CHAPTER II

LITERATURE REVIEW: THE CONCEPT OF EMOTIONAL LABOUR

This chapter explores the concept of emotional labour by reviewing selected important papers ranging from 1996 to 2014. This review gives us an idea about the construct and its other characteristics. The conceptualization of the term “emotional labour” goes back to almost thirty years when Arlie Russel Hochschild explored and studied emotional labour among flight attendants in 1983. Her study of flight attendants was taken forward by other researchers and it eventually became evident how emotion management is being repetitively used by organisations in a “service producing society.” In this sense, “commercial love” is now becoming a part of many service jobs which involves a face to face interaction with customers. Hochschild used the term “feeling rules” to describe societal norms about the appropriate type and amount of feeling that should be experienced in such kind of situation. Emotional labour is Hochschild’s term for this process which moves from “the private realm to the public world of work”. She defined emotional labour as a “management of feeling to create a publicly observable facial and bodily display; it is sold for a wage and therefore has an exchange value”

Expanding on this idea, Ashforth and Humphrey (1993) in their paper “Emotional labour in service role: The influence of Identity” have focused their definition of emotional labour on the genuine behaviours performed during a service interaction. They defined emotional labour as the “act of expressing expected emotions during service interactions.” Similar to Hochschild’s (1983) work, these researchers stated that emotional labour can be considered as a kind of impression management in which employees attempt to reveal a certain perceptions of themselves to others. Emotional labour may support task effectiveness and self-expression
during working hours, but it also may lead to unrealistic customer expectations that cannot be met and may lead the employees to experience emotive dissonance and self-alienation. They claimed that this type of labour could be performed via surface acting and deep acting. Deep acting demands the individual to modify feelings to match the required displays whereas surface acting demands the individual to modify their expressions without altering the inner feelings. The understanding of this definition is very important for our present study where it has been hypothesized that nurses perform surface acting and deep acting as a part of their jobs.

Thereafter, it was found that conceptualizing emotional labour as surface acting and deep acting has roots in an established theoretical model of emotion regulation (Gross, 1998a, 1998b). According to this model, emotion regulation is defined as “the processes by which individuals influence which emotions they have, when they have them, and how they practice and express these emotions” (Gross, 1998b). A model of emotion regulation was proposed, in which emotional indication or stimulus from the environment preceded an individual’s emotional response tendencies which included behavioural, experiential, and physiological responses (Gross, 1998a). In addition, these emotional response tendencies may be modified or regulated, which determines the final emotional responses and expressions. Therefore emotions may be regulated either at the input from the environment (antecedent-focused emotion regulation) or at the output after emotion response tendencies have been triggered (response focused emotion regulation). Later on it was argued that these two types of emotion regulation corresponded to deep acting and surface acting, respectively.(Grandey 2000)

2.1 Emotional Labour in workplace
Grandey (2000) proposed an integrative model of emotional labour from the works of Hochschild (1983), Morris and Feldman (1996), and Ashforth and Humphrey (1993) in her paper. Taking cues from these studies, she argued that the characteristics of the job e.g., frequency, duration, variety (Morris and Feldman’s definition of emotional labour), can serve more appropriately as antecedents of emotional labour. Additionally, observable expressions of emotions, (Ashforth and Humphrey’s 1993 definition), are more likely to be achievable goals of emotional labour (measured as part of performance) with gaining loyal customers. The model of emotional labour also includes situational, individual, and organizational factors influencing emotional labour, as well as long-term consequences of emotional labour. Situational antecedents of emotional labour include interaction expectations (consisting of the frequency, duration, and variety of interactions, as well as the display rules) and emotional events (positive and negative events). Individual difference antecedents include gender, emotional expressivity, emotional intelligence, and affectivity. Organizational factors include job autonomy, supervisor support, and co-worker support. She had identified burnout, job satisfaction, job performance, and withdrawal behaviour as consequences of emotional labour.

The primary contribution of Grandey’s model is that she pointed out the importance of surface acting and deep acting in the emotional labour process. There are two main advantages of defining emotional labour in terms of surface acting and deep acting. First, by focusing on surface acting and deep acting as two distinct methods for performing emotional labour, it is possible for emotional labour to have both positive and negative outcomes. For instance, surface acting may be negatively related to job satisfaction due to the dissonance that individuals may experience, whereas deep acting may be positively related to job satisfaction because those individuals may feel a need of personal accomplishment in effectively displaying the become
cautious in getting too emotionally involved with patients to avoid burnout. Therefore, it may be advantageous for them to be trained to surface act in order to remain detached. This conceptualization of emotional labour helped a lot to take the current study forward in the context of nurses.

2.2 Emotional Labour in Nurses.

This section reviews the key papers in the area of emotional labour where the influence of the concept has been studied on nurses.

Sue Phillips (1996) tried to present a sociological analysis of health care. The author opined that, emotional labour has always been an important topic of debate in nursing because of its “perceived importance to those involved in the delivery of health care and to those patients who receive that care”. Secondly, it is very obvious that emotional labour has consequences for nurses and for patients in the workplace and in wider society. Finally, the discussion on emotional labour revealed a tension between the generally accepted theoretical move towards holism in health care and the practical reality of applying holistic health care. This further gave way to the research done in the upcoming years in the same context.

Bolton (2000) recognized the emotional elements of the nursing labour process and picked up the cue for research in this paper. Researchers had already said that nurses’ ‘emotional labour’ is hard and productive work and should be valued in the same way as physical or technical labour. However, the term had failed to conceptualize the instances when nurses “not only work hard on their emotions in order to present the detached face of a professional care taker, but also offers authentic caring behaviour to patients in their care.” Hence the author suggested that in addition
to emotional labour, emotion work too should be studied. Data was collected from a group of gynaecology nurses working in an English National Health Service (NHS) Trust hospital. The nurses in this study described their work as full of emotion and therefore it could be said that this particular group of nurses represented a distinct example. Although, based on this, it is not possible to generalize the results; the research presented in this paper does highlight the importance of emotional complexity of the nursing labour process.

**Angela Henderson (2001)** had earlier conducted a research study entitled ‘Nurses’ social construction of self: Implications for work with abused women’. In the current paper, she tried to elaborate on the findings of the previous study. One of the most consistent themes arising from the previous study involved nurses’ opinion and analysis of the relevance of emotional engagement/detachment in their practice. For nurses, the high degree of satisfaction in the emotional rewards of their work with patients is contrasted with their dissatisfaction in relation to nursing education and their views of the lack of valuing of work by others within the healthcare system. Nurses have often complained that they hardly receive any kind of support in the workplace. Thus the paper tries to explore the importance of supporting them in relation to the emotional aspects of their work. The other feature of the paper focuses on how individuals manage the emotions of other people. Here, several techniques of interpersonal emotion-management have been discussed, the cue of which has been drawn from observations of a psychodrama-based encounter group which deliberately manipulated its members’ feelings. Analysis revealed that a number of strategies (e.g., group enactments, provocations, comforting) which, when used in sequence, produced first emotional loss of control in the individual and then gave rise to positive emotion. Group harmony was sometimes affected by these interpersonal emotion-management techniques both positively and negatively. Some techniques
may be similar to those used in military training and cult group recruitment, although further research attention is needed in these arenas. This research thus hinted towards the importance of including variables like emotional intelligence in the EL research.

Andrew McVicar (2003) had studied the concept of stress in nurses. He had proposed that stress perception is highly subjective which had been supported by literature. This may result in some kind of variation between nurses in their identification of sources of stress, especially when the workplace and roles of nurses continuously keeps changing. Similar evidence had been found to occur among nurses in the United Kingdom health service. To identify and categorize nurses’ perceptions of workplace stress, a thorough literature search was conducted from January 1985 to April 2003 using the key words nursing, stress, distress, stress management, job satisfaction, staff turnover and coping to identify research on sources of stress in adult and child care nursing. Views of practitioners documented in the (post-1997) United Kingdom Department of Health literature was also checked. It was found out that workload, leadership/management style, professional conflict and emotional cost of caring had been the main sources of distress for nurses for many years, although there is varying opinion on the magnitude of their impact. This paper also reviewed the propositions of the subjective aspects of the perception of stress for nurses who, with teachers and managers, are a professional group most likely to report very high levels of workplace stress (Smith et al. 2000). Differences in Pay and different shift work schedules seem to be becoming more prominent as major sources of distress for nurses, to the extent that they are displacing other sources. Lack of reward is an increasing source of frustration (Ball et al. 2002) and contributes to role disengagement, a component of burnout (Demerouti et al. 2000,p no 456). There remains a discrepancy of pay for newly qualified nurses when
compared with that for police officers and teachers, two professional groups traditionally compared with nurses (Duffin 2001, p no 12; Holyoake et al. 2002, p no 24), and nurses are especially upset with governmental failure to address the issue of salaries (RCN 2002). Furthermore, the authors found out that, proposals to remove clinical grades and to link pay to competency indicators through the ‘Agenda for Change’ programme (Department of Health 1999) did not help to reduce anxieties over levels of pay (MacKenzie 2002, p no 24). Shift working, particularly night shifts, traditionally attracts pay augmentation but also is shown to have a significant negative effect on personal and social life. Prolonged shift work also has a health risk as it produces symptoms that correspond closely to those of mild or moderate distress (Efinger et al. 1995, p no 309). Supporting the nurses thus becomes very important. On the other hand, stress intervention measures should centre on prevention of stress for individuals. To achieve this, new tools would be required to assess the intensity of individual distress. The authors found out that an individual’s stress threshold, sometimes referred to as stress ‘hardiness’, is usually dependent on the characteristics, experiences and coping mechanisms of the person, and also on the organizational circumstances under which demands are being made. Evaluating stress is thus very tricky in an occupation as varied and difficult as health care, yet the effectiveness of organizational involvement to reduce or eliminate sources of stress will be very useful for nurses.

Mitchell and Smith (2003) in their article explored the nurses who worked in the learning disability department by trying to find evidence for their emotional labour. This paper offered insights into both the “methodological and political issues connected to emotional labour in nursing” and explored other issues. Specifically the paper addresses the progress of learning in nurses and the way in which its role is defined in terms of emotional labour. Detailed material
from textbooks, proceedings of curricular development meetings and GNC inspectors' reports were scrutinized. It was suggested that emotional labour provided a shared experience between different branches of nursing expanded over different periods of time. Such “shared experience” is particularly helpful to nurses of the learning disability department. It was further suggested that emotional labour as a concept should be used to help in understanding the nature of work of the nurses who redefine the rules and nature of their job.

**de Castro (2004)** in his paper proposed that the occupational experience of workers in service-oriented jobs can have profound effects on their health and well being, such as burnout and job dissatisfaction. The growing service economy and resultant proliferation of service-oriented jobs in current times and in the future must be acknowledged and investigated. The move from an economy driven by manufacturing industries to one dominated by service industries has taken place and currently prevails in the United States. In recognizing this shift in the "work" experience of the American work force, the changing nature of work related hazards must also be considered. Emotional labor has come to be known as an appreciable aspect of work involving direct interactions with clients and customers that can lead to adverse psychosocial outcomes. These relationships revealed the potential unpleasantness of service employment in which the performance of emotional labor is unavoidable. Although worker attributes can influence the emotional experience on the job, emotional labor is also likely to threaten the well being of workers through significantly high demands to express organizationally desired emotions and low control over what emotions can be felt and displayed. Recognition and investigation of emotional labor is necessary to understand its effects on worker populations. Conceptual models featuring emotional labor are available to guide research. However, discrimination among them based on utility and application in relation to identified study objectives and needs is essential.
McQueen (2004) had studied the role of Emotional intelligence in nurses. According to the author, the concept of emotional labour was already studied, so he proposed that there is a necessity to study the contribution of emotional intelligence in the nursing context. Thus in this paper, the author aimed to present an analysis of the literature on emotional intelligence and emotional labour to put forward the value of the construct. CINAHL and MEDLINE databases were referred to for the literature review. The results of this review were presented in the paper. The author reinstated that it is a well known fact that emotional labour is very important in establishing “therapeutic nurse–patient relationships” but also carries the risk of ‘burnout’ if prolonged over a period of time. To prevent any kind of damage, nurses therefore need to adopt strategies to protect their health. The author thereafter pointed out that Emotional intelligence inherently thus played an important part in forming successful human relationships. Analysis of the literature further suggested that the modern demands of nursing draw on the skills of emotional intelligence to meet the needs of direct patient care and co-operative negotiations with the multidisciplinary team of the hospitals. Emotional intelligence has its roots in the social intelligences first proposed by Thorndyke (1920, p no 229), who noted that it was of value in human interactions and relationships. He concluded that social intelligence was distinct from academic abilities and was a key to success in the reality of life. Within the group of social intelligences, Gardner (1993) distinguished two types of personal intelligences: interpersonal and intrapersonal. Interpersonal intelligence was related to the ability to understand other people and to work well in co-operation with them. Intrapersonal intelligence involved being able to form an accurate picture of one’s ownself and to use this to operate successfully in life. The latter included the ability to be self-aware, to recognize one’s own feelings and to take account of them in social behaviour. In traditional training programmes, nurses thus should be encouraged to
conceal their emotions and to maintain a professional barrier. This conferred some protection to them from the emotional concerns of patients (Menzies 1960, p no 99). The way in which work was organized, with nurses approaching patients to carry out particular tasks of a physical nature, helped to preserve this. In recent decades, however, there has been deviation from maintaining distance and detachment towards an appreciation of involvement and commitment (Williams 2000, p no 665). Furthermore, the beginning of primary nursing has resulted in less formal nurse–patient relationships than those traditionally encouraged. Many ideas such as partnership, open communication and ‘new nursing’ are now appreciated in health care, (Savage 1990, p no 43), which laid emphasis on the importance of nurse–patient relationships. The value of each nurse adopting a holistic move towards patient care and addressing psychological, social and spiritual needs has been recognized (Benner 1984). The move to support partnership in health care requires open communication and mutual understanding that can be supported when there is good rapport between patient and professional (McQueen 2000, p no 725). Getting to know patients always helps nurses to understand concerns, foresee patients’ needs and adds to job satisfaction (Luker et al. 2000, p no 779). In adopting principles of holistic care, partnership and intimacy, nurses get to know their patients as persons and experience emotional responses to their pain. They are, consequently, now more exposed to both physical and emotional distress of the patients and have to deal with this as element of their work. While it was now considered adequate for nurses to show their emotions as they identify with patients and show their humanity (Staden 1998, p no 149), there is clearly also a requirement for them to manage their emotions if they are to present help and support. In this respect, Omdahl and O’Donnell (1999, p no 1362) differentiated between “empathetic concern and emotional contagion.” They advised nurses to use strategies that encourage empathetic concern and stay away from emotional
contagion. The work of Hochschild (1983) is key to understanding emotional management, and her analysis demonstrated that work is involved in managing emotions. The benefit of patients feeling cared for can be demonstrated in physical actions, attentiveness, and the time that nurses give to meeting their requests (Smith 1992). The quality of care may be improved when nurses can connect with patients, notice and act on cues, foresee needs and wishes, and react accordingly to address bodily, mental and spiritual aspects of care. Muetzel (1988, p no 95) describes this level of engagement as ‘being there’, nurses linking with patients physically, psychologically and spiritually. Von Dietze and Orb (2000, p no 171) proposed that it is important for nurses to practice compassion because it affects their decision-making and actions, contributing to excellence in the practice of nursing. Similarly, Henderson (2001) claimed that emotional involvement by nurses may contribute to the quality of care because the majority perceived emotional engagement as a requirement of excellence in nursing practice. Thus, it seemed that emotions are not to be released, but rather have an important place in the quality of care one can provide. Brechin (1998, p no 172) identified other factors that may be associated with nurse–patient relationships and relevant to evaluating the quality of care. These included the importance of macro and micro communications, suggesting that these are primary to the way care is perceived. The author also acknowledged the value of ‘intrapersonal experience’ and the impact of caring relationships on the self-esteem of both care takers and those being cared for and the satisfaction experienced by both. Nurses also enjoyed the benefit from emotional labour. Engaging with patients at a personal level has been reported to be satisfying, and job satisfaction is also achieved when feedback of appreciation is given by patients (McQueen 1995). However since emotional labour is skilled and demanding in nature (James 1992, p 492), it can be both stressful and exhausting. Unrelenting work of this nature can adversely affect nurses’ physical
and psychological health, potentially leading to burnout (Benner & Wrubel 1989). A balance is therefore required to provide intimate, personal attention to patients while recognizing personal limitations and engaging in coping mechanisms to protect oneself from burnout. One such techniques is to carefully allocate patients so that the more demanding patients are shared amongst all nurses and supervisors (Staden 1998). While the value of EI is becoming recognized, the author feels that there is a need to address this issue in nursing curricula. Nurses feel that they lack essential social skills (Secker et al. 1999, p 645), and employers indicate that qualifying nurses are not equipped to adapt to the working world (Bellack 1999, p 3). The aims of incorporating EI training into nursing curricula should be to improve understanding of oneself and others and to develop improved skills when addressing psychosocial needs. McMullen (2003, p19) states that ‘Cognitive intelligence on its own offers little preparation for the emotional challenges that you will meet in the course of your medical career’. While this quotation is taken from the British Medical Journal and was intended for doctors, it appears to be relevant to nurses because of the close nurse–patient contact and relationships that can develop during the course of nursing work. Furthermore, emotional challenges may not be restricted to relationships with patients, but also arise with colleagues and with patients’ relatives. Recognition of the importance of EI in relationships and in work performance seems to be an important starting point. Its relevance in recruitment and nursing curricula has been acknowledged but has still to be included as a requirement in nursing education programmes. Approaches can be incorporated into educational programme to foster these skills, in particular, in areas of self-awareness, self-regulation and social skills. Cook (1999, p 1296) highlights the need for self-awareness in nursing and is concerned that a more structured, rigorous approach to teaching be taken to address this quality than that of experiential learning currently adopted. He
drew attention to the financial drive that resulted in pressure on universities to teach students in large groups and the unsuitability of large group teaching to the realization of some teaching aims and learning outcomes. Teaching methods and specific learning outcomes in the development of EI must be made explicit if this is to be included in the teaching programme. Based on the theory emerging in this area, approaches that incorporate reflective practice and self-evaluation may be ways to approach the issue. These may be important skills for life-long learning and professional development. The environment within which learning takes place also needs to be addressed to provide a trusting and supportive setting within which students felt safe to explore their feelings and voice their opinions (Rogers 1969, p 159). It thus became clear that there is much scope for further research to ascertain the most advantageous ways of advancing EI and of teaching and supporting nurses in their emotional work.

Annabelle Mark (2005) proposed that in health care, the dominance of rationality serves both a scientific and emotional purpose, because the former provides the cognitive means by which emotionally unacceptable procedures and activities are allowed to occur to individuals as patients. It is thus an almost unique setting within which the role of emotion needed further attention. Getting the emotional agenda wrong in health care became particularly worrying because of the nature of the activity, and the costs to both patients and staff. Cartesian rationality may provide the philosophical underpinnings of the science of medicine, but the historical story behind this split between emotion and rationality was found in the need to search for proof to confound quackery and falsehood in the administration of medicine to the uninformed (Porter, 2003, p 555). However, its more recent manifestation, within the evidence based medicine movement (Davidoff et al., 1995, p 1087), confirms the continuation of medical practice as being more of an art than a science, and much of this artistry was found within the interpersonal
relationship between patient and clinician However, this continuing dichotomy has led to a re-
iteration of the needs for acts and evidence, not only at the scientific, but also the organizational
level (Hewison, 2004, p 337) in health care. This general discussion of the issue of emotion in
relation to the organization of health-care work is relatively new, but aspects of it have appeared
in the professional literatures for some considerable time, for example in 1959 Isabel Lyth
Menzies (Menzies, 1960, p 99) published her seminal work that looked at the nursing service of
a general hospital. This described how the evolution of structure, role and process was a defense
against anxiety. A complicating factor to the discussion of these issues, nevertheless, can be
found within the role of health care itself, because emotional dysfunction in individuals is often
relegated to the domain of the psychologist and psychiatrist. This removes it from a matter of
serious organizational concern to one of clinical malfunction. It is refreshing therefore to have, as
the opening papers to this special issue, contributions from two clinical professionals who
showed how their specialist knowledge enables rather than confines the development of
understanding in this area. In health care the impact of emotion or affect in patients can lead to
problems for staff both in the way they may absorb the toxicity of such emotion or by their
denial of it. When looking at the range of articles and the progression of ideas in health care that
has been demonstrated, it is possible to see some movement from a concern with individual
capacities to one in which the patient and organization are involved as part of a whole system ,in
which emotions play an integrating role. This may tell us something about the future direction of
both theory and practice. The article by Mann considers the role of emotional labour in health
care and its dominance within the nursing literature (Smith, 1992) where what can be termed
much of the front line emotion work (Grandey, 2000) has taken place. While emotional labour
fits with the nurses’ role concept of caring in this predominantly female occupation, it does continue the separation of the embodiment of emotion from the identity of the professional.

Anthony J. Montgomery et al (2005) studied the emotionally taxing character of health-care job which had been increasingly recognized. The current study aimed to examine the relationship between surface acting and hiding negative emotions with work interference with family (WFI) and family interference with work (FWI) among Greek health-care professionals. The research was a cross-sectional study of 180 Greek doctors and 84 nurses using self-report measures. The sample was based on a convenience sampling. The results indicated that, for doctors, surface acting at work was positively related to work interference with family and, for nurses, surface acting at home was positively related to family interference with work. The finding further explained the importance of the need to train students to understand and cope with emotional demands. It also highlighted the need for communication-skills training courses assisting in the emotional awareness and emotional management.

S. Mann (2005) found out in his study that for many within the nursing profession, the work role involves a great deal of emotional work or ‘emotional labour’. Such emotional work can be performed through ‘surface acting’ in which the individual simply feigns an appropriate emotion, or through ‘deep acting’ in which they actually try to feel the required emotion. The current study aims to aid understanding of the complex relationship between components of emotional labour and stress within the mental health nursing sector. Thirty-five mental health nurses completed questionnaires relating to a total of 122 nurse–patient interactions. Data were collected in relation to: (1) the duration and intensity of the interaction; (2) the variety of emotions expressed; (3) the degree of surface or deep acting the nurse performed; and (4) the
perceived level of stress the interaction involved. Nurses also completed Daily Stress Indicators. Results suggested that: (1) emotional labour is positively correlated with both ‘interaction stress’ and daily stress levels; (2) the deeper the intensity of interactions and the more variety of emotions experienced, the more emotional labour was reported; and (3) surface acting was a more important predictor of emotional labour than deep acting. Implications for mental health nurses are outlined.

In another paper (2005) S Mann and Cowburn intended to assess the literature on emotional labour in the health-care sector and the advantages and disadvantages of such performance for both nurses and the patients. The main aim was to develop a new health care model of emotional labour which could have had implications for health-care management in terms of policy and education. The author came up with a new model explaining the antecedents and consequences of emotional labour. Both the positive and negative consequences, particular to health-care settings, had been drawn. The author strongly said that emotional labour should be formally recognised as a key talent in assisting the patient, with emotional proficiency being trained in novel ways outside the prescribed classroom course. Health-care professionals should be offered education on managing the effects of emotional labour performance.

Erickson and Grove (2008) in their paper noted that empathy and emotional care have historically been an integral part of nursing education, nursing practice, and nurse identity (Bishop and Scudder 1990; Chambliss 1996; Hilton 1997; Kalisch 1973; Staden 1998; Woodward 1997). In the paper they opined that it was not necessary to draw attention to a doctor’s ‘bedside manner’ or a nurse’s ‘tender loving care’, as these things is very common. What should be of interest to the researchers is the fact that there are lots of changes occurring at the end of the twentieth century that can primarily alter the perception about “how healthcare
professionals should perform their jobs”. As increasing numbers of patients face chronic illnesses requiring lifelong management, and treatment processes give emphasis to the use of multifaceted medical and/or pharmacological technology, the healthcare providers deal with an ever-changing landscape of care (Phillips 1996). Many working in health and human services have been asked to align the “egalitarian models” of care with competitive models of economic efficiency. The challenge was to find out whether the public really expected the more ‘old-fashioned’ forms of care within the modern medical encounter. The authors stressed on the fact that research should try to find out to what extent might this market mentality have an impact on determining the way how physicians, nurses, and patients experience the performance of ‘sentimental work’? Paradoxically, the economic rationalization of health care and the increasing use of advanced technology have occurred at the same time that social and medical scientists have uttered a mounting interest in the more human (e) aspect of provider–patient interaction. Similar to dealings within the financial marketplace, this inconsistency may restate that in the marketplace of human interaction, people give importance to things that have become rare. In such case, genuine gifts of “emotional caring” are required in contexts where it has become difficult to confer them (Bolton 2000; Hochschild 1983, 2003). As a result, in healthcare organizations where ‘new production standards of gracious hospitality ... link performances of emotionality to profitability’ (Bone 2002, p no 143), the private, human gift of ‘paying respect with feeling’ has been transformed into a commodified form of emotional labor (Hochschild 1983). This effortful progression occured through the use of different methods. Individuals can manage their feelings by trying to suppress the emotion they are experiencing, change one type of emotion to another, or work to evoke or create an emotion where none exists (Hochschild 1979, p 553). “For instance, a beginner physician or nurse might actively try to suppress feelings
of nervousness about a new procedure through surface-acting techniques. Instead of letting the hesitation show through, they might work to present a calm, neutral facial expression in front of the patient. Healthcare professionals might also try to reassure patients and their families by evoking positive emotions through surface-acting processes.” For example, nurses may smile during their interactions with others even though they are not currently feeling happy. To the extent that such surface-acting efforts are directed toward changing how a nurse actually feels, this process would be characterized as expressive emotion work since the focus is on changing the expression seen by others (Hochschild 1979, p. 567). One nurse described the performance of expressive emotion work this way: “You know how, some days, when you smile, and then all of a sudden you’re happier. If you don’t smile, then you’re like blank. I feel that, for me, a good strategy is to sort of force myself to do that and then you start feeling better and forget about the bad.” Using “cognitive” or “bodily deep-acting” techniques can also be a strategy used to induce emotions. Cognitive deep-acting techniques include attempts to modify one’s view of a situation or person in order that one might actually come to feel more positively or negatively. Bodily deep-acting techniques are used when one tries to manage what is being felt by changing the physical symptoms of the emotion. ‘counting to 10’ and the use of deep breathing exercises to calm oneself would be examples of bodily deep acting (Hochschild 1979, p no 556). Erickson and Grove also pointed out that there are different reasons for individuals to engage in “emotion management”. One of the most common reasons is to follow emotion norms. Emotion norms, or feeling rules, are learned through socialization and refer to ‘beliefs about the appropriate range, duration, intensity, and targets of private feelings’ (Thoits 1989, p no 321; Gordon 1981, p no 262). The same has been restated by Ashforth and Humphrey (1993) who suggested the examining of the influence of ‘expression norms’ or ‘display rules’ (Ekman 1982; Mann 2005, p
no 309). In both the case, these sets of rules are created, reinforced, and maintained by individuals who share a common culture (Sass 2000, p no 336; Parkinson et al. 2005). The display rules recognized within “occupational communities and professional organizations” have a propensity to be more detailed than the norms prevailing in general forms of social interaction, although they tend to be consistent with these broader cultural guidelines (Ashforth and Humphrey 1993, p no 99). For example, “the gendered emotion norms that characterize the educational experiences and occupational cultures of nurses and physicians are consistent with the traditional power and status distinctions found between women and men more generally”. That is, women/nurses are expected to be caring and fostering toward others while men are expected to display more emotional detachment during their interactions (although displays of anger would also be expected to occur). The current healthcare settings place increasing emotional demands on healthcare providers (Bone 2002, p 141; Mark 2005, p 279). Development of the expertise which is necessary to effectively manage with these demands and perform the mandatory emotion management on the job is, thus, fundamental to enhancing patient outcomes and to ensure that patients will not ‘suffer from the ill health of the professionals themselves’ (Mark 2005, Brunton 2005; Larson and Yao 2005). Healthcare providers who are able to perform emotion management effectively are able to manage the emotional reactions of their patients in ways that directly influence the patients’ resulting physical and psychological health (Mann 2005). As such, emotion management is a part of the healthcare delivery system that medical and social scientists, managers and administrators of healthcare organizations, physicians have begun to appreciate the usefulness of the emotional labor process for understanding how their own interactions with patients may influence outcomes within contemporary healthcare contexts (Larson and Yao 2005; Mark 2005; Montgomery et al.
Thus it becomes very important to study and understand the connection between caring and nursing which may in turn also explain the recent drive to clarify that nurses also perform emotional labour when caring for patients. Some scientist took the philosophical path and explained emotional labour not as a task but as a gift that nurses give their patients, some scholars have emphasized that certain forms of care should be seen as resulting from a choice nurses make because they want to, not because they have to (Bolton 2000; Bolton and Boyd 2003; Lewis 2005).

Gary and Smith in 2008 had proposed that emotions in health organisations tend to remain tacit and is always in need of clarification. Often, emotions are made invisible in nursing and reduced to make it a part and parcel of ‘women’s work’ in the domestic sphere. Smith (1992) applied the notion of emotional labour to the study of student nursing, and concluded that further research was required in this context. This meant investigating what is often seen as a tacit and unmodified skill. A follow-up qualitative study was conducted over a period of twelve months to re-examine the role of emotional labour and in particular the ways in which emotional labour was orientated to different clinical settings. Data were collected from 16 in-depth and semi-structured interviews with nurses based in East London (United Kingdom). Findings illustrated the emotional labour in three different settings (primary care, mental health and children’s oncology). Findings showed the different ways in which emotional labour is used and reflected upon by nurses in these three clinical areas. This is important in improving nurse training and best practice as well as helpful in offering an initial synopsis of the culture of care in nursing; investigating several clinical settings of nurses’ emotional labour; looking at changing techniques of patient consultation; and beginning to explore the potential therapeutic value of emotional labour.
Truc Huynh et al (2008) worked on a paper which is a report of a concept analysis of emotional labour. It was reported in the paper that caring was considered as the essence of nursing. Underpinning caring, the internal regulation of emotions or the emotional labour of nurses is invisible. The concept of emotional labour is relatively underdeveloped in nursing. A literature search using keywords ‘emotional labour’, ‘emotional work’ and ‘emotions’ was performed in CINAHL, PsycINFO and REPERE from 1990 to January 2008. They analysed 72 papers whose main focus of inquiry was on emotional labour. They followed Rodgers’ evolutionary method of concept analysis. They found out that emotional labour is a process whereby nurses adopt a ‘work persona’ to express their autonomous, surface or deep emotions during patient encounters. Antecedents to this adoption of a work persona are events occurring during patient–nurse encounters, and which consist of three elements: organization (i.e. social norms, social support), nurse (i.e. role identification, professional commitment, work experience and interpersonal skills) and job (i.e. autonomy, task routine, degree of emotional demand, interaction frequency and work complexity). The attributes of emotional labour have two dimensions: nurses’ autonomous response and their work persona strategies (i.e. surface or deep acts). The consequences of emotional labour include organizational (i.e. productivity, ‘cheerful environment’) and nurse aspects (i.e. negative or positive). The concept of emotional labour should be introduced into preregistration programmes. Nurses also need to have time and a supportive environment to reflect, understand and discuss their emotional labour in caring for ‘difficult’ patients to deflate the dominant discourse about ‘problem’ patients.

Diefendorff et al (2011) studied emotional labour by understanding the way job burnout and satisfaction become affected by a “multifaceted set of direct and indirect effects of display rules”. For the study, the authors first studied “the autonomy view” which examined the direct
effects, and then “the depletion view,” which examined the presence of indirect effects through emotion regulation. They found support for both perspectives. Perception played an important function in this regard. For example the result of unit-level display rules on burnout was indirect which was partially mediated by surface acting and deep acting. The effect of unit-level display rules on job satisfaction was primarily direct, operating independently of individual display rules and emotion regulation. Thus it was found that unit-level display rules had different pattern of linkage with these outcomes variables. The authors also proposed that it might be given the character of burnout and job satisfaction. The authors credited the main difference of the results to the emotional nature of work in contrast to the typical service samples studied in other research. For example, it was very tiring and dissatisfying to alter the strong feelings that nurses’ experience in response to the seriously ill patients compared to the more dull conditions faced by retail or fast food workers.

Matthew D. McHugh et al in 2011 proposed that job dissatisfaction in nurses contributed to expensive labour disputes, turnover, threat to patients etc. The author examined survey data from 95,499 nurses, and found higher job dissatisfaction and burnout among nurses. He noted that nurses are mainly disappointed with their health benefits, which thus highlighted the requirement for benefits review in order to make the benefits more comparable with white-collar employees. Patient satisfaction levels are usually low in hospitals with nurses who are dissatisfied—which is a main finding of the paper. It thus is very important to improve nurses’ working conditions.

Gorgens Ekermans et al (2012) in their paper proposed to explore the inter-relationships between occupational stress, burnout and emotional intelligence in a sample of nurses and determine whether emotional intelligence is a moderator in the stress–burnout relationship.
Further objectives were to explore the dimensions of occupational stress and find out which one account for the greatest variance in burnout in the sample of nurses studied. Given the challenges faced in the healthcare industry in South Africa (staff shortages, budget constraints, overcrowded hospitals and high patient loads; Gibson 2004, Hall 2004), it was expected that workload would be the strongest predictor of burnout. Group differences between respondents working in different wards were also investigated, as there may be differences which could be attributed to these different working environments (Oates and Oates 2008,p 58). A random sample of 220 nurses (across various levels in the nursing profession) was drawn from the database of a private healthcare employment agency which specialised in providing contract healthcare professionals to a private hospital group in South Africa. The selected respondents were called and were invited to be part of the study. Anonymous questionnaire packs were delivered to contact personnel at four different hospitals in the Western Cape Province. The fundamental finding of this research was that higher EI is likely associated with less self-reported work stress and burnout in nurses. Moreover, EI was shown to be a significant moderator in the stress–burnout relationship. Other researchers (Van Dusseldorp et al 2010, p 558) therefore have argued for the EI development and training into nursing curricula to improve the level of EI of nurses. The results of this study provide preliminary empirical evidence that increased EI levels such as the ability to better manage positive and negative emotions and to effectively control strong emotions may benefit the occupational health of nurses who experience high levels of stress.

Pisaniello et. al (2012) in their paper tried to examine the influence of emotional work and emotional labour on health and wellbeing of nurses in a South Australian hospital. Emotional work has been described as acting out of emotions thus having relevance to caring work intrinsic
to palliative care nursing practice and the inherent therapeutic relationships. (Rose and Glass 2010, p 1410). The researchers expected that the two constructs would have distinctive effects on the health and well being of nurses. To do so they took account of the demographic, dispositional and social factors. They argued that emotional display rules may differ according to specific occupational requirements. Nursing is a challenging profession due to the significant emotional demands placed on workers, and there is always a probability that strong emotional states will be experienced by them. It may thus be more exhausting and dissatisfying for nurses to alter those feelings in order to act in accordance with display rules (Diefendorff et al., 2011, p 175). Generally the adoption of business models of health care by many hospitals has meant that nurses spend less time with patients (Hoffman et al., 2009, p 1340). Although this may suit nurses who prefer to perform task-orientated care, the inability to develop meaningful relationships with patients may be detrimental to those nurses who value the more ‘human’ side of the profession (Bolton 2001; James, 1992; Staden, 1998). Nurses dealing with serious illness and the emotional issues of patients may prefer to fail to see the emotional traumas in favour of physical symptoms (Trougakos, Jackson, & Beal, 2011,p 356) as a strategy to conserve emotional resources (Hobfoll, 1993). For instance, if low availability of social support from supervisors is anticipated, nurses may apply “blocking behaviours” in order to avoid emotional disclosure (Bone, 2002, p 145). There has also been a proof that respondents high in negative affectivity or trait anxiety may report stress more often than their counterparts (Jones & Bright, 2001). In this study, the participants were nurses who all worked in a large metropolitan public hospital in South Australia. This was done to limit confounding variables such as differing work environments, patient mix and management practices. On commencement of the project, a clinical nurse manager from each specialty was called and guidance was sought after in relation
to the hierarchical organization, employment position titles and educational background related
to those nurses within each specialty area. The nurses were recruited from the specialty areas of
general medicine, oncology, cardiovascular services, orthopaedic services, trauma services, and
critical care services. Nursing wards included outpatient areas and day wards of the specialty
areas. Each specialty area was provided with questionnaires and a return box. Two hundred thirty
nine nurses responded to the multi-component questionnaire representing a 39% response rate,
which ranged from 24% to 54% across the specialty areas. There were 202 females and 35
males, with a mean age of 36.8(SD=9.79) years. Univariate and bivariate data analyses,
hierarchical multiple regressions were conducted using SPSS Version 18.0. Overall, the findings
indicate that emotional labour is more strongly related to workplace health than is emotional
work and is a slightly a stronger influence on job dissatisfaction. In this sense emotional labour
appears to be different from emotional work. If emotional labour is perceived as a job
requirement or professional standard and emotional work is voluntary, it follows that emotional
labour may act as a stressor, leading to more negative outcomes than emotional work. Overall,
emotional work contributed less variation in negative health consequences than emotional
labour, and more variation in positive outcomes. In particular, emotional work in the form of
companionship contributed to positive health and wellbeing, whereas emotional labour in the
forms of surface acting and negative emotion suppression contributed to the increase in the
severity of negative health consequences and low wellbeing.

Timothy Bartram et al (2012) conducted a study to explore the relationships between perceived
high performance work systems, emotional labour, burnout and intention to leave among nurses
in Australia. Past studies showed that emotional labour and burnout are associated which
subsequently has an impact on the intention to leave in nurses’ sample. Research has evidence
that high performance work systems are connected with a decrease in turnover. The authors thus mainly concentrated on the relationship between high performance work systems and emotional labour as there was dearth of empirical paper in this area. The authors defined emotional labour as efforts which are made to modulate the expression of one’s emotions to meet the expectations of employers or customers. These expectations are based on display rules or norms about appropriate emotional expressions for specific situations (Hochschild 1979, Wharton & Erickson 1997, Schaubroeck & Jones 2000). Employees who have high levels of customer or client contact in emotional situations, such as nurses, are subject to stronger emotional display rules (Schaubroeck & Jones 2000, p 170) and consequently perform more emotional labour. The impact of emotional labour on the individual varies according to the frequency, intensity, variety, and duration of the display of the required emotions and the level of emotional dissonance between the felt emotions and the expected emotions (Morris & Feldman 1996, Brotheridge & Lee 2003). Further the authors took into account the conceptualization of emotional labour developed by Schaubroeck and Jones (2000, p 171) that includes demands to communicate positive emotion and to suppress negative emotion for the purpose of their study. It has proved that nurses may suppress negative and perform positive emotions on a day-to-day basis (Mann 2005, Huynh et al. 2008), therefore, these two emotions are shared in the analysis to ascertain the composite effect of emotional labour. On the other hand, literature defines burnout as a psychological syndrome that involves losing concern for the people with whom one is working and is commonly associated with workers in ‘caring’ professions (Maslach 1978, p 115). In nursing, burnout has consistently predicted intention to leave (Jourdain & Chenevert 2010, p 715). There are three reported components of burnout: emotional exhaustion reduced personal accomplishment, and depersonalization (Maslach & Jackson 1981, p 100; Schutte et al. 2000, p
Emotional exhaustion refers to the “depletion of arousing emotional states”, such as a nurse feeling emotionally drained to adequately care for patients. For the purpose of this study, only emotional exhaustion had been taken into account. Next, high performance work systems play a key role in the achievement of organizational goals and improved individual and organizational effectiveness (Becker & Huselid 2006, Macky & Boxall 2007). HPWS improve performance by enhancing employees’ knowledge, skills, abilities and commitment by providing them with the information and carefulness necessary to capitalize on these skills to effectively perform their jobs (Preuss 2003, p 595). For this study, Zacharatos et al.’s (2005, p 235) conceptualization of HPWS, which include job security, selective hiring, extensive training, teams and decentralized decision making, reduced status distinctions, information sharing, transformational leadership, and high-quality work (defined as appropriate workload, role clarity, and employee control) has been used. Next studies have shown that Emotional labour and burnout are associated with an increase in intention to leave among nurses. Given the shortage of nurses, it is very important to identify management practices that can reduce both burnout and the intention to leave of nurses. A cross-sectional, survey was conducted in Australia with 183 nurses in 2008. Three hypotheses were tested with the help of validated measures of emotional labour, burnout, intention to leave, and perceived high performance work systems from literature. Thereafter principal component analysis was used to examine the structure of the measures. The mediation effect in the hypothesis was tested using Baron and Kenny’s procedure and the moderation effect as stated in the hypothesis was tested using hierarchical regression. Results clearly showed that emotional labour is positively associated with both burnout and intention to leave. Burnout mediates the relationship between emotional labour and intention to leave. Perceived high performance work systems negatively moderates the relationship between emotional labour and burnout. Perceived
high performance work systems also reduced the strength of the negative effect of emotional labour on burnout as well as had a unique negative effect on intention to leave. This meant that if managers and administrative staff of the hospitals ensured effective human resource management practice through the implementation of high performance work systems, it may help reduce the burnout associated with emotional labour. This in turn may assist healthcare organizations to reduce nurse turnover.

Cheng et al in 2013 examined the relationships among emotional labour, team climate, burnout, perceived quality of care and turnover intention among nurses in Australia, with the aim of addressing nurse retention and burnout. Emotional labour refers to the regulation of emotion during interpersonal transactions. It may involve faking unfelt emotions, hiding genuine emotions and deep acting whereby the individuals attempt to influence their inner feelings to induce the appropriate outward countenance. Currently, there is a dearth of literature that investigates the link between emotional labour and perceived quality of care and ultimately turnover intention. The contribution of team climate in the relationship between emotional labour and burnout is still uncertain. A cross-sectional quantitative study conducted with self-completed questionnaires. The study was conducted in 2011 with 201 registered nurses. Validated measures were used to measure the aforementioned constructs. Confirmatory factor analyses were used to examine the factor structure of the measured variables and hypotheses were tested using structural equation modeling. The final model demonstrated that faking has a significant negative influence on perceived quality of care. Hiding predicts burnout, leading to an increase in turnover intention. Team climate moderated the relationship between hiding and burnout, which may subsequently influence turnover intention. The establishment of a strong team climate may
help nurses to manage the emotional demands of their role, promote their well-being and retention.

Klaus helmut and Diestel (2014) researched and proposed that emotional labour is an essential part of the role of nurses with surface and deep acting as the emotional labour strategies. Surface acting involves “the regulation of emotional expression with the aim of bringing it in line with organizational display rules,” whereas deep acting involves “modifying the situation or perception of situations in order to change felt emotions, accordingly.” Since surface acting usually consumed more cognitive control resources than deep acting, the study examined whether nurses’ cognitive control scarcity as a “stable personal vulnerability factor” exercised stronger unfavourable interactive influences on job. A cross-sectional questionnaire survey was conducted for a time period of 12 months. One hospital and three nursing homes for the elderly located in a federal state in Germany were used for this survey. Questionnaires were distributed to the whole nursing staff, out of which 195 nurses filled in the questionnaire. Hierarchical moderated regression analyses were performed. Findings exposed important affirmative relations of surface acting and cognitive control shortfall with indicators of job strain, whereas deep acting was not related to strain. In addition, surface acting was found to interrelate strongly with cognitive control deficits in its relation to strain than deep acting. In contrast to nurses with low levels of cognitive control deficit, the unfavourable influence of surface acting on burnout, depressive symptoms were stronger when high levels of cognitive control deficits were described. Consequently, interference is needed to notify nurses on the harmful influences of surface acting and teach them in the everyday use of deep acting “as the healthier emotional
regulation strategy”. In addition, interference targeted at the improvement of the individual ability for self-control would be helpful to nurses’ wellbeing.

Tsukasa Kato in 2014 proposed that hospital nurses frequently experienced strained relationships with patients as stressors in the workplace. Nurses’ coping behavior is one potential buffering factor that can reduce the effects of job stress on their psychological functioning and well-being. In this study, the association between nurses’ strategies for coping with interpersonal stress from patients and their psychological distress was examined. Participants included 204 hospital nurses and 142 salespeople, who were used as a comparison group. Participants completed measures of coping with interpersonal stress and psychological distress. Hospital nurses reported more psychological distress than did salespeople. Moreover, distancing coping was correlated with high psychological distress in both nurses and salespeople, and reassessing coping was correlated with low psychological distress in nurses. For nurses only, constructive coping appeared to be an effective strategy for reducing psychological distress. It is important for nurses to understand the role of constructive coping in nurse–patient communication and interaction.

Se Hyang Kim and Mi-Aie Lee in 2014 conducted a study to investigate the relationship among turnover intention, emotional labour, and communication competence in nurses. The participants for this study were 297 nurses from three general hospitals in two local cites in Korea. Data were collected by self-administered questionnaires from August 26 to September 10, 2013 and analyzed using descriptive statistics, One-way ANOVA, t-test, Pearson Correlation, Stepwise Multiple Regression with the SPSS/WIN 18.0 program. The average scores for turnover
intention, emotional labour, and communication competence respectively, were 3.45, 3.08, and 3.44 out of 5. The novices recognized that their emotional labour and turnover intention were significantly higher, and their communication competence was lower than other nurses. Nurses' turnover intention had a positive relationship with their emotional labour, but no relationship with communication competence. Job satisfaction, frequency of emotional expression, and emotional dissonance had an effect on nurses' turnover intention. The results show that emotional labour and job satisfaction are very important factors affecting nurses' turnover intention. So, nurse managers should try to minimize nurses' emotional labour and maximize their job satisfaction by developing various human relationships educational and support programs and using them.

Vijayta Doshi in 2014 explored the psychological and social experiences of nursing job. Research gap existed in the literature in terms of limiting emotional labour in nursing around patients, thereby neglecting the emotional labour that nurses perform with patients' relatives, doctors and other social actors. The study aimed to firstly understand the emotional labour performed by nurses with respect to patients and their relatives, doctors and the organization. Another aim was to investigate the consequences of emotional labour. The study involved in-depth interviews with nurses in Indian context. It was found that nurses face emotional dilemmas with patients, patients' relatives and organizational demands. In some cases, medication errors and turnover were found to be related to emotional labour. The study enhanced the understanding about emotional labour in nursing and is one of the initial studies in the Indian context. The author also stressed how the nurses juggle between detachment and attachment. Nurses shared their experiences of patients expecting them to feel their feelings when they actually weren’t empathetic. Nurses found difficulty in dealing with those situations
because of the superficial behavior involved. They stated that they underwent depersonalization because of prolonged emotional exhaustion. After spending some time in job they got habitual of seeing people crying and dying without feeling as bad as they felt initially in job. “A person becomes emotionally shallow when one is working in such environment constantly unless some of your family member is the patient..you become emotionally empty. Emotions do not come easily that is if a patient is dying and relatives are weeping, we don’t weep and just console them that its’ okay the patient was unwell, don’t cry..that’s it.” Still some of the nurses shared how sometimes they got emotionally attached to some patients with whom they had spent lot of time especially kids. While patients and the human side of nurses forced them to be empathetic, their job demanded suppression of those feelings because they had to be “stable”, in “control” of their emotions and “poised” otherwise they would not be able to provide proper care to the patients. Further, they suppressed their emotions so that they were able to motivate patients for their fast recovery rather than making them feel like ‘patients’. Nurses did overtime work in their jobs which was never accounted for, neither were they given any compensation/ extra payment or leave. Some of them mentioned that the main reasons for Indian nurses migrating to foreign countries are stipulated work hours and payment for overtime unlike India where there is “exploitation” of labour. Overtime was not just because of staff shortage but also because of non-punctual staff and absenteeism. In one of the nurse’s words: “Overtime happens always.. always. We have six hours duty from 8 a.m. and it’s not necessary that we complete six hours and go home. Our overtime is neither counted, that we worked extra time. If you calculate our duty hours then don’t know so many hours will be extra hours overtime but nobody bothers for that.” Nurses also mentioned about the skewed doctor nurse ratio. They however were of the opinion that they worked as a team with doctors who were cooperative. This cooperation stemmed from
the inter-dependence of doctors and nurse on each other given the shortage of staff. It is because of this inter-dependence that doctors never misbehaved with them in any way. “In our profession there is lot of cooperation and we work as a team because everyone needs the other person. So we can’t misbehave with each other. So, there is lot of cooperation. When we go on lunch then doctors manage the ward and work and likewise when doctors are not there, we manage. It’s kind of a team work.” On the other hand, some nurses stated that some people considered them to be “doctor’s assistant” or “helpers”. They shared their unhappiness with such opinions. As said by one of the nurses: “People think that we are just like that..doctor’s assistance. They don’t realize that how much effort we do in the absence of doctor. Like I told you doctors are mostly not available and at that time we only look after those patients.” Addressing the dissonance, one of the nurses working in a government hospital stated that nurses were at par with doctors in terms of salary and that slowly their social status is improving as their salary is increasing. “People think that nurses are like helpers for doctors. Because of increase in salary such perception is no longer there. Our salary is equivalent to MBBS doctor’s salary.. now the salary has increased and if one is financially good then the status symbol automatically changes.” However, they believed that society also had people who valued them. Therefore, nurses were aware about the mixed societal opinions regarding their job.

2.3 Conclusion

The literature review helped to understand the concept in a much better way. It also helped to analyze the past research and to demarcate the area in which, if research done can add a valuable meaning to the body of the literature. The next chapter thus explains the various gaps in details and discusses about the development of the hypotheses.