The effects of emotional labour on wellbeing: Contrasts between health care settings

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Declaration

I declare that this thesis contains as its main content work which has not previously been submitted for a degree at any tertiary education institution and, to the best of my knowledge or belief, contains no material previously published or written by another person, except when due reference is made in text.

Stephen Brown
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Abstract

The purpose of this research is to examine the emotional labour requirements of nurses and clerks with different interaction requirements to assess whether the context or the perceived role identity affects the conduct, and/or outcomes of, emotional labour. Emotional labour has become an important focus for researchers since Hochschild’s (1983) ground breaking research. Emotional labour has been associated with mainly poor outcomes for employees; however, there is still uncertainty as to the components and consequences of emotional labour. The health industry is one field where emotional interactions between employees and clients are often typified as an important part of the various roles.

Study 1 involved interviews with 21 nurses from three distinct nursing groups (emergency, renal dialysis, and palliative care) as well as emergency clerical workers to explore the dimensions and associations of emotional labour. Study 2 sought to generalise findings from Study 1. Three hundred and twenty five employees from the same groups were surveyed.

The main findings were as follows;

- **Emotional Labour**: The management of natural emotion is a distinct and prominent emotional labour strategy.

- **Outcomes of Emotional Labour**: The management of natural emotion and deep acting are preferable to surface acting due to more favourable well-being associations.

- **Social Support**: Organisational sources of support are crucial for the well-being of employees engaged in emotional labour.

- **Emotional Engagement**: Employees who perceive the emotional engagement in their role as high, may be better prepared for emotional interactions and have better well-being outcomes.
- **Emotional Intelligence and Display Rules**: Employees from all groups used emotional intelligence to guide their emotional interactions with clients.

- **Non-expressive Emotional Management**: In addition to emotional labour, employees from all groups used non-expressive means of emotional management such as the use of information, and space and proximity to control the emotion of themselves and clients.

- **Emotionally Relevant Interactions**: Employees found clients that held some emotional relevance as the most emotionally difficult to deal with.

Together the results show that the management of natural emotion should be included as an emotional labour strategy and, along with deep acting, should be considered preferable to surface acting for the well-being of employees and for organisational outcomes such as turnover intention. Employers can assist employees by preparing employees for interactions and by ensuring adequate support.
Chapter 1: Introduction and Rationale for the Research

Emotional labour, which is the display or constraint of emotional expression as part of the work role to meet organisational, social or occupational expectations, is an integral aspect of working life for many employees (Mann, 1997). Given the importance of emotional management in many occupations and its negative wellbeing associations (e.g. Hochschild, 1983; Pugliesi, 1999; Williams, 2003), its detailed examination is of importance to employees and employers.

Following Hochschild’s (1983) ground breaking dramaturgical perspective of the emotional interchange between flight attendants and passengers, emotional labour research has become a burgeoning research area (Ashkanasy, Härtel, & Daus, 2002). Occupational fields as diverse as hotel staff (Seymour & Sandiford, 2005), doctors (Larsen & Yao, 2005), university employees (Pugliesi, 1999), social workers (Cheung & Tang, 2007) call centre workers, bank employees, and teachers (Zapf & Holz, 2006) have been studied in emotional labour research.

One of the most studied areas for emotional labour researchers has been the health sector, in particular nursing, in which emotional management is a crucial aspect of the role (Mann, 2005). As carers, nurses are seen as sources of emotional support for patients and family members and this role is sometimes considered as important as their clinical duties (Smith, 1992). Numerous emotional labour studies have examined nursing generally (e.g. Cheung & Tang, 2007; Wharton, 1993; Zellars & Perrewé, 2001), as well as specific nursing groups such as those in surgical wards (Mackintosh, 2007), operating theatres (Timmons & Tanner, 2005), gynaecology (Bolton, 2000b), and a baby care unit (Lewis, 2005). But by far the most frequently studied area of nursing in
emotional labour research has been palliative care (e.g. Holmberg, 2006; McIlfatrick, 2007; Skilbeck & Payne, 2003).

Despite the significant focus on emotional labour in nursing, there are substantial gaps in this research area and these represent important deficits in what is known about emotional labour. For example, despite the examination of emotional labour in nursing, the focus in specific groups lacks detailed accounts of how some well established emotional labour components, such as surface and deep acting are used by employees, and vary between groups with greatly differing interaction requirements as well as how these relate to wellbeing outcomes (e.g. Hawkins, Howard, & Oyebode, 2007; Mok & Chiu, 2004; Skilbeck & Payne, 2005). Where nursing has been examined they have tended to be viewed as an homogenous group, such that different nursing specialties were not separated (e.g. Näring & van Droffelaar, 2007 & Yang & Chang, 2007), or they have been seen as a sub-set of some other category, such as human services (e.g. Cheung & Tang, 2007). An exception to this is the work by Theodosius (2008), but even this only offers broad descriptions of surface and deep acting without a detailed analysis of the circumstances under which these may be more or less prominent.

Serious problems associated with aspects of emotional labour including emotional exhaustion (Brotheridge & Grandey, 2002), depression (Mann, 1997) and physical symptoms (Schaubroeck & Jones, 2000), make the detailed study of emotional labour in occupations with a heavy emphasis on interactions with clients, a very important consideration. The major theoretical approaches to emotional labour underline the importance of identifying separate emotional labour components, such as surface
and deep acting, as crucial in determining which aspects of emotional labour provide particular wellbeing outcomes and under what circumstances (Grandey, 2000).

The lack of a specific focus on nursing specialities may lead to assumptions that the emotional labour requirements of nursing are the same across the profession, which may belie the greatly varying emotional management requirements. For example, nurses in emergency departments may be confronted with dynamic and volatile interactions with clients; interactions may be influenced by the need to deal with several cases in quick succession, each with quite different needs. In contrast, nurses working in renal dialysis wards, a group almost entirely neglected in emotional labour research (Dent, Burke, & Green, 1991 an exception), develop long term relationships with patients, often lasting a decade or more and the interactions are lengthy and predictable, several days a week for hours at a time. In addition, there may not be the same focus on the emotional management aspect of the role for emergency and renal nurses as for palliative care nurses, who have previously indicated this aspect of their role as being of central importance (Skilbeck & Payne, 2003).

Grandey and Diamond (2010) have raised the possibility that the outcomes of emotional labour may depend on the job context, depending on whether the interactions are encounters or relationships. If this is found to be the case, the outcomes of emotional labour may have less to do with the occupation and more to do with contextual differences in the interactions between employees and clients. Using nursing as an example, the interactions that palliative care and renal nurses have with clients are more likely to be relationships whereas emergency nurses are more likely to have encounters with their clients. Examining these groups separately to see if outcomes differ, will
provide evidence of the importance that context plays in emotional labour and its outcomes.

Identifying differences in contact requirements, work focus, and the importance placed on emotional management and how this work is carried out between different types of employee-client relationships would help organisations and individuals to prepare and respond more effectively to specific situations. In addition, the examination of how emotional labour and other means of managing emotion is carried out in a profession with such an important focus on its interactions with clients in a variety of circumstances may help to clarify the current disparate state of emotional labour theory.

Nursing is not the only area of health care that is relevant to emotional labour research. Mann (2005) argues that while nursing has received much of the attention in emotional labour research, other health care professionals may also need to manage emotion as a substantial aspect of their role. Curiously, missing from Mann’s considerations are non-professional occupations within health care that have significant contact with patients and their family members, such as clerical workers. The omission of this type of employee is notable given that some clerical staff, such as clerks in emergency departments, deal with patients and family members, often in crisis situations, as the main function of their duties. These clerks are at the front line of the organisation, and employees in similar positions, such as call centre operators, have been found to bear the brunt of public anger and aggression from disgruntled clients (Grandey, Dickter, & Hock-Pen, 2004). However, clerks may lack the self-perception as carers that applies to nurses (Smith, 1992), which could impact on the level of emotional engagement and methods of handling interactions with clients. Therefore, they provide
an interesting comparison to emergency nurses as both groups deal with at least some of
the same clients in a similar timeframe in close proximity but may vary in their level of
emotional engagement and their emotional management strategies when dealing with
clients.

A greater understanding of specific emotional labour requirements of different
health care groups, how these requirements are managed, and how and why outcomes
may differ is important in order to understand associations with wellbeing. Moreover,
given reports of a recent nursing shortage in Australia (Hogan, Moxham, & Dwyer,
2007), hospitals and other health care organisations have a particular interest in
investing in methods of reducing poor individual outcomes in order to attract and retain
staff.

The aims of this research are:

1. To assess how employees are aware of necessary and appropriate
   emotional management, how they assess their level of responsibility for
   this and how these perceptions may differ depending on their role and
   the context.

2. To examine the methods by which employees manage their own and
   others’ emotions in the workplace.

3. To examine the differences in emotional management, well being
   outcomes of emotional management and factors impacting on these,
   dependent on context and role.
To address these aims, four groups will be examined that experience consistently different types of interactions in terms of the context of the interactions and the role of the employee in the interaction. Nurses working on renal wards, nurses in palliative care, nurses working in emergency departments and clerks working in the same emergency departments are included in this study.
Chapter 2: Emotional Labour: A Critique of Current Theoretical Perspectives

Along with the interest emotional labour has generated, numerous theoretical approaches and perspectives have been promoted. Glomb and Tews (2004), while arguing that these approaches represent complementary perspectives; concede “It could appear that the emotional labor domain is in a theoretical quandary, flooded with a multitude of conceptualizations” (p.4). The following review of the literature is intended to provide a clear idea of the state of emotional labour theory and to lead to a conceptualisation of emotional labour that is inclusive of how employees express and constrain emotion as a functional aspect of their role. Included in these theoretic perspectives is a focus on how aspects of emotional labour are associated with wellbeing outcomes and the importance of moderating variables.

2.1 Hochschild’s Original Dramaturgical View of Emotional Labour

The constraint and expression of emotion as a significant aspect of the job role in certain occupations was first acknowledged by Hochschild (1979, 1983). Hochschild coined the term “emotional labour” as the descriptor for this work. Hochschild’s original definition of emotional labour was the “management of feeling to create a publicly observable facial and bodily display” (p. 7).

Hochschild’s (1983) investigation was largely centered on flight attendants and the ways in which they complied with organisational expectations of how they should manage and express desirable emotions in their dealings with passengers. For example, flight attendants are expected to display friendliness by smiling, and allay passenger
fears of flying by presenting a calm demeanor. These emotional expressions are expected even in the face of demanding or abusive clients. Importantly, Hochschild saw that emotional labour included the requirement to suppress unacceptable or non-prescribed emotions, often while simultaneously expressing the required expression, entailing a complex degree of emotional management (see Figure 2.1 for a proposed model based on her theory). Hochschild (1979, 1983) used a dramaturgical perspective in which “feeling rules” or the organisationally defined constraints of acceptable and unacceptable emotional expression are seen as similar to a script. An example of an explicit requirement for supermarket check-out employees is provided by Rafaeli and Sutton (1987).

YOU are the company’s most effective representative. Your customers judge the entire company by your actions. A cheerful “Good Morning” and “Good Evening” followed by courteous, attentive treatment, and a sincere “Thankyou, please come again,” will send them away with a friendly feeling and a desire to return. A friendly smile is a must. (p.23).

**Hochschild’s Dramaturgical Perspective of Emotional Labour**

<table>
<thead>
<tr>
<th>Feeling Rules</th>
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<tbody>
<tr>
<td>- Organisationally determined</td>
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<tr>
<td>- For profit</td>
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<table>
<thead>
<tr>
<th>Emotional Labour</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Surface acting</td>
</tr>
<tr>
<td>- Deep acting</td>
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<table>
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<tr>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Emotional exhaustion</td>
</tr>
<tr>
<td>- Disassociation from true self</td>
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*Figure 2.1.* Model based on Hochschild’s (1983) emotional labour theory.

masking of undesirable emotion, and (ii) deep acting (analogous to method acting), whereby the employee elicits the desired emotions in themselves. For example, a nurse
may prepare for work in a children’s ward by ensuring that he or she is in a happy and friendly mood. Hochschild considered naturally felt emotion in which felt emotion naturally corresponded with the required expression as a type of deep acting, and she referred to this as “passive deep acting”, the implication being that no effort is required.

Hochschild (1983) found that over time, the performance of emotional labour had serious adverse wellbeing outcomes for employees. As an explanation for such negative wellbeing consequences, Hochschild introduced the notion of emotive dissonance, similar to cognitive dissonance, as an uncomfortable internal state, resulting from the tension created from the difference between felt and expressed emotion. Emotive dissonance (often referred to as emotional dissonance) has since been defined as “the expression of emotions that are not felt” (Zapf & Holz, 2006, p.1).

Hochschild (1983) also argued that emotional expression and feelings are such a personal experience that the expression of them for a wage on organisational demand must be inherently unpleasant. Hochschild found that the emotional labour of flight attendants was associated with sleep disturbances, sexual problems, and a general deadening of affect.

Hochschild’s (1983) perspective presents emotional labour very much as an employer driven and directed process in which employees, despite sometimes “rebelling” against the expected expression, are generally at the behest of the organisation and have little choice but to express sanctioned emotions, regardless of what they are feeling. The overriding reason for emotional labour is to increase profit through customer satisfaction and return business.
Hochschild’s (1979, 1983) bleak view of emotional labour as a means by which employers increase profit at the expense of an employee’s wellbeing, has not gone unchallenged in other theoretical perspectives (e.g. Ashforth & Humphrey, 1993; Wouters, 1989). However, there is recognition that Hochschild’s (1983) original accounts of emotional labour, and of how employees manage emotion as part of their role has become the basis for much emotional labour research since. In particular, the importance of the central tenets of surface and deep acting and emotive dissonance have endured and been supported in both qualitative (e.g. Boyle, 2005; Mann, 2004) and quantitative studies (e.g. Brotheridge & Lee, 2003; Martínez-Iñigo, Totterdell, Alcover, & Holman, 2007; Näring, Briët, & Brouwers, 2006). Therefore, even though subsequent research has built considerably on Hochschild’s work, her original conceptualisation can be seen as a robust basis for emotional labour researchers to work from.

2.2. Emotional Labour as Observable Behaviour

Implicit in Hochschild’s (1979, 1983) definition and description of emotional labour is the notion that the management of feeling requires the control of internal processes. Ashforth and Humphrey (1993), in their definition of emotional labour as “the act of displaying the appropriate emotion” (p. 90), view observable behaviour as a more relevant focus for investigation. They argue that observable behaviour is what is seen by clients while internal states are difficult to assess, and conformity may not require altering of felt emotion. In line with this position, Ashforth and Humphrey emphasise that “display rules” is a more suitable term for the emotional expectations of
the organisation or others, as opposed to Hochschild’s focus on “feeling rules” (a position adopted by most authors and in the current research).

Unlike Hochschild’s (1983) bleak assessment of the effects of emotional labour, Ashforth and Humphrey (1993) argue that emotional labour can have positive wellbeing outcomes. This is most likely the case when the employee identifies with the role and has some latitude for expression. This is thought to lead to a more convincing emotional performance, thus facilitating a smooth interaction between the employee and client, leading to the satisfaction of both.

In line with Hochschild’s (1983) position, Ashforth and Humphrey (1993) saw surface and deep acting as core elements of emotional labour. In addition, Ashforth and Humphrey suggested that spontaneous and genuine emotion (emotion that naturally corresponds with display rules), should be considered as a separate, third emotional labour component. This position represents a point of difference to the view that Hochschild (1983) has taken of natural emotional expression as an aspect of deep acting. To illustrate that natural emotion should be considered separately to deep acting, Ashforth and Humphrey provide an example of a nurse who is naturally sympathetic towards sick children, which will lead to exactly the type of empathic emotional displays required as part of the role. This means that the nurse has not had to work to elicit a particular emotion to conform to display rules as is the case with deep acting. The example of the nurse used by Ashforth and Humphrey also shows that the use of genuine emotion is also distinguishable from surface acting as the employee would not have to mask or artificially express a particular emotion.
Ashforth and Humphrey (1993) argued that a key consideration of whether or not emotional labour results in positive or negative wellbeing outcomes rests on the social and personal identity of the employee and how closely this aligns to the role. Using social identity theory (i.e. Ashforth & Mael, 1989; Tajfel & Turner, 1985), Ashforth and Humphrey argued that when employees can more readily identify with the service role, compliance with the emotional requirements may be easy and enjoyable. Such identification is likely to lead to less effort and a more natural performance. In this respect Ashforth and Humphrey saw the outcomes of emotional labour as either positive or negative depending on how well the employee is able to align their identity with their role and conform to display rules.

Ashforth and Humphrey (1993) also expanded on Hochchild’s (1983) idea of how display rules are considered. Where Hochschild saw the organisation as the primary and over-riding formulator of display rules, Ashforth and Humphrey argued that social and occupational norms for appropriate emotional expression also applied. To this end, strong social, occupational or professional norms or standards may over-ride or even stand in place of organisational direction. For example, while there may be a socially derived expectation that doctors show concern to patients (Mann, 1997), nursing, as the caring profession, carries with it a stronger expectation of nurturing as a central aspect of the role (Smith, 1992), which would necessarily entail a greater expression of emotion. Furthermore, these socially and professionally derived expectations would apply across organisations.

Ashforth and Humphrey (1993) also argued that positive wellbeing outcomes may result from emotional labour if the employee is allowed some latitude for self
expression (greater emotional autonomy) as opposed to a tight control on emotional expression in order to conform to exacting requirements. Emotional autonomy is thought to allow for a closer connection with clients in individual interactions, leading to greater job satisfaction and hence, more positive wellbeing outcomes (for a model based on Ashforth and Humphrey’s (1993) emotional labour conceptualisation, see figure 2.2).

**Ashforth and Humphrey’s Emotional Labour Theory**

![Figure 2.2](image)

*Figure 2.2*: Model based on Ashforth and Humphrey’s (1993) theory of emotional labour.

Ashforth and Humphrey (1993) also expanded Hochschild’s (1983) notion of emotive dissonance considerably, arguing that dissonance represents the key problem for employees engaged in emotional labour. Ashforth and Humphrey saw that the uncomfortable and inauthentic self-reflection that dissonance creates can lead to reduced self esteem, depression, cynicism, and alienation. Therefore, surface acting, with its
masking of true emotion and expression of unfelt emotion, is seen as a particular problem. While Ashforth and Humphrey considered deep acting as less problematic than surface acting, they argued that deep acting may also lead to feelings of inauthenticity and self-alienation, especially if the emotional labour requirements are unrelenting, resulting in substantial effort.

Ashforth and Humphrey’s (1993) view of emotional labour as work that is not necessarily associated with poor outcomes for individuals represents a departure from Hoschild’s (1983) views. In addition, the consideration of display rules as being influenced from sources other than the organisation, and the separation of natural emotion as a distinct emotional labour strategy from deep acting, are further developments. Perhaps the most notable inference to be drawn from the difference between the approaches is that the type of role could be important in impacting on outcomes, with more process driven, lower level roles in which there are a greater number of interactions presenting more wellbeing problems. For example, Hochschild’s (1983) focus on flight attendants may represent a much more process focused and repetitive function, without the opportunity to build individual relationships with clients, opposed to the interaction seen in some nursing situations, which may have the possibility for deeper and more individually tailored interactions. Notably, Ashforth and Humphrey use the example of a nurse to illustrate their position on how natural emotion is used in interactions. It may be easier for employees to identify with the relational aspects of a role that has the opportunity for more depth to the interactions and where the occupation carries with it a distinct set of defining characteristics with which the employee can identify.
Ashforth and Humphrey’s (1993) focus on observable expression sees task effectiveness as the whole purpose for the management of emotion. Therefore, expression that is appropriate and leads to a smooth interaction is assumed to be associated with better performance, greater self-efficacy, and easier and more enjoyable interactions. However, their view of natural emotional expression as being confined to situations in which there is a natural concordance between what’s felt and what’s required may be an overly restrictive view of how natural emotions are used to comply with display rules.

2.3. Emotional Labour from an Interactionist View

Not all perspectives view surface and deep acting as core components of emotional labour. Morris and Feldman (1996) define emotional labour as “the effort, planning, and control needed to express organizationally desired emotion during interpersonal transactions” (p. 987), which is a similar definition to most others, but their conceptualization of emotional labour has quite a different focus.

Morris and Feldman’s (1996) view of emotional labour is centered on the idea that the social environment is crucial in determining how individuals make sense of and express emotion. Morris and Feldman (1997) describe the emotional labour construct as consisting of three components: the frequency of interactions, duration of interactions, and emotional dissonance.

This conceptualisation represents a significant departure from Hochschild (1983) and Ashforth and Humphrey (1993), in excluding surface and deep acting as central emotional labour components. Despite differences in how emotional labour is
conceptualised, Morris and Feldman (1996) propose that all components will be positively related to emotional exhaustion and that the emotional dissonance component will be negatively associated with job satisfaction. In terms of outcomes, this position is closely related to Hochschild’s (1983) proposition that emotional labour will mostly lead to negative employee outcomes (see figure 2.3).

**Antecedents and Consequences of Emotional Labor**

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<tr>
<th>Antecedents</th>
<th>Emotional Labor</th>
<th>Consequences</th>
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<tr>
<td>2. Routineness of Task</td>
<td>2. Duration of Interaction</td>
<td>2. Job Satisfaction</td>
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<td>4. Power of Role Receiver</td>
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*Figure 2.3. Antecedents and Consequences of Emotional Labor (Source: Managing emotions in the workplace. By J. A. Morris and D. C. Feldman (1997). *Journal of Managerial Issues*, 9, page 260).*

In a test of their model, Morris and Feldman (1997) focused on four important antecedent factors; explicitness of display rules, task routineness, job autonomy, and power of role receiver. The most notable finding was that emotional dissonance was the only emotional labour component that led to poor outcomes in terms of both emotional exhaustion and job satisfaction leading Morris and Feldman (1997) to reassess their position that emotional labour should produce generally poor personal consequences.
The three suggested components of emotional labour as proposed by Morris and Feldman (1997) have been criticised by Grandey (2000) and Diefendorff and Gosserand (2003) as being unrepresentative of how employees actually express and inhibit emotion. Whereas surface and deep acting could be thought of as methods of actually performing emotional labour, Morris and Feldman’s focus on frequency and duration, while possibly very important in determining how emotional labour might be conducted, does not define emotional labour (Diefendorff & Gosserand, 2003; Grandey, 2000). Furthermore, while it is argued by some (e.g. Rubin, Staebler-Tardino, Daus, & Munz, 2005) that emotional dissonance is a necessary precursor to emotional labour being conducted, it is more of an internal state, rather than the actual effort of expressing or managing emotion (Grandey, 2000). Therefore, even though the very close conceptual and empirical relationship with surface acting means that the consideration of emotional dissonance may be useful to explain the cognitive process behind surface acting, it should not be considered as an element of emotional labour.

2.4. Antecedent and Response Focused Emotional Regulation

Like Hochschild (1983), Grandey (2000) considered both the management of internal processes and outward expression in a definition of emotional labour as “the process of regulating both feelings and expressions for organizational goals” (p. 97). Grandey (2000) sought to combine the situational focus of Morris and Feldman (1996) as antecedents of emotional labour, together with the central tenets of surface and deep acting (e.g. Ashforth & Humphrey, 1993; Hochschild, 1983) as the emotional labour mechanisms by which the display rule demands are met (see Figure 2.4).
Grandey (2000) appealed to Gross’s (1998a; Gross, 1998b) theoretical model of antecedent-focused and response-focused emotion regulation. Gross saw emotional management as being regulated at either one of two points. Antecedent-focused regulation entails anticipating and preparing for the emotionally stimulating event prior to exposure. Conversely, response-focused regulation entails the individual suppressing or modifying their emotional response once the stimulus has been received.

**Figure 2.4.** The proposed conceptual framework of emotional regulation performed in the workplace setting, NA = negative affect; PA = positive affect. (Source: Emotion regulation in the workplace: A new way to conceptualize emotional labour. By A. A. Grandey (2000), *Journal of Occupational Health Psychology,* 5, page 101).
Grandey (2000) saw Gross’s model as being relevant to emotional labour theory, particularly as antecedent-focused regulation is conceptually similar to the notion of deep acting (requiring the modification of feelings before exposure), and response-focused regulation is similar to descriptions of surface acting (requiring the modification of expressions at and after exposure). Importantly, Gross (1998a) found that there was a greater sympathetic nervous system activation associated with response focused regulation as opposed to antecedent focused regulation. Such sympathetic nervous system responses have well-known associations with adverse health consequences (Gross, 1998a), suggesting that surface acting may be a more damaging emotional labour strategy for employees (Grandey, 2000).

Grandey (2000) also saw the emotional labour process as being contingent upon antecedent variables such as the frequency, duration, and variety of interactions. In addition, Grandey argued that the ease of compliance with display rules would be dependent on previous emotional events from work related and personal sources, such as an abusive or critical customer or a sick relative. Grandey suggested that such negative events result in a greater difficulty for a subsequent positive demeanor.

As well as antecedent variables, Grandey’s (2000) model considers individual and organisational factors as having a direct impact on whether surface or deep acting are utilised as emotional labour strategies. The type of individual factors considered includes gender, emotional expressivity, emotional intelligence, and the affective tendency of the individual. Organisational factors include sources of social support and the level of job autonomy. Overall, the antecedents, whether from personal or organisational sources, have an impact on whether surface or deep acting is used.
situations in which demands are frequent and the preceding emotional events are
negative, the employee is likely to be distracted and in a negative emotional state,
resulting in a greater propensity for surface acting to be used, particularly when positive
emotion is required.

Finally, in line with Gross’s (1998a, 1998b) emotional regulation model,
Grandey (2000) saw individual outcomes such as burnout and job satisfaction, and
organisational outcomes such as performance and withdrawal, closely contingent upon
whether surface or deep acting is used as the emotional labour strategy. More stressful
individual outcomes for surface acting are expected and Grandey adds to the idea of
surface acting generating poorer outcomes by arguing that surface acting is more likely
to be detected as insincere by clients, resulting in a less effective performance.

In a subsequent conceptualization and empirical investigation, Grandey (2003)
reorganized the way in which factors were considered. For instance, instead of job
satisfaction being an outcome variable, the level of job satisfaction was viewed as an
antecedent and impacted on how much an employee had to act to comply with display
rules with those high in job satisfaction being more likely to comply more naturally. In
keeping with emotional regulation theory (Gross, 1998a, 1998b), surface acting, but not
deep acting, had a strong association with emotional exhaustion (Grandey, 2003).

Grandey’s (2000, 2003) conceptualization of emotional labour is restricted to
methods of actually expressing and constraining emotion but it also allows for the
impact of antecedent variables. The use of Gross’s (1998a, 1998b) emotional regulation
explains the different cognitive mechanisms behind surface and deep acting and why these strategies might have differential consequences.

The possibility that natural emotion can be an emotional labour strategy in the same way as surface and deep acting is missing from Grandey’s (2000) model probably because the use of natural emotion as an emotional labour strategy is not as easily explained by Gross’s (1998a, 1998b) emotional regulation model. As previously outlined, there is good reason to include natural emotional expression as a means of expressing emotion to meet display rules, and the use of natural emotion can be distinguished from both surface and deep acting. Grandey (2000) also omits Ashforth and Humphrey’s (1993) proposed moderators; social and personal identity. Given that the inclusion of these factors allow for consideration of the influence of the particular role or profession, this exclusion represents a limitation. However, Grandey’s perspective can be seen as a reasonably comprehensive conceptualization of how emotional labour is conducted as well as how antecedents, and organisational and individual factors impact on how employees use emotional labour components and their subsequent association with wellbeing outcomes.

2.5. Conservation of Resources (COR) Theory

The most salient aspect of Hobfoll’s (1989) COR theory as it relates to emotional labour is that when employees expend energy and other personal resources in attempts to comply with the emotional demands of their work, they will seek to replenish these resources, such as through social support. The failure to protect and build resources can lead to fatigue, and ultimately, threats to wellbeing, such as burnout (Wilk & Moynihan, 2005). Social support could be accessed from organisational
sources such as from co-workers or through rewarding interactions and reactions from clients (Brotheridge & Lee, 2002). Therefore, considering Hochschild’s (1983) view that emotional labour is personally taxing, supportive work relations should reduce negative effects (Cheung & Tang, 2007).

In consideration of the COR model, Brotheridge and Lee (2002, 2003) viewed emotional labour as being the performance of either surface or deep acting, but inseparable from these strategies are the situational requirements that determine the required effort or resources that need to be expended. Brotheridge and Lee (2003) acknowledged the use of natural emotion as a means of complying with display rules in their description of emotional labour, but this is absent as a facet of their emotional labour construct. Importantly though, Brotheridge and Lee (2003) argued that even if natural emotion is in accordance with display rules, the emotion must still be managed, which adds to how Hochschild (1983) and Ashforth and Humphrey (1993) view natural emotion as a component of emotional labour. The suggestion of natural emotion requiring active management may be a way of considering the use of natural emotion that covers a wider range of situations other than when there is a natural concordance between what’s felt and what’s required.

Brotheridge and Lee (2003) consider the frequency, intensity, duration, and variety of emotional interactions as part of the overall emotional labour conceptualisation representing demands, and surface and deep acting as the methods used to meet the demands with the management of natural emotion as a suggested (but not included) facet (Brotheridge & Lee, 2003) (see Figure 2.5).
Reference to the COR model does not provide an explanation about how or why specific components of emotional labour are chosen, as is the case in Grandey’s use of Gross’s (1998a; 1998b) emotional regulation model. However, the idea of emotion as a valued resource helps to explain why its replenishment through factors such as emotional support could be important in reducing negative effects such as emotional exhaustion. In addition, the suggestion that natural emotion requires active management and should not only be seen in a one dimensional situation in which the natural emotion corresponds exactly with what’s required, is an important yet undeveloped contribution.

2.6 Control Theory

Diefendorff and Gosserand (2003) explained the emotional labour process in terms of control theory, in which a four step model is used to explain how individuals
constantly monitor, compare and modify behaviour in order to meet certain goals. In terms of emotional labour, control theory is adapted to explain that an individual makes a self-perception of his or her emotional display, compares the actual display to the display rule, acts to reduce any discrepancy (by either modifying behaviour to match the display rule or, if this is difficult, abandoning the display rule as a standard for behaviour), and displays emotion accordingly (see Figure 2.6). Diefendorff and Gosserand see this process as automatic and outside conscious awareness in many situations, but problematic and leading to burnout when substantial efforts are required to meet display rule expectations.

In a test of the tripartite dimensionality of emotional labour Diefendorff, Croyle and Gosserand (2005) identified natural emotion as a distinct dimension in addition to surface acting and deep acting. However, the items used to measure natural emotion appear more focused on the expression of emotions as they naturally comply with perceived display rules and do not appear to reflect efforts to actively manage naturally felt emotions. Similar to Diefendorff et al. (2005), Näring and van Droffelaar (2007) also considered emotional consonance as an emotional labour strategy but once again this also did not include the active management of natural emotion. Näring and van Droffelaar found that emotional labour consisted of four dimensions; surface acting, deep acting, emotional consonance, and suppression of emotion, which was conceptualized as being separate to the active expression of unfelt emotion in surface acting. Other conceptualisations of emotional labour have considered that surface acting consists of both suppression of felt emotion and the expression of unfelt emotion (e.g. Hochschild, 1983).
Diefendorff and Gosserand’s (2003) control theory approach allows for the consideration of surface acting, deep acting, and natural emotion as methods of managing emotion. In the case of natural emotion, the felt emotion may still need to be managed and kept in check and within the bounds of accepted norms for the situation. For example, a palliative care nurse may feel sorrow following the death of a client, but unrestrained sorrow may not be appropriate in front of family members. Therefore, as also suggested by Brotheridge and Lee (2003), the management of natural emotion can be seen as a more inclusive approach to considering how natural emotion may be used.
to conform to display rules as opposed to simply considering situations in which felt emotion naturally corresponds with what is required.

Similar to Grandey’s (2000) view, Diefendorff and Gosserand (2003) take into account affective events which may alter the level of difficulty in actually displaying the required emotion. For example, previous negative interactions with clients who may have been abusive or personal issues such as a sick family member can impact on the ability of the employee to deliver the required emotional expressions and comply with display rules, despite recognising a discrepancy between actual and required expressions (Diefendorff & Gosserand, 2003).

In terms of outcomes, Diefendorff and Gosserand (2003) suggest that when the discrepancy between what’s required and what’s felt is large, much more effort and emotional expenditure is required. This greater effort may eventually result in burnout. In addition, if the employee is unable to conform to display rules and chooses a modified standard for emotional expression, feelings of inadequacy and low job satisfaction may follow (see figure 2.7).

**Display Rules**
- Mostly organisationally directed

**Emotional Labour**
- Surface acting
- Deep acting
- Natural emotion

**Outcomes**
- Job performance
- Burnout
- Feelings of inadequacy
- Job satisfaction

*Figure 2.7. Model based on Diefendorff and Gosserand’s (2003) theory of emotional labour.*
Diefendorff et al.’s (2005) application of control theory to the emotional labour process provides an explanation of how discrepancies between required and displayed emotional expression are constantly monitored and modified if necessary. Control theory considers that affective events may impact on the ability of employees to match display rule requirements. Diefendorff et al. (2005) and Diefendorff & Gosserand (2003) also allow for the idea that the management of natural emotion is an emotional labour strategy in addition to surface and deep acting.

2.7 Action Theory

Zapf, Vogt, Seifert, Mertini and Isic (1999) take an action theory view of the emotional labour process. The core tenet of action theory is that individuals seek to actively engage in their environment, to have some level of control over their condition and are generally not passive respondents to environmental demands (Frese & Zapf, 1994). As applied to emotional labour, action theory components include; regulation requirements (display rules and other antecedents), regulation possibilities (control over how requirements may be met), and regulation problems (stressors that impede meeting regulation requirements). Regulation problems occur when requirements exceed the resources of the individual or if regulation possibilities are limited. For example, emotional dissonance is seen as a regulation problem due to a lack of choice (low control) the individual has in meeting display rules (Zapf et al., 1999).

In accordance with action theory, Zapf et al. (1999) conceptualised emotional labour using the following six factors; requirements to display positive emotions, requirements to display negative emotions, variety of emotions, sensitivity requirements
(all emotional regulation requirements); interaction control (emotional regulation possibilities); and emotional dissonance (emotional regulation problems).

In a further development Zapf (2002) identified the actual emotion work strategies as automatic emotion regulation (similar to natural emotion), deep acting, surface acting, emotional deviance, and sensing emotions. All of these are responses to job requirements to display positive or negative emotions, the level of emotional dissonance and sensitivity requirements. In his inclusion of emotional deviance, Zapf called upon the work of Rafaeli and Sutton (1987) who argued that emotional deviance is the act of displaying emotions which are counter to display rule requirements. Zapf argued that emotional deviance is a response to display rules in which an employee either chooses not to comply or is unable to comply due to emotional exhaustion.

Sensing emotions is considered by Zapf as an emotional labour strategy used to guide responses and shape the behaviour of the client. Zapf sees the main problem for individuals engaged in emotional labour as emotional dissonance and its relationship with burnout and suggests that autonomy and social support represent control mechanisms that may alleviate regulation problems. Autonomy may not only be achieved by allowing employees greater latitude in expressing emotions as they see fit, but could also be achieved by providing timeouts from situations in which display rules need to be closely observed or where there are largely negative interactions (see Figure 2.8).
In summary, action theory is used to show that emotional labour strategies (regulation possibilities) are used by employees to meet display rules (regulation requirements) with stressors such as emotional dissonance (regulation problems) making this match more difficult (Zapf et al., 1999). Emotional dissonance is thought to be moderated by social support, and emotional and job autonomy (latitude for emotional expression and withdrawal), showing how emotional dissonance may lead to burnout. A problem with Zapf’s (2002) approach is that emotional deviance (expression that is counter to display rules) and sensing emotion are included as emotional labour components. While these factors may be important in the overall emotional regulation process they cannot be considered as ways of expressing or constraining emotion in order to meet display rules as is the case with surface and deep acting and the use of natural emotion, and therefore should not be considered as components of emotional labour.

Figure 2.8. Model based on Zapf et al (1999) and Zapf’s (2002) theory of emotional labour.
2.8 Summary of Theoretical Perspectives

As defined by most authors (e.g. Ashforth & Humphrey, 1993; Grandey, 2000; Hochschild, 1983), emotional labour is the act of displaying appropriate emotional expression as part of the work role. Emotional labour is most commonly thought to consist of two main strategies; surface and deep acting (Grandey, 2000), both of which fit the behavioural focus behind most definitions. Less certain is the notion that the use or management of natural emotion may also be an aspect of emotional labour. While some authors have discussed the natural concordance between what is felt and what is displayed as a kind of fortunate happenstance (e.g. Ashforth & Humphrey, 1993; Hochschild, 1983), this may be a limited view of how natural emotion may be used as an emotional labour strategy. Ashforth and Humphrey’s (1993) example of a nurse who may naturally feel sympathy at the sight of an injured child is an example of a natural concordance between required and expected emotion expression. On occasions it may be easy for a nurse to comply with display rules with little effort, however the ease of compliance, even for natural emotion, may exist on a continuum, and be more difficult depending on the circumstances. For example, in the event of the death of a well-known patient, a nurse may feel substantial grief of which some, but not all, would be appropriate as an emotional display to relatives.

The use of natural emotion as an emotional labour strategy has only received very limited empirical interest (with Diefendorff et al. (2005) and Näring and van Droffelaar (2007) as exceptions). Given the substantial hypothesised difference in wellbeing outcomes resulting from surface and deep acting (Grandey, 2000), the investigation of how natural emotion is used as a third emotional labour strategy may
provide important information in respect to the welfare of employees who manage natural emotion in their role.

Some emotional labour conceptualisations include, as components of emotional labour, factors other than means of actually expressing or constraining emotion in order to comply with display rules. For example, Morris and Feldman (1996) include the duration, frequency of emotional labour as well as emotional dissonance in their conceptualisation and Zapf (2002) include emotional deviance and sensing emotions. As Grandey (2000) points out, the problem with using antecedent requirements such as the frequency of interactions, or the uncomfortable internal state of emotional dissonance as components of emotional labour is that these do not explain what employees actually have to do to perform emotional labour. While situational demands and internal states may be very important in determining how employees conduct emotional labour and for explaining negative outcomes, these are best conceptualised as correlates but not emotional labour itself (Grandey). Similarly, emotional deviance, while representing a behavioural response, is not a method of attempting to comply with display rules. Therefore, the consideration of what constitutes emotional labour should be restricted to strategies for compliance with display rules.

As argued by many (e.g. Ashforth & Humphrey, 1993; Diefendorff et al., 2005; Diefendorff & Gosserand, 2003; Grandey, 2000; Hochschild, 1983; Morris & Feldman, 1996; Zapf, 2002; Zapf et al., 1999), the consideration of factors which may impact on the emotional labour process, influence the use of emotional labour strategies, and also affect outcomes, must be considered. However, deciding upon which factors to include or exclude remains a substantial point of conjecture.
Grandey’s (2000) incorporation of the work of Hochschild (1983), Ashforth and Humphrey (1993), and Morris and Feldman (1996) represents a reasonably comprehensive overall conceptualisation of the emotional labour process. Grandey considers that antecedents in addition to display rules and emotional events will affect the choice of emotional labour strategy, which will also be impacted by some organisational and individual factors. The choice of strategy is important as Grandey is able to appeal to Gross’s (1998a, 1998b) emotional regulation theory to show how surface acting may lead to poor outcomes. However, Grandey does not include natural emotional expression as a separate emotional labour component. In addition, the exclusion of social and personal identity as a moderator to wellbeing outcomes, as argued by Ashforth and Humphrey (1993), are important omissions. The issue of identity may be especially important in the current research given nurses’ image as carers (Smith, 1992), which is not expected to be replicated in emergency clerks despite their close proximity to, and dealings with, similar clients in the same timeframe as emergency nurses.

Therefore, despite Grandey’s (2000) conceptualisation of the emotional labour process as perhaps the most comprehensive to date, it’s proposed that the management of natural emotion should be considered as an emotional labour component and that social and personal identity should be considered as moderators to wellbeing outcomes.

2.9 Emotional Labour in Health Settings

The current research is focused on the investigation of distinct health care groups as a means of adding to the understanding of emotional labour. However, some have questioned whether mainstream emotional labour theories are applicable to nursing (de
Raeve, 2002), and Mann (2005) has suggested that the specific interaction requirements of health care employees require a separate model of emotional labour. However, the previous wide applicability and relevance of emotional labour theories to many occupational situations, including health care, suggest that these arguments are not soundly based.

While de Raeve (2002) argues that Hochschild’s (1979, 1983) emotional labour concepts of deep and surface acting cannot be applicable to nursing, as acting or non-genuine emotional expression would violate the trust required in the nurse-patient relationship, this view is not supported empirically. For example, Bolton (2000b) and Garel, Etienne, Blondel, & Dommergues (2007) provide clear evidence of surface acting in their descriptions of how nurses covered feelings of abhorrence and grief when faced with foetal abnormalities and deaths. In terms of deep acting, research has also demonstrated that surgical nurses coped with stressful and distressing events by taking on a work persona in which certain personal characteristics, such as a calm demeanour, was cultivated more diligently than in the non-work persona (Lewis, 2005; Mackintosh, 2007). Importantly, this was seen as subjectively protective in that nurses spoke of the work persona as shielding them from becoming too emotionally involved with distressing events such as a patient death.

Even though the repudiation of surface and deep acting in nursing can be challenged, many emotional labour studies that have examined nursing have spoken of emotional labour, either without any reference to, or only an occasional mention of, surface or deep acting, emotional dissonance, display rules, or other terms commonly associated with emotional labour theory (e.g. Dent et al., 1991; Henderson, 2001; Lewis,
Consideration of these emotional labour components and associated factors has been identified as being extremely important in terms of their associations with wellbeing outcomes (Grandey, 2000). Therefore, their neglect as considerations in specific situations in an occupation with such a central focus on relationships with clients represents a substantial and important gap in emotional labour research.

A second argument for a specialized model of emotional labour in health is proposed by Mann (2005), based on the notion that the relationships between health care providers and clients (typified by nursing as the caring profession) represent deeper and markedly different interactions than those seen elsewhere. In addition, despite being increasingly influenced by a more consumer and market driven focus (see Dickens, Sugarman, & Rogers, 2005 and Mann, 2005), health care is still perceived as different to commercial type occupations in which emotional labour has been widely studied, such as call centre operators (e.g. Holman, Chissick, & Totterdell, 2002; Lewig & Dollard, 2003; Zapf & Holz, 2006) and retail customer service roles (e.g. Johnson & Spector, 2007; Tolich, 1993; Totterdell & Holman, 2003). However, while the unique situations and requirements of health care settings may not map onto other occupational settings, employees in many occupations that could be considered unique, such as hotel service employees (Kim, 2008), university lecturers (Ogbonna & Harris, 2004), and adventure guides (Sharpe, 2005) have all been shown to use the well established emotional labour components of surface and deep acting.

Descriptions of the use of surface and deep acting in nursing indicate that, at least in terms of the conduct of emotional labour (e.g. Bolton, 2000b; Garel et al., 2007;
Lewis, 2005; Mackintosh, 2007), health settings may be no different to other occupations. This does not mean that antecedent, individual and organisational factors and outcomes may not interact differently, but this could be the case amongst a variety of settings. Therefore, even though different health settings may produce distinct or even extremes in terms of interaction requirements, rather than being seen as requiring a separate model of emotional labour, these situations can be used to clarify and add to emotional labour theory more broadly.

A further reason for not considering health care as a separate emotional labour entity is that some employees in this industry may have more in common with previously studied groups in emotional labour research, in terms of work demands, than they do with health care professionals. For example, clerical employees working in emergency departments deal with some of the same clients as emergency nurses in close proximity and within a similar timeframe, but these clerks could not be expected to share an identity as carers that has been found to exist amongst nurses (Smith, 1992). The possible difference in how these two groups perceive themselves raises questions as to how they may manage their relationships with clients. Moreover, examination of the emotional labour of emergency clerks is important given that they are often the first point of contact for angry, stressed, or otherwise distressed clients, and employees in similar circumstances have been found to suffer from burnout in the face of client abuse (Grandey et al., 2004). Therefore, emergency clerks represent an important comparison group to nurses, and in particular to emergency nurses. In addition, given that emergency clerks often deal with clients in such difficult circumstances, wellbeing
outcomes from the emotional management aspect of their role is in itself an important focus.

A tension currently exists between many descriptions of emotional work in health care (particularly in nursing) and emotional labour theory and emotional labour research more generally. A purpose of this research is to use specific instances of different interaction types as evidence of how emotional labour is conducted and how emotions are managed, in order to further inform emotional labour theory. The consideration of nursing as being generic or even as part of a wider category in terms of the emotional management requirements and how emotional labour is conducted, belies greatly differing types of interactions and their requirements. Many nurses work in one specific setting or another for long periods of time. Therefore, the examination of emotional labour strategies and their associations with wellbeing outcomes, along with factors such as support, and how they vary between groups will provide information about the role context plays within a single occupation. This will also provide important information for employers to respond more effectively to meet the needs of employees.

Overall, while health care has received substantial attention in the emotional labour research, there are important deficits in this research area, including those stemming from the view that health care is somehow fundamentally different from other organisational groups in terms of emotional management (de Raeve, 2002; Mann, 2005). While these arguments are flawed, they are reflected in the way in which emotional labour research has been conceptualized and conducted in health care (and especially nursing) to date. The lack of attention to specific emotional labour concepts such as surface and deep acting in settings with unique emotional labour requirements
warrants attention. Also, the lack of consideration of non-professional health occupations (such as clerks) in emotional labour research is important due to the centrality of emotional labour for these employees. Given the general, detrimental health, wellbeing and organisational outcomes of emotional labour, a greater focus on these omissions is needed to develop an understanding of the specific circumstances under which employees are likely to experience more positive or negative outcomes. Therefore, the focus of the current research is to address these omissions.

With the above research focus in mind, four groups from health care settings with markedly different work and interpersonal requirements were chosen for this research. These groups consist of: community palliative care nurses whose role it is to visit terminally ill patients and their family members in the patients’ homes; renal nurses from renal dialysis wards who deal with the same patients in very stable circumstances often for a decade or more; emergency nurses from public hospitals who must work under volatile and unpredictable circumstances with a rapidly changing patient group; and emergency clerks who work in the same setting as emergency nurses but may not share the same professional identity as carers. These groups are not chosen as absolute extremes of the interaction spectrum, but as areas likely to have markedly different requirements in terms of both work and emotional labour demands.
Chapter 3: Emotional Labour: Outcomes, Moderators, and Antecedents

In line with the position of surface and deep acting as core elements of emotional labour, their relationship with outcomes, antecedents, and moderators has been a prime focus of emotional labour research. In particular, research has shown that surface and deep acting have reliable associations with wellbeing outcomes. Much less attention has been given to how natural emotion is used as an emotional labour strategy and how it is related to such considerations. The following empirical review focuses on the emotional labour components of surface and deep acting and natural emotion, their relationship with outcomes, antecedents, and moderators, as well as the identification of important empirical gaps in this research area.

3.1 Emotional Labour and Wellbeing Outcomes

3.1.1 Burnout. It could be argued that the stress related phenomena known as employee burnout may have initially been identified largely as a result of exactly the type of work now conceptualized as emotional labour. The first concerted efforts to conceptualize and examine burnout were made during the mid-seventies (Freudenberger, 1974, 1975), when employees in free health clinics in the United States were identified as having a syndrome-like cluster of symptoms thought to be a result of multiple sources of long-term stress. Burnout was most prevalent in occupations where the employee-client relationship was of central importance to the role (Maslach, Schaufeli, & Leiter, 2001; Schaufeli & Buunk, 1996). Burnout was used to describe a cluster of symptoms that had an identifiable etiology, therefore the concept of burnout was established via a ground-up process rather than by theory (Maslach & Goldberg, 1998).
3.1.1.1 Components of burnout. There are three components of burnout; (i) exhaustion (the central component), (ii) depersonalisation (a self-protective response to exhaustion, a means of distancing oneself from the source of stress), and (iii) personal accomplishment (sometimes reversed to reflect a negative valence in accordance with the other two components) (Maslach et al., 2001). The relationships between these three components depend on which stressors are prominent in the workplace. However, exhaustion (often described as emotional exhaustion (e.g. Lee & Ashforth, 1990), is usually the precursor, or at least occurs in conjunction with one or both of the other two components (Maslach et al., 2001).

As the name suggests, emotional exhaustion is typified by subjective feelings of exhaustion and being emotionally overtaxed without opportunity for replenishment of emotional resources (Maslach & Goldberg, 1998). Emotional exhaustion is the most studied and necessary element for the existence of burnout (Maslach, 2003) and is considered as the first stage (van Dierendonck, Schaufeli, & Buunk, 1998).

Depersonalisation is identified as a common, coping mechanism in response to emotional exhaustion and can be thought of as an objectification of clients, akin to emotional withdrawal (Maslach et al., 2001). While this may provide immediate emotional protection for employees, long term and repeated depersonalisation is seen as maladaptive and could result in a cynical dehumanizing approach to clients (Maslach & Goldberg, 1998).

Finally, a sense of reduced personal accomplishment follows, which encompasses reduced confidence, reduced self-efficacy, and low self-evaluation in
relation to dealings with clients (Maslach et al., 2001). Reduced personal accomplishment is seen as the result of the long-term existence of emotional exhaustion and depersonalisation. It can be thought of as resignation to a lack of effectiveness in the role.

3.1.1.2 Emotional labour and burnout. In research that has examined emotional labour and burnout, the most common finding is that surface acting or the closely related concept of emotional dissonance is positively correlated with at least one burnout dimension. Zapf et al. (1999) identified a significant relationship between emotional dissonance and the burnout dimensions of emotional exhaustion and depersonalisation amongst employees with a substantial level of contact with clients, and Zapf and Holz (2006) found that emotional dissonance was related to emotional exhaustion in a similar sample. In a wide ranging sample including nurses, teachers and social workers, emotional dissonance had a significant relationships with all three burnout dimensions (Cheung & Tang, 2007). Sampling across a variety of occupations, surface acting was associated with emotional exhaustion, depersonalisation and reduced personal accomplishment but, deep acting was not related to emotional exhaustion or depersonalisation and had a significant and negative relationship with reduced personal accomplishment (Brotheridge & Grandey, 2002; Brotheridge & Lee, 2003). Amongst various types of human service employees, surface acting was again associated with emotional exhaustion and depersonalisation, whereas deep acting had no such relationship (Zammuner & Galli, 2005). Police officers also showed a relationship between surface acting emotional exhaustion (Adams & Buck, 2010).
Amongst nurses, surface acting, deep acting and the suppression of emotion were all positively related to emotional exhaustion, and depersonalisation was related to surface acting Näring & van Droffelaar, (2007). Notably, emotional consonance was not associated with negative outcomes but predicted personal accomplishment, indicating that the use of natural emotion may be less problematic than other aspects of emotional labour.

Social support has been identified as the variable most likely to reduce burnout resulting from emotional labour, which is in support of the COR model of emotional expenditure (Grandey, 2000; Gross, 1998b). This is especially true for perceived support from coworkers and supervisors (Brotheridge & Lee, 2002; Halbesleben, 2006; Zellars & Perrewé, 2001) and to a lesser extent, for perceived organisational support (Jawahar, Stone, & Kisamore, 2007), and perceptions of support from the employee’s family (Baruch-Feldman, Brondolo, Ben-Dayan, & Schwartz, 2002). Martínez-Iñigo et al. (2007) also found that employee satisfaction with clients partially mediated the relationship between surface acting and emotional exhaustion.

Qualitative descriptions of the relationships between emotional labour and burnout parallel these quantitative findings. In particular, the ability for nurses to maintain emotional and physical distance from clients in difficult cases can be seen as similar to the concept of the depersonalisation dimension of burnout. As a means of coping, this strategy of emotional management may be seen as adaptive. For example, workers in an abortion clinic explained how they distanced themselves from clients who were hostile or abusive by maintaining physical distance and by adhering to a strict,
clinical interpretation of their role, limiting their emotional involvement (Wolkomir & Powers, 2007).

As the burnout literature suggests, distancing may prove problematic. In an examination of the ways in which nurses manage emotions in a surgical area, Froggatt (1998) showed that nurses sometimes felt the need to distance themselves from clients as protection from emotional exhaustion. However, there was a perception that this form of self protection created a risk of the development of a callous attitude (Mackintosh, 2007). Nurses’ awareness and concerns of the risks that distancing creates was borne out in interviews with patients and their relatives in an acute care ward. These participants described the hallmarks of poor nursing as low involvement and impersonal and low levels of communication, which left clients feeling depersonalised (Attree, 2001).

Overall, the concept of burnout can be seen as an extremely important factor to consider as an outcome of emotional labour. It appears as though surface acting may generally lead to more negative burnout outcomes, suggesting that surface acting may be particularly damaging to individuals in comparison to deep acting.
3.1.2 Job satisfaction. The relationship between emotional labour and job satisfaction is mostly found to be negative in quantitative studies. For example, attempts to control both the emotions of the self and others were associated with low job satisfaction amongst university employees (Pugliesi, 1999), and emotional regulation was also negatively related to job satisfaction in human service employees working in health care (Bono, Foldes, Vinson, & Muros, 2007).

The suppression of unpleasant emotion (surface acting) has been associated with low job satisfaction, and in turn, higher intentions to quit (Côté & Morgan, 2002), and emotional dissonance was found to be negatively related to satisfactory work relations (Cheung & Tang, 2007). In another study, a similar negative relationship between emotional labour and job satisfaction existed, but was moderated by gender, emotional intelligence and job autonomy (Johnson, 2004).

Other studies have produced more mixed results. The perceived requirement to express positive emotion was associated with greater job satisfaction in comparison to the perceived requirement to display negative emotion (Diefendorff & Richard, 2003). Amongst clinical nurses, surface acting was found to be unrelated to job satisfaction whereas deep acting had a positive relationship with job satisfaction (Yang & Chang, 2007).

The general finding that emotional labour has a negative impact on an employee’s sense of job satisfaction is not universal. Wharton (1993) found that employees in high emotional labour occupations were more satisfied with their jobs as opposed to those in occupations with a low emotional labour content, although
classification of emotional labour and non-emotional labour jobs was theoretical rather than empirical.

More telling evidence of a positive relationship between emotional labour and job satisfaction can be found in qualitative studies which have examined emotional labour in a variety of nursing groups. For example, nurses from mixed settings spoke of their satisfaction with their emotional labour work (Henderson, 2001), and despite sometimes being emotionally upsetting (Smith, 1992; Staden, 1998), nurses explained how they derived a great deal of personal satisfaction from their interactions with patients, and this included how they managed their emotion to help patients. In a specialist baby care unit, Lewis (2005) showed that even in the stressful event of a baby death, the emotional engagement with parents was a source of satisfaction.

Palliative care nurses have been found to derive a deep satisfaction from their emotional labour with clients. The emotional engagement with clients is also seen by palliative care nurses as a key aspect of their role. For example, Li (2005) found that palliative care nurses and clients collaborated closely and shared stories of the insensitivity of doctors, which engendered close relationships and was mutually beneficial. Similarly, the connection created between nurses and clients in the process of assisting clients to come to terms with death was found to be extremely satisfying for nurses (Mok & Chiu, 2004).

Overall, subjective perceptions of job satisfaction can be seen to be negatively associated with emotional labour in quantitative studies, although there may not always a direct relationship between the two factors. As with burnout, surface acting appears to
be associated with poorer outcomes. In contrast, qualitative assessments of how nurses in a variety of settings describe their interactions with clients show that they garner satisfaction from this work, although even amongst the extensively studied palliative care group, the identification of surface and deep acting or any other specific emotional strategy in the research is thin. Therefore, further investigation of how nurses and others in health care manage emotion and conduct emotional labour, as well as how these strategies are associated with job satisfaction, are important areas for emotional labour research that are currently lacking.

3.1.3 Psychosomatic associations with emotional labour. Studies that have examined the relationship between emotional labour and psychosomatic complaints, including affective wellbeing and physical symptoms of stress, have mostly shown the same pattern of results as for other outcomes. As is clearly the case for much of the emotional labour research, surface acting (or emotional dissonance) is often seen as the harmful strategy of emotional labour. For instance, surface acting was related to negative affective wellbeing (measured by subjective mood states), although this relationship was moderated by gender, with females more likely to show negative effects when surface acting than males (Johnson & Spector, 2007). Similarly, even though emotional labour was found to generally lead to deficits in affective wellbeing, this was especially the case for females who used surface acting (Johnson, 2004). Zapf et al (1999) also found that emotional dissonance was associated with physical complaints such as headaches and insomnia, and Erickson and Wharton (1997) found evidence that inauthentic emotional displays can lead to depression.
In research that did not differentiate between forms of emotional labour, requirements to control the feelings of the self and others were both associated with increases in psychological distress (Pugliesi, 1999). A similar finding was found in the discovery of a relationship between the requirement to express positive emotion and physical symptoms such as insomnia (Schaubroeck & Jones, 2000).

### 3.1.4 Performance and organisational outcomes of emotional labour.

Negative personal wellbeing associations with surface acting have correlates in performance and organisational outcomes. This is perhaps most easily explained as a function of the likelihood that customers may be able to perceive the inauthentic emotional displays that typify surface acting, thus resulting in more difficult interactions (Ekman, Friesen, & O'Sullivan, 1988). In support of this view, it was shown that call centre workers who used deep acting were more likely to perform their role to a higher level (Totterdell & Holman, 2003). Grandey (2003) found that customers perceived deep acting to be more authentic, which in turn lead to positive interactions between employees and clients. It was also been found that customer affect was moderated by the percieved authenticity of the employee’s expression (Hennig-Thurou, Groth, Paul, & Gremler, 2006).

Together, these results are indicative of the performance related benefits of deep acting over surface acting as an emotional labour strategy. Furthermore, if surface acting is associated with poorer interactions between employees and clients due to client perceptions of inauthentic expressions, surface acting may also lead indirectly to feelings of reduced efficacy for employees.
3.2 Moderators of Emotional Labour.

3.2.1 Social support. Social support is perhaps seen as the most important moderator of emotional distress and outcomes such as burnout (Eisenberger, Huntington, Hutchison, & Sowa, 1986; Halbesleben, 2006; House, 1981). The subjective perception of social support has generally been identified as important in terms of its association with positive wellbeing outcomes for individuals and organisations (Halbesleben, 2006); with for example, social support being associated with reduced symptoms of depression either directly or as a buffer against stress (Cohen & Wills, 1985).

In organisational terms, social support has been identified as having two main forms; instrumental support which is assistance provided in order to carry out role requirements, and emotional support, consisting of talking through emotionally upsetting experiences or the discussion of feelings (Zapf, 2002).

There have been four main sources of support studied in organisational psychology literature, including perceived organisational support (Rhoades & Eisenberger, 2002), perceived support from supervisors, (Schriesheim, Castro, & Cogliser, 1999), perceived co-worker support (La Rocco & Jones, 1978), and perceived support from family members and friends (Baruch-Feldman et al., 2002).

In a meta-analysis of the relationships between these sources of support and the three burnout dimensions, all sources were found to be significantly related to all burnout dimensions, except for a non-significant relationship between family/friends support and depersonalisation (Halbesleben, 2006). Perceived organisational support has
also been associated with job satisfaction and reduced intentions to quit (Cropanzano, Howes, Grandey, & Toth, 1997; Eisenberger, Cummings, Armeli, & Lynch, 1997), and perceived support from co-workers and supervisors has been suggested as a factor in the retention of child welfare employees (De Panfilis & Zlotnik, 2008).

In emotional labour research, there is some evidence of a moderating effect of social support between emotional labour and negative wellbeing. For example, the negative relationship between emotional dissonance and job satisfaction in a sample of customer service workers was found to be significantly moderated by social support from co-workers (Abraham, 1998). Teachers showed a similar relationship of factors, with surface acting being linked to high levels of emotional exhaustion which was reduced with increased social support from co-workers (Näring et al., 2006).

Other research in which emotional labour is assumed to be high but was not actually measured has shown similar patterns. In call centre operators, support from supervisors was negatively related to emotional exhaustion (Wilk & Moynihan, 2005), and combined supervisor and co-worker support was associated with reduced emotional exhaustion and increased job satisfaction (Lewig & Dollard, 2003). In a sample of prison officers, reduced social support was associated with emotional exhaustion, leading to depressive symptoms and absenteeism (Neveu, 2007). Co-worker support amongst prison officers has subsequently been recognised as an important factor for organisations to nurture and facilitate in order to counter work related stress (Tracey, 2008). As with prison officers, traffic wardens experience a high degree of interpersonal conflict as a normal aspect of their role. Support from family members was associated
with reduced burnout for this group, and supervisor support was associated with higher productivity and job satisfaction (Baruch-Feldman et al., 2002).

In studies of nursing, emotional support from co-workers has been identified as important when nurses experienced grief in relation to patients (Staden, 1998), and where co-worker support was lacking, nurses experienced greater stress but the negative effects of emotional labour was moderated by support from supervisors [ward sisters] (Smith, 1992). In qualitative studies, nurses have described the importance of support from supervisors and co-workers as an important coping mechanism in direct relation to the interaction aspects of their role. For example, ward sisters have been described as crucial in setting the emotional tone of the ward, and for providing leadership and direction in emotional expression, whereas co-workers were seen as more important in providing moment-to-moment emotional support (McCreight, 2005). In line with the importance of co-workers as providers of support in relation to specific incidences, both instrumental and emotional support from co-workers was interpreted as an important mechanism to allow nurses to reflect on how they carried out emotional labour and on their relationships with patients (Huynh, Alderson, & Thompson, 2008). Interestingly, most of the qualitative research that has examined the importance of support is devoid of references to the organisation more broadly.

The evidence supports the notion that social support plays an important role in positive wellbeing outcomes for individuals in organisations. In particular, and with reference to Hobfoll’s (1989) COR model, in situations in which emotional expenditure is substantial, emotional support may be particularly relied upon. However, currently lacking in the research is a focus on how support is relied upon and provided in health
groups with distinctive forms of interactions. In addition, many quantitative measures of support are broad, without distinguishing emotional and instrumental aspects.

**3.2.2 Personality and affective disposition.** Personality dimensions, as described in the five-factor model (e.g. John & Srivastava, 1999; McCrae & Costa, 2003) have been associated with emotional labour strategies and resulting wellbeing. The theoretical underpinnings of the five factor model suggest that individuals high in extraversion, conscientiousness, openness to experience, emotional stability and agreeableness should be associated with more positive emotions and an optimistic and engaging approach to interactions with others compared to those who exhibit lower levels of these traits (McCrae & Costa, 2003). Therefore, personality dimensions have been examined in relation to way in which emotional labour is carried out, as well as the resulting wellbeing outcomes.

Individuals high in positive affectivity are thought to be naturally inclined to display positive emotions and have an optimistic outlook compared to those more prone to negative affectivity (Weiss & Cropanzano, 1996). In terms of emotional demands, those high in negative affectivity are expected to find compliance with display rules for positive emotion more difficult in challenging situations where their natural tendency toward a negative affective state is elicited (Morris & Feldman, 1996), such as when dealing with an argumentative or abusive client.

Evidence for the importance of personality and affective states in the performance of emotional labour was supported in research that showed extraverts were able to comply more naturally with the requirement for positive emotions, whereas
participants high in neuroticism relied on surface acting and therefore required a greater effort to comply (Diefendorff et al., 2005). Highly conscientious and agreeable individuals also used less surface acting to comply with display rules, which was thought to be the result of a greater level of dependability and a valuing of positive interactions. The same research also found that the use of natural emotion to comply with display rules was predicted by extraversion and agreeableness, possibly due to the positive affectivity of these traits and the natural compliance with the requirement for positive emotional expression in the role. Finally, deep acting was predicted by agreeableness, with Diefendorff et al. (2005) suggesting that the tendency of agreeable individuals to value positive interpersonal experiences may lead to attempts to actually feel the required emotion.

In a meta-analysis, low neuroticism and high extraversion were proposed as the over-riding moderating factors that positively influence job satisfaction when emotional labour is required (Bono & Vey, 2005). Supporting this, in a variety of occupations, Diefendorff and Richard (2003) uncovered differences between those high in neuroticism and others, with neurotic individuals being more aware of requirements to suppress negative rather than display positive emotions. In turn, being aware of positive emotional requirements was associated with greater job satisfaction, leading to the conclusion that neurotic individuals may be less satisfied with jobs in which they must conform to display rules, due to a natural tendency toward negative affect. Also, Tan, Foo, Chong and Ng (2003) found that extraversion was associated with the display of positive emotions, whereas neuroticism was associated with the display of negative emotions. As the participants in this research were recruited from a fast-food chain in
which positive emotional expression is an explicit expectation, the natural affective state of extraverts can be seen as resulting in an easier compliance with requirements.

Overall, due to the general requirement for the display of positive emotions and the constraint of negative emotions in jobs with high levels of interpersonal relationships, a natural tendency toward positive affect may result in an easier compliance with display rules. Where more effort to comply is needed, particularly where this effort results in the form of surface acting, it is reasonable to expect a high level of negative wellbeing and organisational outcomes. Therefore, employees higher on extraversion, agreeableness, and conscientiousness, may tend to avoid surface acting and adopt deep acting as an emotional labour strategy, which may result in an easier compliance with display rules and more positive wellbeing outcomes.

3.2.3 Emotional intelligence. Emotional intelligence is relevant to emotional labour discussions due to its close conceptual association, particularly in relation to issues of the purposeful management and use of emotion. Like emotional labour, the concept of emotional intelligence and the way in which it has been conceptualised and studied is a hotly debated issue in psychology. There are three main theoretical points of view in respect to emotional intelligence (Clarke, 2006b). These include Salovey and Mayer’s (1990) four facet emotional abilities model, which is assessed by a performance test; a model emphasising non-cognitive skills and competencies which allows an individual to effectively cope with environmental demands (Bar-On, 2003); and a broader conceptualisation encompassing a wide range of abilities such as motivation, empathy and hope (Goleman, 1995).
Goleman and Bar-On’s theoretical approaches to emotional intelligence have received a great deal of criticism. For example, Goleman’s (1995) description of emotional intelligence and his subsequent application to the workplace (Goleman, 1998) have been widely criticised for consisting of far too many components to be seriously considered as representing a distinct factor (Ashkanasy & Daus, 2005; Hedlund & Sternberg, 2000; Salovey & Mayer, 1990). Furthermore, self-report measures of emotional intelligence have been found to be confounded with personality dimensions, indicating that these measures of emotional intelligence add little to what is offered by existing personality theories (Brackett & Mayer, 2003; Davies, Stankov, & Roberts, 1998; Mayer, Salovey, & Caruso, 2000; Schutte et al., 1998). The argument against the emotional intelligence conceptualisations of Bar-On (2003) and Goleman (1995, 1998) is summarised by McRae (2000) who argued that the close relationship with existing personality measures and the inclusive nature of these theoretical positions as a panacea for everything, leaves emotional intelligence, as a concept, on shaky ground.

The four branch model of emotional intelligence can be seen as a more discriminate view of emotional intelligence as it focuses on the perception, management and functional use of emotion and excludes facets such as motivation and empathy, which should not be seen as abilities. Elements include the ability to perceive, understand and regulate emotion in the self and others, and the ability to use emotion purposively (Davies et al., 1998; Mayer, Salovey, & Caruso, 2004a; Salovey & Mayer, 1990). The ability to appraise the emotional state of the self and others and the functional use of emotions can be seen as a specific set of skills and less of a global view of an individual’s functioning (Salovey & Mayer, 1990). The four branch model
has also been found to be distinct from personality measures (Brackett, Mayer, & Warner, 2004) and confirmatory factor analyses have confirmed most of the distinctions suggested by its proponents (Rossen, Kranzler, & Algina, 2008).

3.2.3.1 Emotional intelligence and emotional labour. Despite questions surrounding the validity of self report measures of emotional intelligence, these measures have been used in emotional labour research. Wong and Law (2002) developed a self-report measure of emotional intelligence with the items based on the four branch model (Salovey & Mayer, 1990). These researchers found that emotional intelligence was positively associated with job performance, commitment and negatively related to turnover amongst employees who engage in a substantial level of emotional labour, as judged by supervisors. Where emotional labour was not a substantial aspect of the role, no such association between emotional intelligence and outcomes was observed (Wong & Law, 2002). In two further studies that utilised Wong and Law’s (2002) measure, Johnson (2004) found that emotional intelligence moderated the relationship between emotional labour and affective wellbeing, emotional exhaustion and job satisfaction, but Johnson and Spector (2007) failed to find this relationship. Again using a self-report measure, Mikolajczak, Menil, and Luminet (2007) found that nurses high in emotional intelligence expended less effort in conforming with display rules. In turn, nurses high in emotional intelligence experienced less burnout and somatic complaints.

In a qualitative review of the nursing literature, McQueen (2004) showed that emotional intelligence may be an important factor in the successful performance of emotional labour, having influence over how emotions are expressed and managed,
leading to higher quality care. Similarly, Rubin et al. (2005) argued that individuals with a high level of emotional intelligence are likely to experience less emotional dissonance due to their ability to interpret and manage the emotions of others. As previously discussed, lower levels of emotional dissonance (or the behavioural manifestation of surface acting) have been associated with more positive wellbeing outcomes. Another explanation for an association between emotional intelligence and wellbeing when emotional labour is required could be that those with a greater emotional awareness may be able to more easily identify and correct their own emotional expressions that do not comply with requirements (Ciarrochi, Caputi, & Mayer, 2003).

It appears that emotional intelligence can be considered as a moderator of some of the negative wellbeing effects of emotional labour. In particular, the correct assessment of the emotional state of an individual, and the ability to appraise and use emotion of the self and others to control interactions, may lead to more positive interactions and wellbeing outcomes.

**3.2.4 Gender.** Hochschild’s (1983) original perspective of emotional labour took into account the gendered nature of expectations of emotional work, and how females were predominant in roles in which emotions were a central part of the role. This perspective has continued in subsequent emotional labour research. In an investigation of the Australian airline industry, Williams (2003) went as far as to suggest that female flight attendants were subjugated and treated as emotionally compliant objects. Furthermore, Williams argued that airlines promoted this sexist view of female flight attendants in order to shore up return business and profits. For example, airlines discouraged complaints against passengers who sexually abused flight attendants and
supported archaic work practices that promoted a strict hierarchy in which male flight crews were given unnecessary employment advantages over the mostly female flight attendants (such as the flight crews being given check-in priority for hotel accommodation).

Even in health care, there is clear evidence of the gendered nature of emotional work. For example, Timmons and Tanner (2005) showed how female theatre nurses played a hostess role to male surgeons, and nursing as the “caring” profession has always been seen as women’s work (Smith, 1992). This gendered bias has clear organisational implications in terms of how employees are viewed and treated.

Even though emotional work expected of employees may differ depending on their gender, an examination of these differences is difficult in the current research. As a very high proportion of nurses are female, any realistic comparisons between genders would be difficult. Medical doctors may provide a more equivalent gender mix opposed to nurses, however officers from the participating organisations advised against recruiting doctors as participants because of previous poor response rates due to excessive workloads and other access difficulties. Therefore, an examination of how gender may play a part in how employees perceive their emotional expectations and act accordingly is beyond the scope of the current research.

3.3 Display Rules and Other Antecedents of Emotional Labour

3.3.1 Perceived display rule requirements. Display rule requirements are the rules or emotional parameters imposed on employees, which serve to guide interactions with customers and other individuals in the workplace (Morris & Feldman, 1996).
Often, display rule requirements are thought of in terms of the requirement to display either positive or negative emotions as the situation dictates (Zapf & Holz, 2006). Ashforth and Humphrey (1993) suggest that the whole notion of the management of emotion in the workplace is based on a combination of organizational, social, and occupational norms. Grandey (2000) focuses on organizational factors such as the influence of strict display rules, but this may be best suited to work situations that require a specific, almost standardised approach to customers such as for supermarket clerks (Rafaeli & Sutton, 1987), in customer service (Ashforth & Humphrey, 1993), or in call centres (Goldberg & Grandey, 2007; Holman et al., 2002). In the case of professional occupations such as nursing, professional standards may be more influential than those imposed organisationally (Kramer & Hess, 2002; Ogbonna & Harris, 2004).

The perceived requirement to display particular emotion has been directly linked to wellbeing outcomes. For example, Schaubroeck and Jones (2000) differentiated between the requirement to express positive and negative emotion, finding that when positive emotions were required, job satisfaction was higher compared to when negative emotions were required. However, demands to express positive emotion were related to health symptoms (e.g. sleep disturbances, time away from work due to illness) if employees had a low job involvement or did not identify with their role.

The notion of professional or occupational display rules may have particular resonance within the health sector, particularly amongst health care professionals. For example, there is evidence of a clear delineation in the emotional expression expectations between nurses and doctors (Griffin, 2003; Timmons & Tanner, 2005), and
nursing carries with it the expectation of a certain level of emotional involvement with clients (Smith, 1992). There are several professionally derived, overarching standards for behaviour and guidelines for how interactions between nurses and clients should be managed in Australia. Two of these are codes of ethics (Australian Nursing and Midwifery Council, 2008a), and professional conduct (Australian Nursing and Midwifery Council, 2008b). The code of ethics for Australian nurses highlights the vulnerability of patients and the subsequent requirement by nursing staff to recognize and manage the power differential that this vulnerability creates. The code of professional conduct for nurses explicitly forbids close personal relationships between nurses and patients or their family members. Each place the responsibility for ensuring boundaries that are maintained on nurses. While these guidelines do not specifically prescribe the exact manner in which emotions should be displayed or withheld, they do provide general parameters for behaviour, which may affect the way in which emotions are expressed.

In addition to the above codes, there exists a state government policy with jurisdiction over all health sector employees. The policy and guidelines for the prevention of workplace aggression and violence sets out the rights of health sector employees to be free from aggression and violence in the workplace (Department of Health Western Australia, 2004). This policy applies to all incidences of aggression and violence in all health sector occupations, and therefore covers all employees participating in the current research. Importantly, the policy states that there is a zero tolerance of abusive and violent behaviour from clients towards employees, which may
have ramifications for how employees respond to abusive behaviour from clients and
how they manage emotion as a result.

3.3.2 Antecedents, emotional labour, and outcomes. The frequency, variety, intensity, and duration of emotional expression have been considered as antecedents of
the emotional labour process in previous research (Brotheridge & Lee, 2003). Studies
investigating these four variables have produced mixed results. For example, all four
components have been found to have a positive relation to deep acting, and all except
duration was positively related to surface acting (Brotheridge & Lee, 1998, 2003). In
another study, the duration of emotional expression predicted deep acting (Diefendorff
et al., 2005), indicating that deep acting may be more prevalent in longer rather than
shorter interactions.

Closely related to the perceived requirements for the frequency, variety, duration
and intensity of emotional expression is the notion of emotional autonomy. Where the
above factors are more strictly outlined and enforced by the organisation or professional
standards, emotional autonomy is lower. In support of the idea that a greater latitude for
emotional expression would be positively associated with wellbeing (Ashforth &
Humphrey, 1993), high perceived emotional control (i.e. low emotional autonomy) has
been associated with greater levels of burnout (Brotheridge & Grandey, 2002). This
suggests that those with tighter emotional demands in their jobs may be more prone to
burnout than those without such demands. In another study, perceived supervisor
demands for employees to comply with display rules was associated with emotional
exhaustion but his relationship was moderated by employee career identity (Wilk &
Moynihan, 2005), raising the possibility of a professional versus non-professional dichotomy as a factor that may impact on coping.

### 3.4 Conclusions

Important themes identified from the research review considering the components of emotional labour as strategies of expressing and constraining emotion clearly indicate the areas of research need.

- **Outcomes of surface and deep acting:** It is generally agreed that surface acting (or the closely related concept of emotional dissonance) is a harmful emotional labour strategy (e.g. Brotheridge & Grandey, 2002; Grandey, 2003; Seery, Corrigall, & Harpel, 2008). Where employees regularly mask negative emotion or fake a positive demeanour, negative personal and organisational outcomes tend to result. Deep acting, however, is not associated with the same problematic outcomes, with little evidence of any systematic, negative personal or organisational outcomes (e.g. Totterdell & Holman, 2003; Zammuner & Galli, 2005; Zhang & Zhu, 2008). Therefore, if there are situations or settings in which employees are more likely to use surface acting, or if there are situations in which surface acting may be more detrimental, this information is essential to enable organisations to respond through training or extra support.

- **Management of natural emotion as an additional emotional labour strategy:** While the use of natural emotion has been discussed briefly, it
has received little attention. Diefendorff et al., (2005) showed the use of natural emotion to be not only a distinct factor from surface and deep acting, but also the most prominent emotional labour strategy used by undergraduate students who were also employed in sales, service, healthcare, childcare, and clerical roles, and and Näring and van Droffelaar (2007) found emotional consonance to be associated with better outcomes than other emotional labour strategies amongst nurses. In addition, there are no studies concerning how natural emotion may be managed to comply with expectations. Given the divergent wellbeing outcomes of surface and deep acting, the role and use of natural emotion as a prominent emotional labour strategy needs to be further established.

- **Specific outcomes of emotional labour for nurses**: Associations between emotional labour and poor wellbeing outcomes are much less prominent amongst nurses than other professions. Qualitative research shows that nurses are both engaged with the emotional aspect of their role, and derive a great deal of satisfaction from this work (e.g. Li, 2005), and this is even the case where nurses have used surface acting to express or constrain negative emotion (e.g. Bolton, 2000b). Previous research focused on low status, process driven roles, such as call centre operators (Grandey et al., 2004) or customer service employees (Johnson & Spector, 2007), may show less positive wellbeing outcomes due to tight constraints on how emotions can be managed (low emotional autonomy) or because of the need for deferential treatment towards customers in
profit driven industries. It is also possible that a nurse’s identity as a carer may result in an alignment between personal expectations of a high level of emotional engagement with clients and the actual requirements of the role (Ashforth & Humphrey, 1993). The identification of how perceptions of role responsibilities and requirements are associated with emotional labour and wellbeing, and how these differ according to context is crucial to understanding why nurses may have less problematic outcomes from their emotional labour.

- **Social support as a coping mechanism:** Social support is an important factor in improving wellbeing outcomes, and nurses in particular describe more positive wellbeing outcomes when emotional resources are replenished by the social support derived from supervisors and co-workers (Huynh et al., 2008). Even in occupations where wellbeing outcomes from emotional labour are largely negative, social support provides protection and moderates the negative relationships between emotional labour and wellbeing (Lewig & Dollard, 2003). However, the source of support and its relative importance in assisting employees to cope with emotional labour depending on the emotional requirements of the role is less well understood, and requires further research.

- **Individual factors:** Because most emotional labour requirements consist of demands for the display of positive emotion, it appears that disposition, and in particular a natural tendency towards a positive affect, may well be important in countering negative outcomes (Bono & Vey,
Where individuals have a natural tendency toward positive affect, display requirements may be easier and require less effort. This is likely to be especially important in difficult interactions, in which employees prone to negative affect may struggle to mask a tendency towards negative emotional displays. Personal traits that predict wellbeing outcomes in this context are important to understand.

- **Emotional intelligence**: Emotional intelligence, the ability to understand and manage the emotions of the self and others, is likely to be especially important in potentially volatile situations in which an accurate assessment of the emotional state of clients is important in shaping the interaction, and when the employee is actively engaged in managing the emotional state of clients (McQueen, 2004). Further understanding of how the emotional state of clients is assessed and the importance of this assessment in directing the emotional labour strategies of employees will provide a deeper understanding of how emotional labour is managed by employees.

There is a paucity of research examining emotional labour components in specific nursing groups, the differences in emotional requirements, and how any varying requirements are associated with wellbeing outcomes. An exploration of the overall emotional labour process in greatly differing circumstances in this occupation, in which emotional engagement is such a central focus, is warranted. In addition, clerks provide an important comparison. They work in the emergency departments of public hospitals, alongside emergency nurses and deal with many of the same clients under similar
circumstances, but perhaps without the identity as carers, or the same responsibility for client welfare.

The current research will examine employee perceptions of display rules and how they are derived, subsequent methods of conducting emotional labour, and factors that moderate the relationships between individual emotional labour strategies and wellbeing. Natural emotional expression as an emotional labour strategy is relatively unexplored, so this also will constitute a research focus.
Chapter 4: Study 1: Interviews with Health Care Workers: Setting the Scene (Study 1)

4.1 Research Focus

The overall purpose of the interviews was two-fold; first, to provide qualitative descriptions addressing the broad research aims, and second, to guide the development of a survey instrument for distribution on a wide scale within the four groups of interest.

The interviews were driven by the findings of previous research and the need to explore and understand the identified under-researched areas of emotional labour in the broad arena of health care. Three research aims were proposed in Chapter 1. Specific research questions were developed from those aims and examined in this study:

1. To assess how employees are aware of necessary and appropriate emotional management, how they assess their level of responsibility for this and how these perceptions may differ depending on their role and the context.

Research questions:

a. Which emotional displays are considered appropriate by employees?

b. How do these perceptions of the appropriate emotional displays differ according to the role or context?

c. Do perceptions of the responsibility for emotional engagement with clients differ according to the role or context?

d. How do employees know which emotional displays are appropriate?
e. What role does emotional intelligence play in emotional labour?

2. To examine the methods by which employees manage their own and others’ emotions in the workplace.

Research questions:

a. How is emotional labour conducted by employees in the four health care contexts?

b. What is the role of natural emotion in emotional labour?

c. Do the context or occupation have an impact on which emotional labour strategies are used?

3. To examine the differences in emotional management, well being outcomes of emotional management and factors impacting on these, dependent on context and role.

Research questions:

a. What are the relationships between emotional labour strategies and wellbeing?

b. Do wellbeing outcomes differ depending on the context or occupation?

c. What are the relationships between emotional labour, social support, and wellbeing?
d. Do the relationships between emotional labour, social support and wellbeing differ depending on context or occupation?

e. What role do individual differences such as personality play in emotional labour?

Study 1 consisted of semi-structured interviews with participants from four health care groups. The use of semi-structured interviews allowed for the use of specific research questions to be addressed, whilst also providing the opportunity for detailed descriptions and explorations of how emotional expression is perceived and managed and the form and relative importance of influencing factors such as social support. Given that this research is focused on specific groups in health care, which have been previously unexplored, it was able to yield new information in respect to the way emotions are expressed, controlled and managed. Nurses from palliative care, renal wards, and an emergency department as well as clerical employees from the emergency department of a metropolitan public hospital were recruited.

4.2 Method

4.2.1 Participants. Participants were recruited from two metropolitan public hospitals, one regional public hospital and a non-profit community nursing organisation. All of the above organisations were situated within approximately 75 kilometers of the Perth CBD.

The 21 participants (17 female, 4 male), included five emergency nurses, five emergency clerks, five renal nurses, and six palliative care nurses. The demographic information collected from participants was their gender and the length of time
employed in their current area of work, which varied from six months to 25 years. Ranges of length of service in the four areas were as follows; emergency nurses, two to 25 years; emergency clerks, six months to 30 years; palliative care nurses, one year to 25 years; and renal nurses, ten years to 27 years. To protect confidentiality, the gender breakdown of each group is not provided as it would be likely to identify male participants.

4.2.2 Research settings. The four groups from distinct settings were chosen as representations of very different forms of employee-client contact in terms of the interaction length (for individual interactions and ongoing contact), and the perceived volatility and emotionality of each setting. The four groups are described below.

4.2.2.1 Palliative care. Due to the necessity of dealing with end of life issues with both patients and their family members, palliative care work has previously been described as consisting of a substantial degree of emotion management and a close involvement with clients (Skilbeck & Payne, 2003). The community palliative care nurses interviewed in this study were all employed by a single service provider. These nurses provide a visiting service to homes of clients who have been diagnosed with a terminal illness. The nurses visit clients on a rotational basis, however the actual visiting schedule varies depending on the workload of the nurse and client needs. The length of interaction between nurses and clients varies, but nurses described interactions of an hour or more, once or twice a week, for anything from one or two weeks up to several months, as within the normal range. The community palliative care nurses worked out of one of several bases situated around the metropolitan area.
An initial assessment of the interview data showed very different attitudes of the community palliative care nurses towards their employer than was the case for all other nurses and the clerks. Therefore, a palliative care nurse from a dedicated palliative care ward in a private hospital was also interviewed [PN6] to check for consistency with the community palliative care nurses. Points of difference between the community and hospital based palliative care nurses are indicated in the analysis.

4.2.2.2 Emergency nurses. Individual interactions between nurses and clients in public hospital emergency departments vary in duration but are usually singular. The interactions can be short, less than one hour, or they can last several hours, although due to overcrowding there are exceptions to this with some patients having to wait in the emergency department for a few days before being transferred to a ward. In general terms however, there is little chance for the development of ongoing relationships between nurses and clients in the emergency area. The emergency environment may best be described as unpredictable in terms of both work intensity and emotional involvement. Due to the nature of emergency admissions and occasional lengthy waiting times, nurses in this area must deal with stressed and anxious family members as an ongoing aspect of their role. In addition, these nurses are often required to treat and deal with drug affected individuals who may be exhibiting irrational behaviour.

All of the emergency nurses interviewed in this study were recruited from a single metropolitan public hospital. The emergency department deals with members of the public who come to the hospital voluntarily, with or without the assistance of family members, friends or some other agent as well as those brought in by ambulance. This
results in a volatile and somewhat uncertain environment which can change rapidly, creating shifting priorities and varying levels of work intensity.

4.2.2.3 Patient registration clerks. All clerical interviewees worked in a patient registration role as at least part of their duties and all worked in the same hospital as the emergency nurses. The clerks can be seen as counterpart to the emergency nurses as both groups deal with at least some of the same clients in roughly the same timeframe, in similar circumstances, and in reasonably close proximity. However, there are some major differences between the emergency nurses and patient registration clerks in terms of interactions with clients. First, the patient registration clerks work from behind a security screen and are therefore physically separated from clients. In the event of an emotionally disturbing incident, clerks are able to walk away from the interview window and remove themselves from the interaction. Second, the clerks’ role mainly consists of information gathering. They may not be seen as, or see themselves as, care providers in the same way as nurses. These factors could result in a lower level of emotional engagement with clients and a lower level of responsibility for the emotional state of clients.

4.2.2.4 Renal nurses. Renal nurses were recruited from three wards from different hospitals. In terms of contact with clients, it could be the case that nurses working in renal dialysis wards would have amongst the lengthiest and most intense level of contact with clients compared to most employee-client interactions in any industry. Often in renal dialysis cases, contact with patients lasts for several hours a day, over three days a week, often for ten years or more. Patients receiving renal dialysis usually only cease dialysis in the event of either a kidney transplant or death. Due to the
chronic nature of the illness which requires the same treatment each time, and due to the predictability of the interactions, renal wards can be seen as comparatively stable environments compared to the other three settings. The type of interaction between nurses and clients in renal wards may lead to the formation of more enduring and natural type friendships as opposed to most employee-client relationships.

4.2.3 Procedure The researcher made contact with an officer from each organisation to explain the study and arrange distribution of study advertisements. Attention was also drawn to the research by the relevant contact officer in each organization. The study advertisement (see Appendix A) included basic information concerning questions to be addressed by the research as well as the research aims, the likely duration of the interview, and the contact details of the researcher. Prospective participants contacted the researcher voluntarily. Once participants had made contact with the researcher, an interview was organised at a time and place suitable to the participant.

Each participant was provided with a detailed information sheet (see Appendix B) outlining detailed information about the study including sections on background information, aims, possible benefits and risks, and the same contact details as in the advertisement. There was also a section outlining the interviewer’s right to withdraw participation and consent at any time. All participants provided written consent (see Appendix C for the contents of the consent terms).

A semi-structured protocol was used (see Appendix D). The protocol’s purpose was to gather information in five broad areas; (i) the participant’s recollection of
extraordinary and typical interactions with patients that required them to manage their own emotions and the emotions of clients (emotional labour requirements), (ii) the participant’s impressions of which emotional displays are expected and those that are unacceptable and the issues involved in meeting these expectations (display rules and other antecedent factors), (iii) the emotional responses from patients and/or family members and their impact on the participant (specific setting impacts), (iv) factors that make the emotional aspect of the work easier, assist in coping with emotional demands, and generally make the work more enjoyable or difficult, (v) and the participant’s view of the personal characteristics that makes someone successful in dealing with the emotional aspects of the role. Theoretical terms such as emotional labour, surface acting and deep acting were explicitly omitted from the interview questions. Instead, participants were asked about their interaction with patients and family members and the emotional requirements and emotional management which occurred as an exceptional as well as a normal part of their role.

Interviews were audio-recorded and transcribed and notes were taken by the interviewer. Due to excessive background noise, one of the interviews with a renal nurse was unable to be transcribed [RN1]. However, with reference to the notes of the interviewer, it was considered that the content of this particular interview was consistent with the themes raised and the general descriptions of how emotions were expressed, managed and dealt with amongst the other renal nurses. The transcribed interviews are provided in Appendix E, recorded on the enclosed compact disk.
4.3 Analytic Approach to Interviews

A qualitative analysis approach as described by Dey (1993) was used, which provides detailed instructions for the coding of data which allows for the incorporation of both theoretical and explorative elements. The process involves generating broad categories of responses, each with more detailed sub-categories as a method of extracting common responses among participants or sub-groups. It is very similar to thematic analysis (Braun & Clarke, 2006) and methods used by others (e.g. Clarke & Kitzinger, 2004; Frith & Gleeson, 2004; Pollio & Ursiak, 2006).

As outlined in Dey (1993) there is a multi-stage process. First, recurring themes were identified and noted during the interviews. For example, across almost all participants there was an indication that each interaction had to be managed individually, indicating the absence of a homogenous, highly scripted approach to interactions with clients in any of the sub-samples. Second, each segment of transcribed data relevant to the research questions was coded as a very short paraphrase of what was said. For example, the comment of one participant when discussing the organisational response to a violent patient incident was;

“We had nurse managers come and speak to us but that’s a little bit of a not so good point with me because there’s been no follow up as of six months down the track. I was sent an email with regards to occupational safety people coming to speak to me and going to one of their meetings but it didn’t happen. It still hadn’t happened after six months…”

This segment was coded as (i) perception of inadequate organisational support, (ii) negative feelings toward the organization.
Third, all the individual codes were then sorted into themes and sub-themes, which were checked for their prevalence in the data. Those themes that had limited support across the entire data set or among the participants from the individual areas of interest, or were not considered relevant, were either incorporated into more well-supported themes or eliminated. The final main themes were then checked with the data extracts to ensure the theme was an accurate representation of the data and that names of the themes captured the essence of its content. A summary of the themes identified in the interviews can be seen in Table 4.1. The analysis of the data, following in Chapter 5, is presented in accordance with the themes in Table 4.1 except where indicated in the analysis.

To identify the source of quotations, all comments in the analysis have been labeled with a code indicating the participants’ group (either E [emergency], P [palliative care], or R [renal]), their occupation (N [nurse] or C [clerk]) and a numerical designation (from 1 to 6). The code identifying the participant is displayed at the end of each quote (e.g. [EN4], denoting emergency nurse number four).
Table 4.1 Categories, themes, and sub-themes identified in the Study 1 interviews.

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<thead>
<tr>
<th>Categories</th>
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<td>Non-expressive Emotional</td>
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<td>Management</td>
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<td>Outcomes</td>
<td>Job satisfaction</td>
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Chapter 5: Interviews with Health Care Workers: Data Analysis (Study 1)

The data analysis follows the format presented in Table 4.1 with minor variations indicated in the analysis.
5.1 Emotional Engagement.

A substantial point of difference between the four groups was the level of perceived emotional engagement required as an aspect of the role. These group differences were associated with differences in the amounts of emotional labour and other emotional management strategies that were conducted as well as the purpose for emotional management.

Previous research examining self perceptions in terms of the centrality and importance of emotional engagement found that nurses tend to perceive their role in either one of two ways; as either interpersonally or instrumentally focused (Millward, 1995). Millward suggests that interpersonally focused nurses take a more traditional view of their role of nurses as carers, while instrumentally focused nurses see themselves as being more professionally and clinically oriented. The current research showed distinctions along these lines as well as a clear difference between nurses and clerks in how they perceived and carried out their roles.

5.1.1 Palliative care. For palliative care nurses, the interpersonal functions and the relationship with clients was crucial in helping to achieve what some nurses referred to as “a good death”. Palliative care nurses described a very intense and prominent level of emotional engagement as central to their role, which is similar to what has been seen in other palliative care groups (Johnston & Smith, 2005; Skilbeck & Payne, 2003). The following two comments show the importance of broaching end of life issues with clients;

“You have to feel as they feel. You have to be with them. You have to go on that road with them. Each time you go to someone’s house, you’re on
that journey with them and you need to let them know that they can talk to you about anything and you now not to be frightened to face issues with them. And some of them find it very, very hard to talk about. They don’t want to talk about death. Some of them, especially some of the men, they want to put their head in the sand and it’s not happening but the wife’s feeling it. You’ve got to tend to the wife… you’re going to be with them to the end, see it through to the end.” [PN3].

“…if I’m having a quiet day and I know I can spend a bit more time with someone, is perhaps to ask a question which I know will lead to more questions and give them time to ponder. You know, something else about their dying process….So to me it’s about creating a space in the home with the client and with the family and taking opportunity when it comes up. ” [PN5].

Emotional engagement with clients was central to the role of the palliative care nurses. In this way, they could not be seen as passive respondents to the emotionality of clients, but rather as leaders of the emotional aspect of the interactions, which was of central importance to their work. These nurses also broached emotionally difficult issues with family members, or significant others to the patient, further highlighting the importance of emotional engagement in their role.

5.1.2 Patient registration clerks. The perception of emotional involvement that patient registration clerks had with clients was relatively restricted in that they perceived their role as consisting mostly of information processing. This doesn’t mean that these clerks made no attempt to express and constrain emotion as a means of facilitating a constructive interaction with clients, but they took less responsibility for the emotional state of clients. The following two quotes show that the clerks were mostly focused on the information processing aspect of their role;
“… you’ve got all the questions there on the screen and you ask, you know, name, address, date of birth, health fund, GP… boom, finish! Take a seat you know we’ll process this through and they’ll call you up and the doctor will see to you.” [EC4].

“… you need to be able to get down the information, that’s what you’re there for, to gather information.” [EC3].

The following descriptions indicated that clerks perceived that clients regarded the clerk’s role as of secondary importance in relation to doctors and nurses which may have therefore allowed clerks to distance themselves from clients. In this instance, a clerk noted a different response from clients toward nurses as opposed to clerical staff;

“She’s in uniform (chuckle). So when all else fails, you either get the person to go and talk to the triage nurse because that’s the top line there. They will actually listen to them more than they will the clerk… she’s not telling them any different than we are but it’s just because it’s a nurse that’s telling them and not the clerks which is interesting…” [EC1].

Further evidence that clerical staff considered their role as consisting of a lower level of responsibility for emotional interactions can be seen in situations in which they referred clients to nursing staff and deferred to the perceived higher emotional management skill of nurses;

“…we don’t really have to get into any tangles with any of them, you just say, can you see the nurse please? But you know, if the nurse is talking to someone and they’re looking for some reassurance then you sort of see it as part of your role to say, you know look we’re doing the best we can…” [EC3].
Similarly, another clerk explained how she felt tension between displaying some level of empathy without becoming emotionally involved, which she clearly viewed as outside her role responsibility and capability:

“I guess I felt like I wanted to speak to them more on that but knew that it wasn’t my place. I wasn’t qualified to do that sort of thing I guess. I showed as much empathy and sympathy as I could in my role…” [EC5].

There was a clear difference between the way in which palliative care nurses and the clerical staff viewed the interaction aspects of their work. However, this difference cannot be solely attributed to a difference between nurses and clerical staff more generally. Rather, evidence from the other two groups shows that the level and type of emotional engagement varied between nursing specialties as well.

### 5.1.3 Emergency nurses.

The emergency nurses showed a high level of emotional engagement. However, the reasons for their perception of emotional management as an important aspect of their role differed from the palliative care nurses. As these emergency nurses explained, controlling clients to enable the smooth function of the emergency department, and to reduce the likelihood of harm to co-workers and others, was of prime importance. Therefore, emotional engagement was for instrumental purposes. In this instance, a senior nurse showed the importance of controlling the emotions of clients and the responsibility she took for this in this particular situation in which a client’s son had been involved in a serious accident:

“…the guys in ED were saying just get rid of her, … and in the end I had hold of [name omitted] and I was giving her a big cuddle but mainly…because I had the feeling that she was just going to run off. And in the end I got… her calm enough to be able to say to her… look, let me just go and talk to the doctor just behind the curtains there and just make
sure that your son is ... alive. [I] went and said to the consultant...[name omitted] outside she’s just really distressed, do you think she could just see her son? he said...you can bring her in... as long as you... just stand back, and I said oh we won’t get in the way”. [EN1].

Abusive or violent clients were described as a common feature of the emergency department. As this nurse explained, she took responsibility for ensuring that a client left the department after he had assaulted his partner in front of their small child, and of protecting others in the vicinity. This was achieved by engaging emotionally with the client through the expression of an appropriate level of anger to reject the client’s abusive behavior and was typical in the nurses’ testimonies.

“I screamed, YOU, OUT, NOW, and he just ... he just left. I mean, it was unfortunate that the kid was there but my concern was A, stop hitting her, B that you don’t hit me or anyone else because I was ... I was about four foot away and there were two guys right in front of him and I thought, is he going to lunge forward and punch their heads together?…” [EN3].

The emergency nurses also engaged with clients who were distressed or in need of support but these descriptions were less prominent amongst the emergency nurses compared to the palliative care nurses;

“...it’s when the relatives come in, oh my god, that’s awful and you know I cry sometimes with them or hug them.”... “I like to touch them, stroke their forehead or hold their hand or whatever...I think it’s fairly widely done.” [EN5].
The emergency nurses displayed evidence of a great deal of emotional engagement as a normal aspect of their role. From their descriptions, the main purpose for their emotional engagement with clients was to quell disruptive and abusive behaviour of clients in order to facilitate the efficient and safe running of the emergency department. There was also some evidence that the emergency nurses provided emotional support to clients. There was a substantial point of difference between the manner in which emergency nurses and the patient registration clerks dealt with similar situations. The emergency nurses show that they engage actively with clients emotionally when confronted with abuse and see this was perceived as being within their role parameters. Conversely, the clerks often withdrew from similar situations and took less responsibility for addressing the emotionality of clients in the workplace.

5.1.4 Renal nurses. There was a strong conviction among the renal nurse interviewees that the correct approach to dealing with clients was very important. The renal nurses acknowledged a responsibility for engaging with clients on an emotional level. In response to a question as to whether or not emotional management was an important aspect of the job, a nurse responded in the following way;

“Yes, it is a great part, yeah…Probably some days just to let them talk…Listening to them and again, we can't always solve all their problems and we won't but it’s just to help direct them…” [RN2].

The following comment also showed how nurses on renal wards took responsibility for delivering news of the death of patients to other patients on the ward;
“Other times that you really need to control your emotions is when you’ve had the death of a long-term patient and you actually need to go around and tell all the people that have been with that patient, like sharing the same shifts so they’ve known this patient a long time and you actually need to go around and inform each one of them that their friend or mate has died and often that’s quite hard because they want to know all the details.” [RN3].

However, perhaps due to the close ties that develop in renal wards, the same nurse explained the difficulty some nurses had in dealing with such issues, creating problematic consequences when this level of emotional engagement was required;

“…they need to leave the work area. So they need to ... they actually go to the tearoom or somewhere else to compose themselves. They actually find it very difficult to tell the patient…” [RN3].

The lengthy and regular contact and relationship development lead to a great deal of familiarity between renal nurses and clients. This means that relationships between nurses and clients formed much more naturally than that described from any of the other groups and lent itself to a greater level of disclosure of personal information. This resulted in emotional engagement with clients that is manifest differently than for employees in the other three groups;

“…it’s not like a ward where you have the limited time with them because I’ve known these people for 10 years. I know all about their break ups, their relationships and their house moves and you know, stuff that you probably wouldn’t even know from your family.” [RN5].

Also contributing to the more relaxed environment could be the chronic nature of renal illness in these wards. A senior nurse commented on how she felt the need to occasionally remind other nurses of the status of the patients;
“And you’ve just got to remind people that they’re chronically ill.”

Renal nurses described a need for emotional engagement with clients. However, due to the long-term and intensive contact with clients, and the chronic nature of the illness, this engagement progressed differently than in the other groups. It could be said that the form of this engagement appeared more like a natural friendship than a professional relationship in at least some cases.

5.1.5 Overview of emotional engagement. The level of emotional engagement as an aspect of the role differed greatly between the interviewees from the four groups. The palliative care nurses demonstrated a comparatively high level of awareness and planning to deal with the emotional issues associated with terminal illness and imminent death. The manner in which the palliative care nurses discussed this aspect of the role showed that it was of crucial importance.

The emergency nurses also showed that dealing with emotional issues was very important, but mainly as a means of ensuring the ongoing functionality of the emergency department and as a way of protecting themselves and others. Therefore it could be said that they managed emotion for instrumental purposes. Unlike the palliative care nurses, the emotional management of the emergency nurses was unable to be planned in the same way as the palliative care nurses due to unpredictable nature of the interactions.

For the patient registration clerks, emotional management and the responsibility for the emotional state of clients was seen as secondary to their information processing
role. The clerks showed the importance of maintaining the appropriate emotional demeanour, but where possible, these clerks were prepared to remove themselves from the interaction or refer the clients to a nurse when the interaction became difficult.

Nurses from renal units described situations in which they take active responsibility for managing their emotions and the emotions of clients. However, there was evidence that due to the interaction parameters, renal nurses may be faced with difficulties not seen in the other three groups. The very long and intensive interactions with clients may have lead to the formation of more natural type relationships. Of the four groups, assessing the level of perceived emotional engagement of the renal nurses is most difficult due to the conflicting factors of a high awareness of the importance of maintaining professional distance, juxtaposed against the formation of natural relationships due to the nature of the interaction.

5.2 Emotional Management

5.2.1 Emotional labour. This research has identified the management of natural emotion as a prominent and distinct emotional labour strategy. Previous theoretical conceptualizations of emotional labour have centred largely on surface and deep acting as the principal components (e.g. Brotheridge & Lee, 2003; Grandey, 2000; Hochschild, 1983) with the management of natural emotion as a suggested (Brotheridge & Lee, 2003) or partially defined strategy (Diefendorff et al., 2005; Näring & van Droffelaar, 2007). The current research shows the management of natural emotion can be used purposely, to achieve a specific outcome. The key element in using emotion as it naturally arises as a legitimate tool for conducting successful interactions is that it must be managed carefully. Employees from all four groups used the management of natural
emotion, surface acting, and deep acting, as emotional labour strategies to display and constrain appropriate emotion. Of interest is that the propensity to use emotional labour strategies was closely related to the level of perceived emotional engagement in the role.

5.2.1.1 Management of natural emotion. One of the most important findings from Study 1 was the clear identification of the management of natural emotion as a distinct and prominent emotional labour strategy. This research shows that the management of natural emotion can be seen as a purposeful means to either help a client deal with an emotionally difficult circumstance, to control abuse from clients, as emotional and physical protection for employees, or as a means of ensuring that the care of patients is not compromised.

Some previous conceptualisations of emotional labour have considered naturally felt and natural expression of emotion as a component. However, this aspect of emotional labour is relatively poorly developed as a separate facet of emotional labour and descriptions of how the use of natural emotion forms part of the overall emotional labour construct vary (e.g. Diefendorff et al., 2005; Zapf, 2002; Ashforth & Humphrey, 1993; Brotheridge & Lee, 2003, & Morris & Feldman, 1996). The current research adds to the previous understanding of how the use of the natural emotion may be used to facilitate purposeful interactions and to control the emotions of both employees and clients as an emotional labour strategy in several ways. The management of natural emotion can be clearly distinguished from unmanaged displays of natural emotion and those that serve to damage the interaction between employees and clients or the working environment more generally. Such unbridled and problematic displays of natural emotion can be defined as instances of emotional deviance (Mann, 2004; Zerbe, 2000).
Emotional deviance is an important consideration in the current research and its distinction from the management of natural emotion is crucial. Instances of emotional deviance and their consequences are discussed below.

From the interviews, there are two main circumstances in which the management of natural emotion is identifiable. Firstly, mainly in palliative care work, nurses sometimes described how they allowed their own grief to be shown to clients in order to provide support and display empathy. In the following description, a palliative care nurse explained how she had occasionally been overwhelmed with emotion and had cried with family members. Crucial to the management of natural emotion as an emotional labour strategy is the focus on remaining in control and not allowing the emotion expression to become a burden on the client;

“… there have been a number of times when I’ve cried with the family... I don’t think that’s a bad thing, you know and I don’t try to hide it if it happens ...I want to be a support for them, I don’t want to dissolve into a mess. It’s not her job to be supporting me; it’s the other way around… just so long as you can function though and yourself not be a burden.” [PN2].

Consistent with the theme of retaining control, this palliative care nurse also talked of showing a measured amount of emotion;

“… you can't say that palliative care is without emotion but you don’t show all of it ...You’ve got to remain very professional I would say…” [PN3].

The above descriptions of how palliative care nurses manage natural emotion in order to show empathy and provide support for clients are distinct from both surface and
deep acting. In comparison to surface acting, there is no indication that the emotion in the above descriptions is masked, even though it’s controlled to the point of allowing the nurses to continue to function effectively in their role.

The descriptions of how employees managed natural emotion also differ from deep acting, in that there is no evidence that the particular emotions were elicited prior to the engagement with clients. In fact, these instances of managing natural emotion show that it would not be possible to elicit such emotion or prepare for the interaction as was described in examples of deep acting simply because the emotions described in both the clients and nurses in question could not be readily predicted. In addition, the interviewees did not indicate any conscious attempts to actually elicit the emotion described as is the case with deep acting (Grandey, 2000; Hochschild, 1983).

Amongst emergency nurses, and to a lesser extent patient registration clerks, there was also evidence of the use of the management of natural emotion but with quite different antecedents and for entirely different purposes to the palliative care nurses but with similarly purposeful intentions.

As a response to environmental demands, the emergency nurses and clerks used the management of natural emotion as a means of censuring or controlling the behaviour of clients and to facilitate the efficient operation of the emergency department. The following quotes from emergency nurses show that a measured amount of anger was often used to meet these objectives. In both cases, the nurses were describing instances of disruptive behavior from clients and the subsequent attempts by the nurses to control the clients;
“But a bit of healthy managed anger’s very, very good. Sit down, shut up! …But not out of control anger, you know, managed kind of authority… You know, sorry mate that’s not appropriate here, if you want to be treated you need to settle down and you know I’ll have to get security involved… I’m quite happy to treat you but if you behave like that you’re going to have to go.” [EN5].

“…this is the way it is and if you don’t like it, security will pick you up and you can go to Royal Perth or somewhere like that and they’ll kick you out as well. So you know it’s your choice, behave yourself or we’ll have you moved.” [EN4].

The following quote from a patient registration clerk also shows how the use of managed anger was seen as a legitimate tool to control the interaction in certain circumstances. Of interest in this situation, is the insight into how this clerk made the decision to use anger in response to undesirable behaviour;

“If they overstep the mark… then I think they’ve broken the contract and that’s it. It’s not open slather, I’ve never sworn back at anyone, I wouldn’t do that… you have to deal with it in the best way you can, and if it’s saying to a 16 year old how dare you talk to me like that, who do you think you are?” [EC3].

As with the case for the palliative care nurses, the management of natural emotion for these emergency nurses and clerks is distinguishable from both surface and deep acting. Rather than eliciting emotion or displaying unbridled natural emotion, natural emotion was managed.

The management of natural emotion as a distinct emotional labour strategy may be a mechanism by which employees can protect threats to wellbeing by allowing some negative emotions to be displayed without breaching the acceptable standards of
behaviour. Descriptions of the management of natural emotion also show a sense of connectedness with clients in the case of palliative care nurses.

Previous research that has alluded to the use of natural emotion as emotional labour has tended to consider this in terms of emotional consonance or the natural correspondence between what is felt and what is required. The problem with considering this as a component of emotional labour is that this suggests the lack of a need for any sort of emotional regulation. For example, both Ashforth and Humphrey (1993) and Zammuner and Galli (2005) argue that employees may experience emotions that match what is required and which therefore do not need to be regulated. Ashforth and Humphrey’s (1993) example of a nurse who automatically feels sympathy at the sight of a sick child highlights some problems with the notion that emotional regulation would necessarily be absent in situations such as these. Clearly, even in this example, the nurse must not let his or her emotion extend to the point of becoming an impediment on the ability to function in all aspects of the role. There must be some degree of restraint and emotional management.

Ashforth and Humphrey’s (1993) argument that there are times when the genuine expression of emotion will closely match what is required, resulting in very little effort is not disputed and is supported in the current research. As is evident from the comment of a patient registration clerk, the natural expression of a suitable emotional tone was sometimes easy and enjoyable;

“…you know like they might make a joke about something so you might have a bit of a banter about where they live or where they were born or languages and all that sort of thing. If it’s not busy then you sort
of...quite easily get off the track and get into a conversation about where they live or where they were born...” [EC3]

However, the ease and apparent spontaneity of the use of natural emotion as an emotional labour strategy in some instances should not be used to argue that management of the emotion is not required. Even in situations where what’s actually felt matches what’s required, there is still a need for some level of management (Morris & Feldman, 1996). This is evident in the above quote. In this instance, the clerk used natural emotional expression, which helped enable an interaction that could be seen as beneficial to both the employee and client. However, the clerk was mindful of the busyness of the emergency department as a factor in allowing some interactions to continue longer than others.

There is good evidence from this study to support the management of natural emotion as an emotional labour strategy, similar to the argument made by Ashforth and Humphrey (1993). The allowance for the display of grief through crying and anger as an attempt to provide support and control emotions and behaviour seems acceptable in these health care settings as long as these emotions are carefully managed.

There is evidence from the current research that the management of natural emotion as an emotional labour tool may fortify organisational and personal wellbeing outcomes. When describing the use of managed grief, the palliative care nurses indicated that this strategy was associated with a close connection with clients and a means of providing timely and genuine support. In the case of the emergency employees, the management of natural emotion was a method of trying to reduce the
trouble associated with abusive and perhaps even violent clients from impinging on the employee and the working environment more generally. In these cases, the assertive use of managed anger set behavioural boundaries and enabled employees to show that they would not tolerate abuse.

5.2.1.2 Surface acting. Surface acting, defined as the display of emotion that is not felt or the constraint of felt emotion in order to conform to display rules (Grandey, 2000), was used by all groups in the current research. In line with their great emotional investment in their role, the palliative care nurses showed numerous instances of surface acting. When using surface acting to comply with display rules, the palliative care nurses discussed constraining negative emotions such as anger or frustration as the main consideration. The following comment shows how this nurse constrained her frustration at the client’s non-adherence to the optimal treatment regime;

“…I had to accept that’s his call… This is not my journey, this is not my wife and that’s easy to say necessarily than it is to do but it is the truth… And so if I showed frustration then I’m not being professional.”  [PN5]

In the following example, despite feeling anxious, this palliative care nurse explained how she had to present a calm demeanour in order to reduce the anxiety of a patient and his wife;

“… so I’m sort of trying to keep him calm just letting him know what’s going on because he obviously realises that there’s bleeding happened there and she gets very anxious so I’m sort of trying to keep her calm… and that’s quite anxiety producing for yourself…you’re naturally a bit anxious when things start to bleed… you are able to deal with it but as a person you’re sort of thinking, oh Christ, here we go…”  [PN1].
In the following situation, the nurse hid her own anger as a response to abuse from a client;

“Well I feel upset, I feel angry … and I mean not that I would anyway, but I mean if someone … in your normal work situation is treating you badly, you can say exactly what you want back to them.” [PN4].

Nurses working in renal wards also indicated a need to constrain negative emotions as the prime reason for surface acting. Frustration was the most commonly constrained emotion. This appeared to occur as a result of longer term issues and the ongoing relationships that existed between nurses and patients;

“So you have to really keep yourself in check because sometimes you really just want to say look, you’re as dry as a crisp. You don’t need any more fluid off. You’ve got an obsession because you’ve got nothing else to worry about in your entire life apart from your chronic disease.” [RN5].

This nurse explained how she simultaneously masked anger or frustration, while at the same time ensuring that she displayed a cheerful demeanour;

“If I get days where the first couple of patients piss me off, I go behind the counter and go oh for God’s sake, if they ask me that question one more time I’m just going to scream but then you go out and you go (pause) and you give a nice big smile and just do your job, yeah.” [RN5].

Emergency nurses also felt the need to mask anger and frustration when dealing with clients. As can be seen by the strength of the language used, a high level of frustration and anger was evident in the way they spoke of their more difficult interactions. As a result, there seemed to be a substantial effort required to mask
negative emotions. Implicit in the following two comments was a recognition that keeping clients calm was of great importance in order to ensure the efficient running of the emergency department and to protect all employees in the vicinity;

“……..well my feelings were along the lines of, why don’t you just piss off you fucking waste of space sort of thing, I can’t remember exactly what I thought but I was frustrated but sufficiently aware of the need to calm him down………” [EN2].

“Other days you just feel like saying, fuck off you little tosser. (laughter) But I think you have to look at it as a big picture, if you do anything to inflame these people, you're actually putting your colleagues at risk.” [EN5].

There was no evidence in the interviews with the nurses from the emergency department of surface acting as a means of displaying a happy demeanour or to appear overly friendly. It appears that the need to remain calm no matter what was the prime consideration for these nurses.

For the clerical group, surface acting was also used to mask anger or frustration, although the instances of this happening appear less emotionally charged than was the case for emergency nurses;

“… if somebody gets angry at me, my instant reaction is to get angry back but I normally remember where I am and say I don’t have to be spoken to like that.” [EC2].

“You have to stop your frustration from telling people things over and over again. ...You just have to be calm and repeat what you’ve already probably told them five times, so there’s frustration there.” [EC1].

As already outlined, the patient registration clerks displayed a lower comparative level of emotional involvement with clients and a low sense of responsibility for the
emotional state of clients. Possibly due to this perception of their role plus a physical barrier being present and the subsequent lack of the possibility of a physical confrontation with clients, the clerks showed a lower propensity to express or constrain emotion compared to emergency nurses. This finding is notable given that both groups work with at least some of the same clients in a similar timeframe in the same vicinity.

Hochschild (1983) suggests that not being able to express how one truly feels may lead the employee to feel hypocritical or disconnected with one’s true self. The interviewees never described the need to simply put on a smile while feeling a bland indifference. Instead, surface acting consisted of the requirement to repress emotion (most often anger or frustration) whilst remaining outwardly calm. When discussing instances of surface acting in the current research, participants often used strong and emotional language, indicating that the negative feelings at the time had left a residual or unresolved element.

5.2.1.3 Deep acting. Deep acting or the attempt to actually feel the required emotion (Hochschild, 1983) was described only a few times in the interviews. Palliative care nurses described the most instances of deep acting which was in accordance with their greater level of emotional engagement with clients.

Grandey (2000) has called on Gross’s (1998a) theory of antecedent focused emotional regulation to explain how deep acting contains an important preparatory element. This aspect of how the palliative care nurses elicited the required demeanour prior to their interactions with clients was prominent when these nurses commented on what can be identified as deep acting. In the first example, a nurse explained how she
had to steel herself for a particularly taxing situation prior to each interaction in order to ensure a calm demeanour;

“Yeah, I’d park the car and I’d sort of have to take a deep breath because it was hard going, because you’re not only ministering to the dying girl but you’re also ministering to the mother and it’s really hard.” [PN3].

The following comment showed how this nurse had to be very careful to ensure she was in the right emotional space to broach issues surrounding death. This highlights the importance of deep acting in palliative care for this nurse as well as the centrality of emotional engagement with clients as being extremely important;

“My way of practicing my craft is that if I get a client that I anticipate……… will die in three to six months……… is to kind of just work quietly through things. So if I’m having a quiet day and I know I can spend a bit more time with someone, is perhaps to ask a question which I know will lead to more questions and give them time to ponder. You know, something else about their dying process……… So to me it’s about creating a space in the home with the client and with the family and taking the opportunity when it comes up. Sometimes I try and create it, sometimes it just happens on its own.” [PN5].

One description of how an emergency nurse prepared herself for work is interesting due to how she talked about a particular approach to work coming with the uniform. This has a parallel with how clerks in a study by Rafaeli (1989) were also affected by the wearing of a uniform or some other organisational symbol. In this case, putting on the uniform brought with it a particular persona, separate from her non-work identity and is a clear instance of deep acting;

“…It kind of comes on with the uniform really…It’s really different working in management in civvies, and if they’re busy in ED [emergency department] I’ll do some triage or whatever and it’s really odd. You don’t
feel quite right, so it’s definitely a role you step into… I used to… you know walking across the car park, you know make sure everything goes right … it was a bit formalised I suppose then, but now it just comes with the uniform and walking in the door…” [EN5].

This nurse from a renal unit also discussed the importance of preparation to elicit a mood that was functional;

“Yeah, I sit in the car sometimes and if I’m in a really crap mood, I think oh God just go in there and just keep it clean and straight…” [RN5].

Finally, a patient registration clerk showed that being in a positive frame of mind to begin with, actually served to help the mood of clients and improve the quality of the interaction;

“So yeah you’ve got to sort of start off being really upbeat. The more upbeat and the more like you know friendly you are the more chance you’ve got of getting the same response…” [EC3].

The most prominent aspect of the instances of deep acting described by participants from all groups was that preparation was key to ensuring that the employees involved were in the appropriate emotional space. The ability to be able to get “into the role” and differentiate the personal and private persona was also evident in the interviews and this has been found previously with nurses working in a surgical ward who used this distinction as a protective mechanism (Mackintosh, 2007).

The current research showed that when employees discussed the use of deep acting, they spoke more globally of their preparation for their interactions with clients and made less reference to specific instances of the interactions. This was in contrast to
discussions of surface acting, in which the recollections were more likely to be very specific instances of disturbing or difficult encounters with clients.

5.2.1.4 Summary of emotional labour. The clear and prominent evidence of the management of natural emotion as a distinct emotional labour strategy is an important contribution to emotional labour theory. The management of natural emotion was shown to be an important emotional labour strategy to provide emotional support for clients and to provide psychological and physical protection for employees, co-workers and others in the vicinity. Descriptions of the management of natural emotion were associated with increased self-efficacy and a sense of control for employees.

There were numerous descriptions of surface acting in the interviews. Surface acting was often associated with difficult encounters with clients. Most often, surface acting was used to constrain anger or frustration and was only rarely used to display positive emotion.

There were much fewer descriptions of deep acting compared to the management of natural emotion and surface acting. A notable aspect of deep acting was that it involved preparation. Often, participants talked about getting into the required emotional space prior to interactions with clients. The manner in which surface and deep acting was described by participants was similar to how these components have been considered elsewhere.

5.2.2 Emotional deviance. In light of the strong evidence of the management of natural emotion as an emotional labour strategy, it is important to draw a distinction between emotional labour and emotional deviance. Emotional deviance is also important
to understand for its association with negative outcomes for the individual, organisation
and client. Zerbe (2000) describes emotional deviance as congruence between emotions
that are felt and displayed but incongruence with the display rules or what’s considered
appropriate in the circumstances. Due to the expression of felt emotion in instances of
emotional deviance, there could be some confusion as to the actual difference between
the management of natural emotion and emotional deviance. As will be shown, in cases
of emotional deviance, the lack of emotional management results in fundamentally
different outcomes than when natural emotion is managed carefully. The management
of natural emotion, as described above, is a purposeful and adaptive strategy for the
expression of emotion and regulation of interaction with clients. This is clearly not the
case for instances of emotional deviance.

A number of instances of emotional deviance have been identified in the current
research. These mainly consist of unbridled displays of natural emotion or a lack of
emotional distance that leads to inappropriate behaviour. Sometimes, the actual
emotional expressions are not readily described, but the behavioural manifestations and
consequences of a lack of emotional regulation are explicitly outlined by participants.

As noted above, often in emotional labour research, surface acting is considered
as the element that is most reliably linked to poor personal and organisational outcomes.
Descriptions of emotional deviance shed a slightly different light on the problematic use
of surface acting as an emotional labour tool. The ways in which the participants in this
research describe the negative outcomes of emotional deviance indicates that even
considering all the negative wellbeing outcomes, surface acting may be a better option
for employees than allowing unrestrained displays of emotions to occur. The following
comments all describe both first or third person accounts of emotional deviance and their outcomes. In the first instance, an emergency nurse explains how a volatile and abusive interaction with a client was associated with negative personal and performance related outcomes;

“…I’ve been threatened with death, they say things like...I’m going to find out where you live and come and kill your wife and children sort of thing. So I got into the sort of game playing… well I know people who can come and track you down, hunt you down you piece of shit sort of thing.” [EN2].

Of note is the way in which this exchange impacted on this nurse. The nurse described lasting, negative personal wellbeing and performance related outcomes following this incident;

“That’s not healthy, that’s not healthy for me, him, it’s not a healthy direction...and off course I felt like absolute crap for the whole rest of the shift. This happened at 10 or 11 in the morning and once the adrenalin had burnt off I just felt knackered, mostly drained and then you’ve got to work with that sense of emotional draining…” [EN2].

In the following example, a palliative care nurse described how unrestrained grief resulted in an inability for her to do her job properly and in feelings of low self-efficacy;

“…there was another time when it was a really young ... it was a young child and I started crying and I couldn’t stop. That made me feel really uncomfortable. I thought what use am I here. I may as well leave. Because you then become somebody who needs to be supported and that’s not what our role is. So I was uncomfortable because I was burdening them…” [PN2].
Evident in both the above examples is that when managed properly, displays of natural emotions are considered as functional means of managing emotion and delivering desired outcomes. In contrast, unmanaged expressions are considered personally and professionally problematic.

There were no other first-person accounts of emotional deviance in the interviews with the emergency nurses, patient registration clerks, or the palliative care nurses. There were some third-party accounts of how unrestrained and non-managed emotional expression and its consequences develop over time in the interviews with the renal nurses. In the following example, a renal nurse explained how another nurse failed to manage anger and frustration and how this led to an uncomfortable and public incident;

“…one instance that is classic for me is one of the particular staff members I work with…actually took his anger out at the patient thinking she might actually be eating inappropriate foods with the family members and that actually played out in front of everybody, which is a little bit bad to be doing it and not a good way if you are hoping to get family onside to assist you in assisting the patient to comply.” [RN3].

Descriptions of emotional deviance were important in that they demonstrated that natural emotion must be managed to be an effective emotional labour strategy. Unbridled natural emotional displays as described above were associated with personal wellbeing and performance problems. In contrast, where natural emotion was carefully managed, no such problems eventuated.

5.2.3 **Non-expressive emotion management.** It is evident from the interviews in the current research was that the use of emotion management as an interchangeable
term for emotional labour is problematic. Invariably when discussing notions of emotion management in workplaces, the descriptions and focus of the literature is really all about emotional labour (e.g. Ashforth & Humphrey, 1993; Bolton, 2000a; Brotheridge & Lee, 1998; Grandey, 2000; Hochschild, 1983; Lewis, 2005). For example, Bono and Vey (2005), Mann (2004), and Zerbe and Hartel (2000) all discuss emotion management, but all these discussions are limited to methods of expressing and constraining emotion. Other authors have attempted to distinguish between forms of emotional management but these distinctions focus on the differing purposes and motivations for conducting emotional labour (e.g. Bolton, 2000b; Lewis, 2005).

What is largely lacking from descriptions of emotion management are ways in which methods of managing emotions of the self or others, other than emotional labour, are actually conducted. If other means of managing emotion are used as a way of conducting interactions and controlling emotions, then this would mean that emotional labour should not be seen as an interchangeable term for emotion management. Rather, emotional labour should be considered as a sub-set of emotion management and should be confined to the ways in which the actual display or constraint of emotion is carried out, most often previously described of in terms of either surface or deep acting (Grandey, 2003).

When describing interactions with clients, interviewees from all groups discussed various means of managing emotion. Instead of relying solely on emotional labour, these employees also used other strategies to help develop trust, control the emotions of themselves and others, and provide support for clients. The prominence of
the type of emotional management strategy was largely dependent on the situational
demands.

5.2.3.1 The provision of information. One of the most prominent means of
managing emotion other than using emotional labour was through the provision of
information from the employee to the client. This was illustrated in all of the groups but
often for quite different purposes.

Amongst the renal and palliative care nurses, provision of information (e.g.
health care information) served as an emotional management tool. Specifically, this was
used as a coping mechanism for these nurses as a means of abdicating responsibility for
the poor health care outcomes of non-compliant clients. The following two comments
from palliative care nurses were in reference to the nurses’ repeated but unsuccessful
attempts to engage with the client and provide direction and care options;

“…whenever I tried to bring the conversation up to how things were…
going, it was very much under her terms. Which is fine, ‘cause this is her
death experience not mine…” [PN5].

“You know you can see a way forward and I think the thing that you
have to keep remembering is it’s not your decision to make.” [PN2].

Amongst the renal nurses, the situation in respect to the provision of information
was similar to the palliative care nurses. In the event of the patient being non-compliant,
the nurses were able to quarantine responsibility to the patient as a coping mechanism;
“… it is basically their choice. My role is to provide them with education. If they choose not to follow it, that is their choice, this is their life. I can’t control their life and that’s something I developed. Probably I didn’t have it when I first started working in the area but it’s something you quickly learn to develop otherwise you take the blame for everything.” [RN3].

“…they know that if they’re 10 litres of fluid extra and you can only take off a certain amount then they end up going to emergency. That’s their choice. You tell them the outcome and then they’re adults, they make their choices.” [RN5].

The role of providing information had quite a different purpose in emergency departments. Both the emergency nurses and patient registration clerks described how providing information to clients was used as a means of controlling the emotions of clients themselves. Unlike the case for the renal and palliative care nurses, the clients in emergency departments would be, for the most part, unknown to the emergency employees, especially during the initial contact when the provision of care is likely to be at its most critical. In addition, the need to quell the emotions of anxious, angry and upset clients would seem to be an important step in achieving the primary goal of emergency care. Therefore, the provision of information as a means of controlling the emotions of clients was achieved by developing trust, which in turn, facilitated an efficient emergency department.

In the quote below, which was also used as an example of the emotional engagement of emergency nurses, an emergency nurse used information for the purposes described above. In a life threatening situation, she was able to quell the emotions of the mother of a car accident victim by letting her see that her son was still alive in an emergency cubicle;
“I got her calm enough to be able to say to her… look, let me just go and talk to the doctor just behind the curtains there and just make sure that your son is … alive. Because I … just figured that’s what … she didn’t know, whether he was going to live, die or whether he was already dead… there was a bit of blood and stuff around I figured she could probably cope with that and… she looked at him (pause) and she just said something… in Mandarin to him and she realised that he was conscious, went back out and she was quite happy to sit and wait. And so… just by giving her just a little bit… she could see him… he wasn’t okay in any stretch of the imagination he actually ended up at [another hospital] and had brain surgery, but he was still alive and that was the most important thing… And that was what she wanted and… that diffused that whole situation” [EN1].

Another emergency nurse commented on the importance of being as honest as possible in order to quell the emotions of clients;

“Personally I believe that honesty’s the best thing and don’t sugar coat it, it doesn’t get you anywhere, it gets them wound up. It’s much better to say exactly what the story is if you can.” [EN3].

Reassuring relatives that they will be kept up to date was also important. This emergency nurse described how he might go about keeping the relatives of patients informed as to the patient’s progress and to reassure them that they would continue to get updated information;

“Well look, I would say simply that: look Mrs Jones, I understand that your husband’s extremely unwell. He’s getting a lot of care from some high qualified staff. There are some very good doctors and very good nurses working with him and we’re doing all that we can, and we’ll give you more information as we go along. If you have any questions then ask. So it’s basically just…giving them something to hold on to.” [EN4].
Patient registration clerks also provided information as a means of managing the emotion of clients. Despite a more process focused role for the clerks, they still indicated that they believe the task of providing whatever information they could was part of their role;

“… people are coming to me and saying they don’t know what’s happening and that doesn’t help visitors to understand, well why can't I go and see my dad? At least if you’ve gone and made an enquiry for them, they know that you’ve done your best…” [EC1].

Another clerk explained the state of patient relatives and how this stressed state can be alleviated by providing information;

“Yes very anxious, very worried, sometimes crying… I’m just trying to help them as much as I can …find out information. I think a lot of the time is the fact they don’t know what’s going on.” [EC2].

As is clear from the above testimonies, all groups used the provision of information as a means of emotional management. However, there were major differences between groups in respect to the purpose for providing information. For those employees who have more developed, long term relationships with clients (i.e. renal and palliative care nurses) the provision of information outlining optimal health care options for clients was used by the nurses as a way of distancing themselves from the responsibility of poor health care decisions. The nurses were able to reassure themselves that they had carried out their responsibilities, thereby ensuring that any poorer than necessary wellbeing outcomes are attributed to client decisions.
Those employees that had shorter term interactions with clients in the acute care setting of the emergency department (i.e. emergency nurses and patient registration clerks) used the provision of information for quite different purposes. In the case of the emergency nurses, information was used to control the emotions of clients (particularly the relatives of patients) to ensure the efficient running of the emergency department was not jeopardised. The clerks also used information to manage the emotion of clients. This seemed to be mainly as a way of providing support and alleviating the stress of the client who may not have know what was happening to sick family members.

5.2.3.2 Proximity and space. There is evidence that nurses and clerks in the emergency department were aware of the importance of their proximity to clients. For the emergency nurses, due to the nature of their close dealings with patients, this was less of an emotional management option than for the patient registration clerks who are physically separated from clients by a security screen. The use of proximity and space to relation to clients was an important mechanism to control the emotions of the employee and the client, depending on the situation.

The clerks spoke of the option of removing themselves from any interaction in which the client was abusive;

“… if all else fails, you do have to walk away…because sometimes people are so irate that they don’t want to see that they’re actually not being rational.” [EC1].

“…and even to say I’m not prepared to talk to you, I’m going to walk away… otherwise you can actually be sat there for half an hour arguing or trying to pacify someone who has got no intentions of being pacified.” [EC3].
The comments from the clerks showed that removing themselves from abusive interactions is a realistic, sanctioned and effective means managing their emotions. The clerks were able to disassociate themselves from the clients in these situations, which seemed to enable them to remain calm and allowed them to attribute the difficulties in the interaction solely to the abusive client. This can be seen as an important emotional management tool as the clerks retained a sense that they were not responsible for the abuse they received while still maintaining control over the interactions.

One emergency nurse also showed evidence of using proximity and an awareness of space as methods of controlling the interactions with clients and of managing emotions. However, perhaps due to the requirement to work very closely with clients and a greater sense of being more emotionally engaged as part of their role, they seemed unable to simply remove themselves from clients in difficult situations. Instead, this nurse explained how she worked to keep the relatives of a deceased boy apart so she had time to diffuse a volatile situation by allowing anger in the relatives to subside;

“… he was only eight or nine and he had drowned…they must have worked on him for two hours before they finally gave up…And the father came in the ambulance. He was so distressed he didn’t even know his name or anything… it was awful. And then all the other relatives started coming… and I went off to give the details to the clerks and stuff and into ED… and I came back and they were all just about at fisticuffs at this poor guy because they were accusing him of couldn’t look after his son and so I managed to get them separated and … I had this family…outside… in the ambulance bay chatting to them and I remember that a nurse came out and …said to me oh what’s going on…? And I said oh can you just deal with the…father … in the relatives room… managed to diffuse the whole situation…” [EN1].
In the above instance, the nurse was concerned with controlling the emotions of the clients and wasn’t focused on subjective protection as was the case for the clerks who had removed themselves from abusive interactions. The same nurse also described how she had to be careful in how she positioned herself during an emotionally charged interaction;

“I can recall I was in the Emergency Department and we had to tell a family that their brother had died ... when I go into situations like that I always think about where they are in the room, where the door is, where am I going to stand, can they get out the door? Am I going to be in the way? Because you’ve got to think about all these things. Is there a good escape route for me as well?” [EN1].

The above description of how this nurse considered her position in the physical environment for a particular interaction is clearly a method of self-protection from physical harm. However, it also showed that in the event of the client becoming aggressive or otherwise overly emotional, the nurse was aware of not placing herself in a position where she may have inflamed an already difficult situation, thereby attempting to actively exercise a level of emotional control over the clients.

5.2.3.3 Summary of non-expressive emotional management. The above descriptions of participants’ methods of managing the emotions of themselves and their clients show that descriptions of emotional labour as the sole consideration of, or even as the definition for emotion management, are incomplete. While emotional labour strategies have been given a good deal of attention in previous research, other methods of managing emotion in workplaces have been neglected. It is proposed that when considering emotion management, other aspects of achieving the desired outcomes of
managing emotion other than the expression or constraint of emotion (i.e. emotional labour), must also be considered for a holistic representation of emotion management. From the current research it can be seen that the provision of information and the utilisation of space and the proximity to clients are important strategies as a means of ensuring physical and emotional protection for employees and clients.

5.3 Antecedents

5.3.1 Expectations/display rule requirements. The interviews show that the interactions between employees and clients from these groups are complex, particularly for nurses. This is in line with other findings (James, 1992; Theodosius, 2008), which showed that formal organisationally derived display rules were less prominent shapers of the interactions with clients as opposed to the individual requirements of each situation. The interactions are very rarely scripted and organisational directives as to what is an appropriate emotional display are largely lacking. This is the case even for commonly perceived display rules amongst the interviewees. In addition to the individual requirements of each interaction, there is evidence of the importance of direct feedback from co-workers and clients. Only occasional reference was made to training, while professional standards and guidelines were not mentioned as having an impact on how these employees manage their emotions and interactions with clients. In response to questions about which emotions are seen as acceptable and unacceptable, employees from all groups indicated that restraining unbridled anger and remaining calm were the most important display rule requirements.

5.3.1.1 Emotional intelligence. Overwhelmingly, the interviewees perceived that the most important direction for the manner in which interactions should be
managed was by way of their assessment of the requirements of each individual situation. In order to achieve this, these employees described how they gauged the emotional state of clients and then used this information to shape the form of the interaction and set the emotional boundaries. This display rule shaper was a strong theme amongst all groups even for the renal nurses whose long term interactions with the same clients on an ongoing basis means that situations in which they must assess the demeanour of new clients quickly is much less frequent.

The requirement for these employees to be perceptive of the emotional state of clients has obvious links to theories of emotional intelligence. In particular, the four branch ability model of emotional intelligence (Davies et al., 1998; Mayer et al., 2004a; Salovey & Mayer, 1990) is applicable to the way in which these employees described how they must sense emotion and respond appropriately.

For the emergency nurses and, to a lesser degree, the patient registration clerks the emergency department is an environment in which the emotional state of clients needs to be assessed quickly to avoid the likelihood of confrontation, and to provide emotional support. In the following comment, an emergency nurse mentioned how she made an assessment of a client and perceived the likelihood of him becoming aggressive;

“He was actively fine but I thought he was actually … what I would refer to as on simmer, like in other words, the potential to get aggressive”. [EN3].

In a similar vein, the following comment from an emergency nurse explained how she recognised the likelihood of trouble emanating from a client’s behaviour and
sought to quell this by showing empathy. In doing so, she was able to perceive, understand and regulate the emotion of the client and herself and then use her own emotion to diffuse a potential problem;

“I think that’s one of the main things with triage you’ve actually got the power to stop a lot of bad behaviour at that point. If ... if they’re being abusive you can say, look what’s happened and you can say, that looks really horrible, how about I get you something for the pain and you know … you can diffuse the situation then”. [EN5].

In terms of providing emotional support, the following comment shows how this emergency nurse used her intuition and an ongoing awareness of the client’s reaction to guide the interaction and emotional display. In this instance the nurse reflected on a time she had put her arm around a distraught relative of a patient;

“Nursing is so much intuition based…And I think you do tentative things first, like you see how it’s received and then… Some people you just don’t touch…” [EN5].

Similarly, this emergency nurse indicated the importance of assessing the emotional state of the client before using humour;

“I can’t help being funny and I find that’s helpful, sometimes when you’re interviewing people…and sometimes you can get it wrong. You wouldn’t do that with everybody because sometimes it doesn’t work, you just have to hope, you make a judgment in your mind …” [EN3].

The patient registration clerks were also aware of the importance of assessing the emotional state of clients before attempting to establish deeper interactions. Unlike the emergency nurses, the clerks seemed more interested in using their intuitive assessment
of the client as a means of having a more in-depth conversation simply as a friendly gesture, perhaps without the same functional purpose;

“...I mean I think your own instincts tell you whether you can chat with this person or not. Some people are just too sick so you just get through the basics you can with them and that’s it but then there are other people like visitors from overseas who might be travelling and you’ll have a conversation with them…” [EC1].

The palliative care nurses were also particularly mindful of the client’s emotional state as a shaper of display rules. This was seen as crucial as a determining effect on how close the relationship between the nurse and clients may become. The following comments stress the importance of correctly assessing the demeanour of the clients for the palliative care nurses. The first comment was made by the hospital based palliative care nurse;

“... I think you’ve got to be really flexible and I think read people and everybody’s different, so the way you might deal with one person you … you can’t deal with another person. So you’ve got to be good at reading personalities and body language…” [PN6].

The community palliative care nurses had similar thoughts;

“I guess it’s sort of going into situations everyday and … and then you’re aware of you know, what you feel is appropriate and what’s not.” [PN1].

In the case of the emergency nurses and the patient registration clerks, sensing the emotional state of clients quickly was considered important due to the lack of an existing relationship. For the palliative care nurses, while the relationships between
nurses and clients developed over a longer period, they still needed to be aware of the emotional parameters of their interactions soon after they made contact with clients in order to connect with them at the appropriate level.

For nurses working in renal dialysis wards the relationships are usually well developed and there is not the same emotional volatility as an ongoing aspect of the interactions. Nevertheless, the requirement to constantly monitor the response from clients was seen as an important guide to how the interaction is to be managed. A point of difference between the renal nurses and the other three groups is that for the renal nurses, long term information about the clients personality was interwoven into the assessment of how they should be approached and the level of emotional involvement that was deemed as appropriate;

“We share that with them as well and sometimes it’s that laughter and that joy and having a joke but you sort of ... you gauge, I mean I gauge from the response I’m getting from the patients and from colleagues.” [RN3].

“...I’d look at everybody individually and just see, some cope better than others, some like to be independent, some like to by mollycoddled a bit. So yeah, it depends… I think you need to be careful who you are directly honest to and who needs a bit of a softened touch as well. I think that’s very individual with the personality…” [RN4].

There is clear evidence in this data from all four groups of the use of the emotional intelligence components as described by Davies et al. (1998), Mayer et al. (2004a), and Salovey and Mayer (1990). Previous research has been unsuccessful in attempts to identify emotional intelligence as a moderating factor between emotional labour and wellbeing outcomes such as emotional exhaustion and job satisfaction
(Johnson & Spector, 2007). A possible reason for this could be that self-report tests of emotional intelligence, such as that used by Johnson and Spector (2007) are thought to be confounded with personality tests (Hedlund & Sternberg, 2000; Mayer, Caruso, & Salovey, 2000; Mayer, Salovey & Caruso, 2000) and may be a poor measure of an ability such as emotional intelligence (McRae, 2000). It may also be the case that emotional intelligence should be thought of as a shaper of display rules and therefore as a determinant or antecedent of emotional labour strategies rather than as an intervening mechanism between emotional labour and outcomes. This view of the relationship between emotional intelligence and emotional labour is in accordance with an overview of the literature conducted by McQueen (2004), who focused specifically on studies that had examined emotional intelligence in nursing. McQueen found that emotional intelligence could be the tool by which emotional labour is successfully conducted.

The current research findings are in line with the views of McQueen (2004) and show that employees from all four groups used emotional intelligence components in order to determine the type of emotion utilized as well as the level of emotionality. The finding from the current research that clerical employees also used emotional intelligence to shape the interaction parameter with clients indicates that McQueen’s finding could be applicable more broadly than just in relation to nurses.

5.3.1.2 Social referencing. In addition to individual assessments of each situation, there was a perception amongst the interviewees that feedback from colleagues was an important shaper of display rules. In the following comment, a renal nurse asserted that anger was inappropriate and indicated that the organisation was absent in her perception of how display rules were derived. Instead, it can be seen that
feedback from co-workers and clients were considered important shapers of the interaction parameters;

“I guess from the feedback you get, not only from your colleagues but from the other patients around you because everything’s so close, they know what you’re saying to other people… Particularly if you get somebody that’s very angry with you and nurses have been known to react with anger back, you’ll get, well that wasn’t very nice…there’s some people I really used to admire and I thought I like their style and you take bits of that because it works.” [RN1].

A similar situation existed for the clerical employees with learning from co-workers seen as important;

“They’re [new employees] not sure how to phrase things to ask people questions, they’re not used to speaking to them in an interview manner. So that often comes from just watching someone else do it and I’ve had a couple of… clerks say to me I like the way you asked that question rather than someone else…” [EC1].

5.3.1.3 Organisational and professional influences. Comments indicating that specific emotions were either expressed or restrained as a direct organisational directive were mostly lacking from the testimonies of the interviewees. This point was illustrated by a patient registration clerk who spoke of a lack of organisational direction for employees not to get angry with clients, even for new employees;

“Yeah, no one says it throughout that point when you start the job. No definitely not, definitely not. You’re just kind of supposed to know that (chuckle) that you don’t give anything back to the patient…” [EC1].

There were a few references to broader organisational or professional direction in terms of the management of interactions with clients. In some situations, display rules
or guides for the interaction were generated for specific purposes. The employer of the community palliative care nurses was the most active in generating display rules in this way. Unlike the strict adherence to display rules as implicitly demanded in some low level customer service roles (Rafaeli & Sutton, 1990) these instances of display rules were not described as prescriptive but suggestive of how difficult interactions could be managed.

There were two main examples of how the organisation provided guidance by generating specific display rules. The first of these was the organisational response to the issue of the appropriateness of crying as a display of grief when interacting with clients. Two community palliative care nurses explained their perception of the organisation’s view on this issue in the following way:

“………If I feel to cry with them, to cry with them which………. was really good to hear………..” [PN3].

“………. our organisation does say; look, there are times when it is appropriate to cry.” [PN4].

Despite organisational sanctions to display emotion in this way, it’s clear that the decision stayed with the individual nurse. In the quote below, the nurse regarded crying in front of patients as a betrayal of hope;

“… if they see you as the registered nurse caring for them suddenly crying then I think that could take away from their hope.” [PN4].

The second instance of an explicit organisation intervention into the manner in which the interaction was managed was seen in the development of a script to help
palliative care nurses broach the difficult issue of gathering next of kin information where family members were estranged;

“So what we developed was a little paragraph that nurses could use and it goes like ... well if something happens to you and you can’t tell us what you want, who do you want us to call. So it’s just a bit more gentle ........ it’s none of this death you know, unconscious, you know that kind of stuff. It helps ... it gives people the words to actually say ........” [PN2].

Once again, there was not a requirement to use this in an interaction, only the suggestion and offer of it as a means of assisting the interaction if an individual nurse wished to do so.

The high level of organisational involvement evident amongst the community palliative care group may have been specific to the organisation. The hospital based palliative care nurse indicated little in the way of a similar level of involvement from the hospital. In response to a question about the organisation’s understanding of palliative care issues, the nurse responded in the following way;

“I think in the medical fraternity generally there is this mindset that you cure, you make better, and so even within the medical fraternity I think palliative care is not well understood and it’s sort of avoided and I think that there has been unhappiness with bringing palliative care into the hospital.” [PN6].

There were few instances of explicitly formed display rules amongst the other three groups of employees. The one major exception to this was the training available to patient registration clerks and emergency nurses. This training consisted of strategies to deal with difficult or abusive clients. The availability of this training seems to have been
a response to the emergency department environment in which employees are subject to regular abuse from clients.

The perceived efficacy of this training appeared to be particularly salient in the clerical group. The following statements indicated that the training had a substantial impact on the day-to-day management of the interactions between these clerks and their clients;

“There is something in the hospital that has helped me and that’s the training that we get with regards to dealing with people in an aggressive situation… I think that really stands me on good ground as well with regards to being able to listen to the person and… I find that the training has helped me interact with patients a lot better, yeah. It does keep me calm.” [EC1].

“I’ve done a few of those courses… they do help…because… it shows you where your limits are in terms of like what I can say and what they can say to me and how I can say to them, that’s enough…”. [EC2].

It’s notable that the training was hardly mentioned amongst the emergency nurses and it could be the case that employees in clerical type roles are more receptive to scripted interactions and explicit instructions as they are more suited to the type of interaction they are engaged in. Amongst the emergency nurses, there were only two comments in relation to any other sort of professionally based training or education as a determinant of how interactions should be managed. In the first comment, an emergency nurse explained how the education in her hospital based nursing training has had a lasting effect on the way she interacts with clients;

“…when I did my training all those years ago that was something that was instilled in us that you don’t get too emotionally involved…I was
always trained that there’s… this invisible line… that you don’t cross over…” [EN1].

In the following comment, this emergency nurse also made reference to learning about interactional skills in his nursing training;

“In our nursing training ... I specifically remember a lecture that says what’s a professional person and how do they react? And this was very early in my nursing training and… they talked about things being on time and correctly dressed and respectful and people skills. There was a people skills course talking about the adults and the child and the interactions…” [EN2].

Despite the above few examples, there was little indication of training, professional standards or organisational direction as explicit considerations in the minds of these employees as shapers of display rules. Two exceptions were the suggestions for specific types of interactions for the community palliative care nurses and the hospital based training for dealing with abusive clients for the clerical employees. In both cases, the organisational input appears very well received by employees.

5.3.1.4 Overview of display rule perceptions. The evidence from the current research suggests that unlike Hochschild’s (1983) flight attendants, those working in health care settings may be required to be far more responsive to individual situations. Therefore, the interactions and emotional expression may need to be developed on a case by case basis without the explicit requirement for specific emotions or detailed scripts. Other health care studies have found similar results (Theodosius, 2008; James, 1992).
An obvious implication of this finding is that any occupation that involves greater depth in terms of interpersonal contact will require a much more nuanced approach to the interpersonal interaction as opposed to those occupations with very short interactions or those that are process driven. Contrary to the expectation that lower level, process driven roles may be more inclined to be subject to very specific display rule scripts, the finding that the community palliative care group were provided with the most detailed suggestions for dealing with particular situations is in some ways counter intuitive. However, the existence of these scripts could be explained by the level of organisational involvement with assisting these nurses to deal effectively with difficult situations.

As described by Ashforth and Humphrey (1993), identity with the role carries with it expectations for the ways in which employees conduct themselves. In relation to nurses in particular, a strong identity with the role may lead to conformity with professionally or socially derived accounts of how nurses should manage emotion. In line with this view, the general “rules”, such as the requirement to remain calm and refrain from displaying overt anger or frustration, could simply be seen as what may be considered professionally appropriate.

Overwhelmingly, amongst all groups, the interactions proceed in response to the needs and reactions of clients. This entails the perception, understanding and regulation of emotion and its use as a functional means of achieving a particular outcome, which is in line with the four factor model of emotional intelligence (Davies et al., 1998; Mayer et al., 2004a; Salovey & Mayer, 1990). This is important for clerical employees as well, despite their process focused role and lower comparative level of emotional involvement.
with clients, suggesting that emotional intelligence may be important in health settings
generally and not just amongst nurses.

5.4 Moderators

5.4.1 Social support. Due to group differences in how social support is provided, its relative importance, and its form, the analysis is presented on a group by group basis. The sub-theme components of co-worker support, supervisor support, organisational support, and family/friends support are discussed for each group with comparisons in the summary.

The current research goes beyond previous research findings examining the importance of social support and emotional labour together by explaining in depth why some sources of support may be perceived by employees as more important than others, the specific nature of what support consists of for these groups, how some sources of support become more crucial when others are unavailable, and how the importance of support varies according to the level of emotional engagement in the role and the subsequent emotional expenditure by employees. Furthermore, there is evidence in this research that organisational support can prove valuable in enabling other, more immediately accessible sources of support, such as that from co-workers, despite being less salient to employees. In line with COR theory (Hobfoll, 1989), the importance of support can be seen as a reflection of the centrality of emotional engagement in the role, with the evidence suggesting that it is particularly important in palliative care.

5.4.1.1 Palliative care nurses. The palliative care nurses explained that emotional support is crucial to their ongoing viability in the role and their general sense
of wellbeing. Most important was support derived from co-workers. Following a question as to the importance of co-worker support, two palliative care nurses responded in the following way:

“Couldn’t do without it... I think there is a lot of sharing of experiences and not just the good stuff, there’s a lot of sharing of the stuff that hurts and the stuff that doesn’t work and people are more prepared to lay themselves bare with other nurses... And they are hugely understanding of the kind of thing that you are experiencing and... it’s a given that you know that you’re a priority for each other... So whilst our counselors and chaplains and support managers and... even the admin staff, everybody’s back here at the base and available, it’s usually other nurses that you tend to on the immediate situation for support... There’ll always be somebody at the end of the phone... when there’s somebody young or if it’s somebody really stressful or it’s really sad... you say, well give me a ring when you get out and let’s have a talk.” [PN2].

This palliative care nurse reflected on an especially difficult case in describing the importance of co-worker support;

“...generally I think deal with it ourselves...she was with us in and out for a long, long time and we found that really difficult...we all support each other...I think because other people [palliative care nurses] understand. I mean it’s not only me going through that sort of grief... with her particularly but knowing we’re all going through the grief...” [PN6].

Despite not being physically present, this comment shows the emotional availability of co-workers at stressful times;

“But then when I come out of the home and...pick up the phone and yell at my colleague or sob over the phone to them. I mean... that’s an option.” [PN5].
The following description of a particularly challenging interaction with clients shows that the timeliness of emotional support may be even more important in very difficult situations. On this occasion, two nurses were working together and left the home of a bereaved family at the same time:

“… we were together and ... she’d died and we were attending to her and the family and… the time came for us to leave and we said to each other I’ll see you back at base, we’ll have coffee. Which was great but it was a fairly long drive. And we got back to the base at the same time and we saw each other at the door and we were just a mess. We’d both been crying all the way home ... all the way back to the base and what would have been better would have been if we’d left ... instead of driving all the way back if we’d just gone somewhere together.” [PN2].

In addition to other nurses, the existence of co-worker support was evident in this nurse’s description of how members of the interdisciplinary team helped provided support to one another;

“It’s not just the nursing staff, we have counsellors and chaplains and our care aides and volunteers, all of those people are all... part of a team and sometimes support indirectly can come from those people as well... So there’s a care aide going in everyday helping with the care, if we’re doing terminal care with someone, they might be the person... that you get the support from rather than your actual...nursing colleagues.” [PN5].

From the above testimonies, the importance of co-worker support for the palliative care nurses was clear. Previous qualitative descriptions of the importance of support from co-workers in nursing from different settings has shown similar findings (Gunther & Thomas, 2006; Lewis, 2005). However, co-worker support for palliative care nurses may be especially important due to the nature of the work and the lack of available support from other sources. A prominent theme from the interviews with the
palliative care nurses was that support from family and friends was distinctly lacking even if it was actively sought out. As the following comments show, support may be unavailable even from those closest to the palliative care nurses;

“like my husband for example, I can’t talk to him about anything to do with death or dying because his whole face changes…Almost a genuine fear that…this is so sad…Yes, you see this look and he goes, oh that’s terrible, he says you can’t talk about that, I don’t want to talk about that…” [PN4].

“I don’t talk about work at home…because when I first started and I looked at my husband’s eyes when I was talking about it, I don’t think he needed to have that experience in his life.” [PN5].

The same nurse explained the difficulties of discussing similar issues with close friends;

“When I first started at palliative care I went to a barbeque and I just got the job and I was happy…I was very excited and I went to this barbeque with all of our friends and they said have you got a new job? I went yes, yes, I’m a palliative care nurse. And there was this deathly silence and I may as well have said I was being a stripper. And that’s when I understood that it’s not something that you talk about when you go and play softball and standing in the supermarket queue… you can’t talk to people who don’t understand it… that it’s really good that Mr Jones died today. It’s not acceptable. But you can come back to the base and go oh thank God he’s died.” [PN5].

The perception of a lack of non-organisational support was not universal, as the following comment shows, however, the capacity for this nurse to discuss her feelings about the job was limited;

“… if things concern me, I like to talk it over and [name of partner omitted] good. He lets me talk about my day and he does the same, he talks about his day and I’ll tell him anything that (pause) has affected me and he does the same, but we don’t talk about it to anyone else. It just stays with us”. [PN3].
Accessing non-organisationally based support for these palliative care nurses was problematic, despite attempts to access emotional support from family and friends. The importance of co-worker support was crucial due its timeliness, availability and depth of understanding. From a COR perspective, the fact that one possible source of support was unavailable due to the sensitivity of the subject matter and a lack of understanding, it would follow that the available and most beneficial support would become even more crucial. This appears to be precisely the case from the evidence in the interviews with the palliative care nurses.

It is been found that job related stress may not be as high for palliative care nurses as is the case in other seemingly less emotionally demanding occupations due to attention given to the development of coping strategies (Valchon, 1995), including emotional support from colleagues (Alexander & Ritchie, 1990; Valchon, 1995). The interviews with the palliative care nurses go beyond these findings by showing that the importance of co-worker support is due to the shared understanding of the nature of the work and the subsequent manner in which co-workers make themselves available to one another.

The existence of organisational support was also evident in the interviews with the community palliative care nurses. The following comment describes the existence of a dedicated, imbedded employee assistance structure, specifically aimed at helping employees to deal with emotional issues. No such embedded service was evident from any of the other groups or organisations;

“There’s a monthly session with a counsellor which happens for those people who want to come along and about an hour or an hour and a half.
And it can take any form… it’s a bit like an amoeba, it really doesn’t have much structure other than knowing it’s available… you can be there every month but it’s new too, and you know pagers are diverted so people can go…The counsellor of the team is available informally to all of the staff during the meeting and outside the meeting.” [PN2].

The palliative care nurses did not indicate that support from the organisation was as crucial as that derived from co-workers. However, it certainly could be the case that the organisation set the tone for a supportive environment by ensuring that support mechanisms were prominent and easily accessible for the community palliative care nurses in their organisation. Therefore, organisational support may be very important even if it is less salient to the nurses than that derived from co-workers.

For the community palliative care nurses, co-workers support is mainly in the form of emotional support. As the above comments indicate, organisational structures are in place to also provide emotional support but the organisation was also active in providing instrumental support as well;

“Not many people want to do it and so the staff that they do have, they want to retain and so if you’ve got any issues…if there’s any rosters or anything that they could help you with…you tell them what you want because they don’t want to lose you…” [PN3].

In the following description of how a difficult interaction was dealt with, it’s clear that the organisation was mindful of assisting the palliative care nurses to overcome problems through active participation and facilitation;

“…this one particular guy springs to mind and he would not hear any talk of him deteriorating any further and dying. So the way we got around it ... we had this team discussion and the way we got around it was to actually say what if you’re wife ... ‘cause his wife’s his main carer…”
what if something does happen to her… what would you like us to do? And he actually realised then, so now we’ve got a little bit of a plan so if something happens to her, we know what to do… So that was a really good feeling.” [PN2].

In addition to these instances of organisational support, as has already been described, the organisation was also active in providing direction for how the nurses could display grief by crying with clients and by helping develop a script for situations where next-of-kin were estranged (see section 5.3.1.3).

Despite a general concordance between the experiences of the community palliative care nurses and the palliative care nurse working in the hospital ward, the issue of organisation support presents a stark contrast. The hospital based palliative care nurse spoke of a lack of understanding and support from the organisation;

“Because we now work in a surgical and medical hospital so we’ve got these beds in the middle of an acute hospital… they tend to leave us… we’re like the block of concrete that nobody talks about and they just sort of go around us all the time… they just think we’re a bit spooky I think, they just avoid us.” [PN6].

In the case of the palliative care nurses, the clinical nurse specialist (CNS) is closest to what would normally be considered as a supervisor. A blending of some aspects of the role of the CNS with the regular role of the palliative care nurse meant that a nurse/CNS distinction may not be prominent (a situation found elsewhere, i.e. Rhoades and Eisenberger, 2002). This may explain a lack of references to supervisory support in the interviews with the palliative care nurses. The interviews with the palliative care nurses included one interview with a CNS, who indicated that part of her role consisted of similar work as for the other nurses;
“They will call me in… if they’re having difficulties, so I see the more complex clients and occasionally I will do visits on my own ‘cause if the workloads a bit busy… if the nursing staff have got things to do, I’ll take that client on my own. So I tend to tap in to the more complex ones”. [PN2].

The occasional references to the role that the CNS plays, shows that support was available from this source;

“……… yeah, we’ve got a CNS who’s over us and if we have any problems, we can ring at any time or even ring up people who also do the same as us”. [PN3].

In another instance, the training provided by preceptors (CNS trainers) when nurses first learnt the role, was described as more collaborative than directive;

“I think at the beginning of the training very much they talk … like it’s more of a role modelling perhaps than a guidance, rather than a set of instructions”. [PN5].

The perception of the CNS as a co-worker is in line with the general finding that there is a lack of a clear hierarchy amongst the health care professionals in palliative care. This finding is in accordance with previous research that has found palliative care to be characterized by the absence of professional rivalries thereby increasing the availability of support more broadly (James, 1992). This comment explains the team focused approach evident amongst these palliative care nurses;

“So the doctors and the counsellors and the chaplains and the other nurses and the other specialists and the dieticians and OTs and … everybody who you work with are very client focused. And there’s not much ego and I certainly think that this is the best area. If you’re looking
for an area of specialty to work within, I think palliative care has that respect for, you know, the team approach”. [PN2].

Compared to the other groups in this research, the palliative care nurses expressed the greatest reliance on support which may be due to a greater level of emotional engagement as a normal part of the role. The palliative care nurses gave the impression that there was general lack of understanding as to the nature of their work outside the organisation, and for the hospital based palliative care nurse, within the organisation as well. Therefore, co-workers, the source of the most understanding, timely, available and relevant support, was considered all the more important.

It could be the case that dedicated organisational structures and provisions that appear to exist for the community palliative care nurses serve to raise the importance of a supportive environment, thereby assisting employees to support one another, which is in line with the organisational approach as suggested by Bram and Katz (1989). Whereas co-workers may provide the most important emotional support, the organisation can be seen as important in assisting instrumentally and by underpinning the importance of support more generally.

5.4.1.2 Emergency nurses. Emergency nurses work in a dynamic and often hostile environment. This environment often creates the need for the immediate physical presence of co-workers. Obviously, this type of support cannot be as easily provided by the organisation more broadly or from outside sources. Supervisors, in the form of CNS’s or nurse managers, maybe in a position to provide such support, however it’s
obvious that co-workers were the most realistic means of the provision of this type of support.

The importance of social support for the emergency nurses in this research was closely linked to their high level of emotional engagement with clients. However, whereas the type of interaction with clients for the palliative care nurses demanded a high level of emotional support, the support required of the emergency nurses was mostly instrumental. The dynamic and volatile environment in the emergency department appeared to result in the need for a very immediate and job focused form of support to enable the ongoing viability of the department. As with the palliative care nurses, the most important form of support was perceived to be provided from co-workers although certain organisational structures were crucial in enabling emergency nurses to manage interactions with clients effectively.

The emergency nurses displayed less of a tendency to view themselves as responsible for the emotional state and emotional progress of clients. Instead, the emotional management of clients and themselves was linked to the ongoing efficiency of the emergency department and the safety of all in the vicinity. In contrast to the palliative care nurses, the clinical aspects of the role appeared to be far more important to the emergency nurses. However, co-workers were still available for timely emotional support for fellow emergency nurses, although as these comments suggest, there wasn’t the same imperative for this type of support that existed amongst the palliative care group;
“… we kind of debrief amongst ourselves, you know go and have a fag and ... yeah that was terrible...That’s much more helpful than an organised debrief. I mean who’s going to talk in a group?” [EN5].

“But then people are quite good they do talk at morning tea, you know that’s comforting, that debriefing is not official but there’s a lot of that that goes on”. [EN3].

Of much more importance for the emergency nurses was the need for immediate instrumental support, which was evident in the following description of the way in which a nurse intervened in a difficult situation. This episode also highlights the way in which co-worker support was important due to its immediacy and the depth of understanding, which didn’t appear to be readily available from other sources of support;

“…if you see they’ve got a problem you can intervene in the appropriate way... I remember having dealings with a child…and I’m not particularly good with kids anyway and I just couldn’t sort of deal with this one at all... one of the nurses, [name omitted] sort of moseyed over… and she just said, you don’t seem to be dealing with this, should I take your place? And I said, fine, she’s one of your patients and I looked after hers…” [EN2].

By far the most important support provided by co-workers was that associated with the ever-present danger associated with violent or abusive clients. This was shown to be uppermost in the minds of the emergency nurses when discussing how they supported one another. The potential volatility in this environment was associated with the need for the emergency nurses to be vigilant and to provide a physical presence as support when there was a possibility that colleagues may have been in danger;
“ED nurses tend to be good in a sense…you hear someone shout, you hear a raised voice, you tend to go and investigate rather than walk away from it, whereas if you’re out in the street and you hear someone shouting, most people walk the other way. With us we walk towards it to see if you need help, so that’s us helping each other out.” [EN3].

“We should just have empathy for the person and you’re colleagues of course. I mean that kind of environment, if you hear someone shouting, go and look and make sure there’s no one stuck in a room...” [EN5].

There were very few references to supervisors in the interviews with the emergency nurses. Similar to the palliative care group, this could have been due to the CNS’s working alongside nurses in emergency departments, almost as co-workers. The few references to supervisors and the comments of the clinical nurse specialist interviewed showed supervisory support to be at least occasionally important. This support was also described as largely instrumental;

“Like I think they’re very supportive like that......... They come and actually physically help.” [EN3].

Perhaps due to the younger age of some emergency nurses and the requirement for a more regimented approach in the dynamic emergency department, the environment may be less egalitarian than for the palliative care nurses. The following comment from the CNS shows how she coached a young nurse in an interaction with a client;

“… I think that they should be being developed as well and I see that as part of my role, then I’ll listen to what they have to say and then I’ll say to them so what are you going to go and... say to the patient now?...And I’ve even got them to run through... what they’re going to say and that so they’ve got some idea of what they’re going into.” [EN1].
The emergency nurses in this research described the level of organisational support in mostly negative terms, which is in accordance with the responses from the clerks. The following three comments all describe a general lack of perceived organisational support;

“Well the institution doesn’t care for patients at all… I’m quite serious… it doesn’t care for the staff… So we’re expected to be compassionate and caring in an environment that isn’t caring and compassionate” [EN2].

“…I know why I never went into management. It’s horrible, it’s quite toxic really. The management don’t support, they don’t see us as people, we’re just numbers.” [EN5].

There was also evidence that these general, negative comments may have a genesis in the organisation’s handling of critical incidences with clients and a subsequent perceived lack of emotional support. Furthermore, the negativity generated from perceptions of these situations was lasting. In the following comment, an emergency nurse explained how, in her role as a health and safety representative, she was privy to nurse’s complaints about a lack of managerial presence after an emotionally disturbing incident;

“………they’d just talk to me and tell me how nobody in the upper echelons of the place actually care about them and you know like various people who should have came in that night never came in and people knew that … look people have not been able to forgive that”. [EN1].

In respect to an organisational direction for an appropriate way to provide emotional support to distressed clients, an emergency nurse made the following comment;
“That’s certainly outside the scope. I mean… if you have any lecture saying you have to think about the psychosocial and give support to relatives, that’s it, that’s the stock standard phrase in everything. It doesn’t say how you might go about doing that. You know, give support to relatives, okay. Hi… yeah done”. (laughter) [EN5].

Despite the above comments, there was evidence that the organisation provided some important support mechanisms that are relied on heavily by the nurses in the emergency department. As described previously, overarching directives from the state government health department outline a no tolerance approach to abuse from clients (see section 3.3.1) and these directives appear to have been adopted by the organisation in question. Emergency nurses made numerous comments as to their reliance on security guards and their organisationally sanctioned capacity to have abusive clients removed from the hospital. These organisational sanctions allow for the emergency nurses to engage with clients effectively and protect themselves and others in the vicinity.

Another way in which the organisation can be seen providing instrumental support to the emergency nurses was the training provided to help employees deal with violent or abusive clients. However, for the emergency nurses, the importance and salience of the training did not appear to be high. One experienced nurse said she had never heard of the training. Another nurse explained that he was too busy, despite the training being mandatory;

“… I haven’t had the mandatory hospital aggression training… I haven’t got time to do it (chuckle) and I mean I’ve got a senior nurse who would help me for ages and we tend to be in senior roles which don’t have any time for stepping away and doing supportive stuff” [EN4].
As discussed, the palliative care nurses were able to easily access organisational support from imbedded support services that the organisation provided. The case for the emergency nurses was different, with no existing embedded counselling type arrangement. Instead, these nurses were able to access an EAP service, consisting of appropriately qualified counselling staff for the provision of support. Comments in respect to the EAP service and its utilisation were mixed:

“Yeah oh and I think one of the best things ... is knowing that there’s outside counselling services if you’re willing to use it...I used it, it went well.” [EN1].

“As an external service that can be brought in any time you like, any time you need to or if there’s a critical incident and you’re grieving and that sort of thing required within 24 hours then that service is available and we just have to ask for that and we can get it or have it arranged. It’s extremely rare it gets used…in fact I haven’t used it for a long time…” [EN4].

“… we get all this sort of tokenism…oh we’ll, we’ll put in this employer service or you know you can go and ring up somebody. At the end of a shift, it’s like saying you know if you’ve got a problem you can write it down….at the end of a shift you just can’t be stuffed”. [EN2].

Rarely did the emergency nurses express a need to access support from non-organisational sources. Unlike the palliative care nurses who spoke of the difficulties of raising emotional issues with partners or friends, the emergency nurses didn’t show a great need for this type of support or any of the same difficulties if the subject matter was raised outside of work. The required support, most reliably sourced from co-workers, needed to be immediate and mainly instrumental in assisting the maintenance of the safe and efficient working arrangements in the department. The residual need to
discuss emotionally difficult issues as was evident in the interviews with the palliative care nurses, was mostly absent with the emergency nurses.

Despite some very negative perceptions of the level of organisational support, the provision of security guards and the sanctioned authority to have clients removed if they become violent or abusive could be seen as very important measures for emergency nurses to have at their disposal. The security element was crucial in allowing emergency nurses to present an assertive front to abusive clients and to ensure that behavioural boundaries were respected and maintained.

5.4.1.2 Patient registration clerks. The interviews with patient registration clerks showed a low reliance on instrumental and emotional support in relation to the palliative care and emergency nurses. In line with COR theory, this lower requirement for support was associated with lower perceptions of emotional engagement as a normal part of the role and a more disengaged approach to clients. A further factor in the clerks’ ability to retain a more distant approach could be that they were physically separated from clients and perceived their role as mainly process oriented.

As has been demonstrated, the clerks still engaged with clients and used various emotion management strategies. Similar to the palliative care and emergency nurses, co-worker support was the most important source of support, once again due largely to its immediacy. The support derived from co-workers was mainly instrumental for these clerks; although there were some descriptions of emotional support in the interviews. Of interest was that the lower need for social support generally was associated with less effusive comments regarding co-workers; a situation not found in the interviews with
the palliative care or emergency nurses where support from co-workers was described as imperative. Nevertheless, as the following comment from a clerk demonstrates, instances of co-worker support was important at times for these patient registration clerks:

“… when a drunken person comes in and he gets triaged the majority of the girls will say… this one’s for you. I don’t mind dealing with it at all so I’ll take it over because I know their abuse and the language they use is quite foul… in return I get supported by them as well…every time I see a mother with a baby, she would sit down in front of me and start to breastfeed and… I keep thinking that she is feeling awkward about it but she has to feed the child you know and there’s no other place but in front of me… I feel… uncomfortable interviewing her…so I have to pass it on. My colleague is a girl, I say look can you complete this interview for me… and they know exactly why I want them to do it…” [EC4].

As with the emergency nurses, the patient registration clerks had to occasionally endure abusive clients. Despite the lack of a physical threat, support still seems to have been important during these occasions. In the following comment, a clerk explained how she assisted colleagues during difficult interactions:

“… if the person working alongside me was having to work … especially if it was a younger person, they’d be sat and I’d stand behind them so I was actually standing over the person on the opposite side of the counter who… was always sat down and I found that that helped as well because I thought I’m not letting them think they’re getting away with this. If there’s two of us then…there’s more that we can say and there’s more that we can do…” [EC3].

Following a disturbing incident, this clerk explained how she was assisted by her co-worker. The theme that shared experience was important is evident in this description, similar to the finding amongst palliative care and emergency nurses;

“They were generally concerned because we’re in those sort of situations… sometimes we actually tend to help each other more than the supervisors or the co-ordinators will help us because we all know what
we’re going through, what we’re facing. So you know it’s really good to have a backup with your work mates”. [EC1].

Generally, interactions with clients were described as being less intense for the clerks than for any of the nursing groups and there were comparatively fewer identifiable instances of emotional support. One such instance described how a clerk spoke very briefly to a co-worker after dealing with a bereaved family;

“I went back to my desk and my co-worker was there and I just ... she said are you okay and I said no, I’m a bit upset and she said oh, and I just expressed to her how I was feeling and then I pulled myself together and then I did my job.” [EC5].

The manner in which the clerks spoke of the level of co-worker support was mixed. There were numerous negative accounts of how co-worker support was lacking and how this was related to a general feeling that the environment was unfriendly and that there was reluctance for co-workers to help out during times of high workloads;

“I’m finding too that because there’s new staff coming in, the staff that are already there are too busy with their own agendas… I have heard a couple of people say this is the most unfriendly environment they’ve ever worked in.” [EC1].

“… the workers weren’t getting on and it impacted on everybody… to me it wasn’t friendly anymore.” [EC3].

There were only a couple of references to supervisor support. These were also mixed with some clerks indicating that the supervisor was very helpful in dealing with emotional issues. After an upsetting incident with a client, one clerk described the way in which her supervisor provided support;
“...I almost cried. I can’t remember ... how the conversation went but ... she [the client] gave me hell. She said I’m being ignored here, it’s all your fault and just completely went troppo...And I thought blimey what did I say... I went back in and [name omitted] was there, the supervisor, and he was old school, very skilled, brilliant, he said I told you [name omitted], don’t go out into the waiting room. I said you’re right [name omitted], I won’t do it again.” [EC3].

A further description shows that supervisors were not always viewed as supportive in times of high workloads;

“Yeah, the fact that we don’t have enough help from the supervisors or other areas where there’s people that have jobs that don’t require an awful lot of time so they stand around doing nothing while we’re rushing our butts off. That gets me agitated. That gets me annoyed, really annoyed...” [EC2].

The manner in which the patient registration clerks spoke of the level of co-worker and supervisor support as compared to the palliative care and emergency nurses represents a point of difference. For the palliative care and emergency nurses, the greater requirement for support was associated with more positive comments about co-workers. It could be the case that due to the reliance on one another for support, these nurses may have placed greater value in the relationships with their co-workers and therefore worked harder to maintain them. In the case of the clerks, a lower level of emotional engagement appeared to be associated with a reduced availability of support and perhaps a reduced need as well. The clerks also described generally poorer relationships with co-workers and supervisors.

In addition to the low level of co-worker support amongst the clerks, in general, the organisation itself was also spoken of in very negative terms. The clerks perceived...
the organisation’s management as being unresponsive in times when emotional support may have been required;

“... even when there have been some (pause) violent incidents, there’s no ... debriefing, very little debriefing. In the whole time that I’ve been there... counselling has only been offered once and that was because a staff member (pause) suicided.” [EC3].

A lack of organisational support was also seen in the absence of any sort of facilitation or encouragement of contact between co-workers. The community palliative nurses described a situation in which nurses were easily able to communicate freely with one another despite them mostly working alone. The following comments show that this level of communication may have been lacking amongst the clerks even though they work in close proximity to one another;

“We have a conversation here and there but nothing, we don’t have the same lunch hours, we’re not allowed to, so it’s hard to be social with the people you work with because you don’t have any outlets of social interaction.” [EC1].

“…what really bugs me is when you get a new person starting the job, like they put them... they put them through this training and then they’re under your wing for a while. I have to go to lunch or tea at that specific time, regardless of how busy it is out there...I’d rather have a late lunch, or an early lunch or a tea break so long as ... there isn’t a crowd there waiting to be processed. But...you’ve got to go to lunch regardless...and I feel that’s totally wrong because it’s the new person on the block and you know he’s confused…” [EC4].

Contrary to the above complaints about the level of organisational support, the organisation’s provision for training to assist employees deal with violent and aggressive clients was extremely well received amongst the patient registration clerks.
Furthermore, the training was at the forefront of the minds of these employees when discussing the manner in which they deal with difficult clients:

“…we have courses… to deal with angry people… they do help …Because it…shows you where your limits are in terms of …what I can say and what they can say to me and how I can say to them, that’s enough … and you don’t have to deal with them… you do get something out of it, there’s no doubt about that…” [EC3].

Even though the training is considered to be very useful, it seems that it has been applied very inconsistently. As one participant described, she had been working as a clerk for five months and had not received the training to help deal with difficult clients;

“I think there is training but I haven’t been told of any specific courses or anything.” [EC5].

Another clerk had missed this training for various reasons for an extended period;

“…it’s probably five or six years since I did one of these courses, mind you but yeah, they gave me different things to say like how to answer something that’s been said to you, which has gone out of my head at the moment… Actually the rest of the department did one last year and I just never did it. I don’t … they miss my name off all the time…” [EC3].

Organisational support for the patient registration clerks was perceived as lacking. Despite this, there was good evidence that the training provided by the organisation to deal with abusive clients was perceived as important, well-targeted and meeting the needs of the clerks in their dealings with clients. This was a different situation to the emergency nurses who only mentioned the same mandatory training
when prompted. Another interesting difference between the emergency nurses and patient registration clerks was their perception of the EAP service. From the comments of the emergency nurses, this service was salient, if not perceived as extremely useful in all cases. However, the clerks did not mention the EAP in the interviews, despite having the same access to the service. It could be the case that the EAP was not perceived as important to the clerks due to a lower need to access support generally, which was in line with their comparatively lower level of emotional engagement as a part of their role.

The patient registration clerks also described a fairly relaxed attitude towards the discussion of workplace issues with family members. As the following comments illustrate, these clerks had no trouble in raising emotive workplace issues with family members even though they didn’t show a great need for this type of support. These two comments show that support from family members was an almost incidental factor;

“I’ve had a rule with my kids ever since I’ve worked in emergency. If I talk about work outside of work, slap me (laughing) and they still do that. Mum’s talking about work”. [EC1].

“I didn’t take it any further. I don’t know whether I should have. When I went home I talked to my husband about it”. [EC5].

On a slightly different note, this clerk explained how she found it difficult to come to terms with serious medical cases when she first started in the role. It’s evident that she was unable to talk about this with her partner, similar to the experiences of the palliative care nurses. For this clerk however, there wasn’t the same need for ongoing and intensive emotional support as was a constant theme for the palliative care nurses;

“…not so much now but when I first started, I guess, I did especially if it was an emotional thing like a child dying or something in there. That
used to sometimes affect me or a teenage boy in a car accident which could be one of mine… Something like that might affect me… and I might take that home. I might just think about it and I wonder what the family are feeling like at night… I still do, but not as much like I used to…” [EC2].

The patient registration clerks showed a reduced need for support as opposed to the palliative care and emergency nurses. This was associated with a lower level of emotional engagement and emotional management strategies. The clerks also described poorer perceptions of available support from all organisational sources and no reference was made to the organisation’s EAP service. These findings are interesting when considering that a prime method of emotional management of these clerks is to disengage with clients and remove themselves from interactions completely. This strategy was not available to the three nursing groups and indicates an ability to distance themselves emotionally from clients and deal with any abuse more independently.

In situations where support was important, these clerks demonstrated a reliance on co-worker support due to its immediate availability. In the main however, the clerks showed very inconsistent perceptions of both organisational and non-organisational sources of support and no real reliance on any particular source as critical to their sense of wellbeing.

5.4.1.3 Renal nurses. In contrast to the palliative care and emergency nurses, there was less evidence of the same prominence or importance of support from co-workers, supervisors or the organisation in the interviews with the renal nurses. The routine and stable environment of renal dialysis wards may have been associated with far less emotionally confronting situations as opposed to the other three groups, thereby
resulting in less need for regular support. However, co-workers were still seen as the most prominent source of support seemingly due to their availability and shared understanding of the issues involved. There was evidence of emotional and instrumental type support from co-workers. This support consisted of informal discussions;

“… if things do tend to get to us we do talk ... have some sort of debriefing session with each other…” [RN4].

“I just find like especially with staff at the moment, we’re all quite open and we do talk and if it comes to a patient, we do speak about it and see what ... we bounce ideas off of each other.” [RN2].

However, at times when renal nurses were emotionally challenged, the atypical need for emotional management skills and the lack of an ongoing requirement for intensive support may have resulted in an unpreparedness for these nurses to provide effective support for one another. When speaking of a co-worker’s emotional management skills during stressful times, the following comment was negative, criticizing the ability of some co-workers to manage emotion effectively which resulted in difficulties in the workplace;

“There’s times when I’ve had to manage my emotions because of the other staff members involved and I have to bite my tongue (chuckle) and in particularly stressful times, sometimes the staff that you work with don’t have the coping skills and fall apart...they often can't then function particularly well at work because they are distressed and I mean I’m thinking in particular there’s probably two staff that I’ve regularly worked with that if you hear of a death, I just know that (chuckle) I’m going to be the one that has to sort this out and that they’re going to become quite distressed.” [RN3].
While the following quote was not in reference to an incident between colleagues and not involving a client, it was also in accordance with the theme that co-worker support was perceived as generally lacking:

“I felt really unsupported then but the funny thing is all the staff were singing the same tune but no one else would come forward and you know go in the office and say look, we’re having the same problems and it was just awful.” [RN5].

The one reference to a CNS reflected very briefly on her role as the person to consult regarding workplace issues. This comment also alluded to the CNS being regarded as a colleague, which was also the case for the other two nursing groups;

“…we can always go to her and say ... oh I'm not happy about this, or what could I have done better and ...So it’s more with our work colleagues…” [RN4].

Co-worker support seemed to be of occasional importance to the renal nurses interviewed in this research. However, it could be the case that at precisely the times when this support was most critical, the lack of emotional management as a normal aspect of the role in this particular environment resulted in an inability for nurses to respond effectively and actually support one another.

Organisational support did not appear to be prominent in the minds of the renal nurses in terms of need or availability. The renal nurses commented on the lack of direction offered by the respective organisations in assisting in helping to deal with emotional management issues;
“…they [nurses] get emotionally tired and that’s when I think the organisation needs to look after them and maybe say would you like to do a couple of months in another area and that’s what doesn’t happen.” [RN3].

The following quote was in reference to a patient who had threatened a nurse. Of note is the difference in the way in which the handling of this incident was described as opposed to the testimonies of similar instances amongst the emergency nurses:

“…you know the first inkling of a situation like that, you think they’d be on top of it and say right, if this patient is threatening you, we’re going to do this and this and have a system in place but it doesn’t always seem to be that way. I think it’s always after the event, oh well maybe we’ll get security next time. I think it's always gently, gently approach and sometimes (chuckle) I think that’s not the answer.” [RN5].

In a similar situation, this nurse displayed a lack of preparedness to deal with an abusive client;

“…we had this…gentleman who used to yell at me and like from being fairly confident, I just kind of couldn’t handle him and it just got progressively worse and worse. And at that time the way it was structured, I used to work every Tuesday, Thursday, Saturday 12 hour shifts and this gentleman was on every day to the point I had to get him moved because I felt I can't cope”. [RN2].

Furthermore, the same nurse described a lack of thought for how she might be supported, in her explanation of how she dealt with the problem;

“Try and be nice and say oh, this shouldn’t happen… I just thought I’m going to try and deal with it myself…With time, it settled”. [RN2].
There is a clear difference between the above two comments, and the way in which emergency nurses explain how they dealt with regular abuse and relied on co-worker and organisational support. Also of note is that the failure of an adequate response to abuse created difficulties which were long lasting. Such continual negative affective workplace experiences in relation to interpersonal interaction may result in emotional exhaustion (Maslach & Goldberg, 1998).

There were limited accounts of organisational measures that renal nurses indicated were useful and even these were not always sustained;

“When we first started in this unit here we’d only been open for six weeks, we actually had a [cardiac]arrest on the machine and I found that quite traumatic, because I was new to dialysis and it was very unexpected…We did get debriefing after that…” [RN4].

“I think we do have a social worker, [name omitted], at the time. She was really good. She would come down and talk but I don’t know that there’s any… she had enough of the job. It was too much for her in the end and I don’t think I’ve heard of anyone doing the role quite as [name omitted] did it…” [RN5].

The existence of an EAP was mentioned in the interviews with the renal nurses. However, as with the emergency nurses and patient registration clerks, and unlike the case with the imbedded service available to the community palliative care nurses, this was not discussed as a prominent feature of the workplace;

“What they offer is an EAP service which is not widely publicised in the area. It’s only if you have something major go wrong and that’s very messy that they might say well we have got an EAP service but it’s actually not pushed. So it’s not visible, it’s not … they don’t encourage us to talk about it. I guess people are left to deal with it in their own way, yeah.” [RN3].
Consistent with the low reliance on support and the low salience of support as an important issue in comparison to the palliative care and emergency nurses, evidence of the perceived importance of non-organisational sources of support was not evident in the interviews with the renal nurses. In fact, the one comment relating to the discussion of workplace issues away from the workplace showed a lack of any need to engage in workplace issues with her partner;

“If I'm tired, and it’s been a long day… 'Cause you’ve been with people all day, and you just want to have half an hour wind down and sometimes that doesn’t happen…. And you sort of think you’d only need to look at my face to recognize… just leave me alone for a while…” [RN4].

The interviews with the renal nurses provided evidence that a low level of active emotional management combined with a routine and generally non-emotive work environment was associated with a much lower need for emotional support. This was in stark contrast with the emotionally demanding settings such as those described by the palliative care and emergency nurses. Furthermore, renal wards, by the nature of the chronic illness of the patients and the extremely long and intense relationship development between nurses and clients, may have created an environment in which emotional management was forgotten. It was apparent that when emotionally difficult situations did arise, it may have been more difficult for nurses in this environment to call upon a practiced and familiar level of emotional management. In relation to support, this may mean that these employees were not in a position to be mindful of the need to provide support to co-workers.
5.4.1.4 Overview of social support. The current research adds to what is already known about the importance of social support as a buffer to wellbeing deficits in work situations in which interpersonal contact and active emotional management is an important part of the role. Support from co-workers was most important for employees groups due its availability and a sense of shared experience and understanding.

This research showed that those employees who expended the greatest emotional resources in their role had the greatest need for support. Furthermore, the type of support that was most beneficial matched the type of expenditure in each situation. For example, palliative care nurses showed the greatest emotional investment in their role of all four groups. The type of emotional expenditure was mainly emotion focused. Their engagement with clients’ and their work in helping them to come to term with issues surrounding death was central to their role. In response to their emotional expenditure, the palliative care nurses sought out emotional support from co-workers. This support was clearly very important with a good deal of forethought as to how this might be accessed when it was most needed.

The emergency nurses also showed evidence of emotional engagement and management as being important in their role; however the purpose of this level of emotional work was mainly as a means of protecting themselves and others in the vicinity and to ensure the ongoing viability of treatment in the department. Therefore, it could be said that they mainly used emotion management skills instrumentally and not as an end in itself. In line with this instrumental purpose, the support that was most crucial to them was also instrumental with only a few references to emotional support. The emergency nurses described how they provided a physical presence in support of
co-workers when confronted with violent or abusive clients. In addition, the organisational mechanisms that assisted and sanctioned the authority of emergency nurses to have abusive and violent clients removed from the workplace were also very important sources of instrumental support. This support gave the emergency nurses confidence to assert their right to be treated respectfully.

In contrast to the high level of emotional management in the roles of the palliative care and emergency nurses, the patient registration and clerks showed evidence of a lower level of the use of emotional management strategies. Consistent with COR theory, this greater emotional distance was associated with reduced need for support as an ongoing requirement in the role. When necessary, it appears as though co-workers were still important, however the clerks’ sanctioned ability to remove themselves physically from the interactions with clients completely, was an individualised emotional management strategy not available to employees in any of the other groups.

The situation for the renal nurses was quite different and serves as an important indicator that extreme types of contact may bring with it unique challenges in terms of emotional regulation. In respect to support, the relaxed, family like environment of renal dialysis wards with the very long and intensive contact with clients was associated with an apparent absence for the need for ongoing support as a buffer to emotional management and the emotional expenditure involved. However, during and after emotionally disturbing instances, the renal nurses described a lack of preparedness to respond on the part of both co-workers and the organisation. Even though the instances in which a significant level of required support may have been rare, descriptions of their
aftermath and a failure to provide adequate support during these times indicates the likelihood of lasting individual and organisational problems. In comparison, the salience of, and constant need for support in the palliative care and emergency nurses was associated with a high level of preparedness. This preparedness to support and be supported may result in less emotional exhaustion and other wellbeing and performance problems even in these environments requiring a great deal of ongoing emotional expenditure.

The social support findings in the current research supports Hobfoll’s (1989) COR model as a way of explaining the importance of support and its relationship to emotional expenditure. Specifically, this research shows that the required level of support varied in response to the level of emotional expenditure, and the type of support needed to match the type and purpose for emotional expenditure. In addition, available and more relevant sources of support become more important when other sources were unavailable.

Previous research has identified various types of support to be important in affecting positive wellbeing outcomes in a variety of situations. The evidence from the current research is largely in line with what has been found previously. For example, a combination of supervisor and co-worker support has been found to lead to increased job satisfaction (Lewig & Dollard, 2003), and reduced levels of emotional exhaustion (Halbesleben, 2006; Lewig & Dollard, 2003). Perceptions of organisation support has been linked to reduced levels of emotional exhaustion (Jawahar et al., 2007) and lower absenteeism (Eisenberger et al., 1986). In health care, the role of the CNS was been found to be important in helping palliative care nurses deal with the extreme emotions
that they were exposed to (Skilbeck & Payne, 2003) and Smith (1992) found that emotionally demanding clients were avoided if support from senior staff was perceived as lacking. Nurses working in a baby care unit explained how co-workers were extremely important due to their presence and understanding and when nurses had to work alone, coping was more difficult (Lewis, 2005). Similarly, nurses have explained that support from co-workers and a sense of working together was important in assisting them to remain in the profession (Gunther & Thomas, 2006).

The current findings suggest that co-worker support was the most important source of support followed by supervisor support. The situation in relation to organisational support was more difficult to assess. There were few direct, positive references to the importance of organisational support. However, there was evidence that organisational support may have been very important to underpin employee attempts to deal with clients. For example, emergency nurses were sanctioned to use the security service to remove abusive clients from the hospital and the community palliative care nurses described a culture of support in their organisation which was underpinned by procedures, policies and support services. It could be the case that organisational attempts to support employees may be less visible but just as important as other sources. Therefore, further investigation is necessary to identify the relationships between different types of support and wellbeing outcomes in different groups.

Another important finding was that relationships between co-workers were more carefully cultivated and protected where the co-worker support was more important. For example, the palliative care and emergency nurses were reliant on co-workers and these nurses described their co-workers in very positive terms and obviously made substantial
efforts to provide support and were aware of its importance. In contrast, the renal nurses and clerks relied less on support and consequently there were less effusive descriptions of co-workers and less focus on the importance of providing support. The clerks and renal nurses were more critical of their co-workers and their working relationships were not associated with the same close bonds. It appears to be the case that the level of need for support is associated with efforts to ensure that supportive relationships are protected and maintained.

5.4.1 Emotionally demanding interactions. A consistent theme to emerge across all groups is that, regardless of how experienced and distanced these employees were in respect to their dealings with clients, there were some situations that were particularly emotionally demanding. Without doubt, having to deal with sick or dying children, or the untimely deaths of the young, created the most distress in these participants. The difficulties associated with cases in which the client had some emotional relevance to the employee, such as patients who are a similar age or appearance as relatives of the employee involved were also prominent. Nurses from renal wards described a slightly different situation, with the added dimension of emotional relevance being generated from the development of long term relationships in addition to the factors mentioned above.

The notion that the illness of children or the untimely death of young people should be particularly emotionally distressing is not surprising. Previous research has shown similar findings. For example, Gunther and Thomas (2006) interviewed nurses from various settings, and many of the distressing and memorable experiences in their roles concerned the untimely deaths of the young. Similarly Boyle (2005) found that in
interviews with paramedics, the attempted resuscitation of children often continued long after any hope of recovery due to the difficulty of having to confront the hopeful and distressed parents. Boyle also found that, as a coping mechanism, paramedics disassociated themselves from elderly patients who reminded them of their own parents.

In line with their high level of emotional involvement, palliative care nurses describe numerous accounts of how the deaths of young people are especially emotionally challenging. A point of difference between the palliative care nurses and the other groups was that for the palliative care nurses, the development of close relationships with the relatives of patients sometimes countered the distress associated with the death of the patient;

“…that’s a real struggle when people are young and they haven’t had enough life. There’s no justice for that kind of thing… When they’re young like that, they’re very close to my kids’ age and I immediately think how would I be as a mum. So that always gets to me”. [PN2].

The same nurse described the prelude to the death of a young woman. Of note was how the situation was at once distressing but also rewarding for this nurse. The establishment of close ties with the family members and the ability to impact positively on their lives was obviously extremely satisfying;

“… just two weeks before she died, she flew over and was bridesmaid at her sister’s wedding and they were showing me the photos and she was beautiful…you could not even tell she was sick and there was one photo where she obviously didn’t realise she was being photographed and she’s pale, incredibly pale and she was in incredible pain and yet her mum told me she woke up on the morning of the wedding and she looked dreadful, she felt dreadful and about an hour before the wedding she just got up and she said right, let’s do this. And she just steeled herself. She was the most amazing person. And so when I saw this photo of her in obvious pain, I thought… you know she did it for everybody else. She made that
wedding beautiful and all the photos beautiful but she was in a lot of distress herself. So that really got to me that she would be so strong and be thinking of everybody else…That was actually a good one… there’s so many blended families in this house and it actually makes you feel proud to be doing this job and you get a lot of good feedback, you get a lot of feel good out of it”.[PN2].

For the palliative care nurses, experiences of death were obviously the focus of their work. The expectation of the death of patients and the ability to form meaningful and supportive relationships with the family of clients assisted in their coping, even in cases that were especially emotionally taxing. Furthermore, as evidenced above, the support of co-workers was particularly in tune with these more difficult experiences.

Even though the other three groups did not attach the same importance of engaging emotionally in their role as did the palliative care nurses, the same theme of the difficulty of dealing with children and emotionally relevant clients was still prominent. The emergency nurses described attempts to stay clinically focused and somewhat emotionally detached. However, this was described as being difficult when children were involved. The following two comments described such occasions. Of note in the second comment is that even though the recollection was from over 24 years ago, it was still memorable for this nurse;

“I came to work on one nightshift…and there were two… they were probably a bit older than my kids…but not by much, one was 9, one was 11, two boys were hit by a car and they were just lying there… ever see the film the 10 commandments with Yul Bryner and Charleton Heston?… this reminded me of a scene from the film, there’s a scene … where the pharaohs sons died, it was just a scene of the naked body of a child lying there dead and the father looks at them, and that’s what these kids were like, they were naked except that there were tubes coming out of them because they were unconscious they were incubated… that’s one thing you find about having children, that when your children are coming
up to or are of an age where they could be… then there’s a sort of an association, that might happen to you, that fear of loss”. [EC2].

“I mean there are some terrible things, you think, well that shouldn’t have happened… particularly sad things like cot deaths … I can remember 1983, 1982, Christmas Day… two on the one day… and I can remember the child’s grandfather, and why wouldn’t you because it stands out as such an unfortunately memorable thing, it’s very, very sad”. [EN3].

The same nurse described the difficulty in trying to control her emotions at this time;

“Oh very hard to control the tears… and what really was the edge was I had a student nurse who was reeling about in just floods of tears and I just looked at her and I said go and sit in the tea room, you don’t need to be here”. [EN3].

This nurse also indicated that some clients reminded him of family members and this created an occasional emotional issue for him;

“…it’s just a problem that keeps developing and makes an emotional undercurrent. He looks like my old man, she looks like my mother, that sort of thing”. [EN2].

The clerks also described occasions when certain clients created an added emotional dimension. In the following comment, this clerk talked about being emotionally detached in most situations but not when dealing with mistreated children;

“I learned how to switch off and switch on again you know… Only kids you know, adults don’t bother me one bit, it’s only watching kids being mistreated”. [EC4].
Similar to the testimonies of the emergency nurses, this clerk explained the difficulties in dealing with incidences involving children of a similar age to her own;

“…if I have someone in that has children about the same age as mine... that can affect me heaps sometimes...overdoses of young people, like my son’s age... I do feel it and it’s very hard to try and keep that kind of stuff in…” [EC1].

The manner in which the emergency nurses and patient registration clerks talked about emotionally relevant clients as being particularly difficult were quite similar. However, there was a clear difference between these comments and the comments of the palliative care nurses who described a close connection with the family members of patients as well as emotional support from co-workers as being important in assisting their coping. These relationships were associated with feelings of satisfaction despite the tragic circumstances. The emergency nurses and patient registration clerks did not show evidence of the same type of relationships with clients or the same level of targeted emotional support to assist them come to terms with these distressing scenarios.

The extra difficulty in dealing with younger patients was not as prominent amongst the renal nurses. This could be due to the tendency for long term renal patients to be older. One nurse estimated the average age of the patients in her ward to be around 70. Despite limited exposure to younger patients, dealing with their demise was still described as particularly difficult;

“I remember a few years ago, we had a young lady. She had three children, a loving husband and it was tragic. She had diabetes and then she had all these complications and basically she was dying and there was nothing anyone could do about it and it was tragic”. [RN5].
Mainly, it seems as though the renal nurses became most upset after the development of long-term relationships with clients in which normal type friendships had developed;

“I just think you know like because we have watched so many people die a horrible death and we just had a lady who, I must admit was probably my favourite, died and within two weeks, she went from… walking, to in a wheelchair [to] not being able to make good decisions…” [RN2].

Amongst all groups, there was clear and consistent evidence that these employees found the deaths or serious injury or illness of young people, or those that had some sort of personal emotional relevance, as particularly difficult. Even those employees who asserted that they were almost always emotionally detached still spoke of the difficulties of dealing with such cases. Such difficulties for nurses have been described previously (Gunther & Thomas, 2006), however this cannot simply be attributed to a professional peculiarity as the clerical employees also spoke of this issue in much the same way as the nurses.

The notion that these employees objectified clients who elicited a particularly strong emotional reaction was absent in these interviews. Smith and Kleinman (1989) explained that trainee doctors managed to remove themselves from the patient emotionally by thinking of them as a type of problem or particular situation, and Boyle (2005) found a similar situation existed for paramedics. The current research showed that even though there were references to patients as “only patients” as well as other evidence that these employees sometimes detached themselves from moment-to-
moment emotional involvement with clients, this was not the case for emotionally relevant cases or in the case of untimely deaths or serious illness of young people.

If this type of interaction is forecast and there is adequate provision for support, as is the case for the palliative care nurses, then coping with this distress may be easier. The difficulty facing emergency nurses and the patient registration clerks was that forecasting such emotionally demanding cases may not have been possible. In addition, if the normal course of events dictated that timely and adequate emotional support was not available, coping with occasionally upsetting incidences appeared more difficult. For the renal nurses, the combination of a lack of ongoing emotional support as a prominent aspect of their role and the establishment of long term friendships with certain clients may have also created added emotional problems when patients died.

5.4.2 Work demands. A prominent theme from the current research was that, amongst the palliative care and emergency nurses, and clerical employees, periods of high workloads impinged on the ability to engage emotionally with clients. Renal nurses did not show any difficulties in engaging emotionally with clients due to high workloads, possibly because of a very stable and predictable working schedule.

The current research also showed that palliative care nurses felt some guilt about neglecting the emotional interaction aspect of their care of clients when they were very busy. Employees from the other three groups did not attach the same significance to the neglect of this aspect of their work. The following comments from palliative care nurses showed how problematic high workloads were for their effective emotional engagement with clients;
“…you’ve only seen one client but you’ve still got seven more to go and your pager’s going crazy so you’ve got three more visits that you need. So you actually need to hand over some visits but you’re two staff down so you don’t know who’s going to pick up those visits … I think you actually start to switch off emotionally because you have to become a bit automatic to get through the day… what can I not do in order to do what I have to do…” [PN2].

Amongst the emergency nurses, workload issues were also an impediment to the ability of nurses to engage with clients. The following comment described that this aspect of the role suffers in these situations;

“Generally you’re a little less patient, and I guess you’d also be overcrowded and when you get less patient you… so instead of treating them as a human being you tend to objectify them more as a problem I suppose”. [EN2].

Despite a lower level of emotional engagement, the clerks still recognized that high workloads created less opportunity for interactions with clients;

“I might get four or five in a row and you have to be able to cope without panic… so you have to be able to keep them on track. ‘Cause some of the patients, especially the older ones, like to have a chat”. [EC5].

For the palliative care nurses, there was evidence that neglecting emotional engagement may have been especially difficult due to their greater level of emotional engagement. As found previously (James, 1992), the palliative care nurses tended to give the interaction aspects of their role a great deal of thought. It also seems as though even in an organisation which is focused on the emotional aspects of the role, as is the case for the community palliative care nurses in this research, limited resources may
naturally lead to a lower level of emotional engagement. For the emergency nurses, time pressure brought with it a reduced level of engagement with clients, but this appeared to be mainly an impediment to the instrumental functioning of the emergency department. The clerks also talked about time pressures reducing interaction time; however they simply indicated the need to move things more quickly.

Overall, apart from renal nurses, the employees in this research showed an awareness of how periods of increased workloads reduced their capacity to interact at a greater level than would normally be the case. In situations in which emotional engagement was an important aspect of the role, this may produce feelings of inadequacy amongst employees who feel guilty about either neglecting clients or depersonalising them.

5.4.3 Individual differences. Indications that individual personal qualities had an impact upon the success of employees in their dealings with clients varied marginally between groups. There was a difference between the comments of the clerks and emergency nurses as opposed to the palliative care and renal nurses in their perceptions of the required personal disposition. This difference possibly reflected the more volatile setting of emergency departments as opposed to the more stable palliative and renal settings. Whereas, the palliative care and renal nurses spoke of the need for empathy and compassion, this was less prominent from participants from the two emergency department groups. The following comment from a renal nurse explained why compassion and empathy were considered important in the context of a renal setting;

“…to understand the paths some of these people are on and understanding … the loss of the life as they knew it and the restrictions
that are now placed on them and the future maybe what they thought it was going to be. So having that empathy and understanding that goes with that.” [RN3].

In the following comment, a palliative care nurse explained that she believed that her own capacity for compassion was central to her role;

“A lot of compassion, I have a lot of compassion for people in that area”. [PN3].

In contrast, the emergency nurses and clerks spoke of the importance of being emotionally resilient and being able to brush off difficult encounters. In the following comment, a clerk described how some clerks took abuse from clients personally and were unable to shrug off such experiences;

“…you know they take it on board and to them it becomes personal whereas…you shouldn’t be taking it personally at all in a department like that…and some people just don’t have that ability to be able to shrug it off…”[EC2].

Similarly the following comment from an emergency nurse emphasised the importance of emotional stability and a non-reactive approach to abuse;

“You need…people who’ve got calm demeanours…and lots of things just can pass them over and they don’t react to lots of triggers…I’ve been asked to go to the ED department to sort things out and people will say awful things to you. And my way of dealing with that is, oh yeah, everybody calls me that and I just move on.” [EN1].

Another notable difference between groups in terms of dispositional differences was the focus on the process driven and repetitive nature of work in renal wards as
opposed to the dynamic and unpredictable situation that exists in emergency
departments. Renal nurses spoke of the requirement for a tolerance of the same work
and clients on a day-to-day basis as important to their ongoing viability in their role. The
following comments were both in response to a question asking what factors contributed
to nurses leaving renal care;

“The repetitiveness of learning the machines, having the same patients,
the same chronic patients.” [RN4].

“They just get sick of the whingeing of the patients because it’s not like
they walk in and say oh, I’ve got a headache, here’s a pill, it’s better. It’s
every part of their body will ache or they’ve got this problem. It’s just so
ongoing and it’s every system of their body, not just the renal disease…
It’s so chronic and it is boring after a while” [RN5].

In contrast, emergency nurses spoke of the need to be able to respond to a fast-
paced work situation with shifting priorities. In the following comment a nurse reflected
on the ability of emergency nurses being unfazed by multiple demands;

“I’ve seen people they’re still triaging patients through and there’s
somebody over there cursing, swearing, carrying on and somebody at the
desk saying I want to go home…they’re still dealing with the ambulance
drivers over here and all this is going on………” [EN1].

Similarly, this nurse explained the need to be able to change focus and deal with
a lack of routine;

“…you know it’s going to be a fast and possibly stressful place and you
must have your wits about…but generally people that work here I reckon
are type 1: short-term, fast movers, assertive …It’s organised chaos is
what it is…and it involves a lot of pattern recognition of how things are
going to pan out and if you don’t have the background for the particular
things that are going on and you don’t recognise where to intervene or what to do then it can be stressful because it’s not predictable and not predictable is stressful to some people…” [EN4].

The above evidence describes the need for some variation in dispositional qualities across groups. However, there was not compelling evidence of the importance of specific personality requirements from any of the groups. Indeed, one palliative care nurse gave a view that a range of personality types co-existed in palliative care;

“…I suppose the characteristics of the … nurses, doctors is as varied as can be. You get some who are extremely, you know the shy, quiet, retiring person and you get those who are loud and outgoing and life of the party type people and sort of everything in between.” [PN4].

Previous research has suggested that higher levels of personality dimensions such as extraversion, conscientiousness, and agreeableness may result in an easier compliance with display rules leading to a lower requirement for surface acting and subsequently more positive wellbeing outcomes (Bono & Vey, 2007; Diefendorff et al., 2005; Tan et al., 2003). The current research has not uncovered any evidence of the requirement for specific personality dimensions for more successful interactions with clients or in the conduct of emotional labour generally or in any particular group. However, this may simply reflect a lack of awareness or focus on specific components of personality dimensions such as those described in the five-factor model (e.g. McCrae & Costa, 2003). Pro-active engagement with clients would appear to be an important aspect of nursing roles and there is ample evidence of nurses leading the interactions with clients and engaging at an emotional level in the current research. This appeared to be less the case for the clerical employees. The current research does not contradict
previous findings but from the participants’ descriptions, personality or individual differences were not prominent as contributing factors to the success of emotional management in these groups.

5.5 Outcomes

5.5.1 Job satisfaction and employee wellbeing. The current research showed that, not only can emotional management strategies be functional, but employees in many different circumstances can enjoy the interactions with clients. Evident from the interviews in this research was that the level of satisfaction with this type of work varied from the deep and profound experiences of palliative care nurses to the much more incidental and less outcome focused experiences of the patient registration clerks.

Many descriptions of emotional management in workplaces have taken a negative view of the effects of this aspect of work on the wellbeing of employees. Emotional management (particularly emotional labour) has been associated with the disempowerment of employees and the requirement of slavish and diligent adherence to organisational demands to please the customer, ensure return business, and improve bottom line returns (Hochschild, 1979, 1983; Williams, 2003).

In the public health care sector, a profit motive and focus on customer satisfaction as the primary goal of emotional management may be less important than for other situations such as the airline industry. As has already been shown, the employees in this research were driven by quite different motives for managing emotions than purely for ensuring return business and profits. Therefore, wellbeing outcomes and satisfaction from this aspect of the role can be considered in quite a
different light than for situations in which employees are pressured to conform to strict rules and satisfy customer demands.

The bleak view of emotional labour as being detrimental to employee can be challenged in this research as has been argued elsewhere (e.g. Ashforth & Humphrey, 1995; Wouters, 1989; Zapf & Holz, 2006). In particular, the palliative care nurses derived much satisfaction from being emotionally engaged with clients and helping them to come to terms with death related issues. The notion of helping client to achieve a good death was of prime importance;

“…but actually it can be quite rewarding if you have what we would call a good death. So a client gets to where … he or she needs to be or wants to be and the family also travel that journey. You know, to be able to pull out of a driveway and go that went quite well. That’s perhaps an odd kind of satisfaction.” [PN5].

In the comment below, the nurse compared palliative care to other nursing work;

“I think out of all the nursing I’ve ever done that’s the most rewarding. I mean you can restore somebody after their appendix or something but … that’s a run of the mill thing it’s common and you know… I think because of the emotional side of grief and loss I feel like I can do a lot … lot more and it’s very rewarding” [PN6].

As was evident throughout descriptions of the manner in which the palliative care nurses engage with clients, there was a good deal of commitment to helping their clients come to terms with either their own death or the death of loved ones. The palliative care nurses displayed a lot of pride in their work and their level of self-efficacy in helping their clients achieve the best possible outcome in difficult situations.
Emergency nurses took a different perspective on the enjoyable or satisfying aspects of their role. The explanations of elements of the role that were satisfying were much more diffuse than was the case for the palliative care nurses. For example, when the emergency nurses described managing natural emotion by displaying a measured amount of anger to control the abuse of clients, there was certainly a type of satisfaction related to their ability to achieve this affectively;

“...And he’s being dragged out the door yelling [unclear] and I said well we did give you two warnings and you still didn’t take any notice so I said the cops are here to take you away and he’s like but you can’t do that, I said yes I can...things like that do happen and you just take it in your stride ... there is a sense of power...” [EN3].

An indication of the dynamic and changing environment of the emergency department could be seen from this nurse’s comment on how she found the ability to persuade clients to come to terms with the fact that a family member should not be resuscitated, as rewarding:

“...I guess the things that I find very enjoyable is when you’ve been able to negotiate for... people that somebody is not for resuscitation, you’ve actually been able to take the patients and the relatives side and help them come to the conclusion that medical science is not going to help them any more and... we can actually do this better so that they can actually die with some dignity... It is difficult but I just talk to them and just say... have you actually thought that there’s nothing else that we can do for them? And they will say oh is it that serious?” [EN1].

Associated with the emotional difficulties of dealing with children was this comment in which this emergency nurse explained that he enjoyed successful outcomes and delivering positive news to parents;
“So if the kid comes in pale and not breathing, that’s a really pretty terminal sign, you know but most things are treatable. So it’s not hard to be optimistic in those sort of cases because really things are going to go fine and I’m a big optimist anyway so I don’t think about the negative sides of those things.” [EN4]

There were also non-specific references to generally enjoying the environment and the people with whom the emergency nurses interacted with;

“I like to be able to look after the ones that aren’t making a lot of noise. And I like managing a difficult situation, I like that. But personally I just like the people… They’re just really nice people.” [EN5]

The way in which the emergency nurses talked about aspects of their interaction with clients as being rewarding was focused on achieving successful treatment related outcomes or ensuring that the department continued to run successfully. This was in accordance with the overall aim for emotional management for emergency nurses. The management of emotion was not an end in itself but had the functional aim to assist the department to work efficiently.

The patient registration clerks also derived satisfaction from their interactions with clients. The clerks described a much more detached approach to clients and were able to disengage from clients due to their physical separation and perception of their role. Due to this more detached approach and lower level of responsibility, the clerks were able to choose the times and situations in which they interacted with clients to a greater degree;
“Some people are just too sick so you just get through the basics you can with them and that’s it but then there are other people like visitors from overseas who might be travelling and you’ll have a conversation with them and you know what? That’s actually a good point because I really love that aspect of the job…Sometimes you do just little things like go and take them a flannel or a drink of water or something like that and it’s really appreciated and you just kind of put yourself in their shoes, you know… I like doing stuff like that. It makes me feel good.” [EC1].

“I just like being part of it and I like to be amongst people with different emotions and different situations and being able to help somebody if I can or just show them a bit of sympathy or whatever and hope that it made their time in there a little bit better, a little bit easier.” [EC2].

All of the renal nurses talked of satisfying aspects of their role. These nurses derived much of their satisfaction from the establishment of long-term relationships with clients. The nurses spoke of their enjoyable aspects of the job as being linked to the good health outcomes of patients and the satisfaction derived from developing a rapport with patients;

“Sometimes you really enjoy looking after some patients and it’s really nice to see them so that is quite a joy. Sometimes the patients that you look after are incredibly interesting people that have had interesting lives, they’ve done interesting things so you can have some really nice conversations and along the way as well you learn a lot about people and about life.” [RN3].

“I have a good old laugh. I go to work and have a laugh…I’ve got some photos that I take in of my boy today and show one of the patients and she tells me all about her grandkids…we have a good old laugh…and I love patient education and I love explaining about their treatments…” [RN5].

Also of importance were the clinical outcomes of their clients.

“Other things that are enjoyable, I mean the success if they do get a transplant to see them not worse and seeing them move on and sometimes it is hard actually seeing somebody get to the position when they don’t want to continue is actually a good outcome… sometimes it’s really a relief and…you actually do feel almost joy but you feel relief that
they’ve actually managed to get to that place themselves and they’ve made a decision and that they’re at peace and content with their decision in life.” [RN4].

There was clear evidence from all four groups that these employees derived a great deal of satisfaction from their interactions with clients. Some of this satisfaction was due to being able to persuade clients to make a particular decision or to help them grapple with the most profound and emotionally distressing issues. Conversely, the clerks appeared able to be choosier about with whom and when they interacted with clients at a deeper level. Furthermore, these interactions were much less weighty than the life and death topics that typified the interactions of the nursing groups.

5.6 Overview of Interview Analysis.

The interview data address the first research aim and three of its associated questions first posed in section 4.1 and presented again below:

1. To assess how employees are aware of necessary and appropriate emotional management, how they assess their level of responsibility for this and how these perceptions may differ depending on their role and the context.

   Research questions:

   a. Which emotional displays are considered appropriate by employees?

   b. How do these perceptions of the appropriate emotional displays differ according to the role or context?

   d. How do employees know which emotional displays are appropriate?
All interviewees from all four groups indicated that there are only very general impressions as to what specific emotions were expected either from the organisation professionally, or from co-workers or clients. When pressed to give an impression of what was expected, the inappropriateness of anger and the display of a calm demeanour were over-riding themes. Regardless of the setting, the type and level of emotional expressivity proceeded very much according to the requirements of the individual interactions, supporting previous findings of nurses engaging in emotional labour (Smith, 1992; Theodosius, 2008).

A further question relating to this research aim:

e. What role does emotional intelligence play in emotional labour?

Is best addressed by reference to the four branch model of emotional intelligence (Davies et al., 1998; Mayer et al., 2004a; Salovey & Mayer, 1990). This model explains how employees from all groups were able to evaluate emotions and respond emotionally to clients in order to ensure optimal outcomes, as has been found previously in nursing (McQueen, 2004). Evidence that patient registration clerks also used emotional intelligence to guide interactions indicates a less scripted approach to interactions than for other employees in similar clerical or process oriented type roles (e.g. Goldberg & Grandey, 2007; Rafaeli, 1989).

The final research question related to this research aim:

c. Do perceptions of the responsibility for emotional engagement with clients differ according to the role or context?
was answered unequivocally by the interviewees: The perceived level of emotional engagement as a role requirement differed markedly between the four groups. Palliative care nurses explained that emotional engagement with clients was a central aspect of their role and an aspect they actively pursue, supporting previous findings (e.g. Holmberg, 2006; James, 1992; Li, 2005; McIlfatrick, 2007; Melin-Johansson, Mok & Chiu, 2004; Seymour, Ingleton, Payne, & Beddow, 2003; Skilbeck & Payne, 2005). Emergency nurses also described instances in which they engaged with clients; however this was mainly to facilitate the efficient running of the emergency department and to protect themselves, co-workers, and other clients. Patient registration clerks, working alongside emergency nurses, showed far less inclination to become involved with difficult interactions with clients and generally did not see this as part of their role. Occasionally there was evidence that interactions between clerks and clients were of greater depth, but this was always of secondary importance to the information gathering aspect of the role. For renal nurses, the more predictable environment of renal wards, combined with the formation of long term relationships with clients, means that engagement with clients proceeded more naturally and was not generally associated with highly emotive interactions as was the case for the palliative care or emergency nurses. However, when asked specifically about their responsibility for the emotional state of clients and their preparedness to engage emotionally, the renal nurses indicated that they considered this to be an important aspect of their role.

Interviews with the emergency and palliative care nurses and the patient registration clerks suggest a relationship between the level of emotional engagement, and the prominence of emotional labour and other emotional management strategies.
Where the perceived emotional engagement in the role was high (i.e. for palliative care nurses) there were extensive descriptions of the use of emotional labour and other emotional management strategies, particularly reflected in instances of deep acting, with palliative care nurses showing a greater need to prepare themselves for their emotional interactions with clients than other employees. Conversely, the clerks’ comparatively low level of a perceived requirement for engagement with clients was associated with fewer instances of the use of emotional labour or other emotional management strategies. The case for renal nurses differs compared with the other groups and is more difficult to understand. While these nurses engaged readily, except for the provision of information as a possible emotionally protective mechanism and some instances of surface acting, renal nurses did not describe as many instances of emotional management strategies compared to the palliative care or emergency nurses.

The finding that the perceived level of emotional engagement varied markedly between groups, and how this perception appears to have influenced the likelihood of employees to engage emotionally with clients are important issues to understand. There seems to be a distinction between occupations, with the clerks indicating less emotional engagement responsibilities, however the situation amongst the nursing groups is not completely clear due to uncertainty surrounding the renal nurses. In addition, there were no clear indications of how the perceived level of emotional engagement was related to wellbeing. Therefore, the likely impacts of the perceived level of emotional engagement on emotional labour and wellbeing require more clarification and a broader understanding.
The second research aim and its associated questions, presented again below, can be summarized together.

2. To examine the methods by which employees manage their own and others’ emotions in the workplace.

Research questions:

   a. How is emotional labour conducted by employees in the four health care contexts?

   b. What is the role of natural emotion in emotional labour?

   c. Does the context or occupation have an impact on which emotional labour strategies are used?

An important finding from Study 1 was that the management of natural emotion was identified as a prominent and adaptive emotional labour strategy throughout the interviews. Employees mainly used the management of natural emotion to display grief and to show anger to correct disruptive, violent or abusive client behavior, and the distinctions between the management of natural emotion and instances of emotional deviance and their differing consequences were also important findings. As expected, surface and deep acting were also identified as important emotional labour strategies, supporting previous research (e.g. Brotheridge & Lee, 2003; Diefendorff et al., 2005; Grandey, 2000; Hochschild, 1983).

In addition to the use of emotional labour as a means of controlling the emotions of the self and clients, other non-expressive emotion management strategies were
identified as being used for the same purpose. This highlights the importance of considering emotional management as more than just emotional labour. Rather, emotional labour should be seen as just one aspect of emotional management.

Non-expressive emotional management strategies included the provision of information and the use of proximity and space. Information was used by all groups although for different purposes. Employees with established relationships with clients (i.e. renal and palliative care nurses), used information to inform clients of the best health care options available, thereby distancing themselves from poor client outcomes due to poor health care decisions. In these cases, the provision of information can be seen as emotionally protective for these employees. Alternatively, for emergency nurses and patient registration clerks, the provision of information was used to establish trust and alleviate stress in the uncertain circumstances of the emergency department. In these cases, employees were focused on reducing the emotionality and stress of the client and allowing the department to function efficiently.

Limited use of proximity and space was also demonstrated as emotion management strategies. The clerks were particularly mindful of being able to remove themselves from situations in which clients were abusive, describing how they remained calm at these times and were able attribute the discord in the interaction solely to the client. The propensity for clerks to remove themselves from interactions was associated with them being physically separated from clients as well as their perception of a lower level of emotional engagement with clients, compared to the nursing groups. Emergency nurses also reported some use of proximity as a means of protecting clients and themselves.
The importance of the use of natural emotion as an emotional labour strategy was evident across the four groups in the 21 interviews. However, wider evidence if its dimensionality as an emotional labour strategy in addition to surface and deep acting is needed. Given the differing relationships between surface and deep acting, and wellbeing outcomes found previously, the consequences of the management of natural emotion is crucial to understand. The interviews suggested that the management of natural emotion was associated with positive wellbeing outcomes, however the exact relationships require clarification. In addition, group differences in these relations is also important given the differing purposes for managing natural emotion as an emotional labour strategy.

The findings for the third research aim and its associated questions, reproduced below, can be considered together.

3. To examine the differences in emotional management, well being outcomes of emotional management and factors impacting on these, dependent on context and role.

Research questions:

a. What are the relationships between emotional labour strategies and wellbeing?

b. Do wellbeing outcomes differ depending on the context or occupation?
c. What are the relationships between emotional labour, social support, and wellbeing?

d. Do the relationships between emotional labour, social support and wellbeing differ depending on context or occupation?

e. What role do individual differences such as personality play in emotional labour?

The relationship between the perceived emotional engagement requirements of the role and the prevalence of emotional management strategies was further extended to the importance of social support. In line with Hobfoll’s (1989) COR model, the interviews suggested that the level of emotional expenditure resulted in a similar need for the replenishment of emotional resources. The current findings emphasize what is already known about the importance of social support (e.g. Abraham, 1998; Brotheridge & Lee, 2002; Lewig & Dollard, 2003; Wilk & Moynihan, 2005), and go further to suggest that co-worker support may be crucial in situations with intense and difficult interactions with clients due to a sense of shared experience and collegiality. In addition, the form of support accessed from various sources matched the purpose of the emotional expenditure, further strengthening the applicability of COR theory. For example, emergency nurses dealt with clients emotionally mainly for instrumental purposes, while palliative care nurses engaged emotionally with clients largely as an end in itself, to assist clients coming to terms with end of life issues. In both cases, support matched what was expended. Previous measures of support in emotional labour research have taken a fairly general focus (e.g. Abraham, 1998; Lewig & Dollard, 2003; Wilk &
Moynihan, 2005) and the importance of co-workers as a source of support has not been found to be as strong as suggested in the current research. It is clear that it may indeed be more appropriate to assess support specifically in terms of its emotional component and its instrumentality, rather than in general terms. This is a research focus for Study 2.

The interviews showed that employees from all four groups derived satisfaction from their emotional involvement with clients, and to some extent, from the emotional labour aspect of their roles as well. In particular, the palliative care nurses talked about a deep satisfaction with their work, which was closely associated with supportive relationships with co-workers and the organisation more broadly. Previous research has also shown that palliative care nurses may experience less stress despite the emotionally taxing nature of their work if supportive mechanisms are available (Valchon, 1995). While the association between emotional labour and wellbeing deficits has generally been consistently established (e.g. Abraham, 1998; Brotheridge & Grandey, 2002; Diefendorff & Richard, 2003; Grandey, 2000, 2003; Grandey et al., 2004; Hochschild, 1983; Näring & van Droffelaar, 2007; Yoon & Lim, 1999; Zerbe, 2000), occupational differences have been noted. Nurses in this study, like those in other studies (e.g. Bolton, 2000b; Henderson, 2001; McCreight, 2005; McMillen, 2008; Smith, 1992) derive satisfaction with their emotional work, however, the findings from the interviews with clerks have not been reported elsewhere. Study 2 will investigate the relationships between emotional labour, emotional engagement and wellbeing in all four groups of employees, and differences between these groups.

Most of the research examining nurses’ views and attitudes towards their interactions with clients has not explicitly focused on elements of emotional labour such
as surface and deep acting, so broad-based investigations of these elements in specific situations are needed. If more broad based evidence of the same themes and associations found in the current study is established, it will become obvious that specific sources of social support are crucial for these employees to maintain their emotional wellbeing and to continue to function effectively in their role. Therefore, Study 2 will assess the prominence of emotional labour strategies and the perceived emotional engagement in the role, as well as how these factors are associated with wellbeing outcomes. In addition, the role of social support and its association with wellbeing will be investigated, particularly social support that is provided in relation to the emotional expenditure with clients. Finally, the management of natural emotion emerged in the current study as a third emotional labour strategy. As there is no available measure of this aspect of emotional labour, quantitative assessments of its relationship with social support, burnout and job satisfaction and how these relationships compare to surface and deep acting are essential as a prelude to the development of any such instrument. Previous research consistently demonstrates negative associations between surface acting and various measures of wellbeing in comparison to deep acting, highlighting the importance of investigating similar relationships when employees manage natural emotion as an emotional labour strategy. These associations will be investigated in Study 2.

5.7 Limitations

There were a number of limitations to the above study. First, the nature of qualitative methods and the constraints of the research project meant that Study 1 was
limited to small numbers of participants. Therefore the results are not generalizable, however this limitation was addressed in Study2.

Second, due to difficulties in accessing participants, all of the emergency nurses and clerks were employed by the same organisation and worked in the same emergency department, which meant that comparisons between organisations could not be made for these groups. The views of the participants may have been specific to the organisation.

Third, many participants became aware of the research and contacted the researcher via recommendations from other participants. Therefore, it is likely that the samples may have consisted of close acquaintances with similar views, rather than a true cross-section of the groups.

Part of the rationale for Study 2 was to address some of these concerns by substantially broadening the participant base of the research.
Chapter 6: Survey of Emotional Labour in Health Care Workers (Study 2)

6.1 Introduction

The focus for Study 2 was to further examine the relationships between emotional labour, emotional engagement, social support and wellbeing initially identified through the interviews of the previous study, using large samples and quantitative analyses. Study One revealed only limited evidence of associations between individual and organisational wellbeing outcomes, and whether relationships between emotional engagement, emotional labour strategies, and the different sources of social support vary across contexts and occupations. The implications for employees, employers, and clients, including the possible effects on burnout, employment continuance and satisfaction will be clearer and stronger following a broad based survey of these relationships and interactions. Based primarily on the findings of Study 1, the following hypotheses are proposed (about the distinctness of NFE from other aspects of EL, associations between EL dimensions and wellbeing, group differences in org support, and group differences in emotional engagement), with the rationale for each hypothesis provided below.

- Hypothesis 1: The management of natural emotion will be an emotional labour strategy distinct from surface and deep acting.

Interviewees in Study 1 clearly identified the management of natural emotion as an emotional labour strategy in addition to surface and deep acting. Previously, the management of natural emotion has only been discussed briefly (e.g. Brotheridge &
Lee, 2003), or measured quantitatively in terms of the expression of actually felt emotion in concordance with what is perceived as appropriate (e.g. Diefendorff et al., 2005; Näring & van Droffelaar, 2007). Study 1 showed that this aspect of conducting emotional labour is carefully managed and used for specific purposes, therefore Study 2 attempted to establish its dimensionality as distinct from surface and deep acting. Items designed to measure the management of natural emotion were created and included as part of an overall measure of emotional labour.

- Hypothesis 2(a) The management of natural emotion and deep acting will be associated with positive wellbeing outcomes overall
- Hypothesis 2(b) Surface acting will be associated with negative wellbeing outcomes overall

Study 1 responses suggested that the management of natural emotion and deep acting were both associated with positive wellbeing outcomes, whereas surface acting was associated with negative outcomes. While the latter negative association has been consistently found for employees and organizations (e.g. Brotheridge & Grandey, 2002; Brotheridge & Lee, 2003; Cheung & Tang, 2007; Zammuner & Galli, 2005; Zapf & Holz, 2006; Zapf et al., 1999), and positive or neutral wellbeing with deep acting (e.g. Brotheridge & Grandey, 2002; Brotheridge & Lee, 2003; Grandey, 2003; Totterdell & Holman, 2003; Zammuner & Galli, 2005), the proposed link with the management of natural emotion has not been empirically tested.
Hypothesis 3(a) Organisational sources of support will be associated with positive wellbeing outcomes. Hypothesis 3(b) Co-worker support will have the highest correlations with wellbeing

Study 1 found that social support varied in importance depending on its source. Co-worker support appeared to be most important due to its relevance, a sense of shared experience, and its availability when most needed. Interview responses suggested that relationships between co-worker support and wellbeing were most important for palliative care nurses; and the survey data will be able to establish a firmer basis for this conclusion. Measures of social support were created to assess both the emotional and instrumental aspects of support, as well as four sources of support: co-worker, supervisor, organisational, and family/friends.

Hypothesis 4(a) Palliative care nurses will report the highest level of emotional engagement followed by emergency nurses, then renal nurses and clerks

Hypothesis 4(b) Those groups reporting the highest levels of emotional engagement will also report the highest levels of emotional labour strategies

In Study 1, palliative care nurses had a high perceived level of emotional engagement and saw their emotional interactions with clients as central to their role. Similarly, the emergency nurses also took responsibility for emotional interactions with clients despite this being for different purposes, i.e., to assist the functioning of the emergency department, rather than as an end in itself. The renal nurses also spoke of the
emotional aspect of their work as being important despite limited evidence of emotional labour compared to palliative care and emergency nurses. The clerks took a different view of their emotional interactions with clients, considering this part of their role to be comparatively limited and they sometimes removed themselves from interactions or referred clients to emergency nurses in some situations. Responses in Study 1 suggested that emotional labour and social support would be associated with wellbeing, as proposed in Hypotheses 2 and 3. However, group differences in the relationships between emotional labour, emotional demands, duration of interactions, emotional engagement, social support, and outcomes were more difficult to assess due to the number of interviewees. Therefore, group differences in the relationships between variables will be examined in this larger quantitative study. The independent variables of emotional labour, its antecedents, emotional engagement, and social support will be assessed for relationships with wellbeing.

6.2 Method

6.2.1 Participants. A total of 325 participants were recruited from seven organisations. Five organizations were public hospitals, one was a private hospital with a public emergency service, and the other was a non-profit organisation providing a range of community nursing services. There were relatively low numbers of patient registration clerks in the respective organisations and in most cases this role was blended with more general emergency clerical work. Therefore, the recruitment of clerical participants was extended from a sole focus on patient registration clerks in study one, to include all clerical employees working in the emergency areas of the respective organisations.
A total of 864 questionnaires were distributed and 325 were returned for an overall response rate of 37.6%. The response rates from the four groups were as follows; emergency nurses 28.3% (154 returns from 528 distributed), emergency clerks 47.5% (47 returns from 99 distributed), palliative care nurses 47.1% (57 returns from 121 distributed), and renal nurses 57.8% (67 returned from 116 distributed).

The average age of the participants for the four groups was as follows: palliative care nurses, Mean = 49.6, SD = 7.5; emergency nurses, Mean = 38.0, SD = 10.1; renal nurses, Mean = 45.3, SD = 8.9; emergency clerks, Mean = 45.8, SD = 11.0. The average time the participants had been working in their current roles was as follows: palliative care nurses, Mean = 10.2, SD = 9.9; emergency nurses, Mean = 6.5, SD = 6.5; renal nurses, Mean = 7.3, SD = 6.4; emergency clerks, Mean = 5.1, SD = 5.0.

6.2.2 Procedure. The researcher made contact with an officer from each organisation to explain the study and arrange distribution of study advertisements. Attention was also drawn to the research by the relevant contact officer in each organization. The study advertisement (see Appendix F) included basic information outlining the main areas targeted by the survey.

The exact details of the distribution of the questionnaires varied between organisations, either handed directly to participants or distributed through the internal mail system. The researcher had no direct contact with prospective participants for the purpose of the recruitment of participants or the distribution of questionnaires.

Upon completion, the participants were requested to either post the questionnaire back to the researcher via an addressed, reply-paid envelope or to deposit them into
boxes specifically for the purpose, which were left in amenities areas of participating organisations. Where allowed by the respective organisations, participants were able to choose to be included in a raffle for a digital camera as an incentive to take part in the study.

6.2.3 Materials.

Participants completed questionnaires, which were identical apart from some variations in the covering letter as requested by individual organisations (for the questionnaire, see appendix G). All cover letters provided information concerning the purpose of the research, a section describing the protection of confidentiality, and the contact details of the researchers. All items, arranged by scale, can be seen in Appendix H.

6.2.3.1 Duration. There were two separate questions which asked about the length of a typical individual interaction with a client as well as the overall length of the contact (i.e. ranging from a single interaction or to several months or years). Many participants did not complete the latter question, which may be because they found the scale difficult to interpret. Hence, due to these issues only the first question was used in analyses.

6.2.3.2 Emotional labour/emotional demands. The next section of the questionnaire contained the Brotheridge and Lee (2003) emotional labour measure, using a five-point scale (1 = never to 5 = always). All items began with the stem “On the average day at work....” which was followed by items measuring emotional expression on perceived frequency (three items), intensity (two items), and variety
(three items), as well as surface acting (three items) and deep acting (three items). Due to high correlations between variables (all greater than \( r = .43 \)), the intensity, variety, and frequency variables were combined to represent an overall measure representing emotional demands (\( a = .87 \)).

To measure the management of natural emotion, the last five items were created by the researcher. These items were designed to reflect the management of natural emotion as described by participants in Study One. The items asked how participants managed emotion to control interactions and the behavior of clients as well as providing emotional support to clients. For example, “I manage my naturally felt emotion to show clients that their behaviour is unacceptable”, “I manage emotions that I actually feel to control the interaction with clients”, and “I show some emotion that I actually feel to provide support for clients”. The distinctiveness of the management of natural emotion from surface and deep acting is explored through factor analysis.

**6.2.3.3 Emotional engagement.** Emotional engagement was assessed using seven items rated on a five-point Likert scale (1 = strongly disagree to 5 = strongly agree). These items were designed to assess the level of perceived importance and responsibility employees had for dealing with the emotional issues and emotionality of clients. This scale was created to capture differences in the perceived emotional engagement that was borne out between groups in Study One. For example, “I am responsible for helping clients to come to terms with emotional problems”. The internal reliability of the emotional engagement items was acceptable (\( a = .69 \)).

**6.2.3.4 Support.** The social support section assessed the level of emotional and instrumental support from co-workers, supervisors, the organisational itself, and from
family and friends. This was assessed by a five-point Likert scale (1 = strongly disagree to 5 = strongly agree). The scales included items from Yoon and Lim (1999) and Baruch-Feldman (2002), with additional items created specifically for this research based on interview responses.

The support items were created to specifically target emotional or instrumental support directly in relation to dealings with clients. For example, an item that was used in all the support sub-scales was “My [co-workers/supervisor, management, family/friends] provide the most important level of emotional support in my job”. The internal reliability of all the support sub-scales was acceptable and were therefore used in the analysis as reliable factors (co-worker support, $a = .84$; supervisor support, $a = .89$; organisational support, $a = .90$; friends/family support, $a = .90$).

**6.2.3.5 Burnout.** The Maslach Burnout Inventory, sourced from Byrne (1991), was used to assess subjective levels of emotional exhaustion, depersonalisation, and personal accomplishment, rated on a seven-point Likert scale (1 = strongly disagree to 7 = strongly agree). All three sub-scales had acceptable internal reliability (emotional exhaustion, $a = .83$; depersonalisation, $a = .75$; personal accomplishment, $a = .72$).
6.2.3.6 Turnover intentions and job satisfaction. Job satisfaction and turnover intentions were measured to assess wellbeing outcomes that relate to the individual and the organisation. Both scales were taken from Jones, Chonko, Rangarajan, and Roberts, (2007), with ratings on a five-point Likert scale (1 = strongly disagree to 5 = strongly agree). Internal reliability was acceptable for both scales (job satisfaction, \( a = .80 \); turnover intentions, \( a = .91 \)).

6.3 Results

First, the structure of the emotional labour scale was assessed using a principal components analysis. Next, group differences and correlations between scales were assessed. Multiple regressions were then used to examine the relationships between the independent and wellbeing, including interaction terms to examine differences in associations across the four groups.

6.3.1 Structure of emotional labour. To examine the factor structure of the emotional labour components, a principal components analysis was conducted using the whole sample. Tabachnick and Fidell (1989) suggest that at least five participants per item, and 100 or more participants in total are required in order to conduct a valid factor analysis. Both conditions were met in this research. Three components with eigenvalues over 1 were identified and examination of the scree plot (Figure 6.1) supported a three-factor model.

A three factor principal component analysis with varimax rotation indicated that the three factors explained 64.4% of the total variance. Table 6.1 shows the results of this analysis, with the major loading for each item as well as cross-loadings above .3. For the purposes of developing orthogonal scales with acceptable reliability, only those
items that loaded on one component above .4 were used for reliability tests, a strategy which meets standard requirements for scale development (Tabachnick & Fidell, 1989). As can be seen from Table 6.1, the three components were in line with the hypothesized factor structure of deep acting (component 1), management of natural emotion (component 2), and surface acting (component 3). All except one item loaded solely on its hypothesized factor, and this item was therefore omitted from scale creation. All components had acceptable reliability with Cronbach’s alphas of .88 for deep acting, .76 for the management of natural emotion, and .71 for surface acting.

The results from the principal components analysis confirm Hypothesis 1 and shows that the management of natural emotion is an orthogonal emotional labour strategy in addition to surface and deep acting.
Table 6.1: Extracted components and component items following the three factor principle component analysis with varimax rotation.

<table>
<thead>
<tr>
<th>COMPONENTS AND ITEM CONTENTS.</th>
<th>Factor 1 Load.</th>
<th>Factor 2 Load.</th>
<th>Factor 3 Load.</th>
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**COMPONENT 1: Deep Acting**
- I make an effort to actually feel the emotions that I need to show to others
- I try to actually feel the emotions that I must show.
- I really try to feel the emotions I have to show as part of my job.

**COMPONENT 2: Management of Natural Emotion**
- I manage my naturally felt emotion to show clients that I’m unhappy with their behaviour.
- I manage my naturally felt emotion to show clients that their behaviour is unacceptable.
- I use my naturally felt emotion to help the interaction with clients.
- I manage emotions that I actually feel to control the interaction with clients.
- I show some emotion that I actually feel to show support for clients.

**COMPONENT 3: Surface Acting**
- I resist expressing my true feelings.
- I pretend to have emotions I don’t really have.
- I hide my true feelings about a situation.
6.3.3. Group differences. Group differences were examined to assess whether the experiences of the groups differed in term of their perceptions of emotional engagement, emotional labour, emotional demands and duration of interaction, the support they received, and their wellbeing outcomes. One way analyses of variance (ANOVA) were conducted to examine mean differences between the groups, and where the differences were significant, Tukey’s post-hoc tests were conducted to identify the source of the difference. For group means and standard deviations for all variables, see Table 6.2
Table 6.2. Group means and standard deviations for all variables

<table>
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</thead>
<tbody>
<tr>
<td>Pall. Nurses</td>
<td>.81 (.31)</td>
<td>3.16 (.58)</td>
<td>3.22 (.50)</td>
<td>3.08 (.68)</td>
<td>2.58 (.64)</td>
<td>2.63 (1.10)</td>
<td>4.24 (.51)</td>
<td>3.51 (.81)</td>
<td>3.15 (.77)</td>
<td>3.63 (.63)</td>
<td>3.34 (1.12)</td>
<td>2.14 (.98)</td>
<td>5.27 (.58)</td>
<td>3.83 (.64)</td>
<td>1.94 (1.00)</td>
</tr>
<tr>
<td>Emerg. Nurses</td>
<td>1.67 (2.17)</td>
<td>3.17 (.61)</td>
<td>3.21 (.54)</td>
<td>3.43 (.66)</td>
<td>2.80 (.72)</td>
<td>2.92 (.95)</td>
<td>4.04 (.52)</td>
<td>3.27 (.72)</td>
<td>2.82 (.71)</td>
<td>3.79 (.76)</td>
<td>3.87 (1.19)</td>
<td>3.37 (1.15)</td>
<td>4.98 (.69)</td>
<td>3.23 (.68)</td>
<td>2.49 (1.15)</td>
</tr>
<tr>
<td>Renal Nurses</td>
<td>2.75 (2.39)</td>
<td>3.11 (.61)</td>
<td>3.28 (.53)</td>
<td>3.41 (.59)</td>
<td>2.52 (.70)</td>
<td>2.69 (.90)</td>
<td>3.96 (.62)</td>
<td>3.81 (.68)</td>
<td>3.17 (.86)</td>
<td>3.87 (.70)</td>
<td>3.38 (1.11)</td>
<td>2.61 (1.02)</td>
<td>4.96 (.73)</td>
<td>3.64 (.65)</td>
<td>2.31 (1.97)</td>
</tr>
<tr>
<td>Emerg. Clerks</td>
<td>.32 (1.19)</td>
<td>3.00 (.59)</td>
<td>2.35 (.52)</td>
<td>3.30 (.70)</td>
<td>2.80 (.66)</td>
<td>2.85 (.94)</td>
<td>4.19 (.58)</td>
<td>3.45 (.86)</td>
<td>3.03 (.76)</td>
<td>3.85 (.71)</td>
<td>3.22 (1.17)</td>
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<td>4.66 (.86)</td>
<td>3.41 (.66)</td>
<td>2.14 (1.12)</td>
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6.3.3.1 Emotional engagement. The perceived level of emotional engagement varied significantly between groups, $F(3, 319) = 36.88$, $p < .001$, with post-hoc analysis revealing that the clerical group reported a significantly lower perceived level of emotional engagement than the three nursing groups. The nurses reported means above the mid-point of the scale, whereas the clerks were below the mid-point. Therefore, Hypothesis 4a, that the palliative care nurses would report greater emotional engagement followed by emergency nurses, renal nurses and the clerks, was only partially supported. This shows that the nurses reported very similar levels of emotional engagement and were different from the clerks in this variable.

6.3.3.2 Emotional labour. The means for the management of natural emotion were the highest of the emotional labour strategies for all groups, highlighting its importance. The means for the management of natural emotion for all groups were above the mid-point but for surface and deep acting, the means were below the mid-point.

There were significant differences in the management of natural emotion, $F(3, 318) = 4.23$, $p = .006$, with post-hoc analyses revealing that emergency nurses reported significantly greater management of natural emotion than palliative care nurses. In addition, renal nurses reported a significantly greater level of management of natural emotion than palliative care nurses. There were significant differences between groups in levels of surface acting, $F(3, 319) = 3.48$, $p = .016$, with post-hoc analyses revealing that emergency nurses reported significantly greater levels than renal nurses. There were
no significant differences between groups in deep acting \( F (3,316) = 1.67, p = .173 \).

Hypothesis 4b, that those groups reporting greater emotional engagement would also report higher levels of emotional labour, was not supported, with the clerks not reporting significantly less of any emotional labour strategy.

6.3.3.3 Emotional demands and duration. Emotional demands showed no significant differences between groups \( F (3,318) = 1.54, p = .203 \). However, duration of interaction did show significant differences \( F (3,287) = 18.10, p < .001 \), with post-hoc analyses showing significant differences between all groups except clerks and palliative care nurses. In ascending order, the reported mean duration of interactions was emergency clerks, palliative care nurses, emergency nurses, and renal nurses.

6.3.3.4 Support. Examination of the support variables shows that for all groups, co-worker support was perceived as the highest, followed by support from family and friends. Co-worker support was the only measure of support with means close to or over four (out of a possible five) on the scale.

Perceptions of all measures of support, apart from support from family/friends, \( F (3,317) = 1.29, p = .277 \), differed significantly between groups. A significant difference in coworker support, \( F (3,319) = 3.63, p = .013 \), was observed, with post-hoc analyses revealing that palliative care nurses reported a significantly higher level of co-worker support than renal nurses. There was also a significant difference in perceptions of supervisor support, \( F (3,321) = 8.11, p < .001 \), with post-hoc analyses showing that renal nurses reported greater supervisor support than emergency nurses. Perceptions of organisational support also differed significantly between groups, \( F (3,318) = 4.68, p = \)
.003, with emergency nurses reporting significantly less support than both renal and palliative care nurses.

6.3.3.5 Outcome variables. Group differences were analysed for the three dimensions of burnout. The means for all groups showed that for there was a significant group difference in emotional exhaustion, $F(3,320) = 6.08$, $p < .001$, with post-hoc comparisons revealing that emergency nurses reported significantly greater emotional exhaustion than all other groups. There was a significant difference in depersonalisation, $F(3,320) = 20.16$, $p < .001$, with emergency nurses reporting significantly greater depersonalisation than the two other nursing groups. The clerks also reported significantly greater depersonalisation than the palliative care nurses. Perceptions of personal accomplishment also differed significantly, $F(3,320) = 6.51$, $p < .001$, with palliative care nurses reporting significantly greater personal accomplishment than emergency nurses and clerks. The clerks reported the lowest personal accomplishment with significantly lower levels than renal nurses.

For the organisational outcome variables, there was a significant difference in turnover intention between groups, $F(3,319) = 3.99$, $p = .008$, with post-hoc analyses revealing that the emergency nurses reported significantly greater turnover intent than the palliative care nurses. Job satisfaction also differed significantly between groups, $F(3,319) = 13.71$, $p < .001$. Post-hoc analyses showed that the palliative care nurses reported significantly greater job satisfaction than the clerks and emergency nurses, and the renal nurses reported significantly greater job satisfaction than the emergency nurses.
6.3.4 Correlations between variables. Correlations between variables in Table 6.3 shows that, of the emotional labour components, surface acting had the poorest wellbeing associations with significant positive relationships with emotional exhaustion, depersonalisation, and turnover intention, and significant negative relationships with personal accomplishment and job satisfaction. Deep acting had a small but significant positive relationship with personal accomplishment and a small significant negative relationship with turnover intention. The management of natural emotion had a moderate and significant positive relationship with personal accomplishment.

The relationship between the emotional labour components and wellbeing outcomes partially support Hypothesis 2a; that the management of natural emotion and deep acting will be associated with positive wellbeing, and fully support Hypothesis 2b that surface acting will be associated with negative wellbeing.

Surface acting can be seen as being harmful to wellbeing whereas deep acting and the management of natural emotion are less problematic emotional labour strategies, and their positive effects appeared to be related mainly to a sense of personal accomplishment. The relationships between the management of natural emotion and outcomes adds to what is known about emotional labour and suggest that this strategy is less problematic than surface acting. Emotional engagement was mainly associated with positive wellbeing outcomes with significant positive relationships with personal accomplishment and job satisfaction, and significant negative relationships with depersonalisation and turnover intention. Emotional engagement was not related to emotional exhaustion.
Table 6.3. Means, standard deviations, reliabilities, and correlations of variables

<table>
<thead>
<tr>
<th>Variables</th>
<th>Mean</th>
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<th>3</th>
<th>4</th>
<th>5</th>
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<td>.07</td>
<td>.22***</td>
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<td>.08</td>
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<td>12. Depersonalisation</td>
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<tr>
<td>13. Personal Accomplishment</td>
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<td>.17**</td>
<td>.18**</td>
<td>.12</td>
<td>-.38***</td>
<td>-.33***</td>
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<td>14. Job Satisfaction</td>
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<td>.45***</td>
<td>.46***</td>
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<td>-.60***</td>
<td>-.46***</td>
<td>.46***</td>
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<td>15. Turnover Intention</td>
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<td>-.36***</td>
<td>-.36***</td>
<td>.04</td>
<td>.56***</td>
<td>.39***</td>
<td>-.37***</td>
<td>-.71***</td>
<td>(.91)</td>
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</tbody>
</table>

Note. Internal reliabilities are in parenthesis. * p < 0.05; ** p < 0.01; *** p < 0.001; $ point-biserial correlations
The results for emotional engagement suggest that having subjective perceptions that emotion engagement and the responsibility for the emotional state of clients is part of the role may help employees be more prepared for interactions and emotional labour.

As predicted by Hypothesis 3a, all workplace support measures (coworker, supervisor, and organisational) were significantly related to positive wellbeing outcomes on all factors. However, counter to hypothesis 3b, co-worker support did not have higher correlations with wellbeing outcomes except for personal accomplishment. Supervisor support had the greatest negative relationship with emotional exhaustion, while organisational support had the highest negative correlation with depersonalisation and the highest positive correlation with job satisfaction. Family/friends support did not show a similar pattern of associations as the organisational sources of support, apart from a significant but small correlation with personal accomplishment.

**6.3.5 Multiple regressions.** Differing contact requirements and relationships with clients between the four settings may be hidden in overall correlations. Therefore, regression analyses were conducted, which allowed for group differences in relationships to be identified. Dummy variables were created for each group, with the clerical group omitted for use as a reference value, and interactions between these groups and independent variables were computed. As recommended by Aiken and West (1991), each independent variable was centered around the mean, and interaction terms were computed by multiplying the centered variable by each dummy variable.

All analyses consisted of a two-step process, the first step being the examination of the relationship between the outcome variable and the centered independent
variable(s) with the three dummy coded nursing groups (with clerks as the reference group). The second step added the interaction terms. Step 2 coefficients are only described where there were significant interactions. Where possible, the analyses were divided into sections, with dimensions of the same construct grouped together.

6.3.5.1 Duration of interaction. The “duration of interaction” variable was found to be highly correlated with group membership, and so was not analyzed due to high multicollinearity (i.e., the groups had markedly different interaction durations).

6.3.5.2 Emotional demands. Table 6.4 shows that, at Step 1, emotional demands only predicted a significant amount of variance of personal accomplishment, indicating that emotional demands were associated with higher personal accomplishment but not predictive of any other outcome.

The emergency nurses were significantly higher on the burnout dimensions of emotional exhaustion and depersonalisation, and all nursing groups reported greater personal accomplishment when compared to the clerks. For the organisational outcomes, the palliative care nurses reported significantly greater job satisfaction.

The overall pattern of results shows that emergency nurses had the poorest wellbeing outcomes while the palliative care nurses reported the most positive results. Most of the group differences outlined above in Step 1 are essentially repeated in each of the following regressions, as the same dummy variables and wellbeing dependent variables are repeated in each analysis. Therefore, only departures from these group effects will be reported in subsequent regression descriptions.
Step 2 revealed a significant $R^2$ change for job satisfaction, arising from a significant interaction between demands and the emergency nurses’ dummy variable, which showed that the relationship between demands and job satisfaction differed between emergency nurses and the reference group (emergency clerks). Post hoc analyses were conducted as suggested by Aiken and West (1991) with the emergency nurse group substituted as the reference group to examine the relationship between demands and job satisfaction for this group (a process followed for all subsequent post-hoc analyses). The results showed a non-significant but positive relationship between demands and job satisfaction for the emergency nurses ($\beta = .11$), compared to the non-significant but negative relationship for emergency clerks ($\beta = -.22$). Therefore, the interaction seems to be explained by a negative trend for the clerks and a positive but non-significant association for the emergency nurses.
Table 6.4. Regressions predicting outcome variables using emotional demands, group membership, and their interaction.

<table>
<thead>
<tr>
<th></th>
<th>Burnout</th>
<th>Organisational Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Emotional</td>
<td>Depersonalis.</td>
</tr>
<tr>
<td>Step 1</td>
<td>F(4, 316)</td>
<td>5.47***</td>
</tr>
<tr>
<td></td>
<td>R²</td>
<td>.07</td>
</tr>
<tr>
<td>Demands</td>
<td>-</td>
<td>.11</td>
</tr>
<tr>
<td>Renal</td>
<td>.04</td>
<td>-.13</td>
</tr>
<tr>
<td>Palliative</td>
<td>.02</td>
<td>-.28***</td>
</tr>
</tbody>
</table>

Step 2

|                      | ΔF(3,316)      | .41                     | .27                    | .96                | 2.16              | .337*             |
|                      | ΔR²            | .00                     | .00                    | .01                | .02               | .03               |
| Demands              | -              | .00                     | -0.22                  | -.11               |
| Emergency            |                | .00                     | .15*                   |
| Renal                |                | .00                     | .25***                 |
| Palliative           |                | .00                     | .23*                   |
| Demands x E          |                | .00                     | -.03                   |
| Demands x R          |                | .00                     | .05                    |
| Demands x PC         |                | .00                     | .05                    |

*p < 0.05; ** p < 0.01; *** p < 0.005

6.3.5.3 Emotional Labour. The results for the management of natural emotion and deep acting show both emotional labour strategies to be associated with better wellbeing and organisational outcomes than surface acting.

Table 6.5 shows that, at Step 1 the management of natural emotion had significant positive relationships with personal accomplishment and job satisfaction. Deep acting had significant positive relationships with personal accomplishment and job satisfaction and significant negative associations with depersonalisation and turnover intention. Therefore, the management of natural emotion and deep acting show null or positive wellbeing outcomes.
Surface acting had significant and positive relationships with emotional exhaustion and depersonalisation, and a significant negative relationship with personal accomplishment. Surface acting also had a significant positive association with turnover intention and a significant negative association with job satisfaction. Together, the results for surface acting indicate significant relationships with poor wellbeing and organisational outcomes. The interaction terms at step 2 were not significant for any wellbeing measure.

Table 6.5. Regressions predicting outcome variables using emotional labour, group membership, and their interaction.

<table>
<thead>
<tr>
<th></th>
<th>Burnout</th>
<th>Organisational Variables</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Emotional Exhaustion</td>
<td>Depersonalis.</td>
</tr>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F(6,312)</td>
<td>7.56***</td>
<td>17.01***</td>
</tr>
<tr>
<td>R²</td>
<td>.13</td>
<td>.25</td>
</tr>
<tr>
<td>MNE</td>
<td>-.06</td>
<td>-.01</td>
</tr>
<tr>
<td>Surface Act.</td>
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<td>.28***</td>
</tr>
<tr>
<td>Deep Act.</td>
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<td>-.12*</td>
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<tr>
<td>Emergency</td>
<td>.26**</td>
<td>.14</td>
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<tr>
<td>Renal</td>
<td>.09</td>
<td>-.11</td>
</tr>
<tr>
<td>Palliative</td>
<td>.05</td>
<td>-.27***</td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ΔF(9,303)</td>
<td>.62</td>
<td>1.52</td>
</tr>
<tr>
<td>ΔR²</td>
<td>.02</td>
<td>.03</td>
</tr>
</tbody>
</table>

*p < 0.05; ** p < 0.01; *** p < 0.001
6.3.5.4 Emotional Engagement. From Table 6.6, Step 1 shows that emotional engagement was predictive of positive wellbeing. There were significant and negative relationships between emotional engagement and depersonalisation and turnover intention, and significant and positive relationships with personal accomplishment and job satisfaction.

Table 6.6. Regressions predicting outcome variables using emotional engagement, group membership, and their interaction.

<table>
<thead>
<tr>
<th>Standardised Betas for Outcome Variables (β)</th>
<th>Burnout</th>
<th>Organisational Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burnout</td>
<td>Emotiona</td>
<td>Depersonalis.</td>
</tr>
<tr>
<td>Exhaustion</td>
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<td>18.81***</td>
</tr>
<tr>
<td>R²</td>
<td>.05</td>
<td>.19</td>
</tr>
<tr>
<td>Engagement</td>
<td>-.05</td>
<td>-.22***</td>
</tr>
<tr>
<td>Emergency</td>
<td>.30**</td>
<td>.31***</td>
</tr>
<tr>
<td>Renal</td>
<td>.08</td>
<td>-.00</td>
</tr>
<tr>
<td>Palliative</td>
<td>.06</td>
<td>-.16*</td>
</tr>
</tbody>
</table>

| Step 2                                      |         |         |         |         |     |
| ΔF(3, 314)                                 | 2.37    | 2.73*   | 1.39    | 3.38*   | 2.59 |
| ΔR²                                       | .02     | .02     | .01     | .03     | .02  |
| Engagement                                 | -.03    |         | -.17    |         |     |
| Emergency                                  | .21     |         | .29*    |         |     |
| Renal                                      | -.21    |         | .13     |         |     |
| Palliative                                 | -.25*   |         | .01     |         |     |
| Engage x E                                 | -.21    |         | -.18    |         |     |
| Engage x R                                 | .02     |         | .08     |         |     |
| Engage x PC                                | -.05    |         | .01     |         |     |

*p < 0.05; ** p < 0.01; ***p < 0.001

When taking into account emotional engagement, all nursing groups showed greater levels of depersonalisation, and lower personal accomplishment and job satisfaction. In addition, the emergency and renal nurses showed greater associations with turnover intention. The results from Step 1 show that emotional engagement was
responsible for a greater portion of the variance with outcome variables than the other independent variables.

The second step showed that the relationships between emotional engagement depersonalisation and turnover intention varied across the groups. Step 2 showed a significant $R^2$ change for depersonalisation and turnover intention; however, none of the interaction terms were significant so no further analyses were carried out.

6.3.5.5 Social Support. Due to the importance of social support for wellbeing in the emotion labour research and in Study 1, each social support measure was examined separately for their relationships to outcomes. Overall, the organisational sources of support were predictive of positive wellbeing, whereas family and friends support had only one wellbeing association.

For co-worker support, Step 1 showed a negative association with emotional exhaustion and a positive association with personal accomplishment. For the organisational variables, co-worker support had a strong negative association with turnover intention and a strong positive relationship with job satisfaction. For Step 2, despite a significant $R^2$ change for turnover intention, no individual interaction term was significant (see Table 6.7).
Table 6.7. Regressions predicting outcome variables using co-worker support, group membership, and their interaction.

<table>
<thead>
<tr>
<th>Standardised Betas for Outcome Variables (β)</th>
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<th>Organisational Outcomes</th>
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<td>15.14***</td>
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<tr>
<td>Depersonalis.</td>
<td>.32***</td>
<td>14.91***</td>
</tr>
<tr>
<td>Personal Accomplishment</td>
<td>-.09</td>
<td>13.69***</td>
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<td>Turnover Intention</td>
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<td>20.48***</td>
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<td>Job Satisfaction</td>
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<td>1.31***</td>
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Step 1

<table>
<thead>
<tr>
<th>F(4, 317)</th>
<th>6.13***</th>
<th>15.14***</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| ΔF(3, 314) | .84     | .06      | .71      | 2.78* |
| ΔR²        | .01     | .00      | .01      | .02   |

| Co-worker Sup. | -.14*   |
| Emergency      | -.06    |
| Renal          | .03     |
| Palliative     | -.15*   |

Adding interaction terms did not explain significantly more variance.

Table 6.8 shows that supervisor support had significant negative relationships with emotional exhaustion and depersonalisation, and a significant positive relationship with personal accomplishment. For the organisational variables, supervisor support was negatively related to turnover intent and positively related to job satisfaction. Adding interaction terms did not explain significantly more variance.
Table 6.8. Regressions predicting outcome variables using supervisor support, group membership, and their interaction.

<table>
<thead>
<tr>
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<th>Organisational Outcomes</th>
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</tr>
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<tr>
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<td>R²</td>
<td>.12</td>
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<tr>
<td></td>
<td>Supervisor Sup.</td>
<td>-.26***</td>
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<td></td>
<td>Emergency</td>
<td>.24**</td>
</tr>
<tr>
<td></td>
<td>Renal</td>
<td>.10</td>
</tr>
<tr>
<td></td>
<td>Palliative</td>
<td>.05</td>
</tr>
</tbody>
</table>

Step 2

|     | ΔF(3, 316) | .79 | .49 | .78 | .52 | .17 |
|     | ΔR² | .01 | .00 | .01 | .00 | .00 |

* p < 0.05; ** p < 0.01; *** p < 0.001

From Table 6.9 it can be seen that organisational support was also significantly and positively related to the burnout component of personal accomplishment, and significantly negatively related to both emotional exhaustion and depersonalisation. Also, organisational support had a significant negative relationship with turnover intent and a significant and positive relationship with job satisfaction. Adding interaction terms did not explain significantly more variance.
Table 6.9. Regressions predicting outcome variables using organisational support, group membership, and their interaction.

<table>
<thead>
<tr>
<th>Standardised Betas for Outcome Variables (β)</th>
<th>Burnout</th>
<th>Organisational</th>
<th>Outcomes</th>
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<td></td>
</tr>
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<td>17.77***</td>
<td>7.67***</td>
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<td>.18</td>
<td>.09</td>
</tr>
<tr>
<td>Org. Support</td>
<td>-.24***</td>
<td>-.15**</td>
<td>.18**</td>
</tr>
<tr>
<td>Emergency</td>
<td>.24**</td>
<td>.14</td>
<td>.25**</td>
</tr>
<tr>
<td>Renal</td>
<td>.07</td>
<td>-.13</td>
<td>.15*</td>
</tr>
<tr>
<td>Palliative</td>
<td>.05</td>
<td>-.27***</td>
<td>.32***</td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ΔF(3, 314)</td>
<td>3.74*</td>
<td>.93</td>
<td>2.16</td>
</tr>
<tr>
<td>ΔR²</td>
<td>.03</td>
<td>.01</td>
<td>.02</td>
</tr>
</tbody>
</table>

* p < 0.05; ** p < 0.01; *** p < 0.001

Finally, Table 6.10 shows that the only significant relationship between family and friends support and the outcome variables was a significant positive relationship with personal accomplishment. Adding interaction terms did not explain significantly more variance.
Table 6.10. Regressions predicting outcome variables using family/friend support, group membership, and their interaction.

<table>
<thead>
<tr>
<th>Standardised Betas for Outcome Variables ($\beta$)</th>
<th>Burnout</th>
<th>Organisational Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Emotional Exhaustion</td>
<td>Depersonalis.</td>
</tr>
<tr>
<td>Step 1</td>
<td>$F(4, 316)$</td>
<td>4.86**</td>
</tr>
<tr>
<td>$R^2$</td>
<td>.06</td>
<td>.16</td>
</tr>
<tr>
<td>Fam./Fr. Supp.</td>
<td>.01</td>
<td>.00</td>
</tr>
<tr>
<td>Emergency</td>
<td>.29***</td>
<td>.16**</td>
</tr>
<tr>
<td>Renal</td>
<td>.07</td>
<td>-.14</td>
</tr>
<tr>
<td>Palliative</td>
<td>.06</td>
<td>-.28***</td>
</tr>
<tr>
<td>Step 2</td>
<td>$\Delta F(3, 313)$</td>
<td>.32</td>
</tr>
<tr>
<td>$\Delta R^2$</td>
<td>.00</td>
<td>.00</td>
</tr>
</tbody>
</table>

*p < 0.05; ** p < 0.01; ***p < 0.001

6.4 Discussion

This study revealed some important contributions to emotional labour theory. Most notable, was that the management of natural emotion was found to be a distinct and prominent emotional labour strategy, confirming Hypothesis 1. Many theoretical conceptualisations of emotional labour have included some manner of the expression of natural emotion in addition to surface and deep acting (e.g. Ashforth & Humphrey, 1993; Brotheridge & Lee, 2003; Diefendorff et al., 2005; Diefendorff & Gosserand, 2003; Hochschild, 1983; Zapf et al., 1999). However, of these, only a few have considered that the use of natural emotion would require some form of ongoing management (e.g. Brotheridge & Lee, 2003; Diefendorff et al., 2005). There are no known previous quantitative studies that have operationalised the management of natural emotion as an emotional labour strategy. The findings from the current research
suggests that the use of natural emotion consists of both a natural concordance between felt and required emotion as well as the management of natural emotion to keep emotional expression within acceptable bounds. Therefore, the management of natural emotion is a more inclusive umbrella term for how natural emotion is used rather than a simple and limited reference the use of natural emotion as an emotional labour strategy. This study also found surface and deep acting to be emotional labour strategies, which has been a consistent finding previously (e.g. Brotheridge & Lee, 2003; Diefendorff et al., 2005; Martínez-Iñigo et al., 2007; Näring et al., 2006).

The current study found that the management of natural emotion and deep acting both had mostly neutral relationships with wellbeing outcomes, with a few positive associations, providing partial support for Hypothesis 2a, that the management of natural emotion and deep acting would be associated with positive wellbeing outcomes.

The management of natural emotion had a significant positive correlation with personal accomplishment, and deep acting had a significant positive relationship with personal accomplishment and a significant negative association with turnover intention. The associations between the management of natural emotion and wellbeing are important and add to what is known about emotional labour. If employees are able to use their judgment to control interactions to and use what they feel in a controlled and purposeful manner, it’s clear that wellbeing need not suffer and may even benefit. The findings of the relationships between deep acting wellbeing in this study been found elsewhere with deep acting being associated with mainly neutral (Bono & Vey, 2007; Brotheridge & Lee, 2003; Gross, 1998a; Martínez-Iñigo et al., 2007; Näring et al., 2006; Totterdell & Holman, 2003; Zammuner & Galli, 2005) or positive wellbeing
associations (Yang & Chang, 2007; Zhang & Zhu, 2008), and few negative associations (Grandey, 2003 an exception). Deep acting is therefore confirmed in this study as an adaptive emotional labour strategy.

Surface acting was associated with negative wellbeing for all outcomes variables, fully supporting Hypothesis 2b. It was notable that emergency nurses reported the highest levels of surface acting and also the poorest pattern of all outcome measures. This study also confirmed surface acting as a damaging emotional labour strategy. Surface acting has been consistently associated with such poor outcomes in previous research in terms of burnout (Brotheridge & Grandey, 2002; Brotheridge & Lee, 2003; Grandey, 2003; Kim, 2008; Martínez-Iñigo et al., 2007; Näring et al., 2006; Zammuner & Galli, 2005; Zhang & Zhu, 2008), health measures (Gross, 1998a; Zapf et al., 1999), organisational commitment (Yang & Chang, 2007), job satisfaction (Zhang & Zhu, 2008), and work/family conflict (Seery et al., 2008).

The combined finding for the relationships between emotional labour strategies and outcomes show that being able to manage natural emotion as it arises and to use it purposefully may be a much less problematic emotional labour strategy than surface acting which involves faking or suppressing emotion. This is a notable finding because Gross’s (1998a) emotional regulation theory suggests that deep acting is less problematic than surface acting due to the way in which emotions are generated in each instance. Gross (1998a) sees deep acting as being antecedent focused where individuals appraise the situation prior to the interactions and prepare by evoking the required emotional state. In contrast, surface acting is a response focused strategy and relies on the moment-to-moment suppression and expression of emotion.
Gross found that surface acting resulted in greater sympathetic nervous system activation and was associated with more negative feelings compared to deep acting. Gross concluded that this was clear evidence of the benefits of preparation (deep acting) as opposed to moment-to-moment emotional responding (surface acting). However, the finding from the current study suggests that even though the management of natural emotion may be response focused, it is not associated with poor wellbeing outcomes. Therefore, Gross’s assertions cannot translate to all methods of response focused emotional expression. It may simply be the case that surface acting is associated with poor wellbeing outcomes due to the greater effort involved (Brotheridge & Lee, 2002, 2003; Zammuner & Galli, 2005), especially if surface acting simultaneously involves the faking of unfelt emotion and the suppression of felt emotion.

This study also showed that organisational sources of support had strong and positive wellbeing associations, confirming Hypothesis 3a. However, co-worker support was not systematically associated with more beneficial wellbeing than the other organisational sources of support, counter to Hypothesis 3b. Support from family and friends was not as important as organisational sources of support in this study, with only one significant relationship with personal accomplishment. These finding replicate the notion from previous research that organisational sources of support are important in terms of support from co-workers (e.g. Brotheridge & Lee, 2002; Kirsh, 2000; Thompson & Prottas, 2005), supervisors (e.g. Brotheridge & Lee, 2002; Dormann & Zapf, 1999; Yoon & Lim, 1999), and the organisation (e.g. Jawahar et al., 2007; Rhoades & Eisenberger, 2002; Thompson & Prottas, 2005).
Similar to the support findings in this study, in a meta-analysis, Halbesleben (2006) also found that non-work related sources of support had a different pattern of relationships with wellbeing outcomes opposed to work related sources of support. Specifically, there was a lack of an association between non-work support and emotional exhaustion. Halbesleben argued that organisational sources of support may reduce emotional exhaustion as they can be accessed when the strain occurs, whereas outside sources of support are not immediately accessible. This explanation may also be applicable in the current study.

Emotional engagement was found to be an important in this study for its associations with emotional labour and wellbeing. Comparisons between groups showed that all three nursing groups reported similar levels of emotional engagement and the clerks reported significantly less emotional engagement than all nursing groups. Therefore, Hypothesis 4a, predicting an ascending level of emotional engagement from clerks to renal nurses, emergency nurses, and palliative care nurses was only partially supported. However, the delineation between nurses and the clerks is notable and in line with the notion of the social identity of nurses as carers (see Smith, 1992). Groups reporting higher emotional engagement (i.e. nursing groups) did not report greater levels of emotional labour strategies, failing to support Hypothesis 4b. The palliative care nurses reported the lowest levels of the management of natural emotion and deep acting, which was surprising given their focus on the emotional aspects of their role. This may be an indication that the work setting and the form of the interaction could impact on how individuals perceive the amount of effort required to conform with emotional requirements. For example, the palliative care nurses might find it easier to conform to
the emotional requirements in their setting compared to the emergency nurses who have much more volatile and difficult interactions with clients.

The regression analyses were used to examine the relationships between independent and dependent variables as well as any group differences in these relationships. The regression analyses showed that emotional engagement had the strongest wellbeing associations (except for emotional exhaustion) of all the independent variables compared to the nursing groups. This shows that the perception of emotional engagement as being an important part of the role was beneficial for these employees. Step 2 of the engagement regression indicated a trend toward emotional engagement being more important for the emergency nurses in relation to reducing depersonalisation and turnover intention. This could mean that in situations in which the interactions are difficult, a clear sense that emotional engagement is an important part of the role may be beneficial for employees. These results add weight to Ashforth and Humphrey’s (1993) notion that identification with the role will improve wellbeing outcomes for employees engaged in emotional labour.

Apart from emotional engagement, a lack of interactions in the regression analyses show that, for the most part, the relationships between the independent variables and the outcome measures were similar for all groups. This suggests that regardless of the setting, emotional demands, emotional labour, and various sources of support may be similar in terms of their relationships with wellbeing outcomes. However, this doesn’t mean that role or context doesn’t have an impact on wellbeing. The emergency nurses reported the poorest outcomes but these outcomes could be more to do with the fact that emergency nurses used more surface acting and may have more
volatile and generally more difficult and unpredictable interactions with clients. At the other end of the wellbeing spectrum, palliative care nurses reported the best outcomes. For the palliative care nurses, the relationships with clients and a high comparative level of co-worker support may help to produce good outcomes in terms of lesser burnout and greater wellbeing. Overall, the results from this study indicate that the form of the interaction and the context matters even if the effects on wellbeing are only due to the way in which the situation produces a greater propensity for surface acting or allows a greater opportunity for support.

6.5 Limitations

This research attempted to provide a comprehensive view of the important relations between emotional labour and other variables and how this might vary between groups, however some limitations should be noted.

First, factors related to the interaction but not related to emotional labour such as the type of relationship with clients, and the existence, or lack of, abuse and work load differences, may be applicable for these groups, and may have impacted on wellbeing measures, but these were not measured.

Second, the measure of the management of natural emotion contained some items that may be specific to certain contexts, which could have resulted in skewed results. For example, three of the items referred specifically to managing natural emotion to control difficult or problematic clients and these items may have been more applicable to the emergency nurses and clerks.
Third, the current study was limited to one non-nursing group (emergency clerks) despite there being many professional and non-professional non-nursing employees working health care. Due to the results from the clerks, which do not necessarily correspond with other emotional labour research with clerical employees, wider investigations in health care are warranted.

Fourth, due to constraints on the scope of the current study, only the most crucial factors identified from Study 1 and from previous research were used in the survey. This meant that some factors, such as emotional intelligence, non-expressive emotional management, and emotionally relevant interactions were not included. These factors may have important associations with emotional labour and wellbeing.

Fifth, the survey data in Study 2 was self-report and therefore prone to common method variance, raising the possibility of spurious covariance.

Sixth, it could be considered that the items used to measure emotional demands included components that may not actually represent greater emotional demands, such as length of interactions. The components of emotional demands as conceptualised in this research may be better dealt with individually, rather than as an overall construct.

Finally, this study was cross-sectional which allows the analysis of relationships between variables but not cause and effect. Therefore, the assumed positive effects of social support and emotional engagement, and the problematic outcomes of surface acting are suggested but not proven in this study.
Chapter 7: General Discussion

7.1 Major Findings

The findings from this research have a number of important implications for how emotional labour should be conceptualized and how the relationships between emotional labour and other factors are considered. The most important findings from the current research are summarized below, followed with detailed description of findings, together empirical and theoretical implications;

- **Emotional Labour**: The management of natural emotion is a distinct and prominent emotional labour strategy.

- **Outcomes of Emotional Labour**: The management of natural emotion and deep acting are preferable to surface acting due to more favourable wellbeing associations.

- **Social Support**: Organisational sources of support are crucial for the wellbeing of employees engaged in emotional labour.

- **Emotional Engagement**: Employees who perceive the emotional engagement in their role as high, may be better prepared for emotional interactions and have better wellbeing outcomes.

- **Emotional Intelligence and display rules**: Employees from all groups used emotional intelligence to guide their emotional interactions with clients.
- **Non-expressive Emotional Management**: In addition to emotional labour, employees from all groups used non-expressive means of emotional management such as the use of information, and space and proximity to control the emotion of themselves and clients.

- **Emotionally Relevant Interactions**: Employees found clients that held some emotional relevance as the most emotionally difficult to deal with.

**7.1.1 Emotional labour.** This research shows that the management of natural emotion should be considered as a distinct and important emotional labour strategy. Nurses and clerks from an emergency department and palliative care nurses all managed natural emotion to control interactions with clients and to provide emotional support. For emergency nurses, managed anger was mainly used to control the aggressive or abusive behavior of clients in order to ensure the efficient functioning of the emergency department and to protect others in the vicinity. For the palliative care nurses, managed natural emotion was used more as a means of allowing some grief to be displayed to provide emotional support for clients. The palliative care nurses described situations in which they cried with clients. For both the emergency and palliative care nurses, it was clear that unbridled and unmanaged emotion was a big problem, both in terms of personal wellbeing and being able to function effectively in their roles. The emergency clerks also described some instance of the management of natural emotion but renal nurses provided no examples of the management of natural emotion as an emotional labour strategy, which could be due to their long-term relationships with clients.
The findings from Study 1 were fully supported in Study 2, with the management of natural emotion being identified as an orthogonal emotional labour strategy, confirming Hypothesis 1. In addition, the management of natural emotion was the most widely used emotional labour strategy. Together the combined results from this research clearly identify the management of natural emotion as an important and prominent aspect of emotional labour.

This research was also notable in that surface and deep acting were prominent emotional labour strategies in these health care groups in both studies. There was good evidence of surface acting and deep acting from all groups across Studies One and Two. Together, these results suggest that theories of emotional labour are just as applicable to health care as other situations in which employees must interact with clients as an important aspect of their role.

Most emotional labour research has been clear in the identification of surface and deep acting as key components of emotional labour (e.g. Ashforth & Humphrey, 1993; Brotheridge & Lee, 2003; Hochschild, 1983). The current research confirms these as key emotional labour components but also adds the management of natural emotion as an important and orthogonal third component.

Natural emotion has been suggested a third component but mostly as a natural concordance between expected and felt emotion (e.g. Ashforth & Humphrey, 1993; Hochschild, 1983; Zapf, 2002). There have been some conceptualisations of emotional labour that have suggested that natural emotion would require ongoing management in order to keep the emotional expression within acceptable constraints (Brotheridge &
Lee, 2003; Diefendorff & Gosserand, 2003) but this notion has received little research attention. The current research shows that employees were aware of the need to keep natural emotion in check and within what they considered as being acceptable bounds.

In Study 1, the management of natural emotion was associated with descriptions of generally positive outcomes, usually in-line with the idea that the management of natural emotion met the purpose for its use. For example, in situations in which it was used to provide emotional support for clients, participants gave evidence of being able to form close connections to clients. When the management of natural emotion was used to control abuse, participant described how they were able to take control of the interaction and achieve the desired outcome. In both cases, the interviewees spoke of a sense of accomplishment in their ability to use manage natural emotion for good outcomes.

The results of Study 2 confirmed the management of natural emotion as an orthogonal emotional labour strategy. It was also used more than surface and deep acting, confirming its importance as an emotional labour strategy.

7.1.2 Outcomes of emotional labour. In Study 1, it was clear that deep acting and the management of natural emotion were associated beneficial outcomes for employees, clients and the organisation, whereas surface acting was associated with poorer outcomes, particularly for the individual. In Study 2, there was partial support for Hypothesis 2a; that the management of natural emotion and deep acting would be associated with positive wellbeing outcomes, but full support for Hypothesis 2b; that surface acting would be associated with negative outcomes. Together, both studies
provide compelling evidence that the management of natural emotion and deep acting are preferable emotional labour strategies compared to surface acting.

Unlike Hochschild’s (1983) position, and in accordance with the views of Ashforth and Humphrey (1995), Wouters (1989), and Zapf and Holz (2006), the combined findings from Study 1 and two show that emotional labour isn’t necessarily associated with poor wellbeing outcomes. In fact, for many employees their emotional labour was associated with a deep satisfaction, particularly when the employee felt a sense of achievement and connectedness with clients.

In Study 1, the palliative care nurses explained how assisting patients to achieve a good death and being close to clients provided the nurses with a great deal of satisfaction. Similarly, despite a much lower level of perceived responsibility for emotional engagement, the emergency clerks also spoke of connecting with people and the provision of emotional support as something they enjoyed.

Study 2 supported the findings from Study 1. The emotional labour components of deep acting and the management of natural emotion all had either positive or neutral wellbeing associations. Furthermore, these findings were common across the groups.

Previous research has showed surface acting to be consistently associated with poor wellbeing outcomes (e.g. Brotheridge & Grandey, 2002; Brotheridge & Lee, 2003; Grandey, 2003; Johnson & Spector, 2007; Näring et al., 2006; Seery et al., 2008; Yang & Chang, 2007; Zammuner & Galli, 2005; Zhang & Zhu, 2008). In contrast, deep acting has had mainly positive or neutral relationships with wellbeing outcomes (e.g. Bono & Vey, 2007; Grandey, 2003; Gross, 1998a; Kim, 2008; Liu, Prati, Perrewa, & Ferris,
2008; Martínez-Iñigo et al., 2007; Totterdell & Holman, 2003; Yang & Chang, 2007; Zhang & Zhu, 2008). In these respects, the findings from the current research are in-line with what’s been found previously. The added dimension of the management of natural emotion and the finding that the relationship with outcome measures are similar to deep acting suggest that managing natural emotion and perhaps being given the autonomy to do so, is more beneficial to the individuals, clients, and the organisation, compared to surface acting.

The consistent wellbeing associations between emotional labour strategies and wellbeing outcomes does not mean that the context and the interactions within aren’t important considerations. It appears as thought the type of interaction and its impact on how emotional labour might be carried out could affect wellbeing outcomes. For example, the emergency nurses had by far the most volatile interactions with clients, reported the highest levels of surface acting and also the greatest level of emotional exhaustion. In their descriptions of how they used emotional labour in Study 1, the emergency nurses spoke of constraining negative emotion as a prominent emotional labour strategy. Surface acting and its associations with emotional dissonance (see Abraham, 1998) has been associated with many wellbeing deficits as previously described. In particular, the requirement to constrain negative emotions may have physiological effects such as sympathetic activation of the cardio-vascular system (Gross & Levenson, 1997). Therefore, this aspect of surface acting may be particularly damaging psychologically and physiologically. In terms of the particular characteristics of the context, the typical form of the interactions are very important considerations,
particularly if they tend to lead to surface acting rather than deep acting or the management of natural emotion.

7.1.3 Social support. Study 1 showed that co-worker support was the most important source of support for all groups in respect to the emotional demands on employees. Co-worker support was important because of a sense of shared experience between co-workers and because it was available when needed. Other organisational sources of support were also important but the references to supervisors and the organisation itself were less common and not described as imperative. Support from outside the organisation was less important, either because of a need for employees to separate work and home life or because of a lack of understanding about aspects of the work situation amongst family members or friends.

In Study 2, Hypothesis 3a was supported, with all organisational sources of support (co-worker, supervisor, and the organisation itself) having positive relationships with wellbeing. However, counter to Hypothesis 3b, co-worker support did not have the highest relationships with wellbeing. The results from Studies One and Two indicate that co-worker support may be the most salient form of support to employees but support from supervisors and the organisation may also be important, especially if it serves to set a supportive tone in the organisation or if policies and procedures facilitate support between co-workers as was the case for the palliative care nurses.

The importance of social support to employees in relation to wellbeing outcomes is well-established in the organisational literature generally (Eisenberger et al., 1986; Halbesleben, 2006; House, 1981). Social support has also been identified as an
important moderator between emotional labour and wellbeing outcomes (Abraham, 1998; Brotheridge & Lee, 2002; Näring et al., 2006). The current research goes beyond what has been found previously by identifying the type of support that’s important in specific situations, the reason why some sources of support may be more important than others, and how the imperative for support is related to the level of engagement and emotional expenditure.

Study 1 showed that where the emotional expenditure was for the purposes of providing emotional support to clients (i.e. palliative care nurses), the required support was also emotional in nature. In addition, the palliative care nurses identified emotional engagement with clients as a very important aspect of their work and they described a great deal of emotional expenditure in meeting these requirements. In line with the high level of emotional expenditure, the level of support that was required was also high.

For the emergency nurses and clerks, the purposes for emotional engagement with clients was more for instrumental purposes and its primary aim was to ensure the safety of people in the vicinity of the emergency department and its continued efficient operation. Both groups described instrumental support as being important, in accordance with the reason for engagement with clients. The clerks were much more easily able to withdraw from interactions with clients and didn’t appear to feel the same responsibility for engaging emotionally with clients compared to the emergency nurses.

For the renal nurses, emotional expenditure was and emotional effort was only required intermittently, despite their high perceived responsibility for emotional engagement. The routine and non-emotive setting of renal dialysis wards meant that the
renal nurses did not have the same ongoing exposure to abuse or life and death situations that existed for the other groups. Social support for the renal nurses seemed to be less important than for the other nurses.

The COR theory (Hobfoll, 1989) has been previously provided as an explanation for the importance of social support to replenish the emotional resources after emotional labour (Brotheridge & Lee, 2002). The interviews from Study 1 can be seen as providing additional evidence for this position with higher levels of emotional expenditure being associated with a greater need for support.

The results from Study 2 showed that organisational sources of support were also associated with good wellbeing outcomes for all groups. However, support from family and friends did not share the same wellbeing associations. Previous research has also shown that support from family members may have a different set of associations with outcomes opposed to organisational sources of support (Baruch-Feldman et al., 2002). A possible reason for lower associations between some outcomes measures and non-organisational sources of support could be that support may be most beneficial at the time of the interaction in the case of instrumental support, and soon after the interaction when emotional support is needed. This means that support from family and friends may be less effective due to its remoteness. In addition, the palliative care nurses in particular spoke of a lack of understanding about their work from people outside the organisation or from outside palliative care workers.

In Study 1, participants from all groups spoke of co-worker support as being particularly important due to its availability and a sense of shared experience. In terms
of availability, this was especially important when instrumental support was needed. For example, emergency nurses often discussed a preparedness to go to workmates aid in the event of a physical threat. Obviously, non-work sources of support would be totally unavailable in these situations and even organisational sources of support that were not immediately available, or only occasionally present (such as supervisors), would be less effective than co-workers.

The results from Study 2 were not completely in-line with the Study 1 findings. Study 2 results showed that all organisational sources of support were associated with good wellbeing outcomes and co-worker support was not any more important than the either supervisor or organisational support. In fact, the correlations and the results from the regression analyses show that co-worker support had marginally lower beneficial wellbeing associations than supervisor and organisational support (personal accomplishment an exception).

A meta-analysis of the organisational support literature has suggested that measures of organisational support could be influenced by a variety of factors including the perception of fair treatment and working conditions (Rhoades & Eisenberger, 2002). The measures of support in Study 2 were a combination of existing, generic support scales plus items designed specifically to measure support needed in relation to emotional interactions with clients. However, it’s possible that the Study 2 support measures were also influenced by factors other than support directly in relation to emotional interactions with clients. Future research could focus solely on items designed to assess the level of emotional and instrumental support in direct relation to emotional interactions.
Study 1 also showed that another major reason for the importance of co-workers as support was a sense of shared experience. Even though this was a prominent theme throughout the groups, it was most clearly demonstrated in the interviews with the palliative care nurses. The palliative care nurses described how support from family and friends was unavailable due to a lack of understanding of the palliative care process, and the difficulty in discussing end-of-life issues. This seemed to bring the importance of organisational sources of support into sharper focus for these nurses. Even in the interviews with the nurses, there was mention of a great understanding between co-workers in terms of working requirements and interactions with clients.

The combined findings from studies one and two show that organisational sources of support are very important for the wellbeing of employees in these groups. There is good support for Hobfoll’s (1989) COR theory in the finding that where emotional expenditure was high, there was also a high need for support. In addition, if some sources of support were unavailable, available sources became even more crucial. The purpose of emotional expenditure was also matched by the requirement for support. For example, emotional expenditure for instrumental purposes was met with a need for instrumental support and emotional expenditure for the purpose of providing emotional support was met with a need for emotional support. Sources of support that were closest to the point of emotional expenditure, either in terms of proximity or shared experiences were also the most important. Where emotional expenditure and the subsequent need for support was greatest, there appeared to be more efforts to maintain supportive relationships.
7.1.4 Emotional engagement. Emotional engagement was an important factor in this research both in terms of how employees perceived their emotional engagement responsibilities and also for the relationships between emotional engagement and wellbeing. In Study 1, employees who described greater a responsibility for emotional engagement as a role requirement, also described more instances of all emotional labour strategies. Palliative care nurses described high levels of emotional engagement followed by emergency nurses, and then renal nurses and emergency clerks.

There was also evidence that the purpose and form of emotional engagement varied according to the demands of the role and the context. Millward (1995) has described such distinctions in terms of nurses seeing themselves as either mostly providing emotional support as “ministering angels” or more clinically and professionally oriented.

There was evidence of Millward’s (1995) emotionally and instrumentally focused nurses in the interviews. Emergency nurses spoke of emotional engagement as important but more as a means of ensuring the safe and efficient operation of the emergency department rather than as an end in itself as the palliative care nurses did.

The renal nurses also stated a belief in emotional engagement as a role responsibility but there were much fewer descriptions of how their emotional engagement played out day-to-day. This is probably due to the very stable environment of renal dialysis wards and the very long term relationships between nurses and patients.

There was a stark difference between the emergency clerks and emergency nurses in how they perceived their emotional engagement as a role responsibility. The
clerks spoke of withdrawing physically and emotionally from clients and showed a propensity to refer difficult cases to the emergency nurses. An interesting aspect of the interviews with the clerks was their perception of how clients viewed them in relation to nurses. The clerks described situations in which they felt clients held them in lower regard interpersonally and in terms of information that they provided in comparison to the emergency nurses. This seemed to provide some justification for the clerks to be much less emotionally engaged in relation to emergency nurses.

Previous research has established emotion engagement with clients as an important part of nursing (e.g. Bolton, 2000b; James, 1992; Smith, 1992; Weir & Waddington, 2008). In line with Study 1, there have also been distinctions identified in terms of emotional engagement between nursing areas. For example, palliative care nurses have been seen as particularly focused on emotional engagement with clients as an important part of their role (Johnston & Smith, 2005; Skilbeck & Payne, 2003), whereas this has been found to be less the case for other nurses such as those who work in emergency departments (Henderson, 2001).

Despite the findings in Study 1, Hypothesis 4a, predicting that palliative care nurses would have the highest level of emotional engagement followed by emergency and renal nurses, and then emergency clerks, was not supported in Study 2. Also, Hypothesis 4b, that groups reporting the greatest levels of emotional engagement would also report the highest levels of emotional labour strategies in Study 2, was also not supported. The clerks did not report significantly less emotional labour strategies than any of the nursing groups.
Some of the differences between Studies One and Two could have something to do with the professional identity of nurses as carers (Smith, 1992). It may be the case that nurses have an identity as someone who provides emotional support and engages emotionally, regardless of the context. All nursing groups reported very similar levels of emotional engagement but the clerks were significantly lower.

The unexpectedly similar levels of emotional labour strategies in Study 2 could also be related to differences in the requirements of the settings and may indicate that employees consider that emotional requirements and displaying the right emotion as more effortful for those with difficult interactions regardless of the profession. For example, from Study 1 it was evident that the emergency department was easily the most emotionally difficult setting, with stressed, volatile, abusive, and sometimes violent clients being typical. In Study 2, the emergency nurses reported the highest levels of all three emotional labour strategies and despite reporting the lowest emotional engagement, the emergency clerks did not report significantly lower levels of emotional labour than any of the nursing groups. By contrast, the palliative care nurses described the importance of their emotional interactions in Study 1 as very important and something that gave them a great deal of satisfaction but overall they reported the lowest levels of emotional labour in Study 2. Therefore, emotional displays and emotional interactions were much harder work for the emergency nurses and clerks, which was reflected in the Study 2 levels of emotional labour. On the other hand, the palliative care nurses may not have considered that their emotional interactions with clients as anywhere near as effortful, hence their lower levels of reported emotional labour in Study 2. It would make sense that instances of emotional labour may have been easy to
identify when the palliative care nurses were simply talking about their work in Study 1 but not reflected in response to direct questions about how they managed their emotion in Study 2 because this may not have been seen as effortful.

Further explanation that palliative care nurses were more pro-active in their emotional engagements and why this may have resulted in less effort can be seen in how the palliative care nurses described their profession progression towards palliative care. There was evidence that nurses moved to palliative care after a long consideration and as a “calling”, which was absent in the interviews with the other nurses and the clerks. The following comment reflected a typical sentiment:

“Well I always wanted to work in that field [palliative care]. I’ve had a desire to do that for a long time and I’ve been nursing a long time but… I just got fed up with working for 20 years as a nurse and then the thing that really brought me back to nursing was if I could work in palliative care… I decided I’d gain experience on the oncology ward… and I worked there for about four and a half years… then I felt confident enough…” [PN3]

It was clear that the palliative care nurses sought out palliative care work and did not simply consider the palliative nursing role as simply convenient as was the case for some of the renal nurses and emergency clerks.

An important finding from Study 2 was that emotional engagement was associated with positive wellbeing outcomes in all measures except for a non-significant relationship with emotional exhaustion. This could indicate that when employees are aware of their emotional engagement responsibilities and take responsibility for the emotions of clients, they may be better prepared for emotional interactions, which in turn may lead to better outcomes.
Study 2 revealed that perceived emotional engagement was significantly lower for the clerical group compared to all nursing groups. However, there were no significant differences between the nursing groups. The finding that clerks reported a much lower level of perceived responsibility for emotional engagement compared to nurses is not surprising. Clerks could not be expected to share the social identity of nurses as carers. Conversely, the finding that the perceived emotional engagement between nursing groups was very similar was a little surprising given that the renal nurses talked of a much more routine and non-emotive work environment without the frequent extreme emotional interactions of the other nursing groups. These results suggest that nurses may have a strong shared identity regardless of the particular role and context.

The regression analyses from Study 2 showed that apart from a non-significant relationship with emotional exhaustion, the associations between emotional engagement and wellbeing measures were all significantly related to good outcomes. This is evidence of Ashforth and Humphrey’s (1993) assertion that the need to perform emotional labour and be engaged emotionally may increase the likelihood of identifying with the role. This may provide employees with a greater sense of accomplishment and job satisfaction, reduce turnover intention and reduce depersonalisation when employees carry out emotional labour as per the role expectations.

7.1.5 Emotional intelligence and display rules. Study 1 showed that the four branch model of emotional intelligence can be used to explain how employees in all groups approached interactions with clients. There was little evidence of direction from the organisations as to which emotions should be displayed or constrained and it seemed
that employees were given latitude to decide for themselves what was appropriate in each circumstance.

For all employees, the most important determinant of display rules varied in accordance with the individual interactions. Employees spoke of assessing the emotional state of individuals, deciding on an emotional approach, and then managing their emotion to achieve a desired outcome, which encompasses the four-branch model of emotional labour (see Mayer et al., 2004a; Salovey & Mayer, 1990). The use of emotional labour as an antecedent rather than as an intervening factor in emotional labour has been previously been identified in emotional labour research in nursing (McQueen, 2004). This research also found that clerks used emotional intelligence to guide their interactions and their emotional approach to clients, indicating that McQueen’s findings are applicable more broadly. Mann (2004) has suggested that when display rules are not explicit, employee judgment becomes more important, and it appears as though the use of emotional intelligence could be an important method of making these judgments.

Unfortunately, there is a great deal of conjecture as to whether emotional intelligence can be improved within individuals. For example, Mayer, Salovey and Caruso (2004b) point out that if emotional intelligence is a latent and intrinsic variable, then it will probably be relatively stable within individuals and difficult to modify or improve. Despite this view, some researchers have claimed that training can improve emotional intelligence (e.g. Clarke, 2006a). A lack of clear evidence one way or the other means that the effectiveness of training to improve emotional intelligence is still in doubt. However, given the apparent importance of the four branch model of emotional
intelligence as a shaper of interactions and emotional engagement with clients in this research, if proven effective, training could be very important in assisting employees to better deal with clients. This may be particularly important in difficult interactions and stressful environments.

From the Study 1 interviews, it was clear that especially for nursing participants, there was a lack of organisationally defined display rules. The general notion of the importance to remain calm and not be drawn into volatile interactions with clients seemed to be in widely shared yet fairly vague agreement. In terms of a pre-existing requirement to display or constrain specific emotions, most participants expressed the belief that the constraint of anger was most important. The lack of a clear pre-existing display rules, leads to the conclusion that knowledge about what was appropriate or inappropriate was most determined by social or professional norms (Ashforth & Humphrey, 1993), which would assumedly be largely determined by the social identity of nurses (Smith, 1992).

The situation for the clerks was slightly different. The clerks gave indications that they relied upon training to deal with difficult clients as important in terms of what to say or not to say to angry or abusive clients. However, from participant descriptions, this training did not seem to be specifically focused on directing participants to express or constrain specific emotions. As with the nurses, the clerks only described display rules in vague terms and did not identify a directive source for their perceptions of what was appropriate.
7.1.6 Non-expressive emotional management. The current research was notable in the finding from Study 1 that emotional management of both the self and others consisted of means other than expressing and constraining emotion. Previously, emotional management has been used as an interchangeable term for emotional labour (e.g. Bono & Vey, 2005; Mann, 2004; Zerbe & Hartel, 2000). However, the interviews from Study 1 showed that emotional labour is only one part of emotional management. Therefore, emotional labour and emotional management should not be used as interchangeable terms.

There were two ways in which employees used non-expressive means of managing emotion. First, the use of information was used in all groups to placate distressed clients, and also as a means of subjective emotional protection, to distance employees from the poor health care decisions of clients. Second, clerks and emergency nurses used proximity and space to remove themselves from abusive clients and to remain calm, ensuring subjective emotional protection. In addition, there was limited evidence that emergency nurses used proximity and space to calm clients in emotionally upsetting situations.

The use of information was particularly prominent and used in different groups for different purposes. For example, palliative care and renal nurses described the provision of information as means of abdicating responsibility for poor outcomes resulting from the non-optimal health care decisions of clients. In these situations, nurses made sure that they provided information to clients as to the most beneficial way forward in order to alleviate suffering or promote health. When clients acted against
such advice, nurses were emotionally protected due to their capacity to distance themselves from the poor decision making and attribute responsibility solely to clients.

For emergency nurses and clerks, the situation was quite different with the provision of information being used to control the emotions of clients and to ensure that the function of the emergency department was not compromised. These employees discussed how they gave information, mainly as to the condition of patients, which served to quell anxious and emotionally upset clients, who in these cases were usually the friends and relatives of patients. There was an understanding amongst the interviewees that not having enough information was the basis for clients becoming distressed and more difficult to deal with. Therefore, providing information alleviated clients’ emotional distress.

Interviewees also described how they used space and proximity to control the behavior and the emotions of clients and themselves. However, unlike all the other means of managing emotion, this method was restricted to the clerks and nurses working in emergency departments. In line with their lower perceived responsibility for emotional engagement, clerks used withdrawal from interactions as means of emotional protection when confronted with abuse from clients. There were also less prominent indications that emergency nurses may have used space and proximity to diffuse or contain emotionally upset clients; however it appears as though nurses did not feel their role responsibility allowed them to withdraw readily from client as the clerks were able to.
The combined findings that showed employees in these groups used emotional management strategies that did not involve emotional labour means that emotional management should not be used as an interchangeable term for emotional labour. Emotional management should be thought of as an umbrella term and all methods of managing emotion, including those outlined above, whereas emotional labour is concerned solely with the expression and constraint of emotion as part of the work role. Together, these findings showed that non-expressive emotional management, and the use if information in particular, were important strategies for employees from these four groups. These findings are important because they highlight that when considering how emotions are managed in the workplace, it’s important to look beyond emotional labour and to consider emotional management and all its possibilities in a broad context.

7.1.7 Emotionally relevant interactions. Study 1 showed that employees from all groups found that interactions with clients that held some sort of emotional relevance, such as patients resembling a loved one, or the untimely death or illness of children, as the most emotionally difficult.

Study 1 showed that emotionally relevant cases were much more difficult for employees to come to terms with. Clerks and nurses from all groups described child patients (particularly if the employee was a parent) or patients that reminded the employee of a loved one, as more difficult for the participant to deal with emotionally. As Gunther and Thomas (2006) also found, some stories of memorable patients were notable for their clarity even long after the event. The importance of this finding is that despite the ability of employees from these groups to prepare for everyday situations, and even allowing for the buffering effect of social support, there may be some cases
that bear a far greater emotional cost than others. These cases may be more difficult for employees to deal with at the time but may also have a residual effect, which could weigh heavily on the capacity for long-term coping and may have serious performance consequences as well.

Previous research in health care has shown emotionally relevant cases to be comparatively more difficult for employees to deal with. For example, Boyle (2005) described how paramedics distanced themselves from elderly patients who reminded them of their own parents, and how they prolonged the resuscitation attempts of children long after any reasonable hope of recovery. In addition, Gunther and Thomas (2006), found that nurses sometimes developed stronger bonds with some patients, which made the patients’ death more difficult to deal with.

7.2 Organisational Implications

The current research has some clear practical implications for employers, employees, and educators.

7.2.1 Emotional labour and emotional autonomy. The most important finding from this research was that the management of natural emotion was an important emotional labour strategy. Furthermore, the management of natural emotion was associated with similar outcomes as deep acting and both strategies were preferable to the deleterious strategy of surface acting. These findings add to what is already known about how best to prepare employees for the emotional interactions in their roles.
By allowing employees to assess the requirements of individual interactions and to then manage their natural emotion accordingly, employers are in effect, allowing some emotional autonomy. Previous researchers have commented on the importance of emotional autonomy in organisations for employees to avoid negative wellbeing outcomes (e.g. Brotheridge & Lee, 2002; Wharton, 1993). The current research provides further evidence of the importance of emotional autonomy to express and constrain emotion based on subjective assessments of the situation, rather than being subject to strict emotional expression requirements, which are often a precursor to surface acting (Zammuner & Galli, 2005).

In Study 1, employees described how they used deep acting by preparing for interactions through cognitive and emotional change and preparation. It has been suggested that such strategies should be encouraged with employees to limit moment-to-moment emotional responding, typified as surface acting (Gross, 1998a; Spencer & Rupp, 2009). The current research suggests that, in addition to deep acting strategies, employees may benefit from being allowed some autonomy to express managed natural emotion, particularly if this strategy reduces the likelihood of surface acting. Employees would benefit from being taught about emotional labour strategies and the best methods of expressing and constraining appropriate emotion to protect their own wellbeing and the wellbeing of clients, co-workers, and to achieve optimal organisational outcomes.

7.2.2 Emotional expectations in the role. Emotional engagement was associated with positive wellbeing in this research and there was a difference between nurses and clerks in their subjective perception of this aspect of their role in Study 2. This is an important because emotional engagement was associated with the manner in
which emotional labour and other emotional management strategies were managed in Study 1. For example, emergency nurses and clerks considered that emotional engagement was an important responsibility in the role and this was associated with substantial efforts and a preparedness to engage with clients. Conversely, the clerks perceived a low level of emotional engagement and handled their interactions accordingly, including being prepared to withdraw completely from interactions. It was clear that the clerks saw their actions as being sanctioned by the organisation and this was a direct result of the training they had received to deal with difficult or abusive clients. The implication for organisations is that role clarity, and in particular the emotional requirements and expectations of the role, may be crucial information for employees to ensure that they are aware of their exact expectations. That’s not to say that employees need to be directed to express or constrain particular emotion in specific circumstances, rather it means that employees must be aware of their responsibilities to engage and their sanctioned ability to withdraw from clients as a role requirement or expectation.

Ashforth and Humphrey (1993) have suggested that employees are happy when they are conforming with their subjective expectations of their role, including their emotional expectations. Previous emotional labour researchers have suggested that nurses could benefit from information as to the emotional labour requirements of the job, prior to the start of formal training (Huynh et al., 2008) and as an ongoing aspect of their education (Landa, López-Zafra, Martos, & Aguilar-Luzón, 2008). These suggested interventions fits with the importance of role identity and role expectations from the current research, which showed that employees need such clarification to optimize
wellbeing and role effectiveness. Employers should ensure that employees are made aware of the emotional requirements of the job, and their level of responsibility in order to be better prepared for this aspect of their role.

Further to the importance of informing employees about their emotional expectations, the current research findings suggest an additional element to information and training. Given the large differences in the emotional requirements of different nursing contexts, there should be more emphasis on nuanced emotional work requirements. In this way, nurses that are more suited to, or more attracted to, particular types of interactions may be better informed to be able to choose a particular specialty area to suit their preference for interactions.

7.2.3 Social support. The importance of social support as an aid to emotional interactions was an extremely important finding from the current research. Furthermore, the specific ways in which support was provided and accessed according to the situation suggest specific ways that organisations can help employee and organisational outcomes. Co-worker support was the most important source of support in Study 1 but all organisational sources of support were of similar importance in Study 2. This suggests that even though employees may consider their co-workers to be most important source of support, the actions of supervisors and the organisation also have a substantial impact on outcomes.

One way in which organisations can act is to assist co-workers to support one another. Evidence of how this can happen can be seen in the interviews with the community palliative care nurses. There were substantial organisational efforts to
provide an environment in which emotional support was valued, including group and individual debriefing sessions and additional help from supervisors in difficult cases. Employees and were also included in generating scripts for the nurses to use in difficult discussions with clients. Such measures and a concerted focus on the importance of support were associated with a high level of co-worker support, including planning for contact between employees in emotionally upsetting cases, and ensuring time for contact. In the case of the community palliative care nurses, the organisation set the example of the importance of support and facilitated and encouraged co-worker support.

Jenaro et al. (2007) has suggested that nurses be educated as to the importance of various forms of support and how they can assist one another when emotional resources are spent in the course of emotional labour. The importance of this message was highlighted in this research. In addition, this training and information should also extend to non-nursing groups who also deal with clients as a substantial part of their role.

The current research provides added information that should be considered when educating employees about the importance of social support. Employees should be guided as to how to provide the most beneficial form of support in particular situations. For example, providing a physical presence and being able to recognise when co-workers require help was important for emergency nurses, whereas making plans to listen to the thoughts and feelings of co-workers after an emotionally difficult interaction was important for palliative care nurses. To be able to provide such nuanced information to employees, employers must first make assessments of the type of emotional support that is required in specific situations.
In addition to highlighting the importance of certain forms and sources of support, the current research showed that clients that had some emotional relevance were more difficult for employees to come to terms with. Teaching employees to recognise such situations and to be able to respond appropriately could also be part of this general education.

7.3 Limitations

This research makes important contributions to the study of emotional labour; however some limitations must be recognised.

From Study 1, small numbers of participants meant that the results could not be generalized. Some of the differences between groups may have been organisational differences as the emergency and nurses and clerks were all employed in the same emergency department. Due to the recruitment process, participants may have been alike in their attitudes and beliefs. Finally, the data was collected from just 21 participants, limiting generalizability. Study 2 was designed to address some of these limitations by broadening the participant base in terms of numbers and organisations.

For Study 2, some factors which may have impacted on wellbeing outcomes were not measured including the type of relationship with clients and work load stressors. The management of natural emotion contained items that may have skewed responses for particular groups. The survey data was all self-report, which could have resulted in spurious covariance.

There were some limitations that were applicable to both studies. First, the research methodology was cross-sectional; therefore causal relationships from this
research are alluded to and assumed but not proven. Second, participants in this research initiated contact with the researcher entirely of their own volition, therefore while it’s assumed that the responses are representative of the groups from which these employees were accessed, this may not be the case.

Third, the choice of groups was essentially arbitrary even though there were good reasons to believe that the chosen groups differed on the variables of interest and in terms of their typical interactions. The focus of this research, involving three nursing groups, largely excluded other occupations. There is no reason why other, non-nursing health care groups, would not yield new and different information in terms of emotional labour and associations with wellbeing and other variables. Validation of the survey in another sample is required. The nuances of various health care groups remain an underexplored area in emotional labour research and requires further attention.

**7.4 Future Research**

Future directions for emotional labour research can be identified from the limitations in the current research.

The survey measure for the management of natural emotion in Study 2 requires further development. The measure could be improved by ensuring that the items are a more generic measure of managing natural emotion rather than being focused on specific reasons for this emotional labour strategy. This will make the measure more applicable to any employee who uses the management of natural emotion, and therefore more relevant across groups and situations.
Causal relationships between variables are assumed but not proven in this research. Longitudinal studies are required to analyze and establish causal relationships between emotional labour, emotional engagement, social support, and outcomes.

The group differences identified in this research highlights the need for a more nuanced approach to emotional labour research. The form of interaction has an obvious effect on how emotion is managed and on outcomes, so different groups with specific patterns and forms of interactions needs attention. In addition, the current research identified some non-expressive emotional management strategies that were carried out for specific purposes in particular situations. It’s likely that such strategies or their purpose may differ for other groups so this also requires further investigation.

7.5 Concluding Comments

This research was groundbreaking in the identification of the management of naturally felt emotion as a distinct and important emotional labour strategy. Emotional labour has been identified as an important aspect of working life for many employees and the current research has confirmed this.

This research also showed that associations between emotional labour components and wellbeing outcomes were very similar despite big differences in the emotional and interactional requirements with clients between groups. Differences in outcomes between employees in different occupations and contexts had more to do with the interaction type and the emotional labour strategy used rather than different responses to the same strategies. This has important implications for employees and
organisations in that if the emotional labour strategy can be predicted, the likely wellbeing associations will also be identifiable.

This research also suggested that being engaged with the emotional aspect of the role and indentifying with the role requirements is important for employees. If the emotional interaction requirements of particular situations are clearly identified, prospective employees will be more able to make decisions as to their suitability and be able to prepare for the role more readily.

The importance of organisation sources of social support was found to be extremely important for the employees in this research. It appears if social support is when readily available and in fitting with the purpose and level of emotional expenditure, much of the previously identified wellbeing deficits may be avoided.

The results from this research have important implications for organisations, especially in helping employees to prepare for their emotional labour to be able to provide crucial support for co-workers to ensure that threats to wellbeing are reduced or even improved as a result of their emotional work.
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Appendix A

Study 1 Advertisement
How does your interaction with patients affect your wellbeing?

If you are a nurse working in the renal, palliative care, or emergency areas, or a clerk in patient registration or emergency, your help is being requested to investigate the effects of the emotional interaction with patients on your wellbeing.

I am interested in finding out;

- How you know what constitutes the correct emotional expression/management?
- Which factors help this aspect of your work?
- Which factors make this aspect of your work more difficult?
- Is emotional interaction with patients difficult or rewarding?

The aim of this research is to help individuals and organisations respond to the needs of employees and help them cope more effectively.

The initial phase of this research consists of one-on-one interviews of approximately one hour’s duration. Due to staffing pressures, these interviews must be conducted outside normal work hours, at a time and place suitable for you.

If you are interested in participating or would like more information, please contact myself; Steve Brown PhD candidate, during office hours on 9360 6474 or mobile 0411 478 570. Alternatively, you can contact my principal supervisor Associate Professor Max Sully during office hours 9360 2253.

If you wish to talk to an independent person about this research you can contact Murdoch University's Human Research Ethics Committee on 9360 6677 or email ethics@murdoch.edu.au

This study has been approved by the Murdoch University Human Research Ethics Committee (Approval No. 2007/257)
Appendix B:

Study 1 Information Sheet
Project Title: The effects of emotional labour on wellbeing: Contrasts between health settings.

Investigator (s)       Associate Professor Max Sully
                       Dr Paul Bain
                       Associate Professor Pia Broderick
                       Steve Brown, PhD candidate

Contact Person        Steve Brown
Address               c/o School of Psychology, Murdoch University, South St. Murdoch 6150
Telephone No.         (08) 9360 6474
                       Mobile: 0411 478 570

You are invited to participate in this study.

Background
Research has shown that the emotional interaction between employees and their clients can lead to detrimental personal and organizational outcomes. A few studies have been conducted on the emotional management requirements in health care settings and these also indicate that frequent and negative interactions are particularly problematic. We are interested to learn which factors help or hinder the wellbeing of employees and how this differs in health settings that involve varying types of contact with patients. The areas of interest in this research include renal, palliative, and emergency nurses as well as patient liaison, registration and emergency clerks. If you are employed in any of these areas we are inviting you to participate in semi-structured interviews to be conducted over the next few weeks.

Aim of the Study
The aim of this study is to examine, in depth, the different health care settings and to identify which variables vary in importance in terms of moderating positive and negative outcomes depending on contextual differences.

What Does Your Participation Involve?
We would like to know about you experiences and perceptions of the emotional requirements of your work and what factors help or hinder you ability to deal effectively with your own emotions and the emotions of patients as part of your role requirements. We will ask you a series of questions specifically targeting your perceptions of what type of expression is required as well as the manner of interaction. Other questions will focus on perceptions of factors that make the emotional interaction more difficult or easier.

It is important that you understand that your involvement is this study is voluntary. While we would be pleased to have you participate, we respect your right to decline. There will be no consequences to you if you decide not to participate. If you decide to discontinue participation at any time during the interview, you may do so without
providing an explanation. All information will be treated in a confidential manner, and
your name will not be used in any publication arising out of the research. All of the
research will be kept in a locked cabinet in the office of Associate Professor Max Sully.

**Possible Benefits**
Considering previous findings that emotional interaction between employees and clients
often leads to employee burnout, this research is designed to better understand how the
relationships between emotional management and various other factors tend to combine
to produce an outcome. These findings will then be used to inform organizations and
individuals as to measure that can be taken to reduce negative effects and promote
individual and organizational wellbeing.

**Possible Risks**
There are no specific risks anticipated with participation in this study. However, if you
find that you are becoming distressed, the interview will be terminated and you will be
advised to receive support from your organization’s EAP service.

**Questions**
If you would like to discuss any aspect of this study please feel free to contact either
Max Sully on ph 9360 2253 or Steve Brown on ph 9360 6474 (mobile 0411 478 570).
Either of us would be happy to discuss any aspect of the research with you. Once we
have analysed the information we will be mailing / emailing you a summary of our
findings. You are welcome to contact us at that time to discuss any issue relating to the
research study.

**Contact**
My supervisor and I are happy to discuss with you any concerns you may have on how
this study has been conducted. If you wish to talk to an independent person about your
concerns you can contact Murdoch University’s Human Research Ethics Committee on
9360 6677 or email ethics@murdoch.edu.au

We would like to thank you in advance for your assistance with this research project. We
look forward to hearing from you soon.

This study has been approved by the Murdoch University Human Research Ethics Committee (Approval
No. 2007/257)
Appendix C

Study 1 Consent Form
Participant Consent Form

The effects of emotional labour on wellbeing:
Contrasts between health care settings.

- I __________________ have read the information for this study.
- Any questions I have asked have been answered to my satisfaction.
- I agree to be interviewed for this study, and for the interview to be recorded provided my name is not used in any publications arising out of the study.
- I know that I can change my mind and stop at any time.
- I understand that all information provided is treated as confidential and will not be released by the researcher unless required by law to do so.

Participant: ___________________________ Date: _____ / _____ / _____
Interviewer: ___________________________ Date: _____ / _____ / _____

This study has been approved by the Murdoch University Human Research Ethics Committee (Approval No. 2007/257)
Appendix D:
Study 1 Interview Protocol
Interview Protocol

Begin with a description of the research topic and aims.
This research is focused on the interactions between nurses/clerks and patients. I will be asking questions about how you have to manage your emotions when dealing with patients, the types of emotions that are directed at you from patients or their family members and what you may do as a result of this. I will also be covering issues relating to how this emotional interaction has positive or negative impacts on how you feel generally and the type of things that help or hinder your ability to cope with the emotional demands of your job.

Do you have any questions?

Give them the information letter and get them to sign the consent form.

Stress that they are free to end the interview at any time.

Begin by asking them about working environment and work history in the area.

1. Can you tell me about a time recently when you had to manage your emotion as part of your role as a ________ nurse/clerk? (Follow-up; Also ask about typical day if example is not relevant?)

Emotional Displays

2. (a) Tell me about the emotions you are expected to display as part of your role as a ________ nurse/clerk.
   (b) How do you know which emotional displays are acceptable in your role?
   (c) How do you make sure you show these emotions? (PROMPT IF NECESSARY; faking? deliberately elicit these emotions? or naturally what they feel?)
   (d) Are there times when you feel uncomfortable or constrained by the requirement to display these kinds of emotions?
   (e) How much do you consider this aspect of displaying the right kind of emotion to be part of your job?

Emotional Constraint

3. (a) Tell me about the emotions you are expected to inhibit or constrain as part of your role as a ________ nurse/clerk.
   (b) How do you know which emotional displays are unacceptable?
   (c) How do you make sure you don’t show these emotions? (PROMPT IF NECESSARY; hide these emotions? deliberately constrain these emotions? or naturally what they feel?)
   (d) Are there times when you feel constrained or uncomfortable not being able to display these kinds of emotions?
   (e) How much do you consider this emotional constraint to be part of your job?

4. What sort of emotional responses do you, or other nurses in your area, get from patients or their families?
   (a) Is there a recent example you can use to help illustrate this?
   (b) How does that make you feel?
   (c) How do you respond to this?

5. What are some of the emotional aspects of your work that makes your job more enjoyable?

6. What are some of the things that make the emotional aspect of your job more difficult?
   (a) Are there times when you get emotionally upset or overly involved in the emotion of the situation?
   (b) What types of things help you cope with the emotional demands of your work?
   (c) What types of things reduce your ability to cope?

7. What personal characteristics do you think would make someone more likely to be successful in respect to the emotional management aspect of your role?

Thank them, ask for any other information and advise that they and will be notified of findings if they wish.
Appendix E:

Study 1 Transcribed Interviews (on disk)
Appendix F

Study 2 Advertisement
The emotional cost of work.

How do your interactions with patients and their family members affect you?

If you are an emergency, palliative care or renal nurse, or a patient registration or emergency clerk, your assistance is sought in this research which aims to improve the working lives of employees in health care.

By filling in this survey, you can help in the understanding of what makes interactions with patients difficult, and what helps you cope. We will also be asking about the level of support you receive from the organisation, co-workers, and supervisors and how you feel about your job generally.

Thankyou for your participation.
Appendix G

Study 2 Questionnaire
The Emotional Cost of Work.

To the Participant,

I am a PhD candidate, conducting research into various aspects of the effects of how emotions are managed when dealing with clients in the workplace.

This research is intended to inform organisations as to how to improve workplaces and your views are considered important.

I am interested in how you express and manage emotion when interacting with clients, how you deal with the emotions of clients, and the effects these aspects of your role has on your wellbeing including how well supported you feel from co-workers and your organisation.

If you are renal nurse, emergency nurse, palliative care nurse, or an emergency or patient registration clerk, you can assist in this research by completing the attached survey, which consists of questions relating to how you manage emotion during your interactions with clients.

Confidentiality
The aim of this research is not to examine individual responses. Only the average responses by participants in different organizations or how demographic information such as age or years of service impacts on people’s responses will be studied. The information obtained from this survey will be considered confidential and no names or other information that might identify you will be used in any manner. The organizations that are participating in this research will receive aggregated data in relation to the overall survey results; however, apart from the researchers, no other person will have access to any completed survey questionnaires. Participation in this research is entirely voluntary.

The questionnaire should only take around 10 minutes to complete. You are welcome to view the results of the survey upon completion at http://www.psychology.murdoch.edu.au/

If you have any questions about this research you can contact my principal supervisor, Professor Max Sully on 9360 2253 or alternatively you can contact Murdoch University’s Human Research Ethics Committee on 9360 6677. If you experience any distress as a result of involvement in this research, Associate Professor Pia Broderick, a practising clinical psychologist, on 9360 2860 is available to answer any queries or concerns.

Thankyou for your participation.

Stephen Brown, PhD candidate          Professor Max Sully, Principal Supervisor
Instructions
Please answer every question or item on the questionnaire with the response that most accurately reflects your situation.

The first section of the questionnaire is concerned with demographic information; please indicate the response that applies to you for each question.

The second section of the questionnaire contains survey items that are designed to assess how you manage your own emotions and the emotions of clients. There are also items pertaining to workplace support and other points of interest. Each item consists of a statement or a question. Your task is to simply circle the response that indicates your level of agreement or level of accuracy with the particular statement. If you do not know the answer to an item please circle the number that you believe represents the best response.

Where questions contain the word “clients” this means patients, family members of patients or anyone else associated with the patient that you may have to interact with as part of your role.

Returning the questionnaire
Once you have completed every response, please place the questionnaire in the self-addressed, reply paid envelope.

Part 1 - Demographic Information

1. Age: _________ years

2. Your gender:  □ Male    □ Female

3. Current employer:  ____________________________

4. Years of service for current employer: ______ years ______ months

5. Please indicate your area of work.  Emergency nurse □    Renal nurse □    Clerk □
   Palliative care nurse □

6. Years in your current role.________________________

7. Employment status:
   □ Full time    □ Part time    □ Casual
   □ Other (please specify)________________________

The next question asks about the length of interaction you have with clients.

8. A typical interaction I have with a client takes about _______hours _______minutes.

9. Is the interaction ongoing? If so, please indicate over what time frame.
   _______ days per week, over _________ weeks or _______ years.
# Part 2 - Survey Items

The following items ask about your interaction with clients. Please respond by indicating how often each one applies to you. For the second item “adopt” means to actually feel the emotion you believe is required in your role. For the eighth item, this is asking how many emotions are required of you during an average day.

**On the average day at work**

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>...how frequently do you display specific emotions required by your job.</td>
<td></td>
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<tr>
<td>...how frequently do you adopt certain emotions required as part of your job?</td>
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<tr>
<td>...how frequently do you express particular emotions needed for you job?</td>
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<tr>
<td>...how frequently do you express intense emotions?</td>
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<tr>
<td>...how frequently do you show some strong emotions?</td>
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<tr>
<td>...how frequently do you display many different kinds of emotions?</td>
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<tr>
<td>...how frequently do you express many different emotions?</td>
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<tr>
<td>...how frequently do you display many different emotions when interacting with others?</td>
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<tr>
<td>...I resist expressing my true feelings.</td>
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<tr>
<td>...I pretend to have emotions I don’t really have.</td>
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<tr>
<td>...I hide my true feelings about a situation.</td>
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</tr>
<tr>
<td>...I make an effort to actually feel the emotions that I need to show to others.</td>
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</tr>
<tr>
<td>...I try to actually feel the emotions that I must show.</td>
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<tr>
<td>...I really try to feel the emotions I have to show as part of my job.</td>
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<tr>
<td>...I show some emotion that I actually feel to provide support for clients.</td>
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</tr>
<tr>
<td>...I manage my naturally felt emotion to show clients that I’m unhappy with their behaviour.</td>
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</tr>
<tr>
<td>...I manage my naturally felt emotion to show clients that their behaviour is unacceptable.</td>
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</tr>
<tr>
<td>...I use my naturally felt emotion to help the interaction with clients.</td>
<td></td>
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<tr>
<td>...I manage emotions that I actually feel to control the interaction with clients.</td>
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</tr>
</tbody>
</table>
These items ask about your interaction with clients. Please indicate your level of agreement with each item.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neither agree or disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being emotionally engaged with clients is crucial to my role.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am not qualified to deal with the emotional upsets of clients.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Helping clients with their emotional issues is not part of my role.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I refer emotionally upset clients to other health care professionals.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am responsible for helping clients to come to terms with emotional problems.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I don’t get too involved in the lives of clients.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Part of my role is to try and control the emotions of clients.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

These items ask about how well you are supported in relation to work related problems. Please indicate your level of agreement with each item.

**These items refer to co-workers.**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neither agree or disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>My co-workers are helpful to me in getting my job done.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My co-workers provide the most important level of emotional support in my job.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My co-workers can be relied upon when things get tough on the job.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My co-workers do not support me if I am involved in an emotionally upsetting situation with a client.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I can talk to my co-workers about emotionally difficult incidences with clients.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My co-workers are the people who really best understand what the interaction with clients is like.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My co-workers are willing to listen to my job related problems.</td>
<td>1</td>
<td>2</td>
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<td>5</td>
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</tbody>
</table>

**These items refer to supervisors.**

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<th>Disagree</th>
<th>Neither agree or disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
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</thead>
<tbody>
<tr>
<td>My supervisor (s) can be relied upon when things get tough on the job.</td>
<td>1</td>
<td>2</td>
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<td>5</td>
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<tr>
<td>My supervisor (s) provides the most important level of emotional support in my job.</td>
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<td>5</td>
</tr>
<tr>
<td>My supervisor(s) really does not care about my wellbeing.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Statement</td>
<td>Strongly disagree</td>
<td>Disagree</td>
<td>Neither agree or disagree</td>
<td>Agree</td>
<td>Strongly agree</td>
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</tr>
<tr>
<td>My supervisor (s) supports me if I am involved in an emotionally</td>
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<td>5</td>
</tr>
<tr>
<td>upsetting incident with a client.</td>
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<tr>
<td>I can’t talk to my supervisor (s) about emotionally difficult</td>
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<td>2</td>
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<td>5</td>
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<tr>
<td>incidences with clients.</td>
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</tr>
<tr>
<td>My supervisor (s) is the person who best understands what the</td>
<td>1</td>
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<td>5</td>
</tr>
<tr>
<td>interaction with clients is like.</td>
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<tr>
<td>My supervisor (s) is willing to listen to my job related problems.</td>
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<td>5</td>
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</tbody>
</table>

**These items refer to the organisation you work for.**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neither agree or disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The management of my organisation best understands what the interaction</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>with clients is like.</td>
<td></td>
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</tr>
<tr>
<td>Management provides the most important level of emotional support in my</td>
<td>1</td>
<td>2</td>
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<tr>
<td>job.</td>
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<tr>
<td>My organisation does not value my contribution to its wellbeing.</td>
<td>1</td>
<td>2</td>
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<td>5</td>
</tr>
<tr>
<td>My organisation supports me if I am involved in an emotionally</td>
<td>1</td>
<td>2</td>
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<td>4</td>
<td>5</td>
</tr>
<tr>
<td>upsetting situation with a client.</td>
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</tr>
<tr>
<td>I can talk to managers about emotionally difficult incidences with</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
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<tr>
<td>clients.</td>
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</tr>
<tr>
<td>My organisation really cares about my wellbeing.</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My organisation is willing to help me when I need a special favour.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I feel that my organisation has prepared me to handle emotionally</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>upsetting situations with clients.</td>
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</tbody>
</table>

**These items refer to your friends and family.**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neither agree or disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>When something goes wrong at work, I can talk it over with my friends or</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>family.</td>
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</tr>
<tr>
<td>My friends/family doesn’t understand what the interaction with clients</td>
<td>1</td>
<td>2</td>
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<td>4</td>
<td>5</td>
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<tr>
<td>is like.</td>
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</tr>
<tr>
<td>My friends/family help me feel better when I’ve had a hard day at work.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My friends/family are interested and proud when something good happens</td>
<td>1</td>
<td>2</td>
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<td>5</td>
</tr>
<tr>
<td>at work.</td>
<td></td>
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</tr>
<tr>
<td>My friends/family support me if I am involved in an emotionally</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>upsetting incident with a client.</td>
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</tr>
<tr>
<td>My friends/ family provide the most important level of emotional</td>
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<td>2</td>
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<td>4</td>
<td>5</td>
</tr>
<tr>
<td>support in my job.</td>
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</tr>
<tr>
<td>My friends/family care about how I feel about my job.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I can talk to my friends/family about emotionally difficult incidences</td>
<td>1</td>
<td>2</td>
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<td>5</td>
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<tr>
<td>with clients.</td>
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</tbody>
</table>
The remaining items assess how you feel about various aspects of your job. Please indicate your level of agreement with each item.

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Somewhat disagree</th>
<th>Neither agree or disagree</th>
<th>Somewhat agree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel emotionally drained from my work.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>I feel used up at the end of the day.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>I feel fatigued when I get up in the morning and have to face another day on the job.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>I can easily understand how my clients feel about things.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>I feel I treat some clients as if they were impersonal objects.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Working with people all day is really a strain for me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>I deal very effectively with the problems of my clients.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>I feel burned out from my work.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>I feel I’m positively influencing other people’s lives through my work.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>I’ve become more callous toward people since I took this job.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>I worry that this job is hardening me emotionally.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>I feel very energetic.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>I feel frustrated by my job.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>I feel I’m working too hard on my job.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>I don’t care what happens to some clients.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Working with people directly puts too much stress on me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>I can easily create a relaxed atmosphere with my clients.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>I feel exhilarated after working closely with my clients.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>I have accomplished many worthwhile things in this job.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>I feel like I’m at the end of my rope.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>In my work, I deal with emotional problems very calmly.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>I feel clients blame me for their problems.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Statement</td>
<td>Strongly disagree</td>
<td>Disagree</td>
<td>Neither agree or disagree</td>
<td>Agree</td>
<td>Strongly agree</td>
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<tr>
<td>It is likely that I will actively look for a new job this year.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I often think about quitting.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I will probably look for a new job in the next year.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generally speaking, I am very satisfied with this job.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am generally satisfied with the kind of work I do in this job.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most people on this job are very satisfied with this job.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>People on this job often think of quitting.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I frequently think of quitting this job.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Thank you for your time and participation!