" (p. 15) emerged repeatedly. Although morning shifts, characterized by a heavy workload, are likened to "line work" by staff and permit instrumental emotional labor at best, afternoon shifts allow for more occurrences of therapeutic emotional labor.

Movement is central to the performance of emotional labor in LTCUs, as Fig. 9.3 shows. This is also apparent in an extract from the field diary that I deem particularly eloquent (see Fig. 9.4 to 9.7). I have cut the episode into four parts, almost akin to "theatrical scenes" (although this division is not perfect) in order to better point out what is actually going on and to outline the plurality of dynamics at play in the performance of emotional labor. Fig. 9.4 sets the scene. Fig. 9.5 underlines the communication challenges faced by staff, along with the simultaneous demands they have to deal with, concluding with an unexpected event. Fig. 9.6 insightfully illustrates the movements between regions and consequences for emotional labor and the importance of social support and social sharing of emotions. Fig. 9.7 displays the familiarity of the back region.

Although I always "prepped myself" before an observation sequence, making sure that I was as fully rested and as focused as possible (observation is a cognitive and physical challenge as you need to stand still, staying on the lookout for emotional cues, etc.), it was sometimes necessary to step outside of the front region, even outside of the unit in certain cases.

1/4

Shortly before 4pm.

It is the time when the nursing assistants, who work in pairs during afternoon shifts, give snacks to the residents. I am following a nursing assistant, Alpha (not her real name), who tells me a bit about herself. She has been in the LTCU for six months, on a fixed-term contract (she still has two months left before moving to another position). While chatting, we arrive at the bedroom of a resident, Mrs X.

All the bedroom doors are wide open in the LTCU[(i)], except in the case of residents who prefer to keep them closed at all times (they are also, generally, closed during visits from the entourage of the resident). Mrs X's bedroom is among the 'open-door' ones. Alpha takes a peek. Mrs X, wearing an adult bib, is sitting up in bed and has already been provided with a yoghurt, a spoon and a sippy cup[(ii)] by another nursing assistant. She seems to be struggling to reach for her spoon[(iii)].

Alpha (with me on her heels) pops inside (she keeps the door open behind her) and asks Mrs X: "Do you need a little help?" Mrs X does not respond. Alpha waits for a bit. However, seeing the resident's persistent difficulty reaching for her food while sitting up in bed, Alpha gives her a hand anyway. She helps her to eat by lifting a spoonful of yoghurt to her mouth. Mrs X accepts the offer, opens her mouth and swallows the content of the spoon.

[(i)] This allows staff to check on the residents while passing through the corridor to answer the needs and/or requests of other residents (or their entourage during visiting hours), or while attending to other tasks.

[(ii)] This a drinking cup (or beaker to be precise as to its shape), specifically designed for disabled adults, with ergonomic handles, an anti-spill lid and a spout.

[(iii)] If you have ever tried to eat food placed on an overbed table while sitting up in a hospital bed (and by that, I mean *propped up* in bed, not sitting on the edge of the bed), you will appreciate how awkward it is. Usually, it is difficult to sit up properly, and the height of the table is rarely optimal. At the best of times, managing to eat and drink in these conditions without 'making a mess' is no minor feat. If you add to the picture the fact that the resident is small and frail, almost engulfed in the bedding, that her hand movements are unassured, and that her bed has side rails (to prevent her from falling over), which means that the overbed table is very high as it has to be pushed over them, you will understand that help can be very much needed...

Fig. 9.4. "She Is Nasty," the Sippy Cup Incident (Extract From the Field Diary) [1/4].

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A few mouthfuls later, Alpha spots another resident, Mrs Y[(iv)], who is wandering down the corridor, with a glass of water in her hand. Alpha calls her from inside Mrs X's room and asks Mrs Y to go back to her own room to drink her glass of water.

In the absence of any response from Mrs Y, Alpha puts the spoon and the yoghurt back on the table, leaves Mrs X a short while (without, incidentally, informing Mrs X of why she is leaving her) and goes to speak face to face with Mrs Y in the corridor: "Go back to your room, we drink while sitting down, not standing up." Mrs Y, who looks clearly lost, answers "no" (it is not clear, though, if she has heard Alpha or not). At this point, another nursing assistant who is passing through the corridor takes over.

Alpha thus returns to Mrs X's room (with me in her shadow). She resumes feeding the resident mouthfuls of yoghurt. After a time of silence, she confides in me in a half-tone that she hopes to work in A&E (accident and emergency) or in SICU (surgical intensive care unit) after leaving the LTCU, adding "I just love it when there is technical care involved."

At this point, Mrs X starts slapping the hand of Alpha, who interprets this gesture as a request for her to stop the 'feeding process'. Alpha exclaims: "You are full? Alright then. You should tell me rather than slapping me! I'll wipe your mouth then?" Alpha then asks: "Do you want to drink?" Mrs X does not react. Alpha asks again, raising her voice: "Mrs X, do you want to drink?" The resident answers with a nod.

Alpha then gives her the sippy cup which Mrs X takes in her hands. She starts drinking eagerly. Alpha comments with a smile: "Go on then! Going down the red lane smoothly?"

Suddenly, Mrs X throws the sippy cup at Alpha's face. Alpha is sprayed with liquid from the cup onto her arm and uniform.

I myself am utterly shocked. I *absolutely did not* see this coming.

[(iv)] During a previous observation sequence, I had learned that Mrs Y is suffering from Alzheimer's disease. She is hospitalized in the LTCU while waiting to be transferred to a dedicated Alzheimer unit, better suited to her needs. The team members I have spoken to are very fond of Mrs Y, whom they find endearing.

Fig. 9.5. "She Is Nasty," the Sippy Cup Incident (Extract From the Field Diary) [2/4].

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In a flick of a switch, the relaxed atmosphere vanishes. The tension mounts instantly. You can actually *feel* the anger exuding from Alpha.

Alpha is fuming: "How nasty!", "Mrs X, you are not nice!"

Still boiling, she turns to the resident and looks at her straight in the eye. In a raised voice, she lectures Mrs X: "I am not here to have water thrown at me!", "I am here to help you eat and you start slapping me!", "That I cannot accept.", "You are *so* nasty doing this!"

Alpha storms out of the room, her uniform partially soaked and stained with liquid, bellowing "she is nasty!", as we cross paths with the relatives of another resident (their curious glance in her direction and nonplussed attitude suggest that they have heard her shout).

We pass another nursing assistant in the corridor. Alpha shows her gown: "Look, Mrs X just sprayed me!", "she threw her sippy cup at my face!", "she *really* is..." The other nursing assistant completes her sentence: "*Nasty*, she is nasty!" Alpha repeats "Oh yes, she is *nasty*."

Mrs Y is back wandering down the corridor. Alpha walks towards her, displaying her tarnished gown: "Look, I got sprayed!" Mrs Y gently takes her arm in her hands and mutters indistinctly. The words "to eat" are perceptible. Alpha bounces back on these words: "No, I have not even eaten yet...", "and water has just been thrown at me!" Alpha affectionately strokes Mrs Y's hand then leaves her and goes ahead down the corridor, looking for her dedicated "partner" for this afternoon shift, Epsilon (not his real name). She finds him in another room. He is just finishing helping a resident to eat.

Alpha and I enter the room. Here the atmosphere is very different. Relaxed, even jovial. Epsilon jokes: "You're not going to eat the pot, are you?" He laughs while the resident, his eyes smiling, gives a small chuckle. The resident then turns his attention to the TV screen where a program is running.

Epsilon prepares to leave the room but, seemingly unable to contain her thoughts and feelings any longer, Alpha spills her story. She concludes: "Some residents have dementia, in that case I forgive everything, but here there is no dementia, she is just *plain mean*."

Fig. 9.6. "She Is Nasty," the Sippy Cup Incident (Extract From the Field Diary) [3/4].

4/4

Epsilon and Alpha briefly reminisce on previous incidents with Mrs X. During these exchanges, Alpha's body language starts to open up. Epsilon evidently tries to help Alpha put the incident into perspective, stating "there *is* a pathology though, in her case." Alpha shrugs: "She does not have dementia but there is *indeed* a 'psycho' component. I don't think it's something like Alzheimer's."

Epsilon emphatically affirms: "Not everybody with Alzheimer's was a nice person before getting it. *You have jerks everywhere.*" This last sentence instantly feels like a 'winner statement' to me, as an observer. As if Epsilon had just found the right key to open the metaphorical door to help Alpha escape from the spiral of the incident and how badly it affected her.

Alpha, who up to that point, had been leaning against the wall suddenly 'tilts'. She stands up straight and concedes: "It's true. But Mrs X was apparently a very sweet and gentle person before. Since being hospitalized, things have changed." As she leaves the room with Epsilon and they walk side to side in the corridor, Alpha reiterates: "She is very *conscious* of what she is doing, though." Epsilon thus tells her in a reassuring tone: "OK, I'll go and see her later, then."

It is now break time.
The whole team gathers in the break room. Junk food, sweets and coffee are in hot demand, so is the need to check personal messages on cell phones. Alpha shares her account of the incident to the other team members (at least, those who did not know what happened). At this point, although the memory of the incident is still fresh in her mind, Alpha has clearly recovered a certain level of calm. After briefly talking about the incident within the team, the tone progressively turns from shared indignation and sympathy to gossip as other topics of conversation are naturally woven into the collective discussion. These topics range from the faulty coffee machine to what they will do on their day off, to elements of their personal lives (the upcoming birthday of one of the staff's children, in particular), to the uncertain weather.
A nursing assistant asks who wants to come with her "for a fag" outside but finds few followers to brave the light drizzle.

[Note: time elapsed between the start of the incident with the sippy cup and the last mention of it ~ 10 minutes]

Fig. 9.7. "She Is Nasty," the Sippy Cup Incident (Extract From the Field Diary) [4/4].

Indeed, while conducting the study, I realized that I was myself navigating through the various zones after being confronted with an emotionally intense episode, or if I needed some "downtime" to recharge, regroup, recuperate (the chair is a welcome comfort after prolonged standing and to-ing and fro-ing). Aside from self-preservation, shifting zones allowed me to take notes and/or reflect on an emotionally draining episode. Fineman (2003, p. 38) argued that "[r] etreating to a less-demanding emotionalized zone can reduce the personal costs of emotional lab[or]" as the "prescribed performances can stop, and the public mask be lifted, or at least exchanged temporarily for an alternative one," which is exactly what I experienced as an immersed researcher.

DISCUSSION

All the world's a stage, And all the men and women merely players. (Shakespeare, 1961/1623, p. 266, Act 2, Scene 7)

This research has implications of different natures, which will now be discussed, along with limitations and future perspectives.

Theoretical Implications

The conjunction of the multidimensionality of space as a concept and the thought-provoking nature of the theatrical metaphor help further develop scholarly understanding of emotional labor. Through this study, the exploration of the interrelations between space and emotional labor has yielded new perspectives and insights by painting a spatially nuanced vision of "the intricate nooks and crannies" behind the performance of emotional labor. Rather than centering on the mainstream strategies of deep and surface acting, it is the subtle hues of therapeutic, instrumental, and collegial emotional labor that have mainly guided observation and analysis.

This research has uncovered various instantiations of in-betweens, anchored in liminality, movement, and directionality, as well as the degree of "mutability" of front and back regions with one being imbued with qualities of the other depending on circumstances and organization spacing. Transitional and mixed regions epitomize the nonlinearity in emotional labor performance in the case of health-care professionals. Furthermore, by combining static and dynamic approaches, multiple layers of emotional labor performance and interconnections with space have been given substance.

The ambivalence between constraints and resources that space generates has also been made visible. Working in the front region is particularly emotionally demanding, with deeper space levels (i.e., bedrooms versus shared living area) and closer physical proximity (i.e., hygiene care), leading to more intense enactments of emotional labor. Meanwhile, moving through transitional regions plays a key role in helping to prepare for upcoming encounters and relieving part of the pressure felt. Shifting zones and retreating to the back region where social sharing of emotion can be done is a resource that should not be underestimated.

To my knowledge, bridging space and emotional labor together as has been done in the present research is a novel approach. Although it does not follow the "Framework for Unit-level Emotional Labor (FUEL)" (Niven et al., 2013, p. 113), this study still contributes to literature both on dyadic and unit-level emotional labor by choosing to envisage the level of each LTCU as well as observing one-to-one interactions. As well as underlining the broad tendencies of emotional labor spatiality during shifts, fieldwork has provided information on how emotional labor is spatially enacted within a single emotional episode and the multiple trajectories and fluctuations in the level of engagement involved in the performance of emotional labor.

Drawing on a musical metaphor, this research has contributed to exposing the *polyphonic* quality of emotional labor performance within LTCUs. Polyphony is "a form of composition in which multiple melodies are performed at the same time, each retaining its own individuality as it harmonizes with others" (Albert, 2013, p. 155). From an organizational point of view, this denotes the simultaneous occurrence of a diversity of rhythms, punctuations, sequences (Bartunek, 2016; Bartunek & Woodman, 2015), and multiple tonalities that are expressed during the spatially situated performance of emotional labor, both at the dyadic and unit levels.

Delivering a narrative account of the results and gradually building analytical strata has helped to better shed light on "the good, the bad, and the ugly" of emotional labor performance in health care and to convey the complexities at hand. This is consistent with Morin's (2005/1990, p. 22) idea that "anthropo-social phenomena" obey "complex principles of intelligibility" that have to be faced rather than dissolved or hidden. As "a mutilating thought necessarily leads to mutilating actions" (p. 23), it is crucial not to shy away from "the muddle (the infinite play of inter-retroactions), [. . .] the uncertainty, the contradiction" that are the very essence of anthropo-social phenomena, including emotional labor, and thus warrants "complex thought" (p. 22). Though in many ways this research has only "scratched the surface" of the richness that comes from the interplay of emotional labor and space, it contributes to opening "new territory" for future organizational research on emotions and space.

Methodological Implications

Relying on an *in situ* approach as well as interviews has been paramount to addressing the multiple dynamics arising from jointly studying space and emotional labor. While direct observation is key to unveiling them, future research aiming to delve deeper into this issue could benefit from video-observation methods which "enable researchers to capture emotional interactions within their full social context" and "provide the opportunity to examine the regulatory interchanges between agents and targets and to investigate changes in each party's emotions and regulatory behaviors, to map fluctuations and dynamics over time" (Niven et al., 2013, p. 117) and space.

While such methods could provide even richer empirical material for analysis, technical aspects need to be taken into account (e.g., should a fixed or embedded

camera be used?) as they affect how the research itself is conducted and the realms of possibilities of encapsulating the realities of emotional labor. Furthermore, video-observation methods come with their own caveats: first, one should assess the possible influence on behaviors of knowing your actions are being filmed and secondly, there is the question of confidentiality, image rights, and ethics. This is even more relevant in health-care contexts, as data other than that related to health-care professionals may be collected, for video-observation may record highly sensitive patient-related data. However, it should be noted that video capsules taken from fieldwork could also serve to create dedicated training modules within a health-care service (for instance, in the context of an action research design): specific videos could be used to illustrate specific aspects of emotional labor performance and help develop "reflective practitioners" (Theodosius, 2008, p. 219) through autoscopy-inspired approaches, thus promoting "reflexive emotion management" (idem, p. 201).

Practical Implications

Through the static and dynamic aspects of space outlined in this research in conjunction with the performance of emotional labor, multiple practical implications can be put forth. This is particularly important in the context of hospitals as the health-care sector has been struggling to attract and retain professionals. Alluding to the title of this research, fluoroscopy can be used both to *diagnose* a problem and to guide *treatment*. What is apparent in LTCUs is that, whether voluntarily or not, the level of engagement in the performance of emotional labor fluctuates within and across regions. It is essential to acknowledge the constraints caused by space as well as the resources it may offer for the performance of emotional labor.

Health-care professionals may spontaneously or actively seek certain zones to recuperate when needed. These areas of collective- or self-preservation, nested in the back region, are essential in ensuring the continuing performance of emotional labor and the quality of care. Thus, sketching out various emotionalized zones serves a dual purpose: shedding light on the versatile nature of emotional labor performance, but also underlining their role in reducing the costs of emotional labor. This can be seen from a static perspective, the back region being conducive to restorative moments, and from a dynamic one as shifting from one zone to the other offers the chance to seek refuge in less-demanding areas (Fineman, 2003). The back region is also of potential value for emotion regulation policy that can be developed by organizations: it is important to have such places "where employees can rest away from the pressure and the gaze of the public[, t]he creation of such spaces also allows strengthened solidarity between workers" (Alis, 2009, p. 235).

Practitioner and educator Leah Kuypers proposed the creation of *emotion regulation stations* within schools or other educational settings (Kuypers, 2011). This is not far from the relaxation pods that certain French hospitals have trialed to give health-care professionals tools to better "recharge their batteries." In the case of the pods, the idea is to cut off the outside world in order to take a nap or

practice mindfulness while emotion regulation stations help individuals to take a step back, by isolating themselves from a taxing interaction and either reflecting on it or clearing their heads and minds after what has just happened. Both resources are located in fixed, spatially delimited, areas away from the hustle and bustle of more active zones. This may be a source of inspiration for various organizations, and not only health-care settings, given the size of the service sector where emotional labor is omnipresent. High-quality on-the-job downtime is essential: truly making the break *count* (Trougakos et al., 2008, my emphasis) helps during both a particular shift and future ones by preventing workers from relying extensively on external resources to cope, such as sharing their emotional turmoil at home (Wagner et al., 2014).

In-betweens and liminality have practical implications for management. Nursing supervisors may help their teams understand how to nurture these "spatio-temporal niches," how to make do with *intervals*, either from a static perspective (i.e., within a specific area) or from a dynamic one (i.e., moving across areas). As has been suggested, anticipatory emotional labor is an integral part of work, contributing to an easier performance. As Fineman (1996, p. 557) points out, "the ways organizations divide in emotional architecture and emotion work" can be observed "[w]ith a more sociological eye" in order to understand how specific spaces "come to feel safe or risky for different types of emotional presentation or the sharing of intimacies." By setting the emotional *tone*, the nursing supervisor can help foster an emotional climate conducive to more positive interactions and to creating the "right conditions" to facilitate both anticipatory and standard emotional labor.

This research, therefore, helps underline the structural role of the nursing supervisor in shaping action and emotional labor performance, by giving advice, articulating care and emotions, designing unique solutions to team difficulties regarding the practice of emotional labor. Language is also a key aspect of care and emotional labor, and by shunning inappropriate vocabulary and encouraging more *humanizing* words, nursing supervisors, in effect, impact the actions of their teams and the quality of care.

Social Implications

The social implications of this study are twofold, firstly for the organization as a microcosm of society and secondly for society itself. This research stresses the emotional texture of hospitals, the unique challenges posed by the performance of emotional labor in such a setting. This contributes to giving further explanations of the difficulties in attracting and retaining professionals, but also gives ideas for practitioners to curb this trend by taking into account emotional factors as well as physical, mental, and motivational ones. By sharing the lived experience of health-care professionals in geriatrics, and stressing in what context dehumanization may arise, fieldwork provides insights into why subpar care may occur (obviously, other factors than those put forth here have to be considered, such as working conditions, absenteeism, activity levels, etc.).

This begs the broader question: how do we, as a community, as a society, perceive the elderly? If "humanizing" and "emotionalizing [. . .] understanding of organizational behaviour" (Fineman, 1993a, p. 30) is necessary, the same could be argued outside of the perimeter of the organization. It is paramount to elevate dirty work to dignity work (Ostaszkiewicz et al., 2016) and to recognize how essential relational and emotional components are for the care of the elderly.

Limitations

From a theoretical standpoint, the density of each concept and framework mobilized means that it has not been possible to explore them all in detail within the perimeter of this study. I am thinking, in particular, of the symbolic, aesthetic, and ritualistic dimensions emerging from the combination of space and emotional labor. Individual-level intrapsychic processes and the link with spatial variability have not been studied here, and within-episode variability has only been analyzed from interactional and unit-level perspectives rather than delving into intrapersonal dynamics.

Methodologically speaking, while observation as an *in situ* approach informs the spatial dynamics of emotional labor and the versatile nature of emotional labor performance, the richness of the data collected depends on the ability of the researcher to recount precisely what happened during fieldwork as well as to recall events in detail. The level of understanding of emotions felt at one point in time and individual intrapsychic variability cannot be fully grasped with this methodological approach, which means that part of the spatial emotional labor experience has not been captured. Relying on a qualitative mono-organization study means that generalization is an issue, although reflexivity and resonance give food for thought and thus offer other routes to envisaging the transferability of the findings to other health-care settings or organizational contexts (Cunliffe, 2022).

As for the practical perspectives outlined by this research, they are in effect constrained by the financial resources of the organization that might think of implementing them.

Future Perspectives

A plurality of natural extensions to the findings of this study can be considered. One would be to explore boundaries, both from an individual level and from an intrapersonal perspective, for instance, by investigating the links between the manipulation of emotional boundaries (Hayward & Tuckey, 2011) and space. Focusing on the lived emotional experience of micro-events (Gabriel & Diefendorff, 2015) and how it is "absorbed" and regulated through spatiality is another research avenue that could bring a deeper understanding of the interactions between internal regulatory processes and space. Analyzing momentary shifts in emotional labor would in fact bring time and space together, as would the study of liminal episodes interspersed throughout the length and breadth of a

working day. Methodologically speaking, experience-sampling could prove useful for tackling these issues.

In line with the social implications previously suggested, the appropriation of moral emotions through space may also bring welcome insights. Moral emotions are an integral part of ethical reflections in the organizational context (Lindebaum et al., 2017). They are a yardstick for health-care professionals, as components of emotional requirements, orienting staff behavior to ensure continued professionalism. Moral emotions give clues to potential behavioral adaptations to be made and may betray breaches of professional demeanor.

Finally, another possibility is to concentrate on the sensory experience of both emotional labor and space. Balez (2021), for instance, put forth the emotional power of smells, while Connellan (2013) discussed the impact of the color white, commonly found in hospitals, on the psyche. This approach makes sense in hospitals in general, but also in geriatric care (nursing homes, LTCUs, etc.) because of the daily confrontation with less than welcoming sensory stimulations inseparable from dignity work.

CONCLUSION

Fineman (1996, p. 558) advocated offering “imaginative organizational designs which place emotionality, in both its manageable *and* unmanageable forms, nearer the center of the organizational stage” and, in fact, focusing on the various dimensions of space is, I believe, an innovative and relevant path for emotional researchers going forward.

Gabriel et al. (2023, p. 536) insisted on the “need to *more fully incorporate time* into emotional labor scholarship”; the same could be argued for space. One can only hope that the burgeoning perspectives previously suggested will blossom in the wake of renewed interest in the combination of emotion and space, especially if time is added to the equation. The future of emotional labor research certainly looks bright and exciting.

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