A BRIEF EXPLORATION OF THE SOCIALISATION OF GENDER AND EMOTIONAL INTELLIGENCE TO GAIN AN UNDERSTANDING OF WHY NURSING REMAINS A PREDOMINANTLY SEX SEGREGATED PROFESSION

ABSTRACT

This paper attempts to understand how emotions and emotional intelligence (EI) is gendered throughout the socialisation and development of children into adults and how this affects the sex segregation of occupations such as nursing. This is relevant as nursing is continually used as the scapegoat for healthcare system failures and thus an understanding and appreciation of emotional intelligence and how it is cultivated may elevate the role of nursing, reduce the sex segregation that remains and aid structural reform of the National Health Service (NHS). That is, many of the failures we have seen in recent years have been due in part to nurses being overstretched in their workload and under – supported resulting in a reduced ability to manage emotions or remain emotionally intelligent, due partially to a lack of time with each patient. By increasing the spotlight on emotional intelligence, and the time this requires, in the literature it is hoped that the value of nursing will be elevated and this will be reflected in the structural reforms, which continue within the NHS.

This paper thus begins with an exploration of Hochschild's work as the basis for examining emotional labour, followed by a brief examination of the beliefs held about emotions and the socialisation of emotions throughout childhood and beyond. A dissection of how the healthcare system, and occupations within it are gendered will be followed by a brief exploration of the implications of this. Emotional labour, intelligence and nursing, in general and today, are discussed before drawing the different themes of socialisation, occupational sex typing and nursing together in an emotional intelligence framework to gain an understanding of the complexity of how the three interact today within the National Health Service (NHS).

KEY WORDS

Emotional intelligence; occupational sex segregation; nursing; socialisation; gender

INTRODUCTION

Several professions can be said to be segregated by sex, that is occupational sex typing has occurred where there is a tendency for a particular profession to be seen to be more appropriate for one sex or the other (Mackie 1987). Professions such as teaching, nursing, social work and secretarial work have all been traditionally female sex dominated with many possible reasons for this; including wage potential, hours, skills required, educational prerequisites and so on (Ambert 1976, Ungerson 1983, Cantor 1987, Ferree 1987, Mackie 1987, Zimmerman and Hill 1999). All of these predominantly female professions require a level of emotional labour, as first defined by Hochschild (1983) to involve the "management of feeling to create a publicly observable facial and bodily display", this becomes labour as it is quantified and enters the labour market, in comparison to emotion work or emotional management which is carried out in the private, rather than the public sphere of life (Theodosius 2008). In comparison, typically and predominantly male occupations such as engineering, architecture and medicine do not require the same level of emotional labour but instead require more 'masculine emotions and characteristics' such as competitiveness, curiosity, objectivity and so on (Ambert 1976, Ungerson 1983, Cantor 1987, Ferree 1987, Mackie 1987, Zimmerman and Hill 1999).

There are undoubtedly other factors that can be said to segregate occupations, to more and lesser degrees. For example, race and ethnicity, disability status, age, socioeconomic status, sexuality and gender status; and each of these factors is influenced by a myriad of social determinants which lead to the separations which can be said to occur. When investigating the influence of such factors it is important to acknowledge and begin to examine the interactions between them; as crucially each individual's experience and circumstances influence them in different ways. The author is keenly aware of the importance of intersectionality and that nursing cannot solely be judged as sex segregated, as it is possible to assume other segregations may also occur within. Having said this, an in depth exploration of the interaction

of such factors and how they may affect socialisation and emotional intelligence and thus nursing is far beyond the scope of this paper.

This paper thus attempts to understand how emotions and emotional intelligence (EI) is gendered throughout the socialisation and development of children into adults and how this affects the sex segregation of occupations such as those mentioned above. An exploration of Hochschild's work as the basis for examining emotional labour will be undertaken, followed by a brief examination of the beliefs held about emotions and the socialisation of emotions throughout childhood and beyond. A dissection of how the healthcare system, and occupations within it are gendered will then be followed by a brief exploration of the implications of this. Emotional labour, intelligence and nursing, in general and today, will be discussed before drawing the different themes of socialisation, occupational sex typing and nursing together in an emotional intelligence framework to gain an understanding of the complexity of how the three interact today within the National Health Service (NHS).

A SUMMARY OF HOCHSCHILD'S WORK

Hochschild's work on the relationship between felt and acted emotions and how this is determined by context and can be a commodity was seminal in 1983 (Theodosius 2008). Emotion management - "the management of feeling to create a publicly observable facial and bodily display" (Hoschchild 1983 cited in Theodosius 2008: 14) is taught through socialisation and the society of which we are a part. Hochschild described emotion management as occurring in both private and public spheres; once in the public sphere it becomes a marketable commodity which women particularly were able to capitalise on (Ambert 1976, Theodosius 2008). That is, as discussed below, because of the different ways boys and girls are socialised, girls may be better at emotion management than boys (Ambert 1976, Ryan and David 2008). Hochschild describes different ways in which emotion management occurs, namely through feeling rules and surface and deep acting.

Feeling rules are effectively the standard measurements of what emotion and to what degree it should be felt in reference to the context. These rules vary between public and private spheres, as well as specific contexts and are taught by learning to read the subtle signs of a particular situation and the other people within it.

Surface acting, or the "ability to deceive others about how we are really feeling without deceiving ourselves" (Theodosius 2008:18) enables us to portray emotions we do not feel in order for an interaction to occur with less friction. This is part of the social grease of human interaction, for example one may be feeling ill but come across an old acquaintance, in this situation being foul tempered because of being ill is likely inappropriate and so surface acting can be carried out to allow the interaction to end quickly and smoothly and not jeopardise the acquaintance in the long term.

Deep acting is where "we deceive ourselves about our true emotion as much as we deceive others" and it may be achieved by either exhorting emotion or using our imagination. That is, by remembering similar situations where more appropriate emotions were felt can be relied on to bring out the 'better' emotions for the situation. This gives a more sincere emotion management and interaction but does take some cognitive training to carry out successfully.

However, there is a risk of emotional dissonance developing if emotion management is done regularly as a commodity. Without 'checking in' with our true and often less appropriate emotions by debriefing, residual emotions may build up unconsciously which can lead to feeling inauthentic and unconnected to ourselves according to Hochschild (Theodosius 2008).

BELIEFS ABOUT EMOTION AND WAYS OF KNOWING ARE GENDERED

Within the UK, and similar societies, gender is still treated within a

> *"Differences paradigm - an approach to gender research that reduces the complexity of gender effects to a simple question of whether a difference between women and men exists, fixating on the 'how much' question over the 'why' question"*
> (Shields 2013: 426).

That is, gender is viewed as the differences between male and female sexes, masculine and feminine behaviours and thus stereotypes are perpetuated within this paradigm. This results in scientific research into gender also focusing on differences as this frames how scientists think about gender and thus frame their research and questioning (Shields 2013). The concept of the paradigm affecting our interactions can be exemplified by simple examples such as how the introduction of television into remote communities may change their ideas of lifestyle, from relationships to appearance. The information given to us by mass media and popular culture are influential as to how we think about our own lives (Verheijen 2006). Stereotypes about gender are often related to emotion, with women being irrational and prone to emotional expressiveness, often colloquially described as 'outbursts', whilst men are portrayed as being rational, objective and calm (Shields 2013). Therefore, there is something to be noted in "the role of beliefs about gendered emotion in the performance and maintenance of gendered structures of status and power" and how this affects how we perceive others and ourselves (Shields 2013: 423). Shields (2013) goes on to criticise the differences paradigm further for its simplicity and ability to accentuate differences between genders and ignore those differences which occur within a gender, which one can posit are just as varied as between genders.

Ryan and David (2003) argue that in terms of how they interact with the world, men and women use emotions and objectivity fairly similarly; unless gender is made a salient factor in which case, as Shields (2013) predicts, each sex is more likely to emphasis their belonging to their gender's stereotypes. That is to say, in terms of ways of knowing some people are more likely to use connected knowing and some separate knowing and this is variable by a range of factors, of which gender is one. This does not mean that women are inherently more caring or emotional but rather that they may be better practiced at operating through connected knowing, rather than separate knowing which men tended to use more. But both sexes are capable of both connected and separate knowing; and tend to use connected knowing when interacting with those they feel are of the same social group or identity in some way as opposed to using separate knowing when they interacted with those of another group or identity. That said, there are specific group contexts where this changes, that is, where the group is a group based on a factor which favours either connected or separate knowing; for example, lawyers may accentuate their separate knowing when together whilst nurses may accentuate their connected knowing (Ryan and David 2003). Thus, gender is just one of many factors which have an effect on how we interact with the world, but as gender is made a salient factor through society and the structures within it, it stands to reason that it may have more of a continual effect than some other factors. Therefore, as Ryan and David (2003) argue, context is key to how we interact with our surroundings but gender may be made more salient than other social identities that we all hold.

SOCIALISATION OF EMOTIONS

A brief exploration of how children are socialised with regards to gender and emotional intelligence is paramount to understanding how the two factors interact and are influenced by each other and society. That is, David and Ryan (2003) found women are more practiced at connected knowing, and understanding why this is not an inherent trait is crucial to understanding emotional intelligence, especially in terms of occupation. How we perceive ourselves and others is guided by the culture within which we are situated and raised as this influences and guides our beliefs and values and provides the rules necessary to understand the world (Jessor, Colby and Schweder 1996, Holloway and Wheeler 2010).

Socialisation is "the complex learning process through which individuals develop selfhood and acquire the knowledge, skills, and motivations required for participation in social life" (Mackie 1986 cited in Mackie 1987) and gender socialisation within this is the learning of rules of femininity and masculinity in order to meet the expectations of the current society (Mackie 1987). Mackie (1987) suggests that gender rules are essential to being able to navigate society as they uphold and are maintained through many different veins of society, including many institutions that uphold them, and are themselves upheld by them. Children learn from early childhood what are appropriate behaviours and activities for each sex through their parents and

wider family; with actions and the media speaking louder than any formal teaching (Ambert 1976, Mackie 1987).
According to Ambert (1976) the primary caregiver interacts with children differently depending on the child's sex. Girls are more likely to have more verbal communication with their caregivers whilst boys are less likely to be asked to help with younger siblings; the appearance of girls is seen to be of more importance than the neatness or cleanness of boys and so on. Thus girls are taught from a young age the value of their ability to be emotionally expressive, caring and kind as well as capitalise on their appearance at all times (Ambert 1976).
Within formal education this continues in different ways, girls are generally higher achievers in primary school but their motivation for achieving tends to decrease dramatically as their preoccupation with appearance and boys increases, potentially to internalise their future roles as wives and mothers. Boys, on the other hand, continue with similar levels of motivation and focus on sports and competition. That is, teenage girls develop a world in which boys are the centre, whilst for boys girls are still peripheral to their other activities and achievements. Of course, Ambert wrote this in the 1970s and so relies on the differences, heteronormative paradigm; something which is changing rapidly as such a paradigm is seen to be more and more limiting as gender is beginning to be described as a sliding scale, as is sexuality which is central to the differences dichotomy.
In terms of the labour market, women in the 1970s were often still primarily housewives in white, middle class Western society but where mothers were working this tended to have a huge influence on how their children viewed womanhood and work. Children of working mothers were less likely to believe gender stereotypes, and girls were more likely to envisage working themselves (Ambert 1976). However, girls were not at this time socialised by their surroundings, including media, school and so on, to enter professions other than those sex typed as appropriate for women; such as nursing, teaching or secretarial work. As well as this, their main future occupation was presented as wife, mother and support for their husband. Boys on the other hand, were exposed to a wide variety of appropriate functional labour options, and shown to also incidentally be a husband and father (Ambert 1976, Ungerson 1983).
Thus how the different sexes interact with emotion and react from it is different, but these differences are not innate or physiological, but are instead a result of socialisation throughout life.

HEALTHCARE AS A GENDERED SYSTEM

In terms of the sex typing of occupations within the healthcare system, Zimmerman and Hill's (1999) text dissects how healthcare in itself is a patriarchal system and the medicalisation of illness is also gendered.
In this paper, a focus on the gendered professions of medicine and nursing will be explored as well as the power relations within this. Despite both professions of medicine and nursing being vital to health care provision, there still exists sex typing of both occupations. Despite approximately equal number of women and men entering medical school (Brewer Roskovensky, Grbic and Matthew 2012) there are still fewer women represented in consultancy positions (Connolly and Holdcroft 2006).
Nursing is seen to be an extension of the nurturing role women partake in within the family, and thus it is seen as a natural progression of the family institution of caregiving. This creates barriers for male caregivers as it is seen to be an effeminate role, which as explained above is seen to be less than desirable, whilst women not wanting to remain within this paradigm of occupational possibility face many barriers as well (Ungerson 1983, Zimmerman and Hill 1999).
Having said this, there is a growing body of evidence of the glass escalator experienced by male nurses as patriarchal values result in male nurses being more likely to gain promotion and management positions (Evans 1997). Nurses have traditionally always been women, and through their role as subordinates to doctors a gendered system of superiority has been maintained. That is, until the second half of the 20th century women were not admitted into medical school, and so nursing was the only option and had far less autonomy than nurses have today, with their main task being to support the doctors. According to Zimmerman and Hill (1999), the different skills and behavioural practices needed by each profession were more

appropriate to the different sexes as a result of early socialisation and experience. That is not to say that both men and women do not have an active choice, but rather that the system of healthcare, especially in the past, had made it easier for women to be nurses than doctors by way of flexible working hours and simultaneously attracted fewer men by the prospects of lower income where they would still be expected to support a family, as well as the social sacrifices they would make for partaking in an effeminate role (Zimmerman and Hill 1999).

The scope of this paper does not allow for a more full exploration of all the institutional barriers to men wishing to enter the nursing profession or reasons why women do not gain consultancy. This brief account does however, attempt to highlight that there are a myriad of interactions occurring from early childhood through to occupational choices and within occupational institutions, which render women more likely to be nurses than men, and some of this may be due to how children are emotionally socialised.

EMOTIONAL LABOUR AND NURSING EDUCATION

Smith's work in both the 1980s and the 2000s is littered with examples and inferences of nursing students and recruiters alike believing in the need for nursing students, and thus nurses, to have a 'natural' ability to talk to all sorts of people, to be able to show they care and be appropriate. If this comes 'naturally' to student nurses through a process of socialisation throughout their lives as suggested above, how is it taught and valued within the nursing curriculum and the profession itself? Smith (2012) found that the idea of being taught emotional intelligence, or communication skills was abhorrent to some students, who felt it would take from their individualised care style and lead to the creation of standardised nurses. However, other students indicated a lack of support and guidance with how to deal with difficult situations. Where there was support, similar to nursing education today, it may be provided through class discussion or end of placement debriefing but this was felt to be 'too little, too late' for some situations. Universities use different models in terms of contact with academic and placement staff for emotional support with varying degrees of support achieved (Smith 2012).

As well as this, Smith (2012) discusses a lack of education and guidance in the 1980s around more emotionally challenging issues such as a sudden death or respiratory emergency as a result of the training programme being within a biomedical model of nursing, with ideologies of the nursing process and activities of daily living not well conceptualised for education. More recently, though nursing education still does not use the nursing process concept as a framework it is achieved through the Essential Skills Clusters for Pre Registration Nursing Programmes, frameworks, and the Code of Conduct (Nursing and Midwifery Council 2007 and 2008, Smith 2012). Thus, care, compassion and communication should be integral throughout a nursing programme. However, according to Smith's 2012 research, this is not always the case as it relies on individual students, to an extent, seeking out support from mentors, charge nurses and liaison lecturers as well as personal tutors, senior personal tutors, and University wide services such as the Advice Centre or Counselling Support (Smith 2012). The responsibility of student's mental health being their own ensures they learn to develop coping strategies in order to not develop chronic emotional dissonance (Hochschild 1983) as emotional labour does not end with being a student but rather could be said to increase once qualified.

In conclusion, it seems that emotional intelligence is not directly taught in nursing programmes but rather guidance, support and coping strategies are available to students who seek it out; but obtaining the support when it is necessary is not always possible, easy or timely. It is seen to be crucial that nursing students have some skills of communication and caring to enter a training programme, and thus teaching it can be viewed as a 'fluffy' subject, or 'common sense' (Smith 2012) and this, alongside the need to teach the biomedical side of nursing results in a biomedical focus to nursing education today.

EMOTIONAL INTELLIGENCE IN NURSING TODAY

Emotional intelligence can be defined as

> *"The capacity to be aware of, control, and express one's emotions, and to handle interpersonal relationships judiciously and empathetically"*

(Oxford University Press 2013).

It is a current buzzword within nursing as the nursing profession is criticised again and again within the media for a lack of caring and empathy felt by patients and their families. This is of course a serious allegation, and along with the tragic inquests that have had to occur in the last few years it is certain that nurses are not being as caring and empathetic as they could be, or potentially as they previously were. However, this is not as simple as nurses deciding to no longer care, or being 'too posh to wash' but is in fact a symptom of the changing structures of labour division within the NHS and the resultant time constraints that nurses are under (House of Commons 2013). Thus, emotional intelligence is gaining greater respect and status as nurses with an ability to remain efficient and caring are being seen as a new commodity all over again. For example, nursing leaders such as Professor Serrant -Green and Dr Naraynasamy both discussed the importance of emotional intelligence and development of it through self reflection and regular assessment of self at the first National Junior Leadership Academy retreat in August 2013; whilst Smith (2012) discusses the importance of it when recruiting nursing students and Goleman (2004) discusses it in reference to business leaders.

Going back to Hochschisld's (1983) original work, she found that emotional labour eased the transactions which flight attendants were expected to carry out by ensuring customers felt calm and safe, and therefore more likely to comply with the instructions of the flight attendants. Thus, emotional labour and the development of skill here into emotional intelligence is crucial for the flight attendants' mental health and job satisfaction. This idea is commonly described by nurses or those in a caregiving role and was developed further by Theodosius into more than just presentational necessity, but instead as a crucial component for a nurse to carry out their job with skill (Ambert 1976, Theodosius 2008, Smith 2012). Theodosius' development on Hochschild's seminal work is vital to understanding the two - way nature of the nursing process, how this is summed up and crucial to emotional labour and how this fits with emotional intelligence; as described by Goleman as having a degree of "self - awareness, self - regulation, motivation, empathy, and social skill" (Goleman 2004).

EMOTIONAL INTELLIGENCE AS AN EDUCATION FRAMEWORK

Goleman's (2004) explanation of emotional intelligence and the ability of its components to be taught and developed can allow for the growth of a framework of development for nursing students as emotional intelligence is becoming more and more crucial to the nursing role. That is to say, in today's climate of government cuts and media criticism and possible scapegoating of nurses, tomorrow's nurses will have to be able to not just partake in emotional labour but be emotionally intelligent. Emotional intelligence, alongside the cognitive and technical skills which we can assume will be taught through the nursing programme, will be vital for nurses to be able to navigate the changes to our professional role. As well as allowing us to be politically smart to the changing nature of the healthcare system as a whole; and more importantly to be able to continue to give emotionally sensitive and empathetic care. As nursing leadership becomes ever more important, it is crucial we are able to rise to this challenge. A framework built into the programme, which uses the components of emotional intelligence, may 'de-fluff' the perception of such subjects as 'communication', which are felt to be 'too basic' by many nursing students (Smith 2012); who may consequently have less developed skills. As well as this, the development of such a framework which is used by many global businesses may encourage the male sex to develop their own skills of emotion and care giving without the perception of being effeminate and could enable nursing to become a less sex typed occupation. That is, by giving emotional labour and intelligence the status and attention it requires in a sturdy framework it may allow other professions, government and society at large to gain a greater understanding and respect of the emotional labour undertaken by nurses.

As Goleman (2004) advocates, emotional intelligence can be taught and can increase the success and quality of life of people, young and old, and thus with such a label as emotional intelligence perhaps the traditionally feminine skills of caring, kindness and empathy will not be shameful in young boys (Ambert 1976) but something to be applauded and encouraged in all

our children, just as creativity, curiosity and intelligence are now applauded in both girls and boys (Ambert 1976, Mackie 1987).

CONCLUSION

This paper has attempted to cover a wide scope of material and come to some conclusion as to the value of emotional intelligence, socialisation of children and the sex typing of occupations such as nursing; more information and research could have been presented for each different aspect had there been the opportunity. However, some conclusion of the importance of socialisation of children and how this is done in relation to each gender can be made as it may be leading to emotional expressiveness or lack thereof which gives evidence to a differences paradigm of the sexes. However, as Ryan and David (2003) show and Ambert's (1976) research can be extrapolated to show, both sexes have the aptitude for emotional expressiveness and intelligence, and thus socialisation could be the cause of the differences we see. In relation to the healthcare system and gender, and the sex typing of both medicine and nursing; we can perhaps tentatively say that this is beginning to change more and more. And again, we can turn back to emotional intelligence as a way for this to occur, as suggested by an emotional intelligence framework within educational programmes for nursing at least.

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