Pain and nurses’ emotion work in a paediatric clinic: Treatment procedures and nurse–child alignments

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Abstract

In the treatment of cancer in children, routine needle procedures have been reported to be one of the most feared elements, as more painful than the illness as such. This study draws on a video ethnography of routine needle procedure events, as part of fieldwork at a paediatric oncology clinic documenting everyday treatment negotiations between nurses and young children. On the basis of detailed transcriptions of verbal and nonverbal staff–child interaction, the analyses focus on ways in which pain and anxiety can be seen as phenomena that are partly contingent on nurses’ emotion work. The school-age children did not display fear. In the preschool group, though, pain and fear seemed to be phenomena that were greatly reduced through nurses’ emotion work. This study focuses on three preschoolers facing potentially painful treatment, showing how the nurses engaged in massive emotion work with the children, through online commentaries, interactive formats (delegation of tasks, consent sequences, collaborative ‘we’-formats), as well as solidarity-oriented moves (such as praise and endearment terms). Even a young toddler would handle the distress of needle procedures, when interacting with an inventive nurse who mobilized child participation through skilful emotion work.

Keywords: emotion work; intent participation; nurse–patient interaction; paediatrics; video ethnography

1. Introduction

In the treatment of cancer in children, routine needle procedures have been reported to be one of the most feared elements (Hedén 2012). Treatment procedures have, in fact, been reported to be more painful than the illness as such. This study draws on a video ethnography of routine needle procedure events, as part of a one-year fieldwork carried out at a paediatric oncology unit, and it documents everyday negotiations between children, medical staff and the children’s parents.

All children with leukaemia in the Nordic countries are treated according to the same standardized treatment protocol; needle procedures are always part of cancer treatment, as a large part of the medication requires intravenous administration. Routine needle procedures in the intravenous port for blood access (implanted subcutaneously on the child’s chest) are among the procedures seen as most distressing by children with cancer (Hedén 2012), particularly among the youngest children. In spite of the fact that an anaesthetic ointment is routinely applied on the chest of the child prior to injecting the needle, needle procedures at times cause fear, distress, discomfort and pain.

A topic that has received quite a lot of attention in academia lately is emotion, and a popular perspective within the sociology of emotions deals with how emotions are managed. In the 1980s, the sociologist Arlie Russell Hochschild (1979, 1983) developed a management approach to emotions, in which she maintained that emotions are socially constructed and that this is accomplished via norms or feeling rules. These norms and rules inform individuals about appropriate emotions in particular situations, and how they are to be managed.
Hochschild draws on empirical work on workplaces, including flight attendants in the US airline industry. Flight attendants do emotion work in which they make efforts ‘to seem to feel’ and to try to ‘really feel’ what is appropriate for the job, and they also try to induce appropriate feelings in others (Hochschild 1983). Flight attendants are trained to manage, for example, passengers’ anxiety and fear. In doing this they might be said to be ‘nicer than natural’ (Hochschild 1990: 118), orienting their emotion work to local feeling rules. As pointed out by Hochschild (1983), nursing as a profession calls for related emotion work, even if not all nurses engage in it. Hochschild has not herself applied such analyses to healthcare settings, but she has suggested that her framework would be interesting and feasible.

In line with some earlier studies in medical contexts (James 1992; Smith 1992; James and Gabe 1996; Bolton 2000; Hunter 2001; Miller et al. 2008; Theodosius 2008), this study therefore draws on Hochschild’s notion of emotion work. Many prior studies of emotion work in medical contexts have built on interviews, biographical data or critical discussions of medical routines. In contrast, this study draws on detailed analyses of social interaction. In line with language socialization studies (Schieffelin and Ochs 1986; Duranti et al. 2012) as well as discursive psychology (Potter 1996; Edwards 1997), this study primarily uncovers participants’ perspectives through what the participants themselves (in this case nurses and child patients) say and do, rather than through interviews or other types of self-reports. The focus is primarily on naturally-occurring events that have not been initiated by the researcher.

The present study extends prior research on emotion work in medical context (e.g. James 1992; Bolton 2000) in showing that the collaborative emotion work of hospital staff and parents is, apparently, an important factor behind patient compliance during painful treatment. A major aim of this study is to document in detail the many ways in which nurses engage in different types of emotion work; that is, in distracting and comforting young children in ways that will lessen or alleviate fear and distress.

2. Data

2.1. Medical setting and participants in video ethnography

The data for this study were taken from a larger project that was conducted by the author during sixteen months of fieldwork at a Swedish paediatric oncology unit.1 The corpus of data covers a total of 93 hours of video-recorded interactions of encounters between children and staff. Five children (and their families) were followed and documented during sixteen months of treatment. In all, 22 nurses were documented in their encounters with these children (and their parents/families).2 The children had all been diagnosed with acute lymphatic leukaemia, and at the outset of the study their ages were 2:4 years, 4:3 years and 4:9 years (in the preschool-age group) and 10:10 years and 16:10 years (in the school-age group). All video recordings were made during the children’s medical visits and hospitalization periods. The larger study documents daily routines: e.g. ‘greeting routines,’ ‘needle procedures’ and other encounters with medical staff members.

The fieldwork involved informal interviews (as part of everyday conversations with the children and their parents) and fieldnotes were taken throughout the fieldwork. However, it is the recorded sequences that constitute the most important data of a video ethnography (Ochs et al. 2006; Stivers 2007). In the present study, the target activity (and the analytical unit) is needle procedures and nurses’ emotion work in alleviating children’s pain and anxiety.

The oncology unit is a child-friendly environment, decorated in bright colours and with imaginative art work. The atmosphere was warm and caring, and staff members were quick and willing in providing assistance in keeping the patients active and happy (see Rindstedt and Aronsson 2012 for an extensive discussion).

2.2. Needle procedure as analytical unit

In this study, the analytical units are routine needle procedure events. In total, the video ethnography includes 42 events. However, it should be noted that the fieldwork involved a larger set of observations, in that not all needle procedures could be recorded. There were no recordings during the first weeks of fieldwork. Similarly, I would at times arrive in the middle of a needle procedure event or, on a few occasions, the technical conditions for filming were too complex.

When a child was at the hospital s/he was generally accompanied by a caregiver. Most of the time this was the mother, but the father and siblings were frequently present as well. Moreover, there would at times be several staff members present. This means that most of the recorded encounters were multiparty events. The participation frameworks of the needle procedure events can be seen in Table 1 below.
3. Findings

The analyses concern how the nurses secured patient participation, using emotion work in their interactions with the children. The analyses primarily focus on nurse–child interaction with the three youngest children (preschoolers), as these interactions were rich in emotion work on the part of the nurses. Anxiety and worry – in connection with routine needle procedures – was a problem for these younger children rather than for the school-age children.

It can be noted that the needle procedure took from anything between 1 to 16 minutes to administer, depending on the multiparty negotiations involved.

3.1. Children’s age and nurses’ emotion work

Two school-age children were documented during 22 routine needle procedures, interacting with 13 different nurses. The procedure took place quite quickly and seamlessly for both school-age children in their interactions with any of the nurses. However, Marcus, the youngest of the two school children, spontaneously once said ‘I hate this’ when referring to procedures of this kind, and also commented on the curious phenomenon that it would sometimes hurt a little, and sometimes not at all.

The nurses recurrently also secured the consent of these (older) children to needle procedures and other treatment events by explicitly asking for their consent or through nonverbal negotiations. The needle procedures would take place with a minimum of emotion work on the part of the nurses.

In contrast, the nurses’ interactions with the preschoolers involved substantial emotion work (Hochschild 1983). What was perhaps most important was that the staff members mobilized the children as active agents. This particular unit tried out various routines that were aimed at reducing patient pain in the face of the treatment event, involving letting the child assist in various ways: e.g. to hold on to equipment, to take off adhesive tape, to press injections or to engage in counting rituals. The hospital staff showed many signs of gentle support and a child-oriented attitude.

In brief, the staff would spare no efforts in securing the patients’ intent attention (on informal learning and intent participation, see Rogoff et al. 2003).

<table>
<thead>
<tr>
<th>Patient and age</th>
<th>Number of needle procedures recorded</th>
<th>Time in minutes; Range and average time (m*)</th>
<th>Nurses 22 nurses</th>
<th>Co-present parent(s), sibling(s) and other relatives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preschoolers</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ida 2:4 years</td>
<td>10</td>
<td>1.12–7.15 m=3.79</td>
<td>M &amp; S (9 times)</td>
<td>M = (1)</td>
</tr>
<tr>
<td>Rebecka 4:3 years</td>
<td>4</td>
<td>10.00–16.10 m=13.14</td>
<td>M &amp; F &amp; S (3 times)</td>
<td>M &amp; F (1)</td>
</tr>
<tr>
<td>Elinor 4:9 years</td>
<td>6</td>
<td>1.21–6.06 m=4.03</td>
<td>M &amp; F</td>
<td></td>
</tr>
<tr>
<td><strong>School-age group</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marcus 10:10 years</td>
<td>18</td>
<td>1.56–5.21 m=3.43</td>
<td>M &amp; F (6 times)</td>
<td>F (6)</td>
</tr>
<tr>
<td>Katarina 16:10 years</td>
<td>4</td>
<td>1.52–6.10 m=3.86</td>
<td>M (3 times)</td>
<td>No parent (1)</td>
</tr>
</tbody>
</table>

Note: The sequence is seen to start when the nurse puts on the protective apron (and sterile gloves) and it ends when the needle is inserted. On a few occasions when the nurse already had an apron on, the sequence is measured from the moment s/he announced: ‘here we come’ or the like.
Moreover, they would engage in small talk, oriented to the young patient's interest sphere.

In what follows I offer documentations of needle procedure events, starting with nurse–child interaction, involving a young girl who was almost as relaxed as the school children. Elinor displayed no fear; her father called her 'Stoneface'. But much like in similar events with school children, the nurses would engage in online commentaries, explaining to their young patient what was going on. After that, the needle procedures with the youngest preschooler, Ida, aged 2:4 years, document varied emotion work on the nurses' part. Lastly, there will be an illustrative documentation of parent–child negotiations with a child who often showed fear (which was rare among the others).

As will be seen in all three examples below, the children are at the centre of attention, and they are made to feel special. The excerpts are chosen in order to illuminate and analyse an array of interactional strategies deployed by the nurses.

3.2. Online commentaries and consent (Elinor)

In line with sociocultural theorizing, children learn by actively observing and listening-in on ongoing activities (Rogoff et al. 2003). Children keenly observe and listen in anticipation of their collaborative participation in a shared endeavour. Such intent participation is a key feature of informal learning situations where more experienced people guide and facilitate the learner to become involved and often participate alongside the learner (Rogoff et al. 2003). In many ways, one of the children (Elinor) recurrently positioned herself as an eager learner, who participated intently in everything that went on in the unit and the examination room, fixing her gaze on the nurse and on the equipment.

At the outset of Excerpt 1 (below; see Appendix for transcription conventions), this child ran forward into the examination room, happily mounting the chair. The nurse then jokingly told her that the infusion pump was 'calling for them,' demanding their attention, and the child giggled. Throughout this episode, Elinor was looking at the nurse and the equipment with intense interest. She was thus highly active in her own treatment, but it can also be seen that the nurse recurrently mobilizes her attention and sustained interest by talking about what is going on and what will happen. In the form of what Heritage and Stivers (1999) have called online commentaries, the nurse indirectly invites her as a team member.

**Excerpt 1a**  Child (Elinor 5:7 years), Mother, Father and Nurse Eva

Seating: Elinor is seated on a chair.

1  Nurse → Then let’s see about this then. ((puts on the cloth)) Ops!

2  Nurse → now it slid off but it’s okay anyway. There! There’s a lot of armchair support

3  Nurse → here. Should you have it like this?

4  Child → Uhm

5  Nurse → Is that okay?

6  Father → There.

7  Nurse → Then we’ll wash it.

8  Child → With cold alcohol ((in smiley voice))

9  Nurse → Precisely.

10  Mother → With cold alcohol- it was-

11  Nurse → It’s actually as warm as the room but it sure feels cold.

12  Father → Uhm

13  Nurse → As (.) your body is warmer. And that loudmouth then what should we do about it?

14  Mother → Yes. He does not give up.

15  Child → To say quiet!

16  Nurse → He does not exactly give up. ((laughs))

17  Child → Say quiet! ((smiling broadly))

18  Nurse → Should we tell him to be quiet. He thinks that I should care about him that’s what I think he says.

... ((Child, mother and nurse affirm what was just said))

As can be seen, the nurse recurrently secures the consent of the young patient (turns 1 and 5), who responds affirmatively. The child's compliance is thus an interactional affair.

Through a series of online commentaries (e.g. turns 1, 7, 11, 13, 16 and 18), the nurse comments on what is going on, indirectly making the child part of the action. One aspect of the nurse's emotion work is her joking with her patient. The nurse talks about the infusion pump as a 'loudmouth' (turns 13–18). The child happily catches on and suggests that they should tell it to be quiet (turn 18). The nurse aligns to this joking response, and suggests that the machine is really making noise in order to get attention. The child smiles happily, enjoying their joint joke.
The nurse talked to the child more or less continuously, deploying online commentaries and making a series of comments about what was going on during the needle procedure. These online commentaries seem to serve several functions: they inform the patient about what is coming up, they explain the procedure, and serve as prefaces to the soliciting of consent. Moreover, they can be seen as part of emotion management in that they may work as distracting elements, making the patient attend to technical aspects, rather than to pain or psychological aspects. As can be seen, some of the online commentaries are combined with collaborative 'we'-forms (Brown and Levinson 1987), as well as joking formats (cf. Aronsson and Rundström 1989) as the nurse explains medical phenomena.

Children at times experience the cold liquid as somewhat unpleasant. Evidently, knowledge about the procedure may partly reduce any such discomfort. In this episode, the nurse builds on her patient's intent participation (Rogoff et al. 2003) and explains why alcohol feels cold (turn 13). The child thus acquires more knowledge about clinical facts. What can be noted, though, is that this knowledge is embedded in a series of online commentaries as part of an intimate partnership, where the nurse orients to what the patient already knows and takes an interest in.

Ultimately, father and nurse jointly ask for Elinor's permission to proceed with the treatment procedure (turns 28–29).

Excerpt 1b

28 Father Are you with us Ellie?
29 Nurse → Yes. Should we count or?
30 Child No-o ((stretches throat to expose chest))
31 Nurse → Just squeeze it.
32 Child ((nods))
33 Nurse → Then we’ll do that. ((inserts needle))
34 Mother You’re brave my girl.
35 Nurse → There!
36 Child ((does not grimace))
37 Father Stoneface ((uses English gloss))

One way of making children participate is for the nurse to initiate a countdown before the needle is inserted. But Elinor does not see any need to do this. Instead, she stretches her throat, making it easier for the nurse to reach the intravenous port, and nods affirmatively, offering her consent, when the nurse asks if she may ‘just squeeze it’ (turn 31).

The nurse ultimately says ‘there!’ confirming that it is all over (turn 35). In several of the present needle procedures, staff members give out ‘there!’ as a little response cry (Goffman 1981), confirming that a potentially painful (and fearful) event is all over. Her final ‘there!’ serves as a time framing of the event: both patient and other co-participants then know that the potentially painful part is over. There are several instances where the young patients themselves are the first ones to blurt out ‘there!’ Apparently, one of the comforting routines of this event is to establish intersubjectively that trouble is all over.

Above (as in Excerpt 1a) it can be seen that nurses tend to time-frame routine needle procedures, pointing out to the patients when an event is to start, and when it is all over. It can be seen that Nurse Eva step by step establishes the time frames of the needle procedure: announcing (1) when it is to start, (2) checking if that is okay for the patient, and (3) announcing when it is all over. An important part of patient partnership apparently has to do with such joint coordination of treatment time plans.

3.3. Involving the child in decisions (Ida)

In their work on paediatric consultations, Tannen and Wallat (1987) have discussed doctors’ use of registers: e.g. a reporting register for speaking to colleagues, a conventional conversational register for addressing parents, and a motherese style register for addressing the target child. The motherese style – when speaking to the child patient – was identified by out-drawn vowels, slower tempo, short sentences, exaggerated shifts in pitch and marked prosody. In the present data, nurses and doctors recurrently shifted between different registers/styles. Thereby they would also clarify who they were addressing: child, parent or a colleague. Such disambiguation may be quite necessary in a medical context, marked by polite indirectness (Aronsson and Rundström 1989; Strong 2001).

In our data, a caretaker style was similarly employed by the nurses as ways of shifting between talking with the parents and talking with the children. I will demonstrate below the ways in which the nurse engaged Ida in various joint activities. This means that Ida was engaged as an active party in her own treatment.

In spite of her young age (2:7 years), Ida could take the distress and fear of needle procedures when interacting with an inventive nurse. Initially, the nurse ‘laid the table’ (with plastic gloves and medical equipment) publicly, almost as at a party, and she thereby created...
interest and a pleasant ambiance. The hospital room then contained no secrets; everything was visible and within the child’s own view. The child intently looked at the nurse and at the ‘party table’ where the nurse and the child created a shared focus, as they were both orienting to the medical equipment (see Goodwin 2006 on the coordination of shared attention).

The nurse engaged in substantial emotion work, mobilizing the child as an active participant. The nurse recognized the need to talk to, listen to, and entertain the child, and she actually managed to induce calmness in a situation where the child otherwise might have shown negative emotions.

**Excerpt 2a**

_Child (Ida 2:7 years), Mother, Brother and Nurse Anna_

**Seating:** Child sits on her mother’s lap.

1 Nurse → “You’ll soon have a ride to the roof Mom and you!” Now things get going. *(laughing voice; she refers to the lift mechanism of the examination chair)*

2 Mother Yes.

3 Nurse → “May I scratch away the plaster?”

4 Child Yeah.

In her initial turn, the nurse playfully presents the treatment event as something of a fun ride, a pleasant invitation as it were: ‘You’ll soon have a ride to the roof Mom and you!’ *(turn 1).* Moreover, she addresses this toddler, Ida, in a nursery room register, speaking in an articulated but warm register *(cf. Tannen and Wallat 1987 on different registers)*. The child is also invited to offer her consent to what is happening. It can also be seen that she secures Ida’s consent to remove the plaster *(turn 3)*. Throughout this episode, Ida listens intently, and when the nurse politely asks if she may take away the plaster, she hesitates just a little but still offers her permission *(turn 4)*. A patient–nurse partnership *(cf. Hydén and Baggens 2004)* is thus achieved.

As in our prior example, this nurse also continuously tells the child what she is doing and what she is going to do next in the form of online commentaries *(Heritage and Stivers 1999)*. Thereby the nurse and the child are able to share an implicit agreement about what the nurse is doing. The nurse keeps on talking continuously, and recurrently uses ‘we’-forms, which seems to create a shared orientation to the task at hand and a sense of participation, i.e. creating a medical team with Ida.

**Excerpt 2b**

<table>
<thead>
<tr>
<th>36 Nurse</th>
<th>→ “Now let’s see my little buddy (*) Some bed cover? There that’s where we’ll put it. Is that okay?”</th>
</tr>
</thead>
<tbody>
<tr>
<td>37 Child</td>
<td>→ Uhm.</td>
</tr>
<tr>
<td>38 Nurse</td>
<td>→ “Well yes! And then we’ll wash! I will not wash your mouth! No (*) Oh how nice!” <em>(wash with dressing)</em></td>
</tr>
<tr>
<td>39 Mother</td>
<td>Is it the sutures that are blue there?</td>
</tr>
<tr>
<td>40 Nurse</td>
<td>Yes you see. I just wondered why they haven’t (<em>) they had perhaps got entangled. It seems like they haven’t quite-</em></td>
</tr>
<tr>
<td>41 Mother</td>
<td><em>Resorbed.</em></td>
</tr>
<tr>
<td>42 Nurse</td>
<td>No exactly. “There! Now it got clean and nice (*) There! And then we’ll put it there. And then I’ll hold on and then it’s pricked and then it’s all done. You’re just super brave!”=</td>
</tr>
<tr>
<td>43 Child</td>
<td>=Auh <em>(brief sound of complaint)</em></td>
</tr>
<tr>
<td>44 Mother</td>
<td>The little butterfly that will help us. <em>(referring to needle)</em> Yes (*) And look how nice it got!</td>
</tr>
<tr>
<td>45 Child</td>
<td>Yes.=</td>
</tr>
<tr>
<td>46 Nurse</td>
<td>→ =You know what! Now we’ll put on a plaster right? Should we have a plaster there?=</td>
</tr>
<tr>
<td>47 Child</td>
<td>=Ahu</td>
</tr>
<tr>
<td>48 Nurse</td>
<td>→ Yes so that it will stick. “You’re just so brave”=</td>
</tr>
</tbody>
</table>

The nurse addresses the child with an endearment term *(deploying an inclusive ‘we’-construction ‘let’s’), invoking a patient-partnership orientation or teamwork format *(cf. Brown and Levinson 1987)*. Throughout this sequence, it can be seen that the nurse produces online commentaries explaining what is going on. She recurrently also secures Ida’s permission to go ahead *(e.g. turns 36 and 46)*. Ida listens, looking intently at the nurse and granting her permission to go ahead.

The nurse also engages in a joking exchange about not washing Ida’s mouth. Without much ado, she then inserts the needle *(turn 42): ‘There! Now it got clean and nice (*) There! And then we’ll put it there. And then I’ll hold on and then it’s pricked and it’s all done. You’re just super brave!’* As can be seen, she again offers online commentaries about the procedures. Finally *(turn 48)*, she praises Ida for being super brave.
Praise is common in these treatment procedures (see also parental moves; e.g. Examples 1 and 3), especially in the case of very young patients, like this child. Moreover, she engages in joking. Several researchers (Tannen and Wallat 1987; Aronsson and Rundström 1989; Stivers 2007) have discussed the ways in which doctors and other hospital staff recurrently engage in joking exchanges with their patients.

In many ways, the patient is made to feel special. This is an important part of the nurse’s emotion work. Both the nurse (turn 36 ‘bed cover’ for barrier) and the mother (‘little butterfly’ for needle) can be seen to deploy child-oriented hospital jargon. Moreover, the nurse recurrently makes solidarity-oriented moves, deploying a collaborative ‘we’-format (turns 36, 38, 42 and 46; cf. Brown and Levinson 1987).

In a sense Ida is indeed ‘super brave’. Yet, it should be pointed out that her bravery is, in many ways, the joint achievement of herself, the nurse and Ida’s mother. It is through their emotion work that they jointly manage to solicit and sustain her attention to other matters than the medical treatment. In this entire episode, there are no signs of fear. To some extent, this is probably a result of the nurse’s emotion work. In particular, the nurse engages in a series of communicative actions that may support Ida and alleviate any fear: online commentaries, praise, and small talk.

As can be seen, the nurses, in this episode and in Excerpt 1a, both engage in something of a performance. According to Bauman and Briggs (1990), performance (the enactment of the poetic function) is a very reflexive mode of communication, an especially marked, artful way of speaking. By informing, distracting, comforting, and entertaining young patients, the nurses both engage in emotion work and in artful performances.

3.4. Praise and extended negotiations (Rebecka)

A major objective of the final example (Excerpt 3) is to reveal an ideological dilemma (Billig et al. 1988) when securing reluctant children’s consent to painful treatment, in that conflicting professional ideals clash. On the one hand, there exists a democratic intention: the nurse wants to get the child’s approval to carry out a procedure; but on the other hand, the negotiations may prolong the treatment session and anxiety for the child. The nurse wants the procedure to take place as quickly as possible in order not to let the young patient become fearful. Medical staff members are likely to orient themselves to these opposing positions, and a major aim of the present study is to explore ways in which this is done.

Children vary in the extent to which they are fearful of treatment procedures. Another dilemma concerns who should take over during a crisis when there are several adults present: the parents or the nurse? The parents know the child better, but they are also perhaps more emotionally involved.

Out of all (42) recorded needle procedure events, there were only three events that involved a child displaying acute fear and distress. These cases all involved one child, Rebecka. During the fieldwork, she would gradually get into a state of panic on several occasions, regardless of which nurse administered the treatment. On average, the needle procedure took more than three times as long for her as for any of the other children. Moreover, her most extended episode took eight times as long as the briefest episodes of any of the other children. The child displayed fear and anxiety in her interaction with any nurse, and a lot of emotion work was invested in making her consent to the procedure.

For an extended period in the present episode, Rebecka did not consent to accept the routine needle procedure, and she creatively constructed a series of reasons for postponing the needle procedure: (1) she had to pee; (2) she had to drink something; (3) she had to do poo-poo; and (4) she first had to say something. Successively, she simultaneously got more and more upset as time passed on, escalating from mild fear to panic and agony.

Excerpt 3

Child (Rebecka 4:9 years), Mother, Father and Nurse Ingrid

1 Child I don’t want to. ((tearful voice; returning from toilet visit))
2 Mother Listen! Come here now and check it out! Let’s do it a little quickly so that we-
3 Child But I’m not a bit brave. ((crying voice; places herself in mother’s lap))
4 Mother You are brave.
5 Nurse You’re super brave Rebecka.
6 Mother Now we sit like this so that you could lean down instead.
7 Child No I don’t want to lie: down!= ((crying voice))
8 Mother =Well but we’ve got to now.=
9 Child =Sit sit sit! NO SIT!=
10 Mother =But then can not. But Rebecka! IT’S THEN THAT THINGS MAY GO WRONG. LET’S SIT LIKE THIS! But it’s then things may go wrong.
Camilla Rindstedt

Patient partnership means that even young patients are allowed to express their wishes (Alderson 2007). Rebecka is an active patient, who uses her rights to have a say in her treatment. She has by now left her bed three times, postponing the treatment procedure. Yet, she first issues a series of general protests against the projected treatment procedure (turns 1 and 3). She claims that she is not brave, but is opposed first by the mother and then the nurse, who claim that she is indeed brave, engaging in some joint emotion work, where the nurse in fact upgrades the mother’s ‘brave’ to ‘super brave’ (turn 4).

In fact, Rebecka is also brave in her protests, using her partnership status as a way of bargaining for time. She speaks in a tearful voice, but she does not run away (again), and she is willing to face the treatment procedure. Moreover, she is very distressed at the prospect of reclining, and engages in a series of protests against leaning back, arguing that she should instead be seated (turns 7, 9 and 11). She rhetorically repeats her question in a tearful voice. She is evidently full of apprehension, and the reclining position might make her feel imprisoned.

At the outset of this sequence, Rebecka’s agency is somewhat restricted. She has but very little control in this situation, and although the adults are benevolent, they are bigger and stronger. She is nested into her mother’s lap, and her father is already gently holding on to her. The nurse has also already set the scene for the upcoming feared event. She speaks gently, and has promised to be ‘careful’, engaging in comforting emotion work, but the needle as such speaks a language of its own.

Rebecka is probably aware of the fact that the needle insertion is non-negotiable. In the end, she has to accept it. The notion of partnership implies some kind of symmetry that is not really part of the present situation. The one deal that this young patient would like to make, ‘If you do not insert the needle, I will not cry’, is already ruled out and her remaining agency has to do with time bargaining. The adults do offer her more time (to drink water, to go to the toilet etc.).

In this sequence, Rebecka’s parents attempt to make her accept the upcoming insertion. The mother encourages her, telling her that things are better this time, and the father praises her (turn 35). Yet, Rebecka makes a third try at bargaining with the nurse: ‘But listen Ingrid! If you prick-’ (turn 36). The nurse does not argue with her. Instead, the mother again intervenes, telling her firmly on the recording: ‘Now you’ll have to be quiet!’ (turn 37). At this point, the nurse finally inserts the needle, and Rebecka yells at the top of her lungs.

All through this episode, her parents were very supportive, as was the nurse, engaging in emotion work, praising her (turns 4–5), persuading her, and comforting her. In contrast to the other two cases of needle procedure (Examples 1 and 2) though, the negotiations lasted three times longer, and there were not many signs of nurse–child alignment. The parents were much more active than the parents in the other two cases, perhaps compensating for their child’s fear of treatment, but, on a speculative note, their high level of involvement may of course in turn have led to there being less nurse–child alignment. As in some other encounters observed, the most extended procedures tended to involve extensive parent–child negotiations. In the present data, the parents tended to adopt much the same strategies as the nurses, but they were somewhat more prone to engage in negotiations or praise than the nurses. Conversely, the nurses engaged in more online commentaries and interactive strategies.

4. Concluding discussion

It is almost impossible for a young child to truly understand the long-term importance of undergoing cancer treatment. Much of a very young patient’s compliance therefore draws either on the child patient’s wish to please parents and hospital staff or on his/her respect for the ulterior wisdom of the adults concerned. Emotion work and adult–child alignments therefore become important aspects of treatment procedures.
This paper has documented child–patient negotiations about routine needle procedures in a paediatric context, analysing the ways in which pain and other emotions are closely linked to negotiations between nurses and children during treatment. It can be seen that various ways of interacting with young children during needle procedures might alleviate fear and distress. The nurses’ emotion work with the children seems to be an important feature.

The nurses do a good deal of emotion work when interacting with and creating the right type of ambience for the young patients. In the present data, the nurses’ work does indeed seem to make a difference, and as has been pointed out by Smith (1992: 145), ‘the skill lies in the nurse who is able to recognise that emotional labour is needed and may be required in different forms for different patients.’

Online commentaries (Heritage and Stivers 1999) were important resources for the nurses when engaging themselves in intensive interactions with the young patients. Through online commentaries, jokes, and other distracting events, the child was distracted from feeling fear, discomfort and pain. Simultaneously, online commentaries could be seen as another type of emotion work in that the children were informed in ways that would resemble those of close team members. Care was taken to be open about all routine procedures.

Solidarity-oriented types of emotion work (e.g. endearment terms, encouragement and praise) were also part of the nurses’ emotion work in securing nurse–patient alliances. But, as has been seen, emotion work involves more than praise or a child-oriented register (Tannen and Wallat 1987). What is perhaps most important is nurses’ ways of soliciting and securing the children’s active participation (securing consent, mobilizing collaborative action). Online commentaries form an important part of this work.

We have also seen examples of the importance of entertainment and performance when the nurses interact with their young patients, communicating quite artfully while managing to secure the young patients’ trust (consent) and collaboration.

In the case of young patients, painful procedures may call for a great deal of conversational artfulness, in that the nurse has to establish a temporary working alliance, taking the perspective of the child. Experience with young patients is probably of great importance, but ultimately it is the case that some staff members develop artistry in establishing patient partnership. This study extends prior work on emotion work in medical contexts in documenting the importance of interactive formats and online commentaries. Solidarity-oriented moves (such as praise, endearment terms) are still part of nurses’ emotion work, but, as has been shown, they do not perhaps constitute the most important, or at least are not the only, resources available in the emotional management of child patients.

In the most striking cases, the competent nurse is not only medically skilled, but also a warm caretaker:

<table>
<thead>
<tr>
<th>Resources in aligning with child</th>
<th>Performance (entertaining and distracting child)</th>
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</thead>
<tbody>
<tr>
<td><strong>Online commentaries</strong></td>
<td>Distracting actions</td>
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<tr>
<td>Interactive formats</td>
<td></td>
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<tr>
<td>Mobilizing child in decisions (securing consent)</td>
<td>Child-oriented register</td>
</tr>
<tr>
<td>Mobilizing child in medical action (e.g. taking off plaster etc.)</td>
<td></td>
</tr>
<tr>
<td>Mobilizing child in other collaborative actions (e.g. countdowns before procedure)</td>
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<tr>
<td>Small talk with child</td>
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<tr>
<td>Collaborative ‘we’-form (positioning the child as team-member)</td>
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<tr>
<td>Solidary-oriented formats</td>
<td>Offering gifts</td>
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<tr>
<td>Praise</td>
<td></td>
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<tr>
<td>Endearment terms</td>
<td>Joking mode</td>
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<tr>
<td>Reducing physical distance (e.g. sitting down at child’s level)</td>
<td>Playful talk about treatment/playful presentations of medical artefacts</td>
</tr>
</tbody>
</table>
comforting, entertaining, engaging in extensive emotion work, and leading the child along in ways that reduce or rule out patient worries. It can thus be seen that performance is an important element in nurse–child alignments, which means that the theorizing of emotion management (Hochschild 1979, 1990, 2009) may be extended to take this into account.

Appendix

Conventions of transcription

- interrupted word/utterance
= immediate latching to prior turn
CAPS high amplitude
(): extended sound
(): enclose nonverbal communication, contextual information
" " enclose talk spoken in a marked voice: here, caretaker register
(.) micropause
" " enclose quiet speech
- interrupted word/utterance

Notes

1. For ethical reasons, the name of the university hospital is disguised, as are the names of all participants. The project was approved by the ethics committee at the target university. All families approached agreed to participate in the study. All children were given age-appropriate information and the school children (and parents) provided both oral and written consent.

2. The children also met doctors, play therapists and other staff members, and obviously parents play an important role in alleviating/moderating children’s pain and anxiety, but this article is focused on the emotion work of nurses.

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References


Pain and nurses’ emotion work


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