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*How emotions are shaped within services organizations:  
Empirical studies among portuguese nurses and physicians.*

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How emotions are shaped within services organizations: Empirical studies among portuguese nurses and physicians.

#### ABSTRACT

The management of emotions is an important component of the work of frontline employees, since more and more interactions between customers and employees are valued and affect their perceptions of service quality. In healthcare, the management of emotions takes greater proportions compared to other service organizations because of the proximity and frequency of relationships between customers and employees and the intensity of emotions.

Aiming to contribute to the study of the management of emotions in healthcare, namely the positivity, perspectives and antecedents we developed three studies. The first qualitative study intends to study in a deeper way what physicians, nurses and patients think about the expression and suppression of emotions, that is, the management of emotions. Two different patterns have been found which represent what these individuals perceive as a quality service. Some participants are in favor of expressing emotions and maintaining close and lasting relationships - what we call "relational engagement". While others are in favor of hiding or suppressing emotions and keeping a distance - what we call "performative engagement".

The second conceptual study proposes that there may be other alternative than engage in emotional labor. Employees are expected to suppress or fake their emotions, because there is a presumption that employees inner feelings are not congruent with the emotions that the organization wants them to display. However, employees may also want to act authentically. With employee emotional empowerment employees have the power and ability to manage their emotions in a way they feel

more appropriate to the situation and the customer, minimizing feelings of burnout, stress and job turnover.

The third quantitative study aims to analyze the impact that the work environment may have on the emotional labor performance. It is certain that during their working day healthcare professionals have to deal with intense emotional situations. This forces them to manage their emotions in a strategic way. Some factors are decisive for the management of emotions, such as the work environment. We found that when nurses perceive their work environment as positive they do not tend to adopt a deep acting strategy.

With these studies we intend to clearer the management of emotions in a service context as special as healthcare.

*Keywords:* employee emotional empowerment, emotional labor, empowerment, authenticity, positive emotions, healthcare services, work environment, personality traits, job demands-resources model.

## **PART I: INTRODUCTION**

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## CHAPTER I – CONCEPTUAL FRAMEWORK

The scope of our research project comprises three main areas of study: services marketing, emotional labor and healthcare. “Services marketing” refers to all the activities, benefits and satisfactions which are offered for sale or are provided regarding the sale of goods (AMA). “Emotional labor” refers to the psychological process necessary to adjust organizationally desirable emotions as part of employees work (Zapf, 2002). Healthcare services are the most unpredictable type of services, and the management of emotions takes greater proportions compared to other types of services due to the proximity, frequency and intensity of relationships between healthcare professionals and patients. These three topics are interrelated in the three papers constituting this doctoral thesis and are covered in detail in the following sections. The studies that make up this work aim to understand the individual and relational processes inherent to emotional management in health services interactions between professionals and patients.



**Figure 1** Main topics of the research project

## **1. Services marketing**

### **1.1 What is services marketing?**

Nowadays, the world's economy is characterized as a service economy, due to the increasing importance that the services sector has gained in developed and developing countries (Martin, 1999). Indeed, the growth of the services sector has been an indicator of a country's economic development. All developed countries have gone through a shift from agriculture to industry and then to services as the main sector of their economy. This shift brought changes to the concepts of products and services: products are no longer considered separate from services and services constitute a large part of products.

Initially, the concept of services was restricted to tools to facilitate the sale of tangible products, such as transportation, warehousing, and other logistical services (Martin, 1999). After World War II, the notion of service gained added prominence as manufacturers became increasingly proficient in making "things" and competition between them intensified. The concept of services evolved into significant points of differentiation between companies trying to gain competitive advantage in the marketplace (Martin, 1999). At that point, services were no longer restricted to tools that facilitated the sale of products, but included: (1) an augmentation of manufactured goods; (2) the assistance provided to customers to ease their decision-making processes; and (3) how interactions with customers are handled (Martin, 1999). Nowadays, the service sector has grown exponentially and achieved an important position in the economy of several countries. This sector consists of a wide range of industries, employs an enormous amount of employees, and accounts for a large part of the annual expenditure of consumers and businesses.

Defining services is a complex and difficult task, because this construct comprises a set of personal and organizational activities. A consensual definition of the concept of services does not yet exist; but within the academic literature, multiple designations have been proposed. Table 1 shows some representative definitions that have been proposed over time.

## *Definitions of Services*

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- “All economic activities whose output is not a physical product or construction, is generally consumed at the time it is produced, and provides added value in forms (such as convenience, amusement, timeliness, comfort, or health) that are essentially intangible concerns of its first purchaser” (Quinn et al., 1987).
  - “Activities, benefits, or satisfactions that are offered for sale or provided with sale of goods to the customer, that is, pre-sale and after-sales services” (American Marketing Association)
  - “A process consisting of a series of more or less intangible activities that normally, but not necessarily always, take place in interactions between the customer and service employee and/or physical resources or goods and/or systems of the service provider, which are provided as solutions to customer problems” (Grönroos, 2007).
  - “Economic activity between two parties, implying an exchange of value between seller and buyer in the marketplace” (Lovelock & Wirtz, 2007).
  - “Deed, process, and performance provided or coproduced by one entity or person for another entity or person” (Zeithaml et al., 2009).
  - “Is any act or performance one party can offer to another that is essentially intangible and does not result in the ownership of anything” (Kotler et al., 2009).
- 

**Table 1** Definitions of Services

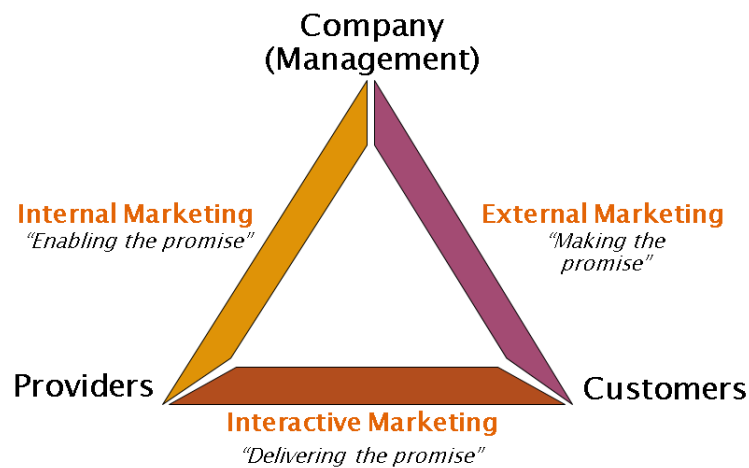
As we can see, most definitions present some distinctive characteristics that services marketing practitioners outlined. Kotler and Keller (2009) identified those distinctive characteristics to explain a service as follows:

- **Intangibility:** services are intangible and do not have a physical existence. This is the component that most differentiates services from products, since services cannot be used, sensed, or observed in the same way as a physical good. As such, it poses a unique challenge to those engaged in marketing a service as they need to attach tangible attributes to an otherwise intangible offering.

- Heterogeneity/Variability: each service offering is unique and cannot be exactly repeated even by the same service provider. This refers to the possibility of varying the quality, or other measures of performance, from supplier to supplier, or even from the same supplier at different times.
- Perishability: services cannot be stored, saved, returned or resold once they have been used. Once rendered to a customer, the service is completely consumed and cannot be delivered to another customer.
- Inseparability/Simultaneity of production and consumption: this refers to the fact that it is not possible to separate the provision of the service from its consumption. Services cannot be separated from the service provider and both service provider and the customer have impact on their outcome.

The marketing of services not only requires the traditional external marketing, but also the internal and interactive marketing (Kotler & Armstrong, 2007). As can be seen in Figure 2, the linkage between the company and employees is designated “internal marketing”. Internal marketing means that the company must effectively train and motivate its employees, as well as other supporting service people, to work as a team and to achieve customer satisfaction (Zeithaml & Bitner, 2000). Next, the linkage between employees and customers is designated “interactive marketing”. Interactive marketing recognizes that customers and employees are co-creators of the service (Gummesson, 2007) and essentially refers to the quality of the service provided in the process of buyer-seller interaction (Syed et al., 2011). Finally, the linkage between the company and customers is labeled “external marketing”. External marketing involves the communication of the firm’s offerings to potential customers (Grönroos, 1996).





**Figure 2** Services marketing triangle (Wilson et al., 2012)

Undoubtedly, marketing plays an important, large and complex role in services organizations. It is responsible for external (create promises), internal (viable promises), and interactive functions (keep promises). It plays a key role in customer satisfaction, relationship with the market, quality and service productivity, and organization's profitability.

Marketing has become a particularly challenging and yet extremely important task. Given the intangibility of services, a large part of the customers' buying decision depends on the degree to which (s)he trusts the services provider. Hence, it is important to listen to the needs of the customer and fulfill them through the appropriate service offering, and to build a long lasting relationship which can lead to repeat sales and positive word of mouth. Due to the increasing homogeneity in product offerings, the frontline employees are emerging as key differentiators in the mind of the consumers. Hence, marketers can leverage on the service offering to differentiate themselves from the competition and attract consumers.

Given today's highly competitive context, where multiple providers are fighting for a limited number of customers, retaining customers is even more important than attracting new ones. Since

services are usually generated and consumed at the same time, they actually involve the customer in the service delivery process by taking into consideration his requirements and feedback.

## **1.2 Delivering and performing services**

### **1.2.1 Employee's role**

The frontline service employees are often referred to as “boundary spanners” because they operate at peripheral level or at the organization’s boundary. They provide a link between the external customer and the environment on the one hand and the internal operations of the organization on the other hand. They serve as a critical function in understanding, filtering and interpreting information and resources to and from the organization and its external constituencies (Wilson, et al, 2012). These positions require extraordinary levels of emotional labor, as employees go through highly stressful situations, and frequently demand an ability to handle interpersonal and interorganizational conflict.

Frontline employees and those supporting them from behind the scenes are critical to the success of any services organization (Zeithaml & Bitner, 2000; Wilson et al., 2012). They are viewed as the organization’s most important asset, can achieve and sustain competitive advantage and have an impact on the image and reputation of the company (Hoque, 2000). When frontline employees provide good quality service, the customer's desires can be met. As a result, the company should recognize the importance of its employees in representing and reinforcing the brand image of the company and delivering the service correctly from the customer point of view (Wilson et al., 2012). Also, the organization should empower employees, because it has numerous advantages: it allows quicker responses from them, they feel more responsible, they are more likely to interact with warmth/enthusiasm, they become a great source of ideas, all of which helps to generate positive word-of-mouth from customers. Empowering employees can also have some drawbacks, such as greater investments in selection and training, higher labor costs, slower and/or inconsistent delivery. In addition, it may violate customer perceptions of fair play, and there is a risk of making bad

decisions. From a customer's perspective, the interaction with the frontline employee is probably the most important aspect of a service. From the firm's perspective, the service levels, and the way service is delivered by frontline employees can be an important source of differentiation as well as competitive advantage.

Wirtz, Chew and Lovelock (2012) assert that frontline employees are a very important part of a service, because they:

- Are a core part of the product: service employees are the most visible element of the service. They deliver the service and affect service quality.
- Are the service firm: frontline employees represent the service firm.
- Are the brand: frontline employees and the service they provide are often a core part of the brand. It is the employees who determine whether the brand promise is delivered.
- Affect sales: service personnel are extremely important for generating sales, cross-sales, and up-sales.
- Determine productivity: frontline employees have a major influence on the productivity of frontline operations.

Lovelock (1981) added four key roles which service employees must fulfill, which contribute to how service is delivered and experienced. First, they have to fulfill the role of innovator because human creativity is key for the ideational innovation necessary to drive business success and growth. Frontline employees significantly help drive innovation volume and radicalness (Ordanini & Parasuraman, 2011). Second, they must take on the role of differentiator, by providing the non-substitutable human touch, which avoids commoditization and makes all the difference in the context of large ecosystems and technology dominance. Third, they must accomplish the role of enabler, by providing customers the resources, role clarity, motivation and rewards they need to successfully do their "jobs" in coproduction (Bowen, 1986; Bettencourt et al., 2014). Finally, they must conform the

role of coordinator, by integrating resources and actors across the service system to create a seamless, successful customer experience.

In sum, we may conclude that it is essential for the management of service industry to understand the needs and wants of the customer and to enable frontline employees to meet those needs and wants (Wilson et al., 2012). The lack of suitable human resource strategies to develop employee's quality and quantity is the common reason for the lower service quality delivery. If the supervisor does not focus on service management issues and if (s)he is not capable of encouraging employees to be service-minded and customer-conscious, the organization ultimately will lower the overall service level (Grönroos, 2001).

### **1.2.2 Customer-oriented service delivery**

With the development of service-oriented concepts and models, marketing had the need to adopt managerial practices that facilitate the customer-orientation of the employees (Shostack, 1977). In particular, the nature of services created the need to empower frontline employees when dealing with customers (Grönroos, 1990). It was from this need that customer-oriented service delivery or customer-oriented service behaviors (COB) emerged.

A customer-oriented service is based on organizational capabilities, human interactions and on the needs and wants of customers (Becker & Wellins, 1990; Cross et al, 2007). A customer orientation allows the company to create superior value for its customers through better understanding of customer needs. It has shown a positive impact on performance both at the company and salesperson levels, and it is crucial for service quality improvement (Narver & Slater 1990). This means that customer orientation allows firms to acquire and assimilate the information necessary to design and execute marketing strategies that result in more favorable customer outcomes. Deshpande et al. (1993) defined corporate customer orientation as a the set of beliefs that

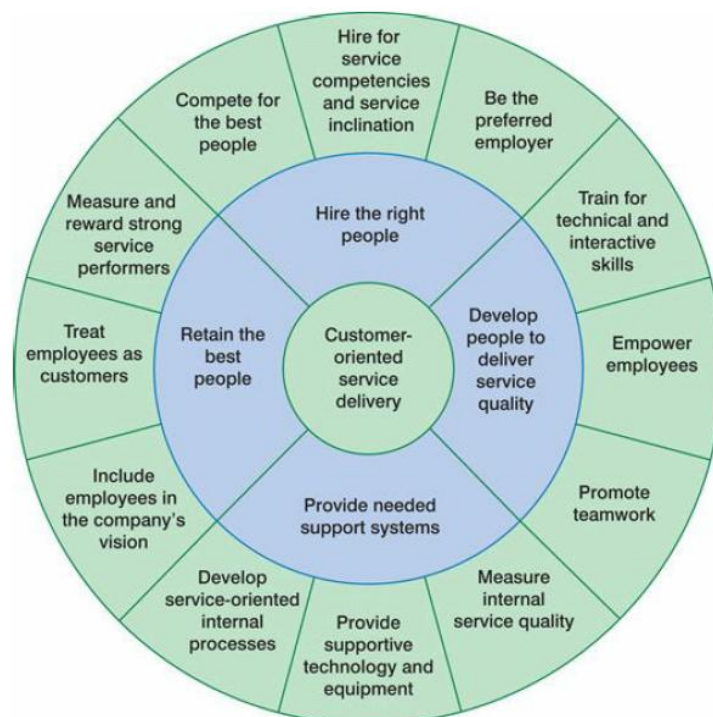
puts the customer's interest first, while not excluding those of other stakeholders such as owners, managers and employees, in order to develop a long-term profitable enterprise.

A complex combination of strategies is needed to ensure that service employees are willing and able to deliver quality services and that they stay motivated to perform in customer-oriented, service-minded ways. These strategies for enabling service promises are often referred to as "internal marketing" (Zeithaml & Bitner, 2000). To build a customer-oriented, service-minded workforce, an organization must (Figure 3):

- Hire the right people: to deliver service quality effectively, considerable attention should be focused on recruiting and hiring service employees. There is a number of ways to hire the right people: compete for the best people, identify the people and compete with other organizations to hire them; hire for service competencies and service inclination, service competencies are the skills and knowledge necessary to do a job and service inclination means their interest on doing service related to that job; and be the preferred employer, provide career and growth opportunities, excellent internal support, attractive incentives, etc.
- Develop people to deliver service quality: once people are hired, the organisation must train and work with these individuals to ensure service performance. They have to provide training for technical and interactive skills, ongoing training in necessary technical skills that allow employees to provide courteous, caring, responsive, and empathetic service. In addition, they should empower employees, by giving them the desire, skills, tools, and authority to serve customers, and enabling them to make decisions, to accommodate customer requests and to recover on the spot when things go wrong.
- Provide needed support systems: to be efficient and effective in their jobs, service workers require internal support systems that are aligned with their needs to be customer focused. The following are strategies for ensuring customer-oriented internal support: measure internal service quality, internal customer service audits can be used to implement a culture of internal

service quality; provide supportive technology and equipment; and develop service-oriented internal processes, internal processes should be designed with customer value and customer satisfaction in mind.

- Retain the best people: an organisation that hires the right people, trains and develops them to deliver service quality, and provides the needed support, must also work to retain them. Employee turnover, especially when the best service employees are leaving, can be very detrimental to customer satisfaction, employee morale and overall service quality. Organizations may retain the best employees by including employees in the company's vision; treating employees as customers, make them feel valued and take care of their needs, the products that the organization has to offer its employees are a job and quality of work life; and measuring and rewarding strong service performers.



**Figure 3** Human resource strategies for delivering service quality through people (Wilson et al., 2012)

### **1.2.3 Services failures**

Although many service organizations focus on achieving customers' satisfaction by providing high quality service, failures can occur, because service failures are inevitable (Hart et al., 1990; Schneider & Bowen, 1999). Webster and Sundaram (1998) stated that even the companies with the best strategic plans and the tightest quality control procedures cannot avoid mistakes in all interactions with customers. Services' characteristics such as real-time performance, customer engagement, simultaneous production and consumption and difficulty of evaluation, greatly increase the chance of perceived failures in service (Lovelock & Wright, 2007b). These characteristics and the fact that services have more variability in their performance, make errors inevitable.

Service failures can be defined as a problem of the service quality or as activities which do not correspond to customers' expectations, such as unavailability, delays or failure in trying to meet customers' expectations (Grönroos, 1988; Zeithaml et al., 1993; Bitner et al., 1990; Webster & Sundaram, 1998; Zeithaml & Bitner, 2000). Hocutt et al. (1997) also defined failure in services as the difference between the lived experience and customer expectation and, as Grönroos's study (1990) concluded, this is presented as being more likely to occur in the services sector where there is a strong human interaction.

Service failures have a negative effect on loyalty behaviour and have been found to be a driving factor in customer switching behaviour (Hays & Hill, 1999; McCollough et al., 2000; Roos, 1999; Zeithaml et al., 1996). When a service failure occurs, customers tend to react with negative word-of-mouth communications, changed behavioural intentions toward the firm, and lost trust in and commitment to the firm. Ultimately, the customer may also end the relationship with the service firm (Smith et al., 1999).

After a service failure is identified, the need to recover the service and customers from a state of dissatisfaction emerges. Lovelock and Wright (2007) defined service recovery as a series of efforts made by a company after a service failure, in order to solve the problem and maintain

customer satisfaction. Tangible recovery efforts, such as discounts, credits, equivalent service offerings have been shown to have a positive effect on customers when recovering from a failure. Other studies (Maxham & Netemeyer, 2002; Ruyter & Wetzels, 2000; Tax et al, 1998) reported that customers also give relevance to how resources are allocated and how the process of service recovery is developed.

It is also possible that after a service recovery, customers become more satisfied with the organization than if they wouldn't have experienced a failure. This is called the "service recovery paradox". It is more likely to occur when the customer does not consider the failure as severe, if (s)he has not experienced prior failures with the firm, if (s)he views the cause of the failure as unstable and if (s)he perceives that the company had little control over the cause of the failure (Wilson et al., 2012).

When faced with a service failure, customers want to be rewarded for the inconvenience and for having to go through the entire customer recovery process, demanding justice and equal treatment (Zemke, 1995; Tax & Brown, 2000). Customers' perception of fairness is based on three components: results, processes, and interactional treatment (Tax et al., 1998). Related to these three components, Sabharwal et al.(2010) distinguish three types of justice that customers perceive during a service recovery situation:

- Distributive justice: this type of justice refers to the concrete and tangible result of the service recovery, i.e., it refers to what the company offers to minimize customer dissatisfaction. Tax et al. (1998) added that customers' prior experience with the firm and their perception of the magnitude of their own loss can affect the fairness of compensation.
- Procedural justice: procedural justice refers to perceived fairness of the policies and procedures used by decision makers in arriving at the outcome of a dispute (Blodgett et al., 1997). Hocutt et al. (2006), for example, found that if a customer perceives a high level of



employee responsiveness in a service recovery, the level of customer satisfaction will be higher.

- **Interactional justice:** refers to customers' perceptions of how they are treated during the service recovery process, through the personal interaction with employees (Maxham & Netemeyer, 2002). In this kind of justice, all the aspects of the interaction between the customer and the frontline employee matter, such as the courtesy with which they are treated, the explanation of the process, and the attention they are given. The way frontline employees operate a service recovery and the way they communicate with the consumer can make this a moment of satisfaction or dissatisfaction (Bitner et al., 1990).

An effective customers' recovery needs to be well planned and managed and does not happen by chance. What is done and how the customer recovery is made, influences customer's perceptions of the effectiveness of customer recovery (Levesque & McDougall, 2000). Training contact personnel to handle service failures is the key to any successful recovery strategy as well as recognizing the importance of a quick response to customers' reactions. The service recovery has an important impact on customers' evaluation, because they are more emotionally involved in the observation of the efforts that the company develops during service recovery, than in providing the same service when performed for the first time. In other words, customers are more dissatisfied when the company fails to resolve the problem than with the failure itself (Berry & Parasuraman, 1991; Bitner et al., 1990).

Frontline employees are the first company members to interact directly with customers. They are also the first to become aware of service failures, and how they will serve customers depends on how they were trained and motivated (Hvitman & Rylner, 2005). Continuous communication between customers and frontline employees should exist not only when there is a service failure but even before, which may provide communication benefits in customer recovery. The existence of

communication between the customer and the employee results in increased customer satisfaction after service failure, increased repurchase intentions and decreased negative word-of-mouth (DeWitt & Brady, 2003).

#### **1.2.4 Role of emotions in service recovery**

According to Nikbin et al. (2015), two types of emotions are inherent in the service failure and recovery context. The first type relates to the emotions that arise immediately following a service failure: the post-failure or pre-recovery emotions. In this situation, customers only experience negative feelings. They can experience a variety of negative reactions when service failure occurs, which may depend on their perceptions of why the service failure occurred (Nikbin et al., 2015). The second type of emotions are the post-recovery emotions, which emerge in response to the evaluation of service recovery strategies. These emotions can be either positive or negative. Despite the existence of these two different categories of emotions, previous studies have generally focused on post-failure emotions, more specifically negative emotions experienced by customers (DeWitt et al., 2008).

Regarding the service recovery process, if the service provider makes a good recovery, a customer's negative emotions may be reduced, while certain positive emotions may be increased. In the same way, if the service provider makes a poor recovery, negative emotions will be exacerbated and positive emotions will be diminished (DeWitt et al., 2008). Thus, understanding pre-recovery emotions is fundamental to provide the adequate recovery strategies and increase customer satisfaction. Managing emotions effectively is critical for service providers in the recovery process (Nikbin et al., 2015).

Customers often experience emotions when perceiving the justice of a service recovery strategy (Schoefer, 2008). Low perceived justice leads to highly negative emotions and low positive emotions (Schoefer & Ennew, 2005). In other words, increasing distributive justice, procedural

justice, and interactional justice can reduce negative emotions and heighten positive emotions in customers (Schoefer, 2008; del Río-Lanza et al., 2009).

## **2. Emotions**

Emotions have been the subject of interest and study in various areas of knowledge. Philosophy, for example, has long shown interest in their study (Solomon, 2004; Strongman, 1996) and in the definition of their contributions to the development of human life and knowledge construction mechanisms. Sociology has been concerned in understanding the relationship between the emotional functioning and membership of social groups (Kemper, 2004). Anthropology, in turn, has studied the connection between emotions and the cultural dimension of society. History has made efforts to describe the course of interest in emotions. And also the neurosciences have shown a growing interest in the emotions and the unique contributions of emotional systems in the characterization of human functioning (Damasio, 2003).

But what do we mean when we talk about emotions? Although the central role of emotions in human psychological functioning appears to be assumed by several authors, their definition is not always clear or consensual. Thus, it is common to find some terminological confusion between feelings and emotions, two terms that are often used interchangeably. According to Damasio (2003), emotions are the foundation for feelings. Both emotions and feelings are "part of the basic mechanisms of life regulation" (p. 28), but feelings contribute to life regulation at a higher level. Being at a more basic level, emotions are taken to be more physiological, and thus publicly observable, whereas feelings are taken to be more psychological, and therefore private. A metaphorical way to explain the contrast is "emotions play out in the theater of the body. Feelings play out in the theater of the mind." (Damasio, 2003, p. 28).

Damasio (1999) defined emotions as patterns of chemical and neural responses, the function of which is to assist the organism in maintaining life by prompting adaptive behaviors. According to

this perspective, an emotion is activated as an automatic reaction to an emotionally competent stimulus. In a higher level of organization there are feelings, which Damasio (2003, p. 86) defined as the "perception of a certain body condition along with the perception of a certain way of thinking and thoughts with certain themes". Gray's model (1987) also contributed to the study of emotions, defining them as "internal states caused by external events to the body". Gross (1998), in turn, pointed out at least three key components of emotion, including the behavioral expression, the subjective experience and peripheral physiological responses.

Emotions do not all have the same characteristics and they are divided into negative and positive emotions. According to Andries (2011, p. 33), negative emotions "are unpleasant states, short-lived, with variable intensity, with a calm or tumultuous conduct reactions and with a relatively low level of awareness". Most experimental studies show harmful effects, such as restricting the repertoire of thinking, the tendency to process negative information and maintaining the dysfunctional cognitive schemes (Barclay & Kiefer, 2014; Lazarus, 1991; Fredrickson, 2001). Positive emotions, in turn, "are pleasant states, short-lived, with variable intensity, with a calm or tumultuous conduct reactions and with a relatively high degree of awareness and a well-defined orientation" (Andries, 2011, p. 32). Positive emotions are associated with increased creativity, spontaneity and responsiveness to stimuli (Andries, 2011).

In the next section we will discuss in detail positive emotions and the emergence of the movement of Positive Psychology.

## **2.1 Positive emotions**

In the second half of the twentieth century, psychology focused substantially on the exploration of concepts such as depression, violence, racism, management of self-esteem and ways to overcome adversity, but developed little empirical exploration of other aspects such as strength, virtues and conditions that lead people to high levels of happiness (Gable & Haidt, 2005). In fact, research has

dedicated much more attention to the study of negative emotions than to the study of positive emotions (Strongman, 1996).

Recently, however, the study of positive emotions has lived a new momentum, because of work developed in the field of Positive Psychology (Seligman & Csikszentmihalyi, 2000). With the emergence of the Positive Psychology movement, established by Seligman in 1998, research began to emerge on areas such as gratitude, forgiveness, admiration, inspiration, hope, curiosity and laughter. Other scientists began to study techniques to improve well-being through motivation, writing, wellness therapy and exposure to green spaces (Gable & Haidt, 2005).

The purpose of the Positive Psychology Movement is not to deny the distressing, unpleasant or negative aspects of life (Gable & Haidt, 2005): this movement does recognize the existence of human suffering, selfishness, dysfunctional family systems and ineffective institutions. What is specific about the Positive Psychology object of study, is that it focuses on the other side of the coin, namely on the ways people feel joy and on the functioning and healthy family systems and the operation of efficient institutions (Gable & Haidt, 2005).

Researchers in Positive Psychology believe that a better understanding of the human forces can actually help prevent or reduce the damage of the disease, and stress disorder (Gable & Haidt, 2005). For example, research on coping has shown that the negative reviews of certain life events that put into perspective own individual capabilities, mediate future stress experiences or suffering (Folkman & Lazarus, 1988). In addition, Taylor and colleagues (2000) provided very compelling evidence that optimism and beliefs, as an individual perceived control, are protective factors of psychological and physical health.

The work of Fredrickson (2001) in this area is particularly prominent and significant. The author has developed a distinctive model to explain the actions of positive emotions called "broaden-and-build" (Fredrickson, 2001), which includes the study of emotions as joy, interest, pride, contentment or love. This theory posits that positive emotions can expand momentary thought-action

repertoires and to build lasting resources from physical resources to social and psychological resources (Fredrickson, 2001).

Unlike negative emotions, which tend to restrict peoples' behaviours, directing them to very specific performances, positive emotions have the quality to extend people's mind to experience the surroundings and to manifest their long-term effects. Also, positive emotions allow the development of personal skills and resources that strengthen the individual and prepare to more effectively deal with the challenges of adaptation. In addition, Fredrickson (2004) gathered preliminary data from some studies that support the broaden-and-build model, and demonstrated that individuals who experience more positive emotions tend to be more creative, more flexible, resilient and better able to generate multiple ways of dealing with a problem and even that positive emotions seem to be able to negate the effects of negative emotions (Fredrickson, 2001; Tugade & Fredrickson, 2004).

## **2.2 Emotional labor**

The concept of emotional labor was first introduced by Hochschild (1983). The author based her work on Goffman's research (1959) to argue that in almost all social interactions people tend to play certain roles and create certain impressions. For this, individuals need to express normatively appropriate emotions, that is, following certain rules of expression. This idea applies also to the social interactions in organizations. Employees have to manage their emotions, as a requirement of their job. The emotional labor, as part of the work, involves expressing emotions that are organizationally desirable, even in unpleasant situations. Thus, emotional labor is defined by Zapf (2002) as the psychological process necessary to adjust organizationally desirable emotions as part of their work.

In organizations we can find a set of requirements, expressed or implied, about what emotions employees must express and when these should be expressed. These requirements are particularly important in activities involving frequent interactions with customers, such as professions related to

services. In these occupations, employees seek to influence customer emotions, through the expression of certain emotions (Hochschild, 1983; Rafaeli & Sutton, 1987). Emotional labor is a necessary component of the work and may even bring benefits to the organization. However, researchers also suggest that emotional labor can have negative consequences for employees, such as burnout, exhaustion and job dissatisfaction (Hochschild, 1983; Brotheridge & Grandey, 2002; Morris & Feldman, 1996; Schaubroeck & Jones, 2000).

Emotional labor is considered by many researchers as a multidimensional concept and can therefore be operated through a set of dimensions (Brotheridge & Lee, 2003). One dimension concerns to the strategies of emotional regulation, described by Brotheridge and Grandey (2002) as the process or experience of managing emotions and their expression in response to work experiences. When a employee does not genuinely experience the emotion required by the organization (s)he can choose to hide or show unfeelt emotions that go against what is required by the organization. Employees can choose to manage their emotions through one of two behaviors widely accepted: surface acting or deep acting (Hochschild, 1983; Mann, 2004).

### *Surface acting*

Surface acting is characterized by masking their own emotions to display the emotions required by the organization (Grandey, 2000). When employees adopt a surface acting strategy they express the emotions required without feeling them, masking their own emotions and expressing in a distorted way the desired emotions. Surface acting translates the discrepancy between inner emotions and organizationally desired emotions by implying an emotional effort, not only to meet the emotional demands of the role but also the need for emotional regulation (Ashforth & Humphrey, 1993; Grandey, 2000).

Several studies have examined the effects of surface acting, both in physical and psychological well-being, as in customer service quality. Ashforth and Humphrey (1993) found that

emotional labor involving emotional discrepancy, by the display of unfeared emotions, can compromise employees' well-being. Surface acting has been related to individual anxiety states, with the loss of sense of authenticity and dissatisfaction at work (Ashforth & Humphrey, 1993; Brotheridge & Grandey, 2002; Brotheridge & Lee, 2003). Grandey (2003) found a positive relationship between surface acting and emotional exhaustion based on two arguments: first, the felt tension due to the effect of emotional dissonance and, second, the energy expenditure because of the effort made. Also Brotheridge and Grandey (2002) demonstrated a positive relationship between surface acting and depersonalization, as well as a negative relationship with personal fulfillment. Brotheridge and Lee (2003) found positive associations between surface acting and both dimensions of burnout and emotional exhaustion and depersonalization. Finally, the discrepancy between the felt and desired emotions, creation of emotional dissonance, masking of the displayed emotions, loss of sense of authenticity and states of individual anguish are factors identified in the literature as potentially responsible for the influence of surface acting in job dissatisfaction (Ashforth & Humphrey, 1993; Brotheridge & Lee, 2002; Grandey, 2000, 2003; Hochschild, 1983). Regarding the effects of surface acting in customer service quality, the literature has associated this strategy to less effective performances, distorted supply of services and negative perceptions of service quality (Grandey, 2000; Hülshager & Schewe, 2011; Kammeyer-Mueller et al., 2013).

### *Deep acting*

Deep acting is characterized by the display of emotions required by the organization through cognitive manipulation of emotions (Grandey, 2000, 2003). When the employee chooses a deep acting strategy, (s)he not only expresses the emotions required, but also controls his/her physical expression and tries to modify his/her emotions by changing thoughts and feelings, in order to fulfill the expectations of emotional display (Grandey, 2000, 2003).



Deep acting has been related to feelings of personal achievement, lower levels of negative emotions and greater job satisfaction (Brotheridge & Lee, 2002; Grandey, 2003; Groth et al., 2009). According to the study of Hülshager and Schewe (2011), deep acting is related to a tendency for employees to feel more satisfied with their work and more competent in the exercise of their roles. Regarding the effects of deep acting in customer service quality, the literature associated deep acting with the most effective performances, most authentic service benefits and positive perceptions of service quality (Grandey, 2000, 2003; Groth et al, 2009). Deep acting has also been related to the authenticity of the emotional expression and personal embodiment (Grandey, 2000, 2003; Hochschild, 1983). To Brotheridge and Lee (2002), this strategy involves the alignment between their own feelings and emotions displayed, allowing an authentic expression of himself which can result in feelings of personal fulfillment.

### *Naturally felt emotions*

The literature describes a third construct considered essential in emotional labor: the expression of genuine emotions. This is the case where employees display the appropriate emotions through the emotions felt and have no need for emotional regulation (Ashforth & Humphrey, 1993; Diefendorff & Gosserand, 2003; Diefendorff et al, 2005). For Ashforth and Humphrey (1993), the focus on surface and deep acting strategies ignore the possibility that employees may, in an authentic way, try and submit organizationally desired emotions. The authors stated that surface and deep acting are compensatory strategies that help employees to express emotions that they do not feel. Diefendorff et al. (2005) identified the expression of genuine emotions as a distinct construct from surface acting and deep acting, hence establishing it as another emotional strategy at work. Their study revealed that the expression of genuine emotions plays an important role in the display of emotions during interactions with customers.

The expression of genuine emotions is reflected in the authenticity of emotional display with a positive impact on customers' perceptions. Also, the expression of genuine emotions is distinguished from surface and deep acting by the absence of effort required to align the experience and the expression of emotions (Ashforth & Humphrey, 1993; Grandey, 2000; Morris & Feldman, 1996).

### **2.2.1 Emotional dissonance**

Emotional dissonance refers to the structural difference between felt emotions and to the display of emotions that are necessary and appropriate in the work context (Zapf & Holz, 2006). It can be considered the essence of emotional labor, as emotional labor is essentially about expressing emotions that are not genuinely felt.

Several authors classify the construct of emotional dissonance in different ways. Rubin and colleagues (2005) consider emotional dissonance as a consequence of emotional labor, while others believe it as a component of the work which arises during the display of organizationally desired emotions, and that can often lead to negative work performances. For Zapf et al. (1999) the concept of emotional dissonance was found as a result of external requirements, rather than a reaction to the displayed emotion or a behavioral strategy. Surface acting, which is a response to the strategy aimed to express an emotion that is not felt, is an appropriate emotion regulation strategy and probably the most used to respond to emotional dissonance. Another point of view of emotional dissonance is that the requirement to display unfeared emotions or to suppress experienced emotions, constitute the essence of emotional labor. However, a problem arises with this approach which suggests that whenever individuals choose to suppress or display fake emotions, eventually bring negative results to their work (Schaubroeck & Jones, 2000). Several studies reinforced the idea that emotional dissonance is directly linked to emotional exhaustion and is commonly experienced by employees who provide services (Van Dijk & Kirk-Brown, 2006).

### **2.2.2 Emotional labor antecedents and consequences**

Most of studies on emotional labor focuses on the antecedents that may lead employees to engage in different strategies of emotional labor. These antecedents can be grouped into a cultural, organizational and individual level. For instance, at an individual level, researchers focused on positive or negative affective predisposition (Cossette & Hess, 2012; Gosserand & Diefendorff, 2005), personality traits (Diefendorf et al., 2005; Qadir & Klan, 2016) and demographic variables such as age and gender (Cheung & Tang, 2010; Morris & Feldman, 1996). Diefendorff, Croyle and Gosserand (2005) found that extraversion and neuroticism were significant predictors of deep acting and surface acting, respectively. Also, agreeableness was a predictor of deep acting. However, open to experience was not related to any of the emotional labor variables. Demographics were also a focus of discussion. Cheung and Tang (2010), Hur, Moon and Han (2014) and Sliter, Chen and Withrow (2013) found that chronological age had a positive effect on deep acting and negative effect on surface acting. Gender, in turn, was only correlated with surface acting. Specifically, men tend to use more surface acting than women.

Regarding organizational factors, many factors were analyzed such as the perceived organizational support (Chou et al., 2012; Hur et al., 2014), perceived display rule demands (Diefendorff et al., 2005), job satisfaction and organizational citizenship behavior (Groth et al., 2006), work experience (Hur et al., 2014), customer orientation (Lee et al., 2016), and organizational identification (Mishra & Bhatnagar, 2010). In a study about the effects of job demands and emotional labor on job satisfaction and emotional exhaustion among nurses, Chou and her colleagues (2012) found that frequency of interacting with difficult patients was positively related to surface acting, whereas the perceived organizational support was positively related to deep acting and negatively to surface acting. Groth, Hennig-Thurau and Walsh (2006) also proposed a set of individual, dyadic, and organizational level antecedents on employees' choice of emotional labor strategy. They concluded that employees with high levels of organizational citizenship behavior will be more likely

to engage in deep acting. They also found that when an employee encounters a customer for the first time he will prefer to engage in surface acting, whereas when there is a higher relationship between an employee and a customer he will engage in deep acting. Mishra and Bhatnagar (2010) showed that by focusing on organizational identification organizations may influence the authenticity of their employees' emotional expressions during customer interactions. Organizational identification was positively related to authenticity of emotional expression.

Regarding emotional labor impact, Hochschild (1983) argues that the emotional demands in an organization can have negative consequences for the psychological and physical health of employees. Most studies have demonstrated the negative effects of emotional labor (Mittal & Chhabra, 2011; Gursoy et al., 2011; Adil et al., 2013), but also some positive effects (Ashkanasy et al., 2002; Hur et al., 2015).

Most empirical studies examined the relationship between aspects of emotional labor and emotional exhaustion, which is the central component of burnout, and results from depletion or loss of emotional resources (Schaufeli et al., 1996). Some authors have proposed that high emotional demands are responsible for the development of burnout (Schaufeli et al., 1996). Interactions with customers are generally considered emotionally demanding. In this regard, frequent interactions that are emotionally intense and long lasting can lead to high levels of emotional exhaustion (Maslach, 1998; Schaufeli et al., 1996). Zapf et al. (1999) found that emotional exhaustion was positively correlated with the requirement to express and deal with negative emotions and the need to be sensitive to others' emotions.

However, only few studies have examined the relationship between emotional labor and other emotional dimensions of burnout. Kruml and Geddes (1998) and Zapf et al. (1999) found a positive relationship between emotional dissonance and cynicism. Another dimension of burnout is the loss of self-efficacy, that is the tendency to evaluate the work in a negative way. The individual's belief

that is unable to achieve its own objectives at work is accompanied by feelings of inefficiency and low self-esteem (Schaufeli et al., 1996).

Regarding the positive consequences of emotional labor, some studies have found a positive relationship between emotional labor and job satisfaction (Wharton, 1993; Côté & Morgan, 2002; Brotheridge & Grandey, 2002; Diefendorff & Richard, 2003), due to the fact that when individuals can successfully meet the requirements to express certain emotions, this may contribute to self-efficacy or personal fulfillment (Pugh, 2001; Tsai, 2001). The employee can express emotions in a spontaneous and genuine way that does not require any effort of emotional regulation (Ashforth & Humphrey, 1993), but contributes to a social situation with positive consequences for employees.

Almost all emotional labor research concluded that emotional displays can impact job performance (Ashforth & Humphrey, 1993; Grandey, 2000; Grandey et al., 2002; Hurley, 1998; Morris & Feldman, 1996; Rafaeli, 1989). This is especially true in the customer service sector, where emotional displays play a key role in how customers experience service encounters (Grandey et al., 2002). Customer service employees, on one hand, experience some pressure to suppress negative emotions and, at the other hand, are encouraged to display pleasant and positive emotions (Brotheridge & Grandey, 2002; Diefendorff & Richard, 2003; Hirschfeld, 1983). Brown and Sulzer-Azaroff (1994) examined the relationship between customer satisfaction and service friendliness and found that greeting customers was positively related to customer satisfaction. In a similar study, Pugh (2001) analysed the rates of employee smiles and eye contact with customers and found that customers' ratings of service quality were positively related to these measures of positive emotional displays. These and other studies showed that customer service employees who display positive emotions tend to receive higher customer satisfaction ratings. Considering the apparent beneficial effects of positive emotional displays, it is important to motivate customer service employees to express positive emotions.

### **3. Healthcare services**

#### **3.1 The Portuguese scenario**

##### **3.1.1 National health service**

The National Health Service (Serviço Nacional de Saúde, SNS) is a structure through which the Portuguese State assures the right to health (promotion, prevention and surveillance) to all their citizens. Its creation goes back to the year of 1979, after the political and social conditions resulting from the portuguese political restructuring of the 1970s.

The primary objective of the SNS is the pursuit by the State of its responsibility for the protection of individual and collective health and for this it is provided with integrated health care, namely health promotion and monitoring, disease prevention, diagnosis and treatment of patients and medical and social rehabilitation.

The government ensures the right to health protection through the SNS, which covers all official institutions and services providing health care under the Ministry of Health, namely:

- Groupings of health centers (Agrupamentos de Centros de Saúde, ACES): mostly ensure the provision of primary health care to local communities. Each ACES congregates several health centers, each of which normally covers the area of a municipality. Each health center may have one or more health extensions outside its headquarters. The health centers are also responsible for attending, with medical and nursing personnel, the local public medical posts, maintained by some parish councils. Each ACES includes specialized family health, personalized health care, community health, and public health units;
- Hospital establishments: mainly provide differentiated health care. Most public hospitals now integrate hospital centers, which congregate and manage several hospital units located in the same city or region. Non-integrated hospitals and hospital centers are classified as group I (local), II (regional), III (central) or IV (specialized);

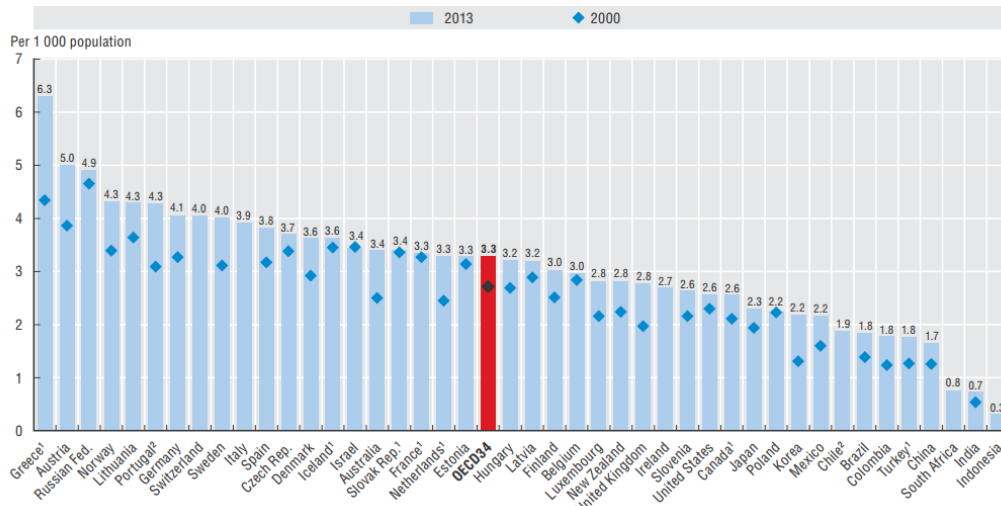
- Local Health Units (Unidades Locais de Saúde, ULS): bring together all health centers and hospitals located in a particular city or region, in a single integrated establishment responsible for the provision of both primary health care and differentiated health care.

The SNS integrates all health care from promotion and surveillance to disease prevention, diagnosis, treatment and medical and social rehabilitation. The hospital network consists of 226 hospitals, of which 107 are private. The 363 health centers are organized in 74 Health Center Groupings (ACES). In 2012, there were 342 Family Health Units and 186 Community Care Units.

In recent years, the health sector has undergone significant changes, ranging from the generalized transfer of the Misericórdias Hospitals to the State, the creation of the SNS, the publication of the Basic Health Law, the change of the legal status of hospitals to *Business Corporation* (Sociedade Anônima – SA) and the construction of new hospitals.

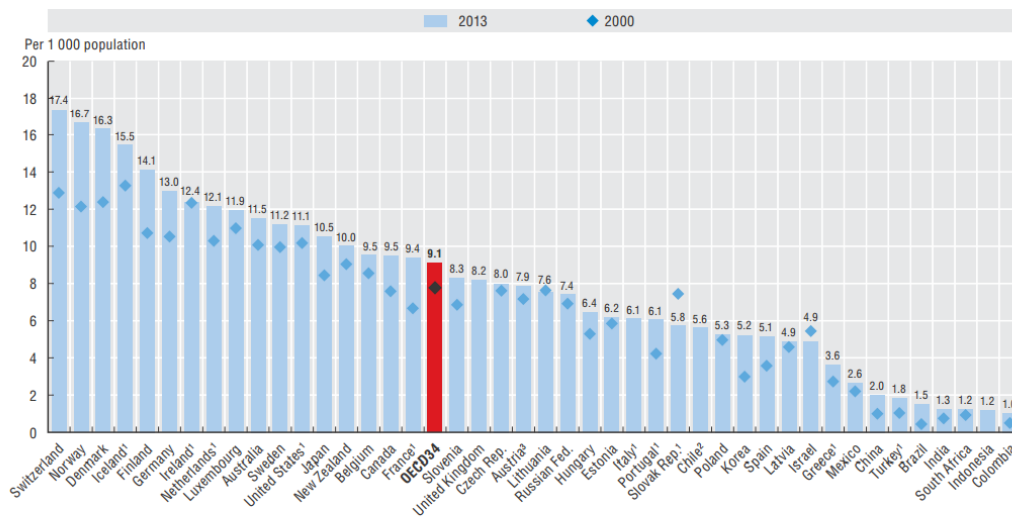
### **3.1.2 Human resources in the health sector**

The health professions, particularly physicians and nurses, represent 2% of the Portuguese working population. Physicians represent a great weight compared with the average for the OECD countries (Figure 4). However, we cannot conclude the same for nurses, since they are below the European average (Figure 5).



1. Data include not only doctors providing direct care to patients, but also those working in the health sector as managers, educators, researchers, etc. (adding another 5-10% of doctors).
  2. Data refer to all doctors licensed to practice (resulting in a large over-estimation of the number of practising doctors in Portugal, of around 30%).
- Source: OECD Health Statistics 2015, <http://dx.doi.org/10.1787/health-data-en>.

**Figure 4** Physicians nurses per 1 000 population, 2000 and 2013 (or nearest year), (OECD, 2015)



1. Data include not only nurses providing direct care to patients, but also those working in the health sector as managers, educators, researchers, etc.
  2. Data in Chile refer to all nurses who are licensed to practice (less than one-third are professional nurses with a university degree).
  3. Austria reports only nurses employed in hospital.
- Source: OECD Health Statistics 2015, <http://dx.doi.org/10.1787/health-data-en>.

**Figure 5** Practising nurses per 1 000 population, 2000 and 2013 (or nearest year), (OECD, 2015)



The number of staff working in the SNS has increased by 18% in the last 20 years: medical personnel increased by 12% and nursing and diagnostic and therapeutic staff more than 50%. By the end of 2015, the number of individuals employed in hospitals accounted for 49.1 thousand physicians, 67.8 thousand nurses, 8.2 thousand diagnosis and therapeutic technicians and 5.3 thousand high technical professionals. Regarding physicians, there were 46 739 physicians certified by the Portuguese Medical Association, i.e., 4.5 physicians per 1 000 inhabitants. Considering the local of residence, 36% of physicians were in the metropolitan area of Lisboa, and 33% in the North. 68% of physicians were specialist physicians. Regarding nurses, there were 67 893 active nurses certified by the Portuguese Nurses Association, of which more than 80% were women. 78% of nurses were generalist nurses.

### **3.2 Emotional labor in healthcare**

Emotional labor has been widely recognized to be a critical component of the role of many healthcare professionals (Phillips, 1996). In particular, many authors argued that nurses are required to express a higher degree of emotional labor as it is considered to be an indispensable aspect of patient care (Hochschild, 1983; Henderson, 2001; Mann, 2005; McQueen, 2004; Gray, 2009). This emotional component involves the regulation and management of feelings, actions and day-to-day reactions as answers to common situations (Skilbeck & Payne, 2003).

Traditionally, nurses have been encouraged to conceal their emotions in order to maintain a professional distance with their patients (McQueen, 2004). According to McQueen (2004), in the training and education programs, nurses were encouraged to hide their emotions and maintain a professional barrier to confer some self-protection. The way work was organized and how nurses approached patients to perform tasks of physical nature, contributed to maintaining this situation.

More recently, it has been followed a shift away from detachment and keeping patients at a distance towards encouraging closer relationships with patients (Williams, 2000; Williams & Aaker,

2002), resulting in a less formal nurse-patient relationship (Henderson, 2001). It becomes acceptable and necessary for nurses to express their emotions as they empathize with patients and demonstrate their humanity. Also, many researchers have suggested that nurses who perform emotional labor are more likely to have an impact on patients' psychological and physical well-being and recovery (Phillips, 1996; Mann & Cowburn, 2005; Gray & Smith, 2009).

Several concepts valued in the healthcare sector, such as open communication, partnership and new "nursing", emphasize the importance of the nurse-patient relationship. Knowing the patient helps nurses to interpret concerns, anticipate their needs, thus adding professional satisfaction. By adopting the values of patient care, partnership and intimacy, nurses get to know better their patients individually, thus experiencing emotional responses to their suffering.

In the course of their roles, nurses engage in a variety of activities that correspond to care in terms of behavior, for example by providing information and advice, committing to the technical support, administering basic care and helping patients physically when required. Associated with these behaviors can arise emotions, such as joy and compassion. Apart from these positively assessed emotions, nurses can also experience negative emotions such as frustration, disgust, irritation and anger. However, it is important that these emotions are controlled in front of the patient. Thus, emotional labor, is more than a presentation of emotions in front of the patients, but also involves the management of the same emotions (McQueen, 2004).

According to Hochschild (1983) emotional labor is guided by "rules of feeling" derived from social conventions, reactions from others or from the individual himself, saying that our life is socially controlled. In the context of nursing when nurses do not feel as they think they should feel in particular situations, they engage in emotional labor to manage, control and change their emotional state to match what they believe to be appropriate for the situation (Jimenez et al., 2012; Cheng et al., 2013). This type of work involves a correspondence between experienced emotions and behaviors shown to ensure the authenticity of behaviors.

Nurses and physicians are one of the professions that most demand for emotional displays; they are specifically required to display caring and kindness (Hallam, 2002). This is due to the social representations of nurses and physicians and to the constant management and suppression of real feelings (Bolton, 2001). Nurses are perceived as someone who is caring, sympathetic, loving and concerned about patients (Leidner, 1991; James, 1992). They are expected to show dedication, support patients emotionally and sympathize with them (Jameton, 1984). Those expectations and stereotypes has made nurses and physicians emotional players (Bolton, 2001).

## **CHAPTER II – METHODOLOGICAL FRAMEWORK**

### **1. Motivation and purpose of the study**

Considering the various studies and various research options in healthcare services, our decision fell on a focus of attention, that is, on the relationships between healthcare professionals and their patients. To circumscribe our study, we delimited this focus of attention on the emotions experienced during interactions between both parties.

Emotions and healthcare services are two main and very current topics that belong to the list of the service research priorities (Orstrom et al., 2015), which makes it interesting to relate them and makes this project important in terms of research. On the one hand, the emotions and relationships between people create more and more impact on them and, at the other hand, healthcare managers have begun to be concerned with the definition of a variety of marketing strategies to cope with the increased competition, especially from private hospitals.

In a review of various studies we found that the majority of studies on the emotional labor process in services focused mainly on the effects of the different emotional labor strategies. Several studies have for example explored the impact of different emotional labor strategies on job satisfaction and customer satisfaction (Barger & Grandey, 2006; Rafaeli & Sutton, 1990), or have studied the negative effects of the use of emotional labor on service providers' well-being (Zapf & Holz, 2006). Studies on emotional labor within the context of healthcare specifically, mainly focused on the relationship with emotional exhaustion and burnout in nursing care (Chou et al., 2012). Research into the determinants of nurses' choice for one of the emotional labor strategies, in contrast, has been rather scarce. The existing studies address several organizational, cultural, and individual factors, in many working populations and organizations. However, what remains largely unexplored are the perceptions of the nursing work environment and its impact on emotional labor strategies.

Therefore, emerged the need to further study this topic of emotional labor in healthcare, given the importance that managing emotions has gained in a growing area like healthcare and because there are some issues understudied.

### *Research Question*

What processes are involved in healthcare professionals' emotional management, and how are they associated with patients' and professionals' well-being?

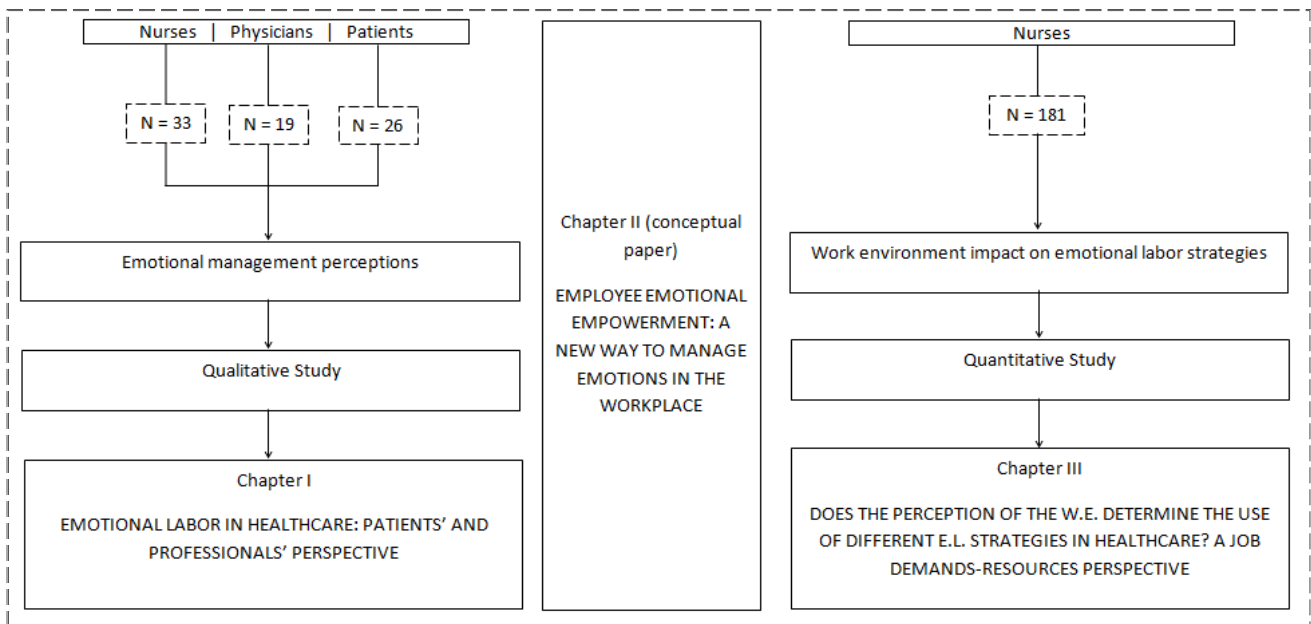
### *Objectives*

To answer the research question, we defined the central objectives that, then, are enunciated:

1. Explore the meanings associated with emotional management by healthcare professionals;
2. Explore the meanings associated with emotional management by patients in the healthcare setting;
3. Examine the association between emotional management and service quality for healthcare professionals and patients;
4. Explore how employees' emotional empowerment can stand as an alternative to emotional labor;
5. Examine how the perceptions of the work environment are associated with the use of different emotional management strategies (surface and deep acting).
6. Examine how nurses' personality traits can moderate the relationship between nursing work environment and emotional labor performance.

## **2. Research design**

This research project includes 1 theoretical paper and 2 studies – 1 qualitative and 1 quantitative (Figure 6).



**Figure 6** Research Design

Initially it was developed a qualitative study, which consisted of in-depth interviews with nurses, physicians and patients. This study allowed the collection of information of the perceptions that these individuals have about managing emotions in healthcare, thus relative to the objectives 1, 2 and 3. Then, we developed a conceptual paper to propose a new way to deal with emotions in the workplace to answer the objectives 4 of our research project. The third stage of our project focused on the collection of quantitative data, through an online survey. This study intended to meet the objectives 5 and 6.

### 3. Research context

These studies took place in several healthcare units, namely public and private hospitals, health centers and private clinics, in Portugal. All these institutions deal with more than one valence, so this research does not focus on any medical and nursing specialty.

According to the last statistics, which report to the year of 2015, there were 225 hospitals in Portugal, of which 118 were public hospitals and 107 private hospitals. Of the total units, 30% are in the municipalities of Lisbon (34), Porto (21) and Coimbra (13) (INE, 2016). Portugal has many private hospitals that are integrated into hospital and clinical networks owned by large private healthcare groups.

Health centers are gathered in groups (Agrupamentos de Centros de Saúde, ACES) to ensure the provision of primary health care to the local communities. Altogether there are 66 groups of health centers, of which 24 belong to the north region, 14 to the center, 22 to the area of Lisbon and Vale do Tejo, 3 to Alentejo and 3 to Algarve (ACSS, 2011).

In 2015, there were 45 private health units. Lisbon concentrates 24.4% of private clinics, followed by Porto with 20%, and Braga, with 15.6%.

#### **4. Target population and study sample**

The target population is composed of healthcare professionals, namely physicians and nurses, and patients. In 2015, the total number of registered physicians in the Portuguese Physicians Association totals 469,152 individuals, of which 47% are men and 53% are women. 33% of physicians are in Portugal. Regarding nurses, the total number of registered nurses in the Portuguese Nursing Association, in 2015, was 67,893 individuals, of which 18% are men and 82% are women. 33% of nurses are in the north region, 22% are in centre region and 40% are in the south. The remaining 5% are in the islands of Madeira and Azores (INE, 2016).

Data were collected in two different phases. First, the qualitative data were collected between December 2013 and March 2014. And, in the second phase, the quantitative data were collected between November and December 2016. Individuals who took part in these studies account for a total of 259 participants. We opted for a convenience sampling to facilitate access to a significant

sample of this population. The selected physicians and nurses had at least two years of work experience and the selected patients attended health units at least once a year.

## **5. Data analysis**

### **5.1 Qualitative approach**

Qualitative research is “an interpretive naturalistic approach to the world” (Denzin & Lincoln, 2005). In other words, qualitative research focuses on the natural settings of a phenomenon and is designed to explore the human elements of a given topic (Given, 2008).

One of the major reasons for doing qualitative research is to explore at a deeper level the phenomena at hand, to discover the personal meanings, perceptions, experiences and perceived impact of those phenomena (Given, 2008). From a post positivist viewpoint or even a constructivist one, reality is personally and socially constructed, so we investigate the variation in that personal reality that defines peoples’ experiences. We also wanted a deep understanding of how people think about these topics, so doing in-depth interviewing is one of the best choices to collect data.

#### *Thematic analysis*

We chose the thematic analysis as a data analysis strategy in order to identify, analyze and report patterns within data (Braun & Clarke, 2006). Thematic analysis targets the identification of implicit and explicit ideas within the data (Daly et al., 1997), emphasizing a rich description. First, the process begins with coding the raw data for developing themes, i.e., recognizing important moments in the data and its encoding (Boyatzis, 1998). Then, is the interpretation of these codes that consists in comparing theme frequencies, identifying theme co-occurrence and displaying relationships between different themes (Guest et al., 2011). Thematic analysis has been considered as a valid and time-effective method of capturing the intricacies of meaning within a data set.



## *Coding*

The thematic analysis has six clearly defined steps that ensure clarity and rigor in the process (Braun & Clarke, 2006):

- Familiarizing yourself with your data: in this step we need to read and reread the data before coding and searching for meanings and patterns. We may take notes on our initial ideas.
- Generating initial codes: this stage involves the production of initial codes for the data that can be done manually or with a software program. After all the data is coded, the data that is identified by the same code should be grouped.
- Searching for themes: after all codes are grouped, we sort the different codes into potential themes. Some codes may form main themes or sub-themes, whereas other codes may be removed. At the end of this stage we should have a collection of themes and sub-themes.
- Reviewing themes: this stage involves refinement of the themes. This means that some themes will collapse into other themes, whereas some themes may need to be broken down into smaller components.
- Defining and naming themes: at this phase we need to capture the essence of what each theme is about to create an overall narrative with all of the data. Also, we can start officially naming the themes that must be concise, punchy and immediately give the reader a sense of what the theme is about.
- Producing the report: this is the final stage of the thematic analysis that consists in the write-up of the report. The report should be a concise, coherent, logical, non-repetitive, and interesting account of the story the data tell.

## **5.2 Quantitative approach**

The quantitative approach is used to identify and present data, observable indicators and trends. This research is generally appropriate when there is the possibility of collecting quantifiable measures of variables and inferences from samples of a population (Creswell, 2014).

We employed strategies of enquiry such as surveys and collected data on predetermined instruments that yield statistical data. We chose the survey because it provides a quantitative description of trends, attitudes, or opinions of individuals (Creswell, 2014). Then, we ran parametric statistical tests and operations, using the software Statistical Package for Social Sciences (SPSS, version 23).

## **6. Dissertation structure**

This thesis comprises three parts. The first one is an introduction, describing both the conceptual and methodological frameworks of the research project. Then, the second part refers to the empirical studies and the third part is an integrated discussion.

Regarding the studies that constitute this thesis, the study 1, “Emotional labor in healthcare: patients’ and professionals’ perspective”, is a qualitative study that examines healthcare professionals’ and patients’ perceptions about the management of emotions at work. The study 2, “Employee emotional empowerment: a new way to manage emotions in the workplace”, reviews the growing body of literature regarding the emotional labor theory in order to propose a new construct – employee emotional empowerment. Finally, the study 3, “Does the perception of the work environment determine the use of different emotional labor strategies? A job demands-resources perspective”, examine the perceptions of the nursing work environment and the moderating effect of nurses’ personal characteristics towards their choice for an emotional management strategy, surface acting or deep acting.

Finally, our integrated discussion presents a reflection on the most important contributions of this research, integrating the theoretical and practical implications. Also, we point out the limitations and delineate the starting point for future research on the management of emotions in healthcare services.

## **PART II: RESEARCH STUDIES**

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**STUDY 1: EMOTIONAL LABOR IN HEALTHCARE: PATIENTS' AND  
PROFESSIONALS' PERSPECTIVE**

## **Abstract**

**Purpose** – The emotional interactions and emotional management between healthcare professionals and patients are relevant but understudied phenomena. The value, meanings, attitudes and strategies of emotional management may be associated with the perceptions of healthcare service quality, patients' satisfaction and even health outcome. Therefore, this study attempts to explore the balance between expressing or suppressing emotions and negotiating closeness vs distance within the healthcare context.

**Design/methodology/approach** – 78 Portuguese nurses, physicians and patients participated in a semi-structured interview and data were analyzed according to the thematic analysis of Braun and Clarke.

**Findings** – The results suggested that healthcare professionals and patients may perceive the process of emotional labor in two different ways: one that favors emotional display and a relational approach between professionals and patients, while the other favors emotional suppression or distance between interacting parties.

**Practical implications** – These findings may help managers define and implement specific strategies regarding the role of emotions in service quality and customer satisfaction.

**Originality/value** – This study provides novel evidence regarding healthcare professionals' and patients' perspectives about the emotional display during healthcare service encounters.

**Keywords** emotional labor, healthcare, service quality, relational engagement, performative engagement, thematic analysis

**Paper type** research paper

## **1. Introduction**

In the context of healthcare, emotional management presents challenges to professionals and patients, due to the vulnerability of patients and the stress involved in the healthcare profession (Naz & Gul, 2011). In most cases, hospitalization represents a challenge for adults and for children as a hospital is usually perceived by patients as an unfamiliar and frightening environment (Ceribelli et al., 2009). Minimizing the adverse feelings caused by hospital settings might include making them less intimidating and impersonal, namely through the humanization of care (Ceribelli et al., 2009). In order to do so, emotional dimensions of this context must be examined, including communication techniques and relational approaches. Therefore, this study aims to contribute to the understanding of such processes by exploring the emotional dimensions inherent to the context of healthcare, specifically in what concerns the construct of emotional labor.

Emotional labor, defined by Hochschild (1983) as the emotional management by professionals for purposes of relating with customers, is often necessary for healthcare to help professionals handle a problematic situation. Nurses, for instance, may have feelings towards a patient or a clinical situation that they do not consider adequate for display, due to their perceptions of patients' expectations or to social and contextual norms (Mann, 2005). Behaviors associated with emotional labor help nurses to manage their patients' reaction by facilitating emotional relief, and has a positive association with psychological and physical well-being and recovery (Mann, 2005).

Despite mounting support regarding the relevance of emotions in healthcare and the role of emotions for healthcare professionals and patients' satisfaction (Chou et al., 2012; Karimi et al., 2013), the way healthcare professionals and patients consider emotions remains understudied. In this study, we want to understand how the display of emotions and the type of relationships that are established in this context are perceived and interpreted by healthcare professionals and patients. Hence, our research questions aim to understand how the management of emotions at work unfolds to healthcare professionals and patients; what meanings are associated with emotional management

by healthcare professionals and patients; and what is the association between emotional management and service quality and customer satisfaction.

Overall, this study provides three key contributions. Based on our findings and regarding the perceptions that healthcare professionals and patients report concerning the use of emotional labor, emotional labor is a two-way process that we called relational engagement and performative engagement. Indeed, the results suggest two different approaches, which are associated with what individuals identify as a good-quality service. Second, this study is the first qualitative study that considers the meanings associated with emotional management by both healthcare professionals and patients. Third, our findings provide specific and novel information to help healthcare managers define and implement strategies to achieve service quality and customer satisfaction.

## **2. What are emotions?**

Studying emotions has specific challenges, as there are not only different theoretical perspectives but also different definitions of what is considered an emotion. Specifically, the terminology used in a variety of disciplines (Brosch et al., 2010) concerning emotions lacks consistency, as different terms are apparently used interchangeably. Bagozzi et al. (1999), Lazarus (1991) and Oatley (1992) defined emotion as a mental state that arises from cognitive appraisals of events or thoughts; emotions are associated with specific actions and behaviors (Lerner & Keltner, 2000). However, there is a consensus which considers emotions as a multicomponent tendency that unfolds over relatively short time spans (Fredrickson, 2001; Diener, 1999; Ekman & Davidson, 1994). In psychology, at least two main approaches to theories of emotions emerged: the dimensional theories and the cognitive appraisal theories. Simply put, the first one advocates that all emotions can vary along a limited number of fundamental, abstract dimensions (Mano, 1991). The dimensions that consistently emerge are valence (or pleasantness), arousal (or activation), and power (or potency) (Larsen & Diener, 1992; Russell & Mehrabian, 1977). The latter approach assumes that emotional



reactions to an event are a result of a personal interpretation of the event itself and of the situational environment (Frijda, 1986; Roseman, 1984).

The most studied emotions are negative emotions like fear, anger, disgust, while positive emotions have been traditionally ignored in research, a tendency that has only started to be surpassed in the last decades with the emergence of the movement of positive psychology (Seligman & Csikszentmihalyi, 2000; Tugade & Fredrickson, 2007; Sheldon & King, 2001; Snyder & Lopez, 2002). Fredrickson (1998) has pointed out some of the reasons for this lingering gap. First, there appear to be few, and less differentiated, positive emotions than negative emotions, as positive emotions have similar facial patterns and little or no autonomic response. Second, the problem-focused approach, which has characterized most of the health sciences and psychology implies that positive emotions are unrelated to ‘problems’ and hence do not need a solution or further exploration (Fredrickson, 2000).

Fredrickson (1998) was one of the first researchers that embraced research on positive emotions. For instance, she found that joy is an emotion that is often experienced while playing and that it is connected with approaching behavior. Feeling contentment allows for people to expand their world view and the view of themselves, which relates to building better social relations and skills (Fredrickson, 2001). Fredrickson (1998) concluded that the positive emotions she studied shared a pattern, and it was different from the one that was elicited by negative emotions. Negative emotions, in turn, are associated with specific action tendencies, and thus, have an effect of narrowing the momentary thought-action repertoire (Losada & Heaphy, 2004). This is why when experiencing fear, for example, we tend to bring the focus of attention on getting rid of the threat. But positive emotions don’t emerge on threatening situations, they occur when we are out of them (Fredrickson & Joiner, 2002).

Fredrickson and Joiner (2002) hypothesized that positive emotions have a broadening effect on the momentary thought-action repertoire, putting away automatic responses and looking for

creative, flexible and unpredictable new ways of thinking and acting. That is the broadening part of the theory. By broadening our perspectives and actions, we tend to build important physical, intellectual, psychological and social resources (Fredrickson, 1998). The broaden-and-build theory, as defined by Fredrickson (2001), is a model that explains the mechanisms behind positive emotions, what their effects are, what the evolutionary reason is behind them and why studying them is so important for our well-being.

In everyday life, the regulation of emotions is essential and cultivating positive emotions is even more vital. The ability to respond to the ongoing demands of experience with the range of emotions in a way that is socially acceptable (Cole et al., 1994) is called emotion regulation theory, that is, the bottom line of the emotional labor techniques (Gross, 1998). Emotion regulation is the conscious or non-conscious control of emotion, mood, or affect, that is, individuals can determine what emotion they should have, when they can feel these emotions, and how they express it (Gross, 2002). Gross (2002) developed a process model of emotion regulation that shows how specific strategies can be differentiated along the timeline of the unfolding emotional response (Gross, 1998; 2001).

Mayer and Salovey (1997) stated that individuals differ in their ability to regulate emotions, which is crucial for emotional intelligence (Gross & John, 2002; Salovey & Mayer, 1990; Salovey et al., 2002). According to Mayer and Salovey (1997), emotional intelligence comprises four interrelated abilities involved in the processing of emotional information: perceiving emotions; using emotions to facilitate thinking; understanding emotions; and regulating one's own emotions and the emotions of others. The importance of these abilities relies on the fact that emotions serve communicative and social functions, conveying information about people's thoughts and intentions, and coordinating social encounters (Keltner & Haidt, 2001). Out of these four abilities, emotion regulation is probably the most important for social interaction because it influences emotional expression and behavior directly. Still according to Mayer and Salovey (1997), individuals with great

emotion regulation ability have a large repertoire of strategies for maintaining desirable emotions and for reducing negative emotions. Additionally, individuals with high emotion regulation ability report greater well-being (Côté et al., 2010), better quality social interactions (Lopes et al., 2005), and lower motivation for revenge (Rey & Extremera, 2014). Recognizing the usefulness of positive emotions, managers increasingly require the display of certain emotions in the workplace.

### **3. Managing emotions at work**

#### *Emotional labor*

Service providers need to be emotionally prepared to effectively respond to customer interactions (Shani et al., 2014), as the work is not only denoted by intellectual and physical labor but also emotional labor, in terms of sincere concern about customers (Zapf, 2002; Jung & Yoon, 2014). Indeed, during a service encounter, service providers have an important role to play, since the customers' perception of service quality is widely based on employee's behaviors (Farrel et al., 2001) and how the customer-employee relationship unfolds. Lin and Lin (2011) pointed out that service encounter satisfaction will be more positive if the service employee's affective delivery is also positive. The service providers' attitudes, behaviors, motivation, job satisfaction and moods influence professionals' performance and customers' evaluations of service encounters (Farrel et al., 2001). However, customers' behaviors, that is, how pleasant or friendly the customer is to employees, can also have an impact on employees' emotion regulation. As Rafaeli and Sutton (1987) observed employees and customers influence each other during an interaction and how customers react to employees' emotion regulation can determine whether the employee experience that regulation as harmful or beneficial (Côté, 2005).

Emotions and their displays are controlled and managed in organizations, by formal and informal means (display rules), to ensure that some emotions are expressed while others are suppressed (Mann, 2005). Employees are expected to align with organizational emotional displays

even when they conflict with inner feelings (Hwa, 2012). When this conflict results in suppressing genuine emotions or expressing fake emotions is called emotional labor. The concept of emotional labor was originally coined by Hochschild (1983) and is defined as the management of feelings to create a publicly observable facial and bodily display. Emotional labor can be considered as a sub-category of “emotion work”, since it has an exchange value, is sold for a wage, as opposed to emotion work that has no exchange value (Hochschild, 1983). Hence, it is related to the process of regulating feelings and expressions for organizational goals (Grandey, 2000). However, often a discrepancy arises between the organizational required emotions and employee’s inner emotions (Zapf & Holz, 2006), that is, emotional dissonance, when the expectation of certain behaviors concurs with employee’s authentic and personal feelings (Shani et al., 2014). According to Hochschild (1983), service providers use two strategies to cope with emotional dissonance: a) surface acting or ‘faking feelings’ to align with expectations; and b) deep acting or attempting to modify feelings to match expectations. Surface acting strategies occur when one performs an emotional display to meet certain rules and expectations. The display of emotions is considered to be inauthentic because the expressed emotions do not match the internal experience of the employee (Grandey, 2000; Côté, 2005). On the other hand, deep acting occurs when a person consciously attempts to feel a specific emotion that matches the expected emotional displays (Grandey, 2003). Service providers try to change what they feel to experience the emotions that they are expected to display (Groth et al., 2009).

Service providers’ emotional labor is valuable for the service industry, on which displays of positive emotions have been associated with customers’ satisfaction (Oliver, 1997), intention to return, service failure recovery (Zemke & Bell, 1990), customer attitude and others (Gursoy et al., 2011; Shani et al., 2014). On the other hand, being ‘forced’ to perform in expected emotional displays has been correlated with low job satisfaction, stress, low quality of life, exhaustion or depression (Gursoy et al., 2011; Karimi, et al., 2013). Accordingly, some authors (Kim, 2008;

Gursoy et al., 2011) draw attention to the fact that emotional labor has double-edge effects in terms of causing positive organizational outcomes and negative effects on employee well-being. For instance, in a study conducted within university's staff, about the extent to which surface and deep acting can lead to emotional exhaustion, Gopalan and colleagues (2013) found that surface acting was positively correlated with emotional exhaustion and negatively correlated with life satisfaction. However, no correlation was found between deep acting and emotional exhaustion, and deep acting and life satisfaction. Most of research demonstrated that deep acting leads to more positive outcomes than do surface acting (Kim, 2008).

### *Emotional labor in healthcare*

Every service setting is created to fill certain customers' needs, even the healthcare setting. However, in most industries, the product or service can be standardized to improve efficiency and quality. In healthcare, every person is chemically, structurally, and emotionally unique. What works for one person may or may not work for another. In this environment, it is difficult to standardize and personalize care in parallel. Furthermore, patients' perceptions of the quality of the healthcare they received are highly dependent on the quality of their interactions with their healthcare provider (Clark, 2003; Wanzer et al., 2004). Hence, the healthcare setting is in some respects different from the overall service industry and requires special management strategies to ensure both employees' and customers' satisfaction.

The relationships that are created between the employee (the healthcare provider) and the customer (the patient) is the aspect that most differentiates healthcare services from other services. These relationships have both emotional and informational components, that is, emotional care and cognitive care (DiBlasi et al., 2001). Emotional care includes mutual trust, empathy, respect, genuineness, acceptance and warmth (Ong et al., 1995). Cognitive care includes information gathering, sharing medical information, patient education, and expectation management (Kelley et

al., 2014). Healthcare providers and patients experience an emotional connection among them, this means there is a rapport between the patient and the professional. This emotional connection has the power to relieve the patient's suffering, in terms of reduced distress (Fiscella et al., 2004; Roter et al., 1995), greater hope and motivation to manage the patient's illness (Thorne et al., 2008; Fox & Chesla, 2008), better treatment planning (Charon, 2006), better adherence to treatment plans (Berry et al., 2008), and better symptom resolution (DiBlasi, 2001; Haezen-Klemens & Lapinska, 1984; Hojat et al., 2011). When doctors and nurses experience an emotional connection with their patient, they feel a sense of achievement, and are thus more satisfied with their work (Shanafelt, 2009; Shanafelt et al., 2009; McMurray et al., 1997; Dunn et al., 2007).

Considering these types of relationships, the emotional labor plays a key role for healthcare professionals regarding the quality of their service and patients' perception of service quality. Emotional management has been deemed to be as important to healthcare professionals as their technical skills or abilities (Banning & Gumley, 2012). These authors found that nurses report that the humanistic elements of nursing care, such as offer sympathy, consideration, demonstrate sensitivity, empathy, emotional support, counseling and education, play an important role in the delivery of care. This arises as a particularly important issue when relating to chronic illness (Banning & Gumley, 2012). Oncology, for example, is one of the most challenging environments in healthcare, and healthcare professionals often develop strong emotional links with their patients (Banning & Gumley, 2012), due to the establishment of a personal connection or continued care.

Nurses are often expected to perform accordingly with their colleagues, patients and other medical staff expectations (Bartram et al., 2012). In a cross-sectional, correlational survey, conducted to 183 nurses, these professionals confirmed that they often need to module their emotions and display something else rather than what they are really feeling (Bartram et al., 2012). The same is valid for physicians, when they are revealing a bad diagnosis, or when they need to confront the family with the death of a relative (Bartram et al., 2012). Healthcare professionals do not really

change their inner sense of felt. They modulate their external self to produce an acceptable and desirable response to go along with the treatment, bringing better outcomes on it and comfort for patients (Jimenez et al., 2012; Cheng et al., 2013).

In turn, healthcare professionals can manage patients' reactions, by providing comfort and allowing them to express their emotions, when they know how to perform emotional labor (Mann & Cowburn, 2005). According to these authors, nurses identified the management of emotions as having a key role in making patients feel better, more comfortable, and more satisfied. They also identified it as a critical aspect of day-to-day work, expressing that it helps to "oil the wheels of nursing work" (Mann & Cowburn, 2005, p.155). Emotional labor is like an invisible bound that helps patients to be satisfied, show better treatment outcomes and even facilitate catharsis (Mann & Cowburn, 2005). In their study about nurses' views and emotions, Banning and Gumley (2012) concluded that these healthcare providers felt that the expression of compassion, empathic understanding and positive feelings towards patients were essential features of their work. The authors also concluded that "nurses who have little or negligible positive feelings, and emotions towards patients would have difficulties expressing their views and providing care for patients" (Banning & Gumley, 2012, p. 803).

In addition to the fact that nursing is one of the occupations most prevalent to requiring extensive emotional labor (Bolton, 2001), emotional labor can be an important strategy for nurses and physicians because it increases self-efficacy – the belief that one can fulfill successfully the requirements of a given task – and task effectiveness (Ashforth & Humphrey, 1993). According to Henderson (2001), nurses are encouraged to demonstrate emotional involvement and commitment to create a less formal nurse-customer relationship and to improve customer outcomes. If nurses demonstrate emotional impassiveness, as when some show unconcern for a customer distress or when social rules are not followed, it can result in poor outcomes for patients (Bolton, 2000). As Smith (1992) discussed a study targeting the public's expectations regarding the characteristics and

emotions displayed by nurses, positive attitudes and feelings seemed more important than technical expertise. Bolton's study (2000) also demonstrated that maintaining an emotional distance reduces attachment to such an extent that professional ability decreases.

As Mann and Cowburn (2005, p. 155) put it, "the nurse who performs emotional labor is able to manage the reaction of the patient by providing reassurance and allowing an outlet for emotions". Such emotional labor can also be therapeutic, due to its impact on patients' psychological and physical well-being (Phillips, 1996). Increasingly, the enhanced autonomy and use of technology in nursing, together with staff shortages and heavy workloads, has reduced the time and energy available for emotional labor (Jimenez et al., 2012). Zander and Hutton (2009) draw our attention to the fact that, although nurses understand the emotions they are going through, it is necessary to ensure that their own expressed emotions enable patients' appropriate care. Emotional labor in nursing is not highly valued by the majority of healthcare organizations (Hunter & Smith, 2007), which explains the link between emotional labor, emotional exhaustion and job burnout. Nurses' emotional exhaustion results ultimately in depersonalization of the service (Grandey et al., 2007).

Regarding nurses, their common social representation includes displaying caring, kindness, sympathy, get involved and be concerned about patients (Henderson, 2001). Physicians are expected to be dedicated, supportive and sympathetic (Naz & Gul, 2011). According to a study by Mackintosh (2000), patients' expectancy of these roles carry high expectations towards healthcare professionals and brings pressure to be up to those social representations, or otherwise they will not be delivering a good service. In fact, given that social representation and the extreme importance of the communication process between customer and healthcare professional it becomes clear that nurses, physicians and other healthcare employees must keep up to the challenge or otherwise they will be compromising patients' satisfaction and ultimately treatment effectiveness (Naz & Gul, 2011).

Patients' satisfaction is highly related with emotional labor (Rego et al., 2010). Patients that perceive healthcare professionals to be kind, use soft voice and gentle manners are much more prone



to feel satisfied (Hayward & Tuckey, 2011). Patients tend to feel more satisfied with healthcare services when they experience that their one's emotions are understood; when healthcare professionals pay attention, and try to understand emotion they enhance patients' trust and respect (Rego et al., 2010). On the contrary, when healthcare professionals fail to understand patients' emotions or neglect attention given to them, they become less likely to share their true feelings or communicate effectively. According to Henderson (2001), patients are more likely to present positive treatment results and satisfaction if nurses can consciously monitor and moderate their own emotional responses.

As we can see throughout the literature and despite being a widespread topic of study, most research on emotional labor has focused only on the display of emotions in a service encounter (Barger & Grandey, 2006; Rafaeli & Sutton, 1990; Pugh, 2001; Yagil & Medler-Liraz, 2013; Sutton & Rafaeli, 1988), and on the negative effects of emotional labor on service providers (Grandey, 2000; Zapf & Holz, 2006; Grandey, 2003). Thus, to date research regarding the perceptions of the display of emotions that plays a key role in healthcare services is still scarce.

#### **4. Research design**

Since our main focus was to explore the perceptions associated with the role of emotions during healthcare service interactions, we developed a qualitative study with semi-structured interviews aimed at exploring and understanding the patterns and processes inherent to the display of emotions. This method offers a balance between the flexibility of an open-ended interview and the focus of a structured survey. The semi-structured interviews are open, allowing new ideas to be brought up during the interview as a result of what the interviewee says. Also, it provides reliable, comparable qualitative data and can uncover rich descriptive data on the personal experiences of participants (Bernard, 2000).

As a data analysis strategy, we chose thematic analysis (Braun & Clarke, 2006) in order to identify, analyze and report such patterns within data. Thematic analysis targets the identification of implicit and explicit ideas within the data (Guest et al., 2011), emphasizing a rich description. Coding is the primary process for developing themes within the raw data, a process involving the recognition of important moments in the data and its encoding prior to interpretation (Boyatzis, 1998). Interpretation of these codes may include comparing theme frequencies, identifying theme co-occurrence, and graphically displaying relationships between different themes (Guest et al., 2011). Thematic analysis has been considered as a valid method of capturing the intricacies of meaning within a data set (Guest, 2012).

### *5.1 Participants*

We conducted 78 interviews, between December 2013 and March 2014, with Portuguese nurses, physicians, and patients. These participants were recruited at one public hospital, one health center and one private clinic in the north of Portugal. All these institutions deal with more than one valence, so this research does not focus on any medical and nursing specialty. The sample consisted of 52 healthcare professionals – 19 physicians (10 women and 9 men) and 33 nurses (24 women and 9 men) – and 26 patients (18 women and 8 men). The ages of the elements of the three groups of participants ranged from 20 to 87 years old ( $M_{\text{physicians}} = 44,95$ ;  $M_{\text{nurses}} = 36,10$ ;  $M_{\text{patients}} = 44,80$ ).

### *5.2 Data collection*

Data were collected through selective sampling, as the participants were selected by considering their knowledge and experience regarding the topic of research. Criteria for selecting participants included having high contact with patients, and, at least, two years of work experience – for physicians and nurses – and going at least once a year to a public healthcare institution – for patients. Patients were randomly approached to respond to an interview, within the space of the health institutions. The first

question "How often do you usually go to a hospital, health center or clinic?" was the elimination factor of these participants. Nurses were indicated by the head nurse and the doctors, in turn, by the directors of the institutions they work in.

Interviews took place at nurses' and physicians' workplace, during their shifts, and in the hospitals' lobby. Each interview lasted approximately one-hour, except for five interviews, which due to busy schedules, only lasted 30 minutes. We developed two similar provisional interview scripts. For nurses and physicians, the script had seven open-ended questions and, for patients, five. Regarding healthcare providers' interview, we asked them, for example, to describe their interactions with patients, how they manage their emotions in front of the patient, what they think are the main determinants of service quality and to tell a story that affected them in a professional and personal level. To the patients we asked, for example, to describe their emotions when they are in a health institution, how they think healthcare professionals should manage their emotions, how the relationship between patients and healthcare provider can influence perceptions of service quality and what they think are the main determinants of service quality. We adapted the scripts by adding or deleting questions, as the data collection and analysis evolved, to obtain a better and deeper comprehension of the main categories.

We obtained written consent to take part in the study and permission to audio-record the interviews from every participant. We also informed them about the research aims and assured them about the confidentiality of the data collected. This study was approved by the hospitals' ethics committee.

## **5. Data analysis and findings**

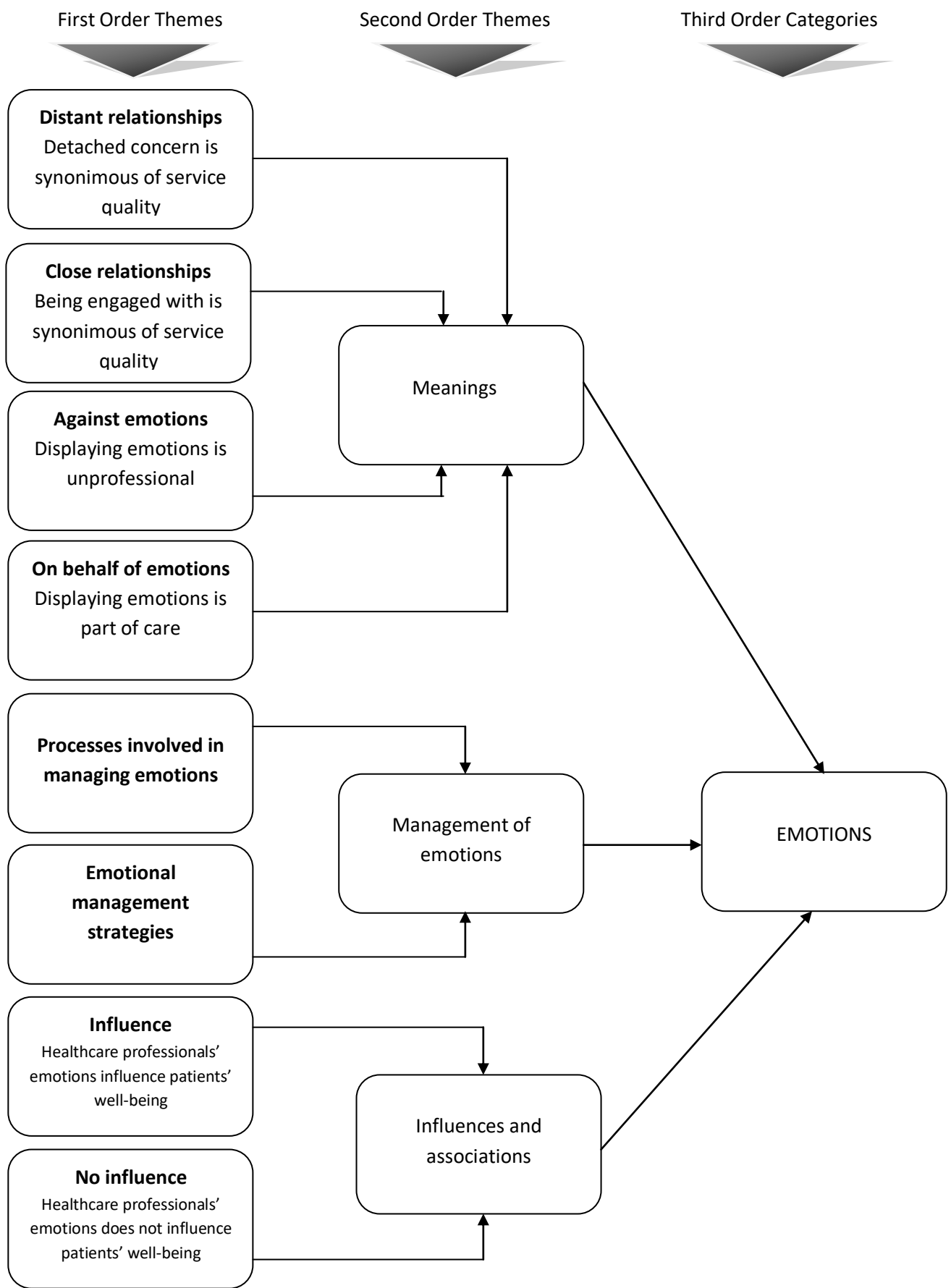
We recorded and transcribed the interviews verbatim and analyzed them through the qualitative software QSR Nvivo10. After 60 interviews, several themes developed into clear patterns became commonplaces, since numerous participants mentioned them. Therefore, we conducted some more

interviews to obtain a more reasoned confirmation of the theoretical saturation. We then closed the process of data collection.

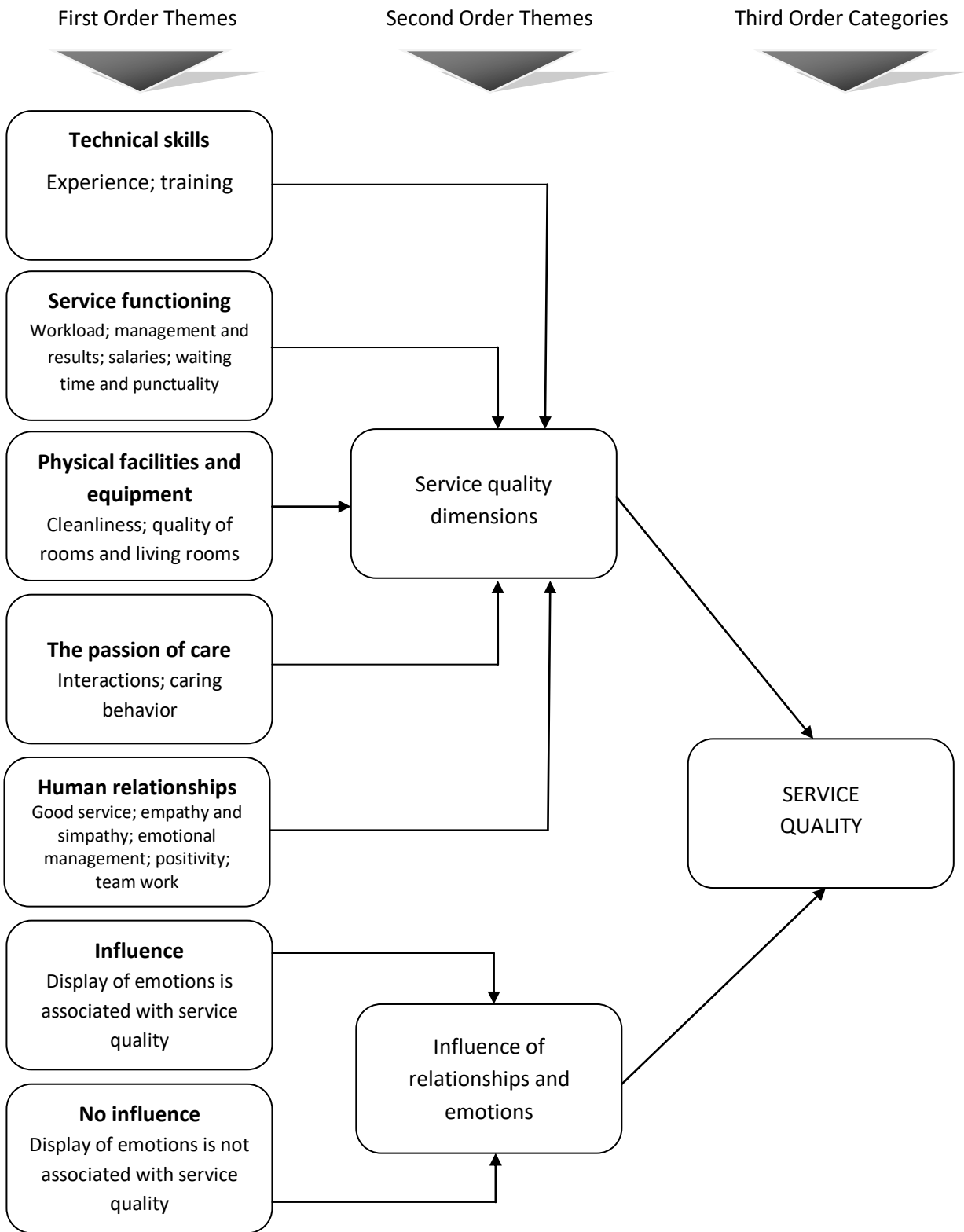
We transcribed all the interviews into field notes (624 pages), listening carefully to all the audios and transcribing them to word documents, and then we searched for relations between ideas and created codes. We organized the data through the qualitative software QSR Nvivo10, according to the following steps: 1) becoming familiar with the data, we read and re-read data in order to become familiar with what the data entails, paying specific attention to patterns that occur (Guest et al., 2011); 2) generating the initial codes by documenting where and how patterns occur. This happens through data reduction where data is collapsed into labels in order to create categories for a more efficient analysis (Saldana, 2009); 3) searching for themes, combining codes into overarching themes that accurately depict the data (Braun & Clarke, 2006); 4) reviewing themes, we look at how the themes support the data and the overarching theoretical perspective (Guest et al., 2011); 5) defining and naming themes, we defined what each theme was, which aspects of data were being captured, and what was interesting about the themes (Braun & Clarke, 2006); and, finally, 6) producing the report, which entails decisions regarding which themes make meaningful contributions to the understanding of what is going on within the data (Guest et al., 2011).

Figure 7 and 8 presents the main results from the thematic analysis. Figure 7 is related to the topic of *emotions*, under which we found themes such as *meanings*, *management of emotions* and *influences and associations*. The theme *meanings* refer to the meanings attributed to the emotional experiences of healthcare professionals and patients. Therefore, is possible to identify two different positions: 1) the management of emotions as fundamental in caring for the patient, underlining the importance of the continuous relationship between the same healthcare professional and patients (*close relationships* and *on behalf of emotions*); and 2) a negative view of emotional experience and expression, viewing it as a non-professional stance, and giving more focus to the patient rather than maintaining a continued relationship (*distant relationships* and *against emotions*). The theme

*management of emotions* presents the processes and strategies mentioned by participants (e.g. being authentic, controlling emotions, faking emotions). Finally, the theme *influences and associations* relate to which kind of associations exist between the healthcare professionals display of emotions and patients' well-being. Figure 8, in turn, is related to the *service quality*. Under this topic we found the main *service quality dimensions*, such as technical skills (e.g. experience, training), service functioning (e.g. workload, salaries, waiting time), physical facilities and equipment (e.g. cleanliness, quality of rooms), and passion of care (e.g. interactions, caring behavior). Also, we found whether the display of emotions was associated with service quality.



**Figure 7** Thematic Analysis - Emotions



**Figure 8** Thematic Analysis – Service Quality

### *6.1 Relationships as 'the key to our business'*

According to figure 7, one of the meanings attributed to the management of emotions reveals that participants found the display of emotions and close relationships between healthcare professionals and patients – which we named as relational engagement – as fundamental to service quality. The display of emotions means that nurses and physicians share their feelings with their patients and show empathy, concern, interest, which is the opposite to the detached concern, that is, to be concerned about something without being emotionally involved (Halpern, 2001). In addition to show concern for the patients, healthcare professionals also get emotionally involved, both with the patient and with the situation (s)he is going through. The expression of emotions is believed to be a way to reinforce the proximity between professionals and patients and therefore serves as a facilitator of their physical and mental recovery, and ultimately of their satisfaction. The proximity and the relationship established between healthcare professionals and patients were also suggested as crucial in providing a personalized treatment, and creating trust, confidence and hope among patients. There is a reciprocal connection between displaying emotions and relationships in the sense that the expression of emotions makes people become closer and intimate and relationships, in turn, urge individuals to share emotions.

In their study, Brooks and Phillips (1996) concluded that nurses believe that their emotional involvement was associated with a more positive result to their patients. Our nurses, also agree with this conclusion. The following statement summarizes this perspective on service quality: “No doubt the quality goes through the humanization of the service, with the nurse being the first link that connects the patient to the services and perpetuates the perception of good or bad hospital’s quality.” (Nurse [N] 13).

The importance of managing emotions also relies on the fact all feelings and emotions that nurses and physicians express affect patients’ feelings and emotions, which will impact their attitudes and behaviors, either positively or negatively (Andersen & Kumar, 2006). According to



physicians and nurses, the display of emotions, if well managed, can be beneficial to patients' well-being. McQueen (2004) stated that the quality of care can be improved when nurses engage with patients and anticipate their needs and wishes. In addition, physicians reported that emotions can act as a medicine for any disease and nurses understand that the way they treat patients can change a patient's day: "The tranquility that we can transmit to patients is able to make them leave the office without the need for drugs." (Physician [Ph] 10). Some patients also illustrated this view that the display of emotions is helpful for improving their psychological well-being, reporting some situations:

"I had a physician who was a very close friend, was very caring and concerned about me and it affected me because it made me feel good. So, the way he showed certain emotions affected and altered my state of mind. And it also happens with negative things. Once, I was operated by a physician who never spoke to me, at that time I was so upset." (Patient [P] 8)

This claim also showed that the strong bonds between patients and healthcare professionals make patients return to that healthcare institution. Goff and colleagues (1997) stated that customers perceive employees as part of the company and positive feelings towards them, carry over to feelings towards the organization. Also, these bonds appear to result from patients' desire to be attended by the same nurses and the same physicians over time. They suggested that it is the only way to get a personalized service:

"A patient is a weakened person, so, sometimes, it is important to establish a stronger connection with a particular professional. That person already knows you, so it gives you courage and strength. They know what your needs are, fears, concerns and so the patient is now more comfortable and, perhaps, also feel safer." (P2)

Nurses stated that they often have close relationships with patients, describing them as "almost friendship" (N19). Nurses reported an attempt to get involved in patients' lives as they perceive that this is advantageous for their recovery and for the creation of a positive atmosphere. A service encounter composed by caring and individualized attention that the service provider gives to customers takes on added significance (Wong & Sohal, 2003), as illustrated by this nurse's personal experience:

"There were moments in my career where I cried with patients' parents. When some situations have a great impact on the family, e.g. diagnosis of a chronic disease, I feel involved too. And with those children that I had the first contact I feel that I am a little more emotionally connected..." (N5)

As we already seen, relationships between patients and healthcare professionals are important to these individuals. They see relationships as crucial to service quality; when there seems to be a poor relationship service quality is perceived as compromised. Hence, the empathic relationship appears as the key to service quality. Brady and Cronin Jr's (2001) study of a new and integrated conceptualization of service quality pointed in the same direction, stating that service providers' empathy is determinant to delivering good service quality. In addition, Di Blasi et al. (2001) stated that when physicians are warm, friendly and reassuring with their patients they are more effective. Physicians reported that when the relationship between healthcare professionals and patients is not positive, the patient cannot take full advantage of the service. Thus, all participants appeared to believe that the technical part of the service delivery does not constitute the whole of the service quality.

Unlike in the past, recently there has been an increased appreciation of involvement and commitment in healthcare services (McQueen, 2004). Some physicians argued for the importance of positive relationships with their patients: "The relationship is the key to our business, if there is no

good relationship the patient does not take full advantage of the service.” (D1); “I think that [the healthcare professional / patient relationship] is one of the key points that will form patients’ perceptions about the hospital. Often, the empathic relationship established between physician and patient overlaps the scientific knowledge and professional competence.” (Ph13). In sum, these healthcare professionals report that they are perceived as the image of the hospital, so, they cannot only provide a technical service but also they must show empathy towards patients as part of their job.

### *6.2 Performances as ‘the only thing that really matters’*

The other meaning presented in figure 7 – which we designated as performative engagement – relates to the idea that some participants considered that emotions are unnecessary to service transactions and that they might even have negative consequences. The job detachment seems to be the reason why healthcare professionals perceived emotions in this way: “I use strategy and game tactics. Zero empathic relationship for my protection. Since I enter and leave the hospital my relationship is purely professional” (N30). They believed that service quality can only be achieved when healthcare professionals maintain a professional distance from patients and focus their attention exclusively on the technical part of the service performance.

In this approach, healthcare professionals try to have a great control of their emotions, avoiding display to patients, as they appeared to believe their work should only be based on technical prowess. As Erickson and Grove (2007) agreed emotions should be controlled to the benefit of the employee and organizational effectiveness. A physician explained why he doesn’t want to show emotions: “I try to clarify and calm down patients and I try to control myself and not to show emotions, because, if I show emotions to a patient with a serious illness, it can complicate the situation.” (Ph3). Some patients agreed with these conclusions: “I think that nurses should control

their emotions, because I think it aggravates the psychological state of a person. Healthcare professionals should always be serene, calm and not show pity in relation to any disease.” (P2).

Emotions, according to these individuals, may create unnecessary alarmism, worsening patients’ psychological state. In addition, patients considered that, if healthcare professionals are too emotional, that is, if they show what they feel about the situation the patient is going through, it may interfere in healthcare. Thus, these individuals suggested that professionals should not get too involved with patients but attempt to be more rational and less emotional. Henderson (2001, p. 133) showed in her study a similar opinion from nurses, saying that “too much emotional engagement may render the nurse incapable of doing the job”. In addition, some nurses viewed detachment to ensure effective nursing or to self-protect against harm. This perspective is clearly illustrated by some patients: “I think that healthcare professionals should act with rationality, however, this should not be confused with detachment and coldness towards the problems experienced by patients.” (P4). According to these patients, the ideal service delivery is a personalized service, showing concern and interest in the patient, maintaining empathy, and not going beyond the emotional level: “Nurses and physicians should act professionally above all. They should ask the questions they consider necessary to make the correct diagnosis. They must have delicacy and compassion for the sick and be unbiased towards particular responses and patients’ behavior.” (P7).

Physicians stated that they shouldn’t show their inner emotions but give at least the impression that they are emotional and sensitive beings, just like patients. Furthermore, they reported they should neither spoil patients nor have personal conversations with them to the extent that this involvement can negatively affect patients' well-being. Physicians want to be serious, clear, objective and professional. Also, they are somewhat less emotionally involved because they spent less time contacting with patients (Argentero et al., 2008). These performance’s characteristics were present throughout the interviews: “I try to be fair, to be correct and friendly. But the patient is not my father,

my brother or my friend, so there must be a certain distance. I can separate things and turn off from situations.” (Ph2).

Meanwhile, some nurses mentioned they must not create and maintain any closeness with patients, since it can affect the experience of both healthcare provider and patient, in relation to the disease. However, is based on literature that nursing leaders engaging in relationships will facilitate successful management (McQueen, 2004). Still, these nurses considered that emotions do not add any value to the service provided. For them, the most important service quality factor was the quality of equipment, teamwork, and technical skills. This view has been commonly argued in the literature, that nurses try to maintain a professional barrier and avoid becoming emotionally involved with patients and so discourage human interaction (McQueen, 2000). For some nurses, interactions with patients were inadequate: “From the moment they [patients] come in until they go away, my relationship and connection remain professional. Empathy is dangerous to my sanity. I keep it to my family.” (N29).

Patients also agreed that their relationships with healthcare professionals did not influence their judgment about the overall service quality. Clemes et al. (2001) confirmed that patients give more importance to service quality dimensions that refer to the core product, which is to successfully treat a medical condition. Some patients explained why they don't agree that their relationship with healthcare professionals influences service quality: “I think this is a bit misleading, because they can be friendly and attentive and able to put us at ease, but they also can be incompetent. So, I do not associate the two things, are different things, so a good relationship with a physician or nurse does not mean that the quality of service is excellent.” (P13). Patients also showed they didn't have a special preference for any healthcare professional; they only wished nurses and physicians to be friendly and professional, as they believed that they could not create bonds of friendship with them.

Furthermore, nurses, physicians, and patients agreed that there was no emotional impact, since they were all able to move away from emotional situations. They were not influenced by

situations that they witnessed as they keep a distance that allows them to act professionally, as some nurses explained: “I act diplomatically. I remain stable and, sometimes, I don’t listen to the dubious complaints of patients. I’m indifferent and I remain neutral.” (N26).

However, there seemed to be a behavioral influence on the extent that when patients are more aggressive healthcare professionals would also tend to be so, and vice versa. A nurse said “My way of being at work depends on the patient and the way (s)he presents himself/herself in the room. If (s)he is polite, I make a regular contact without changing. If (s)he is aggressive, I use cynicism and sarcasm, are infallible weapons to disarm them.” (N27); and a patient said, “From physician to patient, there is an influence because, if the physician is angry, moody and we notice that, we became uncomfortable: nobody likes to be treated by someone with this psychological state.” (P3).

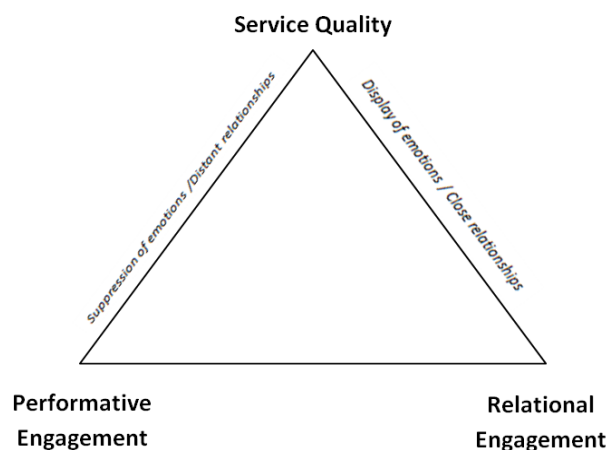
## **6. Discussion**

The emotional interactions and emotional management between healthcare professionals and patients are relevant but an understudied phenomenon. Healthcare professionals’ values, meanings, attitudes and emotional management strategies and its perceptions by patients may be associated with the perceptions of healthcare service quality, patient satisfaction, and even health outcome. Therefore, this study attempts to explore the balance between expressing or suppressing emotions and negotiating closeness vs distance within the healthcare context.

Our findings suggest that there is a dualistic view regarding the management of emotions in healthcare services (Figure 9), namely a reliance on emotions to develop connections – relational engagement – or, in contrast, an emotional control which deflects attention to the technical skills – performative engagement. The first perspective, which is already reported by the literature, underlines the importance and the expression of emotions to establish or develop a close relationship between healthcare professionals and patients, serving also as a facilitator of their physical and mental recovery and experience in the healthcare unit. Hence, this perspective of relational

engagement is advocated when the proximity between professionals and patients is considered essential to the execution of a personalized treatment and to create confidence and hope among patients.

On the other hand, the second perspective - performative engagement – is a novelty for the literature of managing emotions in healthcare. This perspective values the importance of healthcare professionals’ technical capabilities over the use of emotions in their relationship with patients. The display of emotions is deemed unnecessary and even detrimental, since it may adversely affect the relationship between professionals and patients, increasing stress and burnout among them. Thus, these professionals tend to control and suppress their emotions.



**Figure 9** A systemic model of emotional management perspectives and service quality.

Although we found these two different perspectives, the second one was the most frequently reported by respondents from the three groups (nurses, physicians, and patients). However, the performative engagement perspective is contrary to what the literature supports. The literature advocates that nurses themselves consider that the management of emotions is a key role in making patients feel better, more comfortable, and more satisfied (Mann & Cowburn, 2005). This is due in

part to social expectations that perceive healthcare professionals as managers of care (Bolton, 2000; Larson, 2005). Nurses are expected to have not only professional competence but also the necessary sensitivity to meet patients' vulnerability and anxiety (Akerjordet & Severinsson, 2004).

Also, the literature claims that there is a shift from a detached concern for patients, i.e., when nurses are concerned about someone without being emotionally involved, to a wish to be emotionally engaged with them (Halpern, 2001; Cadge & Hammonds, 2012) and nowadays emotional labor it is an indispensable aspect of patient care (Hochschild, 1983; Henderson, 2001; Mann, 2005). However, according to our results, there are still a great number of nurses and physicians that prefer to be emotionally detached from their patients, and healthcare managers have to be aware of these professionals' perceptions in order to set strategies to overcome this issue. We hypothesize that this situation occurs because of three main reasons: 1) nurses and physicians feel the need to protect themselves; 2) they believe that this is the best way to give a quality service to patients; and 3) they are not motivated to emotionally engage with their patients. A study by Kerfoot (1996) that focused on nurse manager's challenge confirms our results, arguing that patients experience many situations where they receive excellent technical care, but the emotional side of their care is not met.

Regarding patients' perceptions about the management of emotions, most patients give great importance to relationships and to positive interactions with healthcare professionals, because they consider that this is a key factor in service quality. The display of emotions makes the professional more human and makes patients feel better. For example, in the case of patients with a more serious health condition, it is good to realize that physicians and nurses also have personal problems. Nevertheless, there are other patients that do not want healthcare professionals to be emotionally engaged with them, because they consider that it may interfere with care and can also create alarmism among patients because they do not have the sufficient knowledge to evaluate the technical part of the service. Also, these patients consider that healthcare professionals should work more with reason and less with emotion.



Our findings are partially consistent with the literature on emotions in healthcare. Some studies about nurses' behaviors and relationships between nurses and patients concluded that patients feel cared for when nurses treat them as individuals and are supportive and available to them, anticipate their needs and appear confident in their work (Godkin & Godkin, 2004; Hines, 1992). The study from Williams (1997) about patients' perceptions concluded that patients give more importance to nursing care that recognized them as a unique individual with a need to share feelings and to have someone listen to them. Patients also reported that nurses' affective activities are more important for quality nursing care than their technical skills.

Even so, a possible explanation for this dualistic view about managing emotions can be what Fotiadis and Vassiliadis (2013) found: a patient's satisfaction with healthcare services depends on their individual preferences, personality and experience, and on their personal experiences during their illness. We also argue that these two perspectives can be related to the type of patients, that is, patients who go to the hospital often, almost daily, argue that healthcare professionals should foster close relationships among them, while patients who go sporadically to the hospital, for example once or twice a year, consider that this emotional side is unnecessary for patient care.

Several studies appear contradictory with our findings such as the work of Bitner et al. (1990) and Allen et al. (2010), that argued that employees' behavior was determinant for customers evaluation of the service; and the work of Pugh (2001) that stated that the display of positive emotions by employees was positively related to customers' evaluations of service quality. Our study reaches a different conclusion because emotional labor was not associated with service quality. Actually, most participants did not indicate the relationships between healthcare professionals and patients and the management of emotions as essential for the quality of service. In fact, is patients' waiting time and healthcare professionals' punctuality that were considered more important. A possible explanation is that both healthcare professionals and patients do not value so much the use of emotions and the relationships they maintain with each other, as they value other factors for the

service quality. Furthermore, the interviews were conducted in public hospitals, which possibly are still viewed only as cure centers and not as care centers.

However, all three groups of respondents, when directly asked about emotions, said that emotions and the relationships between healthcare professionals and patients influence their perception of service quality. There is still to add that, interestingly, participants who responded negatively to this question, i.e., they consider that the management of emotions and the relationships do not influence the perception of the service quality, were only patients. In spite of respondents consider that emotions and relationships between healthcare professionals and patients have some influence on service quality perception, they do not consider these to be a service quality determinant.

## **7. Implications**

The present study presents a dualistic view regarding emotions in the workplace: healthcare professionals' reliance on emotions to develop connections – relational engagement – or healthcare professionals' emotional control which deflects attention to the technical skills – performative engagement. But from these two perspectives, most nurses and physicians tend to control their emotions and to detach themselves from patients because they feel the need to protect themselves. They believe that this is the best way to give a quality service to patients and they are not motivated to emotionally engage with their patients. This is an important challenge in services and, in the case of healthcare it represents a major challenge for administrators. They must adopt certain strategies that will answer the question about what is the right thing for the healthcare institution to do in order to deliver a good service quality: to show or to hide emotions? In this sense, managers should focus on the experience and expression of emotion during service encounters to know how to train healthcare professionals to deliver a better service. Also, managers should be aware of on which

conditions healthcare professionals refuse to do emotional labor so as to be able to counteract this trend.

Another implication is that healthcare organizations might benefit from communicating their emotional labor requirements during the selection process to help individuals decide whether their expressive behavior matches the organization's display rules. However, the organization must also provide the appropriate conditions for professionals to be motivated to do emotional labor.

In sum, emotional labor should not be understood as something that has a negative impact on employees' well-being (Grandey, 2000; Zapf & Holz, 2006; Grandey, 2003), but on the contrary, when properly understood by them, has positive effects both on employees and on customers, gaining special emphasis in healthcare services, because, as Banning and Gumley (2012, p. 804) states, "it is impossible to extract the human element of nursing from the provision of nursing care". Our findings suggest that healthcare professionals perceive the management of emotions and the establishment of relationships with patients as unnecessary and even detrimental to service quality. Therefore, there is a need for managers to encourage nurses and physicians to engage in positive behaviors when interacting with patients, regardless patients' behavior. Even if patients are unpleasant and hostile, healthcare professionals should maintain their positive attitude and additionally express positive emotions.

## **8. Limitations and future research**

Our main limitations are related to the generalizability of the qualitative results, the limited duration of the interviews, due to low availability of participants, and a large gender disparity, with more women than men participating in the study. Another constraint that may have influenced our study was the geographical scope of our sample, restricted to the north of Portugal, in a specific economic and social moment, albeit one that resembles many other European countries undergoing a social and

economic crisis. Furthermore, the interviews were conducted in public hospitals, which possibly are still viewed only as cure centers and not as care centers.

Also, due to its exploratory nature, this study only focused on how healthcare professionals and patients perceive the management of emotional labor in an overall manner, not taking advantage of more specific issues that may explain the phenomenon that results from this investigation. Particularly, it would be interesting to explore with a quantitative approach the personal and contextual antecedents that can be associated with a more critical or distanced relational approach to patients and a more empathic one. Furthermore, focusing on the type of patient, considering how often they go to the hospital, it would be an interesting topic of study.

Future research should also explore if this phenomenon occurs in a variety of clinical specialties and in private and public healthcare institutions as well as the circumstances in which it occurs. We could also apply these new concepts – relational engagement and performative engagement – in other types of services where there is an intense interaction between service providers and customers. Further studies targeting specific emotional labor strategies, namely observational studies, would bring much needed information on the efficacy and well-being correlates for both patients and professionals. Also, in-depth interviews that explore the individual psychological mechanism underlying such specific strategies should shed light on a much understudied subject.

## **9. Conclusions**

This is the first qualitative study about the value, meanings, attitudes and strategies of emotional management by healthcare professionals and its perceptions by healthcare professionals themselves and by patients. Our study contrast with the literature – that states that nurses are care managers – suggesting a dualistic view regarding emotions in the workplace. Not only healthcare professionals but also customers portrayed emotional expression in a positive and in a negative way. In other

words, some healthcare professionals and patients identified with a relational engagement during the service encounter and attributed it to the way they see emotions as an asset in treating patients' diseases and improving their psychological well-being. For this group of participants, emotions were considered intrinsic to the healthcare service. Other healthcare professionals and patients identified with a performative engagement, to the extent that they perceived the display of emotions as useless or even as having a negative impact on their work roles and on patients' physical and psychological condition. They tend to act neutral or to show their true emotions, whether positive or negative, in response to patients' emotions, driven by job dissatisfaction, stress and burnout. These different perspectives are due to the fact that the meaning attributed to "emotions at work" may vary from person to person (Gosserand & Diefendorff, 2005) and may be also due to several factors such as working conditions, healthcare professionals' motivation, physicians', nurses' and patients' perceptions of service quality, type of patients, and patients' personality and experiences, among others. For that reason, the expression of emotions and empathy must not be mistaken for the establishment of personal or intimate interactions beyond the purpose of a relationship between a healthcare provider and a customer. It is, instead, something that should be perceived as part of the job (Henderson, 2001), with the purpose of promoting patient's psychological well-being, ultimately actively contributing to the creation of a positive environment during the service performance. Future research should pursue the objective of studying healthcare providers reinterpretation and consolidation of a new professional identity that, besides goal-oriented, is also person-oriented. The goal of healthcare is well-being, which has a psychological and physical dimension and therefore, any attempts to detach it from the human factor will result in a loss of quality.

**STUDY 2: EMPLOYEE EMOTIONAL EMPOWERMENT: A NEW WAY TO MANAGE  
EMOTIONS IN THE WORKPLACE**

## **Abstract**

**Purpose** – Based upon the results of the previous qualitative study conducted in hospitals, and based upon the emotional labor literature, this paper discusses how the concept of *employee emotional empowerment* can constitute a major practice for service organizations compared to the emotional labor theory. We propose that the concept of *employee emotional empowerment* constitutes a more complete and realistic practice of managing emotions that benefits both the organization and the employee.

**Design/methodology/approach** – This paper reviews the growing body of literature regarding emotional labor. We, then, articulate how employees can manage their emotions without having the sense of burnout and dissatisfaction. We conclude showing how employee emotional empowerment can be a better alternative to emotional labor.

**Findings** – The concept of *employee emotional empowerment* is based on two crucial research streams: empowerment and authenticity. When employees are empowered to manage their emotions, as they may perceive more appropriate, they may easily adapt their behavior and performance to customers.

**Research limitations/implications** – A shared vision of the goals of the organization, organizational support, improvement of employees' skills, and the recognition and appreciation of employees' performance is crucial for an effective implementation of *employee emotional empowerment*.

**Originality/value** – This study adds to the body of literature on emotional labor by exploring a new strategy of managing emotions in the workplace.

**Keywords** – employee emotional empowerment, emotional labor, empowerment, authenticity, healthcare

**Paper type** – Conceptual paper

## **1. Introduction**

Lately has been a growing interest in the role of emotions in organizational contexts, in which social interactions are a significant part of the work (Heaphy & Dutton, 2008). Given that people and emotions are inseparable and employees take their emotions to work, employees' emotions need to be considered an integral part of organizational life (Ashforth & Humphrey, 1995). Emotions influence many organizational dimensions such as decision making, creativity, teamwork, negotiation, leadership and job performance (Barsade & Gibson, 2007). Accordingly, emotions have become part of the job requirements and employees are expected to engage in emotional labor.

According to the previous qualitative study, healthcare professionals and patients have a dualistic view about the management of emotions at work. Some participants found the display of emotions and close relationships between healthcare professionals and patients – relational engagement – as fundamental to service quality; whereas others considered that emotions are unnecessary to service transactions and that they might even have negative consequences – performative engagement. But we still don't know which of these two perspectives is the right or the wrong one, or whether both are right, depending on the services circumstances.

What is certain and defended by literature is that employees normally feel a discrepancy between their inner emotions and the emotions that they are expected to display (Ashforth & Humphrey, 1993; Brotheridge & Grandey, 2002) and the only way to manage this problem is doing emotional labor, through surface acting (faking their emotions) or deep acting (trying to match their emotions to what is expected of them) (Hochschild, 1983). However, we consider that employees may also have the alternative of expressing their true emotions (when, for example, they identify with their work or when they just prefer to work authentically with their customers) and this behavior may have a positive impact for the organization and the customer and also for the employee himself. Therefore, it is important to explore this issue as it can project a different perspective on how to manage emotions in the workplace.



We address this conceptual void by exploring and proposing the construct *employee emotional empowerment* and answering the question how employee emotional empowerment can stand as an alternative to emotional labor? This review demonstrates the conceptual gap and further advances the emotional labor literature, through the presentation of a new practice to develop an efficient and positive management of emotions. As such, the value of this conceptual paper is twofold: 1) complements the theory of emotional labor, helping to better understand how employees manage their emotions at work; and 2) it introduces the concept of *employee emotional empowerment* and proposes as a construct to be empirically studied in future research.

In this article, we proceed three theoretical steps. First, we provide a literature review regarding the emotional labor process and present the boundary conditions of this construct. Second, we explore in detail the emotional labor strategies of surface and deep acting. Third, based on review of the emotional labor process literature we propose the new construct *employee emotional empowerment* and its potential association with patient's satisfaction and employees' well-being, as well as the advantages it brings to the field of service and organization.

## **2. Emotional labor: a limited concept**

Emotional labor is the management of emotions required by the organization. Employees, especially those with boundary spanning roles, are expected to suppress negative emotions and express positive emotions in order to meet what the organization expects from them (Hochschild, 1983). Emotional labor implicitly presumes that the true feelings of employees are not in line with the emotions that the organization requires them to express. This is called emotional dissonance, that means when there is a discrepancy between what employees feel and what they should express, they must engage in emotional labor (Ashforth & Humphrey, 1993; Brotheridge & Grandey, 2002).

The definition of emotional labor has undergone several evolutions. Initially, Hochschild (1983), the mentor of this theory, defined *emotional labor as the management of feelings to create a*

*publicly observable facial and bodily display; emotional labor is sold for a wage and therefore has exchange value.* This definition clearly refers to the fact that employees are required to regulate their own emotions and express them for a commercial purpose. Hochschild based her theory of emotional labor in the dramaturgical perspective of Goffman (1959), where the efforts made by the employees to regulate their emotions according to what the organization requires are performances.

To manage the discrepancy between the emotions felt and the emotions that need to be expressed, Hochschild proposed two strategies that require some effort, namely surface acting and deep acting. Surface acting strategies occur when one performs an emotional display to meet certain rules and expectations. Such display of emotions has been considered inauthentic since the expressed emotions do not match the internal experience of the employee (Grandey, 2000; Coté, 2005). In turn, deep acting occurs when a person consciously attempts to feel a specific emotion that matches the expected emotional displays (Grandey, 2003). Service providers might try to change what they feel to experience the emotions that they are expected to display (Groth et al., 2009). Hochschild (1983) suggested that it is because of employees' efforts to express a positive emotion, while dealing with particularly difficult customers, that emotional work is usually related to burnout and occupational stress.

Unlike Hochschild, Ashforth and Humphrey (1993) based their definition of emotional labor on the behavior of employees as the act of displaying the appropriate emotion. In addition, the authors devalued the surface and deep acting dimensions by stating that it can become routine for employees and therefore are not sources of stress. To these dimensions was also added the possibility for employees to express genuine emotions, which constitutes a flaw in the concept of emotional labor in their perspectives (Ashforth & Humphrey, 1993). A service provider can naturally feel what (s)he is expected to feel and express without having to adopt one of the strategies presented by Hochschild (Ashforth & Humphrey, 1993). According to the authors, this can be considered a third strategy to conduct emotional labor. Regarding the consequences of emotional labor, Ashforth and

Humphrey (1995) focused primarily on the impact of emotional labor on work performance or effectiveness, rather than on its impact on the individual's health. The authors proposed that emotional labor can positively contribute to work effectiveness when customers perceive the emotions as being sincere and genuine.

Morris and Feldman (1996, p. 987) also contributed to the progression of emotional labor literature by refining its definition as "*the effort, planning, and control needed to express organizationally desired emotion during interpersonal transactions*". According to the authors the emotional labor consists four dimensions: (a) frequency of interactions, (b) attentiveness (intensity of emotions, duration of interaction), (c) variety of emotions required, and (d) emotional dissonance. From these dimensions, the frequency with which emotions have to be expressed has been the most studied. The authors assumed that when individuals have to express desirable emotions with high frequency in their work, they can become overloaded and may eventually lead to alienation and emotional exhaustion (Hochschild, 1983).

The concept of emotional labor advanced by Zapf and colleagues (1999) is based on action theory. Accordingly, emotional labor is understood as part of an intentional and goal-oriented behavior. Employees are required to perform certain tasks in a certain way. These requirements are redefined by employees, which include rules to determine how these tasks should be carried out. In service-related professions, these rules may refer to the emotions expressed to customers (Zapf et al., 1999). One of the goals is precisely to perform emotional labor, that is, to behave accordingly to the organizational display rules. Zapf et al. (1999) focused mainly on the situational requirements of the job, rather on the strategies for regulating emotions. The authors distinguished between: 1) the requirement to express positive emotions, 2) the requirement to express and deal with negative emotions, 3) the requirement to be sensitive to the emotions of others, and 4) emotional dissonance.

In order to clarify the contradictions that have emerged in the literature, Grandey (2000) also defined emotional labor. Thus, she considered that emotional labor is "the process of regulating both

feelings and expressions for organizational goals" (Grandey, 2000, p. 97). Grandey (2000) developed a theoretical model based on Gross's theory of emotional regulation (1998). According to Gross (1998) there are two types of emotional regulation: the regulation focused on the antecedents and the regulation focused on the answers. Grandey (2000) sought to match these types of emotional regulation with the Hochschild's concepts (1983) of surface acting and deep acting, respectively. Thus, when individuals adopt a deep acting strategy, they are regulating the precursors of emotion (i.e. emotional regulation focused on the antecedents), modifying the situation or the perception of the situation. On the other hand, when individuals engage in surface acting, they are regulating their emotional responses (i.e. emotional regulation focused on responses), modeling their emotional expressions according to the situations. Grandey (2000) considered that emotional labor can have negative consequences for individuals such as burnout and job dissatisfaction. In the table below we can follow the evolution of the construct *emotional labor*, as well as the main characteristics pointed out by each researcher.

<b>Authors</b>	<b>Definition</b>	<b>Key Characteristics</b>
Hochschild, 1983	The management of feelings to create a publicly observable facial and bodily display.	It does not allow employees to spontaneously and genuinely experience and express the expected emotion.
Ashforth and Humphrey, 1993	The act of displaying the appropriate emotion.	Genuine emotions are considered a third strategy to regulate emotions at work.
Morris and Feldman, 1996	The effort, planning, and control needed to express organizationally desired emotion during interpersonal transactions.	Emotional labor consists of four dimensions: 1) frequency of interactions, 2) attentiveness (intensity of emotions, duration of

		interaction), 3) variety of emotions required, and 4) emotional dissonance.
Zapf and Holz, 2006	Emotional regulation to display organisationally desired emotions by the employer.	Emotional labor is divided into: 1) the requirement to express positive emotions, 2) the requirement to express and deal with negative emotions, 3) the requirement to be sensitive to the emotions of others, and 4) emotional dissonance.
Grandey, 2000	The process of regulating both feelings and expressions for organizational goals.	There are two types of emotional regulation: the regulation focused on the antecedents and the regulation focused on the answers.

**Table 2** Evolution of the concept of emotional labor

In the following section we will analyze in detail the strategies of emotional labor, to which service employees are restricted, namely surface acting and deep acting.

### **3. Surface and deep acting strategies**

To regulate emotions and expressions to achieve organizational goals, two strategies of emotional regulation can be used: surface acting and deep acting, each with different psychological effort requirements (Martinez-Iñigo et al., 2007).

The surface acting strategy is a way of trying to manage the visible aspects of emotions, so as to fit the display rules, while the feelings remain unchanged. Therefore, this is a form of pretending

to feel the expected emotion that leads to the existence of an emotional dissonance between feelings and expression (Zapf, 2002). It is considered a response-focused emotional regulation strategy since it focuses on the regulation of expressions and is used after the emotion has already developed. In this sense, the feelings are not adjusted, but only a management of emotional expression is made, appearing as a kind of a mask. This is achieved through careful verbal and non-verbal presentation, considering facial expression, gestures and tone of voice (Mann & Cowburn, 2005). The emotional response is adjusted and seeks to modify the behavior by suppressing, amplifying or pretending emotions (Grandey, 2000).

Hence, the use of this strategy is especially critical in understanding the potential consequent stress of emotional labor (Grandey et al., 2005). Surface acting has been related to individual states of distress, loss of sense of authenticity, and dissatisfaction at work (Ashforth & Humphrey, 1993; Brotheridge & Grandey, 2002; Grandey, 2000, 2003; Hochschild, 1983; Hülshager & Schewe, 2011; Kammeyer-Mueller et al., 2013; Morris & Feldman, 1997). Grandey (2003) related the surface acting strategy to emotional exhaustion based on two arguments: first, the tension felt because of emotional dissonance and, second, the energy expenditure due to the effort made. Also, Brotheridge and Grandey (2002) demonstrated a positive relationship between surface acting and depersonalization and a negative relation to personal fulfillment. The meta-analysis conducted by Hülshager and Schewe (2011) demonstrated the negative repercussions of surface acting on individual well-being and its influence on burnout. Also, the meta-analysis of Kammeyer-Mueller et al. (2013) evidenced the negative effects of surface acting on employees' health despite their affective traits and the demands of the job.

About the effects of surface acting on the customer service quality, the literature has associated this strategy with less effective performance, distorted service provision and negative perceptions of service quality (Grandey, 2000; Hülshager & Schewe, 2011; Kammeyer-Mueller et al., 2013).

On the other hand, the deep acting strategy focuses on the self-regulation of feelings and arises when individuals try to influence what they feel to truly feel and perform the role that is expected. In this case, not only expressive behavior but also feelings are regulated, and there is a need to direct attention to pleasant things to invoke thoughts, images and memories to induce a certain emotion (Ashforth & Humphrey, 1993; Zapf, 2002) or to reassess the situation to induce the required emotion (Grandey, 2000). It is considered a strategy of antecedent-focused emotional regulation since it occurs before the development of emotion, affecting the perception and processing of emotional stimuli. Therefore, it helps to modify the situation or the cognitions of the situation at the beginning of an emotion, before provoking behavioral or physiological response (Grandey, 2000). Thus, the deep acting strategy results in an emotional state in which the emotions felt and expressed by the individuals are congruent (Mesmer-Magnus et al., 2012), and, therefore, it is often confused with a genuine emotional demonstration of the required emotions (Hulsheger & Schewe, 2011).

The deep acting strategy has been related to feelings of self-fulfillment, lower levels of negative emotions, and greater job satisfaction (Brotherly & Lee, 2002; Grandey, 2003; Groth et al., 2009; Hülshager & Schewe, 2011). Grandey (2003) related deep acting with emotional exhaustion, based on the arguments of the tension felt because of emotional dissonance and the expenditure of energy because of the effort made. According to the author, the modification of one's feelings by the adoption of deep acting requires attention and effort. However, the study did not reveal a significant relationship between these dimensions. On the other hand, Brotheridge and Lee (2002) demonstrated a positive relationship between deep acting and the sense of authenticity which, in turn, was negatively related to emotional exhaustion. According to Hülshager and Schewe (2011), deep acting provokes a tendency for employees to feel more satisfied with their work and more competent in the performance of their duties.

As for the effects of deep acting on customer service quality, the literature has associated this strategy with more effective performances, more authentic services and positive perceptions of service quality (Grandey, 2000, 2003; Groth et al. 2009; Hülshager & Schewe, 2011; Kammeyer-Mueller et al., 2013).

Although deep acting and surface acting strategies are considered ways to help individuals express emotions, they do not arise naturally (Diefendorff et al., 2005). Ashforth and Humphrey argued that an exclusive focus on the strategies of deep and surface acting ignored the fact that individuals could spontaneously experience and demonstrate the appropriate emotions. According to the authors, emotional labor presupposes a performance of functions in accordance with the rules of the organization, so that an employee who genuinely expresses the appropriate emotions does not stop performing emotional labor.

Zapf (2002) proposed automatic regulation as an automatic way of demonstrating the emotions desired organizationally through spontaneously felt emotions. Diefendorff et al. (2005) confirmed the existence of a third distinct process from the strategies of deep acting and surface acting of emotional regulation in which individuals naturally express the emotion felt. Expressing genuine emotions is not just a proxy for low levels of surface acting or not redundant with deep acting; expressing genuine emotions is a separate construct. This strategy requires a much lower level of psychological effort when compared to surface and deep acting (Martinez-Iñigo et al., 2007).

This leads us to conclude that there should be other alternatives that avoid or minimize the negative effects of emotional labor. Therefore, we propose to replace the strict emotion display strategies of surface acting and deep acting with practices that support and value employees. Empowering employees allows them to manage their emotions appropriately by generating authentic positive emotions and helping to overcome dissonance (Lashley, 2001). This, in turn, makes emotional management less costly to employees and more beneficial to organizations.



#### **4. An alternative: Employee Emotional Empowerment (EEE)**

Based on emotional labor literature, we suggest the construct of *employee emotional empowerment* as a practice that organizations should embrace and pass on to their employees to effectively perform a service encounter. We define *employee emotional empowerment* as the degree of discretion allowing employees to display emotions (authentic emotions or emotional labor) that they believe are most appropriate following both their own and the organization interest. The essence of this construct is based on the empowerment and authenticity of service employees that we will explain next.

##### *Empowerment*

Empowerment is a way for employees to take responsibility for the service encounter, that allows them to adapt to customers' behavior and to respond more quickly and effectively to their needs and complaints (Grönroos, 2001). Empowerment practices allow the individualized rather than the standardized service delivery, so that responses and solutions can be tailored to each customer (Rafiq & Ahmed, 1998).

The concept of empowerment underlies the principle that employees are a resource with knowledge and experience and have an interest in being involved. This can be achieved through opportunities and structures created by managers, thus reaching gains for organizations (increased efficiency and effectiveness) and for employees (job satisfaction) (Wilkinson, 1998). The core element of empowerment involves giving employees discretion over certain task related activities (Chan & Lam, 2011). Many service managers agree that frontline employees should be allowed a degree of discretion when dealing with customers, due to the special nature of services, particularly the simultaneity of production and consumption (Rafiq & Ahmed, 1998).

Empowering employees allows to improve their motivation and productivity and in turn to improve service for the customer and market the service products more effectively (Rafiq & Ahmed, 1998). For instance, Grönroos (1990) argued that the empowered employees have the capability to

rectify mistakes and an opportunity to increase sales. Empowerment can increase employees' self-efficacy as discretion allows them to decide the best way to perform a given task (Gist & Mitchell, 1992).

According to Aziz (2009), employees' empowerment is an important tool to manage their emotions and to reduce the emotional dissonance, as such it is a way of managing emotions. author states that the empowerment will guarantee the employee satisfaction at work, which, in turn, will lead to performing a high service quality and contributing to customer satisfaction. Fineman (1993) argued that allowing employees to feel their own power and the importance of their role may help them to manage their emotions appropriately.

Empowerment also has its risks. The main consequences of empowerment are increase the scope of the employees' jobs, slowing down the service delivery process as the empowered employee attempts to individualize the service for customers (Bowen & Lawler, 1992). In situations where employees are empowered to rectify service failures by give-aways there is a risk that employees give too much away, and employees consciously or unconsciously use their discretion disproportionately to bestow better service on customers who are like them (Martin, 1996). However, these risks can be minimized through recruitment as it is necessary to ensure that employees recruited have the requisite attitudinal characteristics and skills to cope with empowerment, training and rewards. Nevertheless, the benefits of employee empowerment are greater and, in the particular case of emotion management, empowerment is needed (Rafiq & Ahmed, 1998).

### *Authenticity*

Employees are required to manage their emotions in a way that matches organizational displays. Usually, this means that employees should suppress their genuine emotions and put on a smile, whether it is authentically felt or not (Rafaeli & Sutton, 1987). However, several studies concluded that customers' reactions to an inauthentic display are less positive than to an authentic (Ekman,

1992; Ekman & Friesen, 1982; Frank et al., 1993). In this sense, several authors have pointed out the importance of authenticity in service encounters (Ashforth & Tomiuk, 2000; Coté & Morgan, 2002; Mattila & Enz, 2002; Pugh, 2001; Tsai & Huang, 2002). First, service encounters are characterized by a dynamic and complex social interaction (Grandey et al., 2005), and second, authentic positive displays are important for both social reasons and financial and long-term benefits.

Several definitions have been advanced to capture the meaning of authenticity (Cranton & Carusetta, 2004; Thompson, 2005; Cranton, 2001) and, as Starr (2008) summarized, authenticity includes a set of attributes: a process of self-discovery where the individual realizes their personal potential and acts on that potential; and the individual demonstrates congruence in ideals, values, and actions in relation to self and others. According to Harter (2002), authenticity involves one's personal experiences- be they thoughts, emotions, needs, wants, preferences, or beliefs. Authenticity was defined as the extent to which one behaves according to what (s)he considers to be her/his true or genuine self (Ashforth & Tomiuk, 2000). Salmela (2005) argued that authenticity refers to the alignment of individuals' actions and behaviors with their internal values and beliefs.

Emotional labor is one of the demands of service roles that describes organizational variables to promote inauthentic emotional displays (Diefendorff & Gosserand, 2003; Rafaeli, 1989; Rafaeli & Sutton, 1987). Hochschild (1983) argued that when employees are required to manage their emotions in return for a wage, they become alienated from their authentic selves. Therefore, the author devalued the possibility of employees having pleasure to work authentically with their customers. Researchers argue that focusing only on surface acting and deep acting as strategies to regulate emotions ignores the possibility of congruence between employees' experience and expression of emotions during customer interactions (Diefendorff & Gosserand, 2003). Diefendorff et al. (2005) confirmed the existence of naturally felt emotion which is distinct from surface and deep acting. The emotional harmony and feeling of authenticity are possible when employees actually

experience the emotions that they are required to express as part of their work (Rafaeli & Sutton, 1987; Ashforth & Humphrey, 1993).

Employees can also behave authentically when they strongly identify with their organizational roles (Asforth & Humphrey 1993; Dieffendorf et al., 2005; Asforth & Tomiuk, 2000) and with the service task (Yagil & Medler-Liraz, 2013). Knoll and Dick (2013) stated that employees identify themselves with the organization when they perceive the organization as successfully representing them as a person, which enacts their personal engagement at work. Furthermore, Sheldon et al. (1997) added that the service environment might take individuals to behave authentically, that people tend to feel more authentic in closer interpersonal relationships. Mayer et al. (1995) concluded that employees' trust on their supervisor make them feel safer and more comfortable in displaying authentic emotions to customers.

Other components that can boost an authentic behavior are indicated by Yagil and Medler-Liraz (2013). In a study on transient authenticity, the authors concluded that customer non-service identity characteristics and employees' awareness of customers attributes drives employees to engage in an authentic behavior. Yagil and Medler-Liraz (2013) claimed that authenticity is a state of temporary psychological autonomy that reflects internal control over emotions, motivation and behavior.

Being authentic can bring benefits to the organization, both for employees and for customers. Kernis (2003), Ménard and Brunet (2011), and Toor and Ofori (2009) stated that genuine self-expression improves psychological well-being and social functioning, and triggers employees' job satisfaction. In-role performance, or employees' introspection about their performance is also identified as being positively associated to authenticity at work (Bosch & Taris, 2014). Wood et al. (2008) claim that the high levels of authenticity result in high levels of satisfaction with life, positive affect, self-esteem, happiness, personal growth, self-acceptance and gratitude. Customers' also benefit from this type of behavior, since employees' efforts to be authentic influence customers'

emotions and perceptions (Hennig-Thurau et al., 2006). In contrast, expressing inauthentic emotions creates difficulty in reducing customers' service-related ambiguity (Barsade, 2002). Hence, ensuring authenticity of emotional expression is as important for the organizations as preventing the inauthenticity during customer interactions.

Unlike emotional labor, which limits employee emotional performance, *employee emotional empowerment* allows employees to manage their own emotions as they see fit with the needs of their customers. This allows employees to adopt a tailored and individualized behavior for each customer and each service context. In addition, the risk of burnout and job stress is mitigated, as employees are not required to act in a way that goes against what they really feel. With this new concept employees can also act more authentically in their work which leads to job satisfaction on the one hand, and customer service quality on the other. More important than a positive display or a service with a smile is to display an authentic behavior, because when they are perceived as inauthentic that can lead to low service quality, customer dissatisfaction and job stress and burnout (Grandey, 2005).

Ideally, employees should be given decision power over the emotions they should or should not express and how to manage those emotions. Because different types of emotion management will be necessary, considering the service context, the type of customer, the type of service situation, and the type of customer-employee relationship, no one better than the employee himself to decide the best emotional strategy to adopt. The next table summarizes the main differences between the constructs *emotional labor* and *employee emotional empowerment*.

	<b>Emotional Labor</b>	<b>Employee Emotional Empowerment</b>
Definition	The management of feelings to create a publicly observable facial and bodily display (Hochschild, 1983).	The degree of discretion allowing employees to display emotions that an employee believes are most appropriate following both their own and the organization interest.

Strategies	Surface acting and deep acting (suppress and fake emotions, change inner emotions).	Whatever employees feel appropriate to display according to the service situation and the customer.
Negative impact	Burnout, job stress, employee turnover (Schaufeli et al., 1996).	-
Positive impact	Job satisfaction, self-efficacy, personal fulfillment (Côté & Morgan, 2002; Pugh, 2001).	Job satisfaction, self-efficacy, personal fulfillment, performing high service quality, customer satisfaction.

**Table 3** Comparing the constructs *emotional labor* and *employee emotional empowerment*

## 5. Conclusions, implications and future research

The topic of emotional labor has been much debated in the literature, especially the strategies that employees should use to manage their emotions in accordance to what the organization expects from them. To summarize, employees cannot be restricted to suppress or fake their emotions because, first, this behavior has a negative impact on their well-being, and second, authenticity must be allowed to adapt each service performance to different customers. Thus, we argue that employees must be empowered, that is, they must be given a degree of discretion to be able to manage their emotions in a way they think is more appropriate, what we call *employee emotional empowerment*.

There are several studies that refute the emotional labor theory, more precisely the strategies of managing emotions, namely surface and deep acting (Ashforth & Humphrey, 1993; Diefendorff et al., 2005). However, there is no theory to date that proposes an alternative for the emotional labor theory. In this study, we have made a theoretical contribution by highlighting the importance of empowering employees when it comes to manage their emotions. This research also contributes to the ongoing debate and discussion about the management of emotions at work, which just focus on the negative impact that the strategies of surface and deep acting may have on employees well being.

Some managerial implications that derive from the employee emotional empowerment consist in recruiting employees who know how to manage their emotions in the context of customer service and train employees to know how to deal with their own empowerment. Also, for an effective implementation of employee empowerment there should be a shared vision of the goals of the organization between employees and managers, employees should have organizational support, namely from their supervisors, there should be an improvement of employees' skills through continuous learning, and the recognition and appreciation of employees' performance is crucial for their motivation.

More research is necessary to explore the relevance and to characterize this new construct and about the conditions and success factors of *employee emotional empowerment*. Therefore, the usefulness of this construct should be empirically studied in the services setting. In regard to the relationship between the *employee emotional empowerment* and organizational positive outcomes, longitudinal studies may help determine whether this is a causal relationship. Multiple types of qualitative data may also be helpful to see if there is a difference between attitudes as gathered by interviews, and actions as seen through observation. Furthermore, the usefulness of the *employee emotional empowerment* could also be tested in several service contexts, especially in healthcare, where the management of emotions takes greater proportions due the proximity, frequency and intensity of relationships between employees and customers.

The inclusion of this construct in future research seems promising, as it might offer researchers a more comprehensive view of the process of managing emotions in the workplace. This will help to minimize employees' burnout, job stress and job turnover.

**STUDY 3: DOES THE PERCEPTION OF THE WORK ENVIRONMENT PREDICT THE  
USE OF DIFFERENT EMOTIONAL LABOR STRATEGIES IN HEALTHCARE? A JOB  
DEMANDS-RESOURCES PERSPECTIVE**



## **Abstract**

**Purpose** – Using the Job Demands-Resources (JD-R) model as the theoretical framework, this study investigates (a) how nurses' perceptions of their work environment predict their emotional labor strategies, and (b) the moderating effect of personality traits on this relationship.

**Design/methodology/approach** – We conducted surveys and collected data on predetermined instruments that yield statistical data. Data were collected through the Portuguese Nurses Council, yielding 180 valid questionnaires. Nurses' perceptions of work environment were measured through the Practice Environment Scale for Nurse Working Index (PES-NWI). Emotional labor strategies, in turn, were measured through the Emotional Labor Scale (ELS). Nurses' personality traits were measured through the Big Five Inventory Scale (BFIS). The hypothesized model was tested through a hierarchical multiple regression and a bias-corrected bootstrap analyses (using 1000 bootstrap samples) with the PROCESS macros developed by Hayes (2013).

**Findings** – The results reveal that a negative perception of the work environment is associated with the adoption of a deep acting strategy. However, nurses' personality traits do not moderate this relationship.

**Practical Implications** – When healthcare institutions offer a good work environment, nurses try to do their utmost to make their emotions correspond with what is expected of them. Thus, healthcare managers need to examine how organizational policies and practices are translated into the work environment.

**Originality/value** – This study provides the first examination of the perceptions of work environment associated with nurses' choice for emotional labor strategies using the JD-R theory as a theoretical lens.

**Keywords** emotional labor strategies, healthcare services, nursing work environment, personality traits, Job Demands-Resources Model

**Paper type** research paper

## **1. Introduction**

Emotional labor, defined by Hochschild (1983) as a form of emotion regulation that creates a publicly visible facial and bodily display within the workplace, is often necessary to help both professionals and patients handle a problematic situation or even daily tasks. Nurses, for instance, engage in emotional labor when they feel that their emotional displays do not match patient or social expectation (Mann & Cowburn, 2005). Such behavior assists nurses in managing their patients' reaction by facilitating emotional relief, and has a positive association with psychological and physical well-being and recovery (Man & Cowburn, 2005). When engaging in emotional labor, nurses can adopt one of these two strategies to comply with organizational requirements: surface acting or deep acting. Surface acting is when employees need to mask their own emotions to display the emotions required by the organization (Grandey, 2000). Deep acting refers to the display of emotions required by the organization through cognitive manipulation of their own emotions (Grandey, 2003).

Research investigating emotional labor in services settings has often emphasized the antecedents and outcomes of managing emotions (Grandey, 2000, 2003; Zapf & Holz, 2006). There is a set of variables at a cultural, organizational or individual level that can predict employee engagement with one of the emotional labor strategies, namely surface acting or deep acting. In turn, the emotional labor performance can lead to several outcomes which can be positive or negative (Gursoy et al., 2011; Karimi, et al., 2013). However, no research to date has examined how the perceptions of the work environment impact employees to choose from one or another approach to manage their emotions.

In the healthcare context, the management of emotions takes greater proportions compared to other service organizations, due the proximity, frequency and intensity of relationships between employees and customers (Mechinda & Patterson, 2011). Also, the essence of the nursing work environment makes it important to study the strategic management of emotions. Healthcare workers

are employed in a complex, stressful, demanding and sometimes hazardous work environment that affects outcomes for both organizational and individual level (Kramer & Son, 2016). Furthermore, research has shown that work environment factors have a direct impact on the health provider performance (Oswald, 2012). Accordingly, we wanted to provide some insight about the impact that the perceptions of this specific work environment can have on nurses' emotional performance.

Also, emotional labor is part of a dynamic and interdependent complex, in such a way that cannot be understood outside the influence of self and identity. When nurses choose to engage in one of the emotional labor strategies their personality characteristics may predict this choice.

To further conceptualize how the perceptions of the work environment, emotional labor strategies and personality traits may combine we searched the literature for a theoretical framework in which to place this analysis. In response to this predicament, we examined the job demands-resources model (JD-R; Demerouti et al., 2001). The JD-R model states that even if employees work in a demanding role, they can experience less stress if the organization provides resources to support them (Demerouti et al., 2001). Therefore, this model helps boost employees' engagement and give the support they need to be happy at work. This makes it a very suitable model for research in the field of emotional labor, because we want to demonstrate that nurses' perceptions of the work environment, as a job resource, determine their choice of emotional labor strategies. A positive perception of the work environment, even in a demanding service sector such as the healthcare sector, can lead to nurse's engagement and to the choice of a more authentic strategy that also contributes to personal achievement, less stress, effective performance and job satisfaction (Brotheridge & Lee, 2002; Grandey, 2003; Groth et al., 2009).

This paper is organized as follows. First, we introduce the JD-R theoretical framework. Next, we build on JD-R theory our theoretical framework about the relationship between work environment perceptions and emotional labor strategies and the moderation effect of the personality traits. Finally, we present the methodology and the findings that resulted from our data.

## **2. Theoretical background**

### **2.1 Job Demand-Resources (JD-R) Theory**

The Job Demands-Resources Model was initially developed by Demerouti, Bakker, Nachreiner and Schaufeli (2001) as an attempt to overcome the limitations of other existing models of employee well-being, such as the demand-control model, from Karasek (1979), and the effort-reward imbalance model, from Siegrist (1996). JD-R model is a well-established model that predicts employee and organisational well-being, by considering a variety of job characteristics and their corresponding interactions on stress and motivation. It was also developed to combine the negative outcomes of work and the health-enhancing effects of positive job characteristics (de Lange et al., 2008). This model has two main assumptions that we will study throughout the paper.

The starting point of the JD-R model is the assumption that regardless of the type of job, the psychosocial work characteristics can be broadly categorized into two groups, namely job demands and job resources (Demerouti et al., 2001; Schaufeli & Bakker, 2004). These two groups influence respectively the health and commitment of employees or more specifically influence the level of burnout of employees. In general, job demands and job resources are negatively related, since job demands such as a high work pressure and emotionally demanding interactions with customers may restrain the mobilization of resources (Bakker et al., 2003; Demerouti et al., 2000, 2001).

Job demands are the physical, psychological, social, or organizational aspects of the job that require continuous effort and are hence related to certain physiological and/or psychological costs (Demerouti et al., 2001). High work pressure, role overload, unfavorable physical environment, and emotionally demanding interactions with customers are some examples of job demands. Although job demands not necessarily assort negative efforts, when job demands are experienced as too high, from which the employee has not adequately recovered, they may turn into job stressors (Meijman & Mulder, 1998).

In contrast, job resources refer to physical, psychological, social, or organizational aspects of the job that are either functional in achieving work goals, reducing job demands and the associated physiological and psychological costs, or stimulating personal growth, learning, and development (Schaufeli & Bakker, 2004). For example, feedback, job control, and social support and other aspects that can foster engagement as well as mitigate the adverse consequences of undue job demands (Bakker & Demerouti, 2007; Schaufeli & Bakker, 2004). Job resources may be placed at the organisational level (e.g., career development, job security, salary), interpersonal level and social relations (e.g., support from colleagues, leadership, teamwork), the job position (e.g., role clarity, participation in decision making), and task level (e.g., skill diversity, task identity, autonomy, and performance feedback). Hence, resources are not only important to deal with job demands, they are also necessary to foster positive thoughts and feelings about work and the organization, human motivation and to achieve work goals (Van den Broeck et al., 2008).

We propose that such positive thoughts and feelings about their role, job and organization may influence the extent to which service employees engage in surface or deep acting. In particular, we focus on work environment perceptions as a key job resource because it is composed by physical and social organizational factors that help achieve goals and foster engagement. A healthy work environment provides the resources needed to help nurses to accomplish their job, which in turn, may influence how nurses do emotional labor.

## **2.2 Work environment perceptions and emotional labor**

To perform a service job adequately, employees may be required to present types of emotion that differ from their inner feelings. Faced with these emotional demands, employees must “manage feelings to create a publicly observable facial and bodily display” (Hochschild, 1983, p. 7), that is, do emotional labor. According to Hochschild (1983), service providers can have two types of emotional labor behavior: a) surface acting – ‘faking feelings’ to align with expectations, ie., when one

performs an emotional display to meet certain rules and expectations; or b) deep acting – attempting to modify feelings to match expectations, i.e., when a person consciously attempts to feel a specific emotion that matches the expected emotional displays (Grandey, 2003).

Frontline employees do not exclusively adopt one approach over another, but this choice can depend on several internal or external factors. For example, may be determined by the amount and quality of resources that nurses have available when they do not experience the required emotions (Chou et al., 2012). Several authors studied the main drivers of emotional labor strategies that can be found at a cultural, organizational or individual level. However, and although there are several studies about the possible antecedents of emotional labor, there is one element, which was not studied yet – the perception work environment.

The work environment includes all external factors and variables that surround an employee and that can have an impact on his/her performance, such as the information, tools, and incentives that support performance (Robinson & Robinson, 1996; Gilbert, 1996). Although we can obtain data regarding work environment factors through various methods, the most reliable is from employees in the given environment (Bell, 2008). Employees provide the best information regarding how work environment factors influence their performance through their interpretation of the reality (Robinson & Robinson, 1996).

Previous studies have suggested that employees' perceptions of their work environment may impact job performance, productivity, job satisfaction and employees' creativity. For example, Maurer et al. (2003) found that the intention and willingness of employees to participate in developmental activities may be influenced by employees' perceptions of supervisory and organizational support. A study conducted to employees at public universities concluded that work environment has a significant positive impact on organizational commitment (Hanaysha, 2016). Yeh and Huan (2017) analysed employees' creativity in hospitality and concluded that social support, resources adequacy and freedom positively affect both employees' quantity and quality of creative

performance. Another study associated work environment with employee job satisfaction in the context of banking, university and telecommunication (Raziq & Maulabakhsh, 2015). They concluded that bad working conditions restrict employees in demonstrating their capabilities and to reach their full potential. According to Wilson et al. (2012) the perceived servicescape can also elicit emotional responses. Being in a particular place can make a person feel happy, light-hearted and relaxed, or may make a person feel sad, depressed and gloomy.

Healthcare employees are employed in a complex, stressful, demanding and sometimes hazardous work environment, which affects outcomes for both organizations and employees (Kramer & Son, 2016). Nurses are at risk of burnout as they are exposed to intense physical and emotional suffering and are frequently the focus of patients' reactions, both affectionate and hostile (Maslach & Jackson, 1982). Several studies found that the nursing work environment and the way in which work was organized were closely linked to stress (Arnetz, 1991; Guppy & Gutteridge, 1991). A healthy and supportive work environment stimulates nurses to use their expertise, skills and clinical knowledge. Furthermore, nurses who work in such an environment are encouraged to provide patients with excellent nursing care (Disch, 2002).

In a study conducted by Kramer and Schmalenberg (2002), nurses indicated eight factors of which they think define the nursing work environment and influence the quality of nursing care: clinically competent nurses; adequate staffing; good nurse-physician relationships; autonomous nursing practice; nurse manager support; control over nursing practice; support for education; and a culture that values concern for patients. Other studies confirmed that the patient safety and quality of care improved in environments favorable to the professional practice (Kirwan et al., 2013; Rochefort & Clarke, 2010). Undoubtedly, research has shown that work environment factors have a direct impact on the health provider performance (Oswald, 2012). For example, Aiken et al. (2008), found that higher percentages of the nurses in hospitals with poor care environments reported high burnout levels and dissatisfaction with their jobs; on the contrary, when professional environment attributes



were evaluated to be better, nurses' work stress decreased, and nurses' satisfaction indicators increased linearly (Tervo-Heikkinen et al., 2008). In sum, perceptions of a supportive work environment are the base for retaining nurses and for increasing nurses' satisfaction (Kirwan et al., 2013; Ganz & Toren, 2014; Zhang et al., 2014).

Accordingly, the perception of work environment may determine how employees perform emotional work, because as a job resource, it may reduce the physiological and psychological costs of the role, help employees reach their job goals as well as feel involved with the organization. Also, the perception of work environment greatly influences employee satisfaction (Irvine & Evans, 1995). Hence, an employee who has a positive perception of the work environment and feels good about his/her workplace will tend to adopt an emotional labor strategy that is more authentic, require less effort and that contribute to job satisfaction. Based on the above discussion, the following hypothesis is postulated:

H1: The WE perceptions will affect the type and frequency of EL performance such that, (a) perceptions of the WE relate positively with deep acting and (b) negatively with surface acting strategies

### **2.3 Personality traits and emotional labor**

Another assumption of the JD-R model refers to the relationships between job demands and resources. There are two possible ways in which demands and resources may have a combined effect on wellbeing, and indirectly influence performance. The first interaction proposed is the buffer effect of job resources on the relationship between job demands and strain (Demerouti & Bakker, 2006). In other words, employees who possess adequate or more resources could better cope with job demands and suffer less; whereas, employees who are lacking resources may not be able to cope with job demands effectively, thus suffering more. Several studies have shown that job resources like social

support, autonomy, performance feedback, and opportunities for development can mitigate the impact of job demands on strain, including burnout (Bakker et al., 2005; Xanthopoulou et al., 2007).

The second interaction is the boost effect of job demands on the relationship between job resource and work motivation (Demerouti & Bakker, 2006). Job resources become salient and influences motivation most when job demands are high. In other words, when an employee is confronted with challenging job demands, job resources become valuable and foster dedication to the tasks at hand.

The literature offers ample evidence for the fact that personality characteristics shape (buffer or booster) adverse outcomes of stressors in general (Bakker et al., 2005). In our study the personality traits functions as a buffer or booster effect on the relationship between the perceptions of the work environment and the emotional labor strategies. The emotional labor performance is not an independent element of customer service employees, but instead it is part of a dynamic and interdependent complex comprising other aspects such as physical and intellectual aspects. Emotional labor performance cannot be understood outside the influence of self and identity. The display of emotions is, thus, dependant on the personality of the employees. When nurses choose to engage in one of the emotional labor strategies – surface acting or deep acting – their personality characteristics, as extraversion, agreeableness, conscientiousness, neuroticism and openness, may predict this choice. In fact, personality characteristics refers to the propensity to react in certain ways in given situations (Caprara & Cervone, 2000) and several authors studied personality characteristics as antecedents of emotional labor (Diefendorff et al., 2005; Gursoy et al., 2011; Qadir & Klan, 2016; Schaubroeck & Jones, 2000; Zhong et al., 2012). However, we study the role of these characteristics as moderators of the impact of the perceptions of work environment, as job resources, on the emotional labor strategies.

Despite the breadth of theoretical perspectives (John et al., 1991; McAdams, 1995), research approached consensus on a general taxonomy of personality characteristics, known as the “Big

Five”. The Big Five postulates that individual differences in adult personality characteristics can be organized into five broad domains: extraversion, neuroticism, openness to experience, agreeableness and conscientiousness (John & Srivastava, 1999). A large body of empirical research has supported the stability and predictive validity of the Big Five across different populations, contexts and countries (McCrae & Costa, 1987). Diefendorff et al. (2005) pointed out that personality traits significantly influence emotional labor strategies and the personality traits of extraversion and neuroticism have been proposed as strong predictors of well-being (DeNeve, 1999; Schimmack et al., 2002).

Extraversion is the trait that predisposes people to experience positive emotional states and to feel good about themselves and the world (George & Jones, 2012). In other words, extraverts tend to enjoy human interactions and to be enthusiastic, talkative, assertive, and gregarious. People who are high in extraversion tend to seek out social stimulation and opportunities to engage with others and tend to be sociable, affectionate and friendly (John & Srivastava, 1999). In a study that examined the association between personality traits and emotional labor strategies, Diefendorff et al. (2005) added that these individuals experience positive emotions more often and thus they may have less of a need to fake their emotions during their interactions (to surface act) and be more likely to display their real feelings. Similarly, Austin and colleagues (2008) found a negative relationship between extraversion and surface acting.

H2: Extraversion will (a) booster the relationship between the perception of WE and deep acting, and will (b) buffer the relationship between the perception of WE and surface acting.

Agreeableness describes individuals as being flexible, courteous, friendly, good-natured, cooperative, trusting, soft-hearted, generous, and tolerant and forgiving (McCrae & Costa, 1991; Barrick & Mount, 1991; Mroz & Kaleta, 2016). These individuals are more likely to express positive

emotions and suppress negative emotions at work. As such, they are greatly motivated to get along with others and try to develop and maintain positive relationships with others (McCrae & Costa, 1991). Studies show that individuals, who score higher on agreeableness, were more likely to engage with deep acting (Kim, 2008; Austin et al., 2008; Kiffin-Petersen et al., 2011). They are expected to put more effort into emotion regulation so that they have positive social interactions (Diefendorff et al., 2005).

H3: Agreeableness will (a) booster the relationship between the perception of WE and deep acting, and will (b) buffer the relationship between the perception of WE and surface acting.

Conscientiousness is related to people that are efficient, competent, hard-working, responsible, and persistent and achievement oriented (McCrae & Costa, 1991; Prentice, 2008). They are careful in carrying out their job tasks as they tend to perform well, and have higher levels of safety performance at work. Because of this, conscientious individuals follow rules for emotional expression and are more likely to display positive fake emotions to fulfill their job responsibilities (Yazdani, 2013). Conscientious people need less effort to express positive emotions and suppress negative emotions; hence conscientiousness is negatively correlated with surface acting and positively with deep acting and the expression of naturally felt emotions (Diefendorff et al., 2005; Kiffin-Petersen et al., 2011; Basim et al., 2013; Austin et al., 2008). Since conscientious individuals are more responsible and careful, they show greater adherence to display rules meet organisations expectations by trying to be more authentic and sincere (Diefendorff et al., 2005).

H4: Consciousness will (a) booster the relationship between the perception of WE and deep acting, and will (b) buffer the relationship between the perception of WE and surface acting.

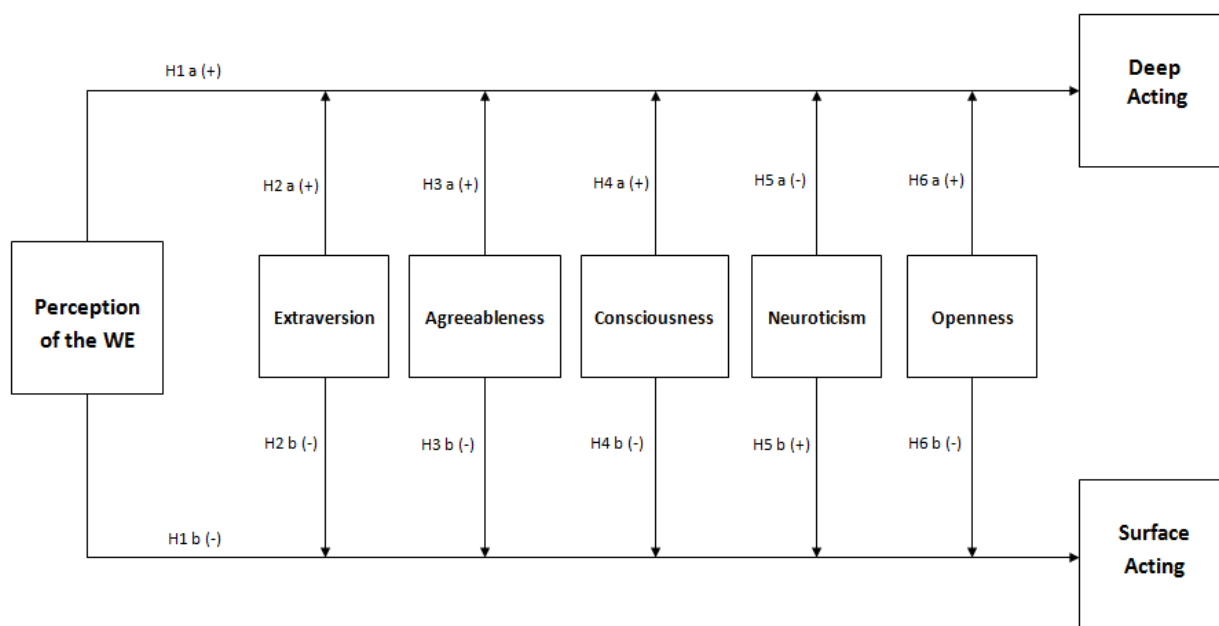
Neuroticism, in turn, is commonly characterized by anxiety, fear, moodiness, worry, envy, frustration, jealousy, and loneliness (Thompson, 2008). Individuals who score high on neuroticism are more likely than average to experience such feelings, to respond more poorly to stressors, to interpret ordinary situations as threatening, and minor frustrations as hopelessly difficult (Matthews & Deary, 1998). Diefendorff et al. (2005) confirmed that individuals with high score on neuroticism would use a surface acting strategy because surface acting requires relatively little mental effort about regulating emotions, whereas deep acting is more demanding (Zapf, 2002). Furthermore, individuals who score high on neuroticism experience more negative emotions and have the tendency to suppress their emotions (Chioqueta & Stiles, 2005).

H5: Neuroticism will (a) buffer the relationship between the perception of WE and deep acting, and will (b) booster the relationship between the perception of WE and surface acting.

Finally, openness to experience describes the breadth, depth, originality, and complexity of an individual's mental and experiential life (John & Srivastava, 1999). This trait relates to intellect, openness to new ideas, cultural interests, educational aptitude and creativity. People with high openness to experience have broad interests and deeper scope of awareness, are liberal and like novelty (Howard & Howard, 1995; McCrae & Costa, 1991). However, this characteristic is not related to any kind of facial expression and any social interaction (McCrae & Costa, 1991). Thus, individuals who score high in openness are not suitable for service providing, because most of the time they are unable to hide their original feelings (Prentice, 2008; Smith & Canger, 2004), so we predict that:

H6: Openness will (a) booster the relationship between the perception of WE and deep acting, and will (b) buffer the relationship between the perception of WE and surface acting.

Therefore, we assumed that personality traits functions as a moderator because it may buffer (decrease) and/or booster (increase) the relationship between the perceptions of the work environment and the emotional labor strategies. Our hypothesized model is represented on Figure 10:



**Figure 10** Hypothesized model

### 3. Research design

#### 3.1 Data collection

We conducted a survey online that was made available to nurses working in various healthcare units, as public and private hospitals, health centers and clinics in Portugal. The participants were told that the purpose of the research was “to explore the association between the relationship nurses / patients and some demographic factors”. The data collection took place during November and December 2016, yielding 180 valid questionnaires. Our group of participants consists of 133 (74%) female nurses and 47 (26%) male nurses. This disparity demonstrates well the Portuguese reality regarding the number of registered nurses in the Portuguese Nursing Council, 82% are women and 18% men.

The men who make up our sample work on average for 18 years ( $SD = 9.28$ ) as nurses, and women work on average for 14 years ( $SD = 10.03$ ). A great part of the individuals has a degree (67%), while very few have only a bachelor's degree (0,6%) and others have a master's degree (30%) and a PhD (1,7%). A great part of nurses' work in public hospitals (52,5%) and half do not have a specialization in nursing (50%).

### **3.2 Measures of constructs**

**Demographics.** A 25-item questionnaire was developed to assess several demographic variables of interest, such as age, sex, job tenure, nursing specialization, type of health institution and educational level.

**Emotional Labor Scale (ELS).** Emotional labor strategies were measured with the emotional labor scale developed by Brotheridge and Lee (2003). This scale is divided into five emotional labor dimensions, however we just assessed the dimensions of surface acting and deep acting because are the ones directly related with what we want to study. The items in the deep acting subscale assess how much an employee has to modify feelings to comply with display rules. Moreover, the surface acting dimension measures the extent to which the employee must express emotions that are not felt and suppress feelings that conflict with display rules (Brotheridge & Lee, 2003). Participants were asked to answer these items in response to the following question "On an average day at work, how often do you do each of the following when interacting with customers?" The dimensions were measured with a five-point Likert scale (1 = never, 5 = always). In the present study, Cronbach's  $\alpha$  for deep acting and for surface acting, respectively, were .70 and .72.

**Big Five Inventory Scale (BFI).** The personality assessment is made through the Big Five Inventory (John & Srivastava, 1999), consisting of 44 items designed to assess personality in five dimensions:

agreeableness, conscientiousness, extraversion, neuroticism and openness to experience. Through a five-points Likert scale, from 1 (strongly disagree) to 5 (strongly agree), participants answered according to the degree they fit into a variety of responses. The 44 items selected for the inventory are composed of short and simple understanding sentences and refer to only one of the five dimensions that make up the Big Five personality. In the present study, Cronbach's  $\alpha$  were for extraversion .81, for agreeableness .70, for conscientiousness .78, for neuroticism .76 and for openness .77.

***Practice Environment Scale for Nurse Working Index (PES-NWI)***. The nurse work environment was measured by the Practice Environment Scale of the Nursing Work Index (PES-NWI; Lake, 2002) which comprises 28 items. We selected the 20 items that best fit our study across the five subscales that are included in the overall tool: nurse participation in hospital affairs (3 items), nursing foundations for quality of care (4 items), nurse manager ability, leadership and support for nurses (5 items), staffing and resource adequacy (3 items), and nurse–physician relationships (5 items). This scale indicates the degree to which various modifiable organisational features are present in the nurse workplace with higher scores indicating more favourable ratings (1 = strongly disagree to 4 = strongly agree). In the current study, we have found excellent internal consistency for this scale (alpha= .91).

### **3.3 Data Analysis**

After coding the variables, the data were processed using the Statistical Package for the Social Sciences (SPSS) for Windows, version 23. The variables distribution was tested for normality by the Shapiro-Wilks test. To test the hypothesized model, we conducted a hierarchical multiple regression for the association between the perception of work environment and emotional labor strategies and the big five personality characteristics and emotional labor strategies, and we conducted bias-



corrected bootstrap analyses (using 1000 bootstrap samples) with the PROCESS macros developed by Hayes (2013) to test the moderating effects.

Due to the conceptual orthogonal nature of the Big Five (McCrae & Costa, 2003), five separate, yet identical analyses were conducted, one for each dimension of personality tested. Following Aiken and West’s (1991) recommendation for using centered variables (i.e., standardized so that their means are zero and their standard deviations are one), each predictor and moderator variable was centered to reduce multicollinearity between the interaction term and the main effects when testing for moderation.

#### 4. Findings

Table 4 presents means, standard deviations and cronbach alphas for all measures included in the study.

Variables	Female		Male		p-value	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.
	Mean	SD	Mean	SD											
1. PES-NWI	2,65	,71	2,94	,84	.02	(.91)									
2. Surface acting	6,17	1,45	6,08	2,03	.75	.00	(.72)								
3. Deep acting	5,73	1,89	6,10	1,65	.23	-.17*	.01	(.70)							
4. Extraversion	28,33	5,41	27,80	5,59	.56	.09	.27**	-.17*	(.81)						
5. Agreeableness	35,0	4,14	32,93	5,24	.007	.04	.20**	-.09	.33**	(.70)					
6. Conscientiousness	36,72	4,38	34,23	5,81	.003	.00	.04	.04	.34**	8**	(.78)				
7. Neuroticism	21,54	5,11	19,70	4,78	.03	-.23**	-.10	.05	-.35**	-.33**	-.24**	(.76)			
8. Openness	36,28	5,24	38,87	5,78	.005	.03	.10	-.08	.38**	.26**	.30**	-.17*	(.77)		
9. Age	37,11	10,22	39,78	9,22		.05	-.12	.12	.10	-.09	.00	-.17*	.06	(n.a.)	
10. Job tenure	14,80	10,03	18,04	9,28		.06	-.16*	.11	.12	-.06	-.03	-.21**	.06	.97**	(n.a.)

\*\* . Correlation is significant at the 0.01 level (2-tailed).

\* . Correlation is significant at the 0.05 level (2-tailed).

**Table 4** Means, standard deviations, internal consistencies (Cronbach’s  $\alpha$  on the diagonal) and Pearson Correlations ( $N = 180$ )

There is sufficient statistical evidence that allows us to conclude that the perception of the work environment is negatively associated with deep acting ( $r = -.17, p < 0.05$ ). This means that the better the perception of the work environment less nurses tend to use deep acting. Extraversion ( $r =$

.27,  $p < 0.01$ ) and agreeableness ( $r = .20$ ,  $p < 0.01$ ) were positively associated with surface acting. In other words, when nurses score high in extraversion and agreeableness they are more likely to suppress and fake their emotions. In turn, job tenure ( $r = -.16$ ,  $p < 0.05$ ) was negatively associated with surface acting. That is, the higher the number of years in the profession, the less nurses tend to adopt a surface acting strategy or the less they tend to hide their emotions. Finally, extraversion ( $r = -.17$ ,  $p < 0.05$ ) was also negatively associated with deep acting. This means that when nurses score high in extraversion they do not tend to use deep acting, i.e., to display more authentic emotions.

With respect to the moderating effects (table 5), we found no interaction effects of the impact of personality traits on the relationship between the work environment perception and emotional labor strategies. Extraversion, agreeableness, conscientiousness, neuroticism and openness were separately examined as a moderator of this relationship in two different steps. The perception of the work environment and each different personality traits were entered in the first step of the regression analysis. In the second step of the regression analysis, the interaction term between each personality trait and perception of the work environment was entered, and did not show a significant increase in variance in deep acting and in surface acting. Thus, the five personality traits were not a significant moderator of the relationship between perception of the work environment and deep acting, and surface acting.

	DV: Deep Acting				DV: Surface Acting			
	Control variables	IV	Moderators	Interactions	Control variables	IV	Moderators	Interactions
Age	.12	-	-	-	-.12	-	-	-
Gender	.08	-	-	-	-.02	-	-	-
Tenure	.11	-	-	-	-.16*	-	-	-
WE perceptions	-	-.17*	-	-	-	.00	-	-
Extraversion	-	-	-.17*	-	-	-	.27**	-
Agreeableness	-	-	-.09	-	-	-	.20**	-
Conscientiousness	-	-	-.04	-	-	-	.04	-
Neuroticism	-	-	.05	-	-	-	-.10	-
Openness	-	-	-.08	-	-	-	.10	-
WE x Extraversion	-	-	-	-.01	-	-	-	.03
WE x Agreeableness	-	-	-	.03	-	-	-	.03
WE x Conscientiousness	-	-	-	-.06	-	-	-	-.00
WE x Neuroticism	-	-	-	.02	-	-	-	.01
WE x Openness	-	-	-	.00	-	-	-	-.00
F	-	-	-	1,82	-	-	-	3,21
R <sup>2</sup>	.03	.03	.05	.05	.03	.00	.10	.10
Δ R <sup>2</sup>	-	.00	.02	.00	-	.00	.10	.00

\*\* . Correlation is significant at the 0.01 level (2-tailed)

\* . Correlation is significant at the 0.05 level (2-tailed)

**Table 5** Moderated regression testing the link between work environment perceptions and emotional labor strategies

## 5. Discussion

Based on the precepts of the JD-R theory, this study developed and tested a research model, which investigates the relationship between nurses' perceptions of the work environment and the emotional labor strategies and nurses' personality traits as the moderators of this relationship. To tackle this objective, six hypotheses were suggested, based on the relevant literature on emotional labor, work environment and personality traits. Generally, we found that a perception of the work environment is negatively associated with the use of one of the emotional labor strategies. To the extent that the more positive the perception of the work environment less nurses tend to adopt a strategy of deep acting. However, we could not confirm the booster and buffer effects of the personality traits. In

other words, personality traits do not interfere with the relationship between work environment perceptions and emotional labor strategies.

*The relationship between the perceptions of the work environment and emotional labor strategies*

In our first hypotheses, *H1a* and *H1b*, we expected that a positive perception of the work environment, as a job resource, would be positively associated with the adoption of deep acting and would be negatively associated with the use of surface acting. Our hypotheses were not confirmed, however the results revealed that there is a negative relationship between work environment perceptions and deep acting and, even if not statistically significant, there is a slightly positive relationship between work environment perceptions and surface acting. That means that nurses' perceptions of their work environment have an impact on their emotional labor strategies, but in the reverse way we were expecting. Thus, as nurses are getting a positive perception of their work environment they do not try to change their inner feelings in order to feel a specific emotion; they instead show an inauthentic expression of themselves, they try to display positive fake emotions.

A possible explanation is that, because they have a positive perception of the work environment, nurses try to do their utmost to make their emotions correspond with what is expected of them. And given this work environment that is quite specific and emotionally tense, nurses 'put on a mask' to ensure that their emotions really match patients' and the organization's expectations. Thus, nurses are more likely to display positive fake emotions to fulfill their job responsibilities. In other words, the perceptions of work environment mitigate the use of emotional labor strategies. In the literature, surface acting is understood as something negative and synonymous of employees' dissatisfaction (Hochschild, 1983; Brotheridge & Grandey, 2002; Morris & Feldman, 1996; Schaubroeck & Jones, 2000). However, in this specific work environment surface acting may be synonymous of employees' job satisfaction and employees' attempt to fulfill their responsibilities.

Our data indicated another important finding. Job tenure is negatively associated with surface acting strategy. The more years of work as nurses least they fake and hide their true emotions, hence less they adopt the surface acting strategy. This finding means that the greater the number of career years, the lower the tendency for nurses to pretend and hide their emotions. Given that increases in job tenure are also accompanied by increases in chronological age, this is in line with the socioemotional selectivity theory that postulates that as people become older they tend to be emotional expressive (Cheung & Tang, 2010; Hur et al., 2014) and avoid suppressing their emotions. People become motivated to maximize the experience of positive emotions and minimize the experience of negative emotions (Charles & Carstensen, 2007). Research on aging and development also confirms our data, suggesting that older individuals give higher priority to socially oriented tasks (Carstensen et al., 1999) and invest their resources more in those goals that match their motivations and interests (Beier & Ackerman, 2001).

#### *The moderation effect of personality traits*

Hypotheses *H2* to *H6* stated that the five personality traits buffer and booster the relationship between the perceptions of the work environment and the adoption of different emotional labor strategies. More specifically, it was predicted that when nurses have high levels of extraversion (*H2*), agreeableness (*H3*), conscientiousness (*H4*) and openness (*H6*) the positive relationship between perception of the work environment and deep acting was higher and the negative relationship between perception of the work environment and surface acting was lower. In turn, when nurses have high levels of neuroticism (*H5*) the negative relationship between perception of the work environment and surface acting was higher and the positive relationship between perception of the work environment and deep acting was lower.

No significant moderating effects of the personality traits on the relationship between work environment perception and emotional labor strategies were found, thus contradicting our

hypotheses. However, our study shows some patterns within the data, as we summarized in table 6. The negative relationship between perceptions of work environment and deep acting, which we found in the first part of the study, happens when individuals score high in conscientiousness and openness and when individuals score low in extraversion, agreeableness and neuroticism. In turn, the positive relationship found between perceptions of work environment and surface acting occurs when individuals score high in extraversion, agreeableness, neuroticism and openness and score low in conscientiousness. These two relationships that are somewhat subjected to different personality traits seem to show an inverse pattern, the personality traits that are high in one relationship appear to be low in the other relationship and vice versa.

		<b>Personality traits</b>	
		<b>High</b>	<b>Low</b>
		<b>Work environment perceptions</b>	
<b>Deep Acting</b>	Negative	Conscientiousness Openness	Extraversion Agreeableness Neuroticism
	Positive	Extraversion Agreeableness Neuroticism Openness	Conscientiousness

**Table 6** Relationship between perceptions of work environment and emotionl labor strategies and personality traits

Furthermore, the results from the hierarchical multiple regression and from Process macros showed some interesting conclusions. For example, having more neurotic personality traits may booster the positive association between perceptions of work enviornment and surface acting; and having less neurotic personality traits may booster the negative association between perceptions of work enviornment and surface acting. Having more extravert personality traits may booster the positive association between perceptions of work environment and surface acting; whereas having low extravert personality traits may booster the negative association between perceptions of work environment and both emotional labor strategies. Having more agreeable personality traits may booster the positive association between perceptions of work enviornment and surface acting; and having low agreeable personality traits may booster the negative association between perceptions of work environment and both emotional labor strategies. Having more conscious personality traits booster the negative association between perceptions of work environment and both emotional labor strategies; whereas having low conscious personality traits may booster the positive association between perceptions of work enviornment and surface acting. Finally, having more open personality traits may booster the negative association between the perceptions of work environment and deep acting and the positive association between the perceptions of work environment and surface acting.

A possible explanation for these results are as follows. First, extraversion refers to the traits of being cheerful, talkative, active and outgoing (Block, 1961, Zellars et al. 2000; McCrae & Costa, 1991). These individuals are optimistic about things, situations and events. So, they may likely to display higher levels of surface acting. Also, due to their social skills, as they can adjust themselves according to the situation, extraverts may easily display positive fake emotions, i. e., surface acting. Our result agrees with Ehigie and colleagues (2012) that found that extraversion was a negative predictor of deep acting and positive predictor of surface acting.

Second, agreeable individuals are tolerant, cooperative, forgiving and caring (Barrick & Mount, 1991). According to McCrae & Costa (1991), such individuals are greatly motivated to get

along with others and establish honest and respected relations. They hardly retaliate when someone treat them badly and they try to maintain the impression that they are very nice, tolerant, sensitive, and trustworthy. Therefore, to maintain that impression, they may tend to express fake emotions and to put on a good face during interactions with others.

Third, conscientiousness relates to being responsible, self-disciplined, and acting dutifully (Costa & McCrae, 1992). Conscientiousness may be negatively related to engage in emotional labor because a conscientious person is believed to possess qualities that reflect non-dependability (Barrick & Mount, 1991; Hough, 1992; Moon 2001). Non-dependable persons make their own decisions, so they don't behave in some way others want them to. Therefore, we can say they need less effort to express positive emotions and suppress negative emotions, that is, to perform emotional labor.

Fourth, individuals who are high on neuroticism are more likely to experience negative emotions and feelings of stress and anxiety. Therefore, they may require more psychological effort to suppress these negative emotions during social interactions. And, because they may want to compensate their inner negative feelings and want to be acceptable in front of others, they may likely adopt a surface acting strategy.

Fifth, openness to experience reflects person's curiosity, originality, intellect, creativity, and flexibility (McCrae & Costa, 1991). According to Prentice (2008) and Smith and Canger (2004) the characteristics attained by openness individuals are not appropriate for service providing, because most of the time they are unable to hide their original feelings. So, they may face more emotional labor and they are unable to regulate the needed emotions during the interpersonal transaction. For these, and to fulfill their responsibilities, nurses may engage in surface acting.

In sum, although there is not enough statistical significance some personality characteristics are positively and negatively associated with both strategies of emotional labor. It is likely that one's personality – a relatively stable pattern of how one perceives and reacts to their environment – will influence how one manage their emotions in the workplace.



### *Limitations and further research*

The present study has certain limitations that need to be acknowledged when interpreting the results. First, the limited duration of the study led to a sample size that is not too large. Therefore, we encourage future studies to allow more time to collect data to be able to work with a larger sample. Second, a limited generalizability of the findings resulted from the small sample size and the convenience sample procedures. An online survey is only available to those who have access to the internet and are comfortable to use the computer. To address this limitation future research should consider face-to-face surveys. Third, the study was based on self-report measures that might lead to common method-variance problems. Future studies might attempt to avoid this problem by collecting data from different sources. Fourth, our sample was predominantly female. This is a typical phenomenon across healthcare industry since most nurses are women. In Portugal is no exception, 80% of registered nurses are women and 20% are men. Fifth, the number of items presented in the survey is higher than the sample size, because we decided to use the original version of the scales and not the short version making this study more reliable. To solve this issue, future studies should increase the sample size and the ratio be at least 3 observations per item. Sixth, participants in the study were placed in units, but the "team" effects were not analyzed. To address this limitation, future research should consider the fact that nurses work in teams and this can affect their perception of the work environment as well as the way they manage emotions. Finally, our study was conducted using a homogeneous sample, namely nurses. Therefore, it would be important to test the external validity of the results for other working populations and organizations. But also, it would be useful if future studies replicate this study to a sample of physicians and make a comparison between these two important healthcare professions.

## **6. Conclusions and implications**

To the best of our knowledge, this is the first study that investigated the association between nurses' perceptions of the work environment and their choice for one of the emotional labor strategies – surface acting and deep acting –, as well as the moderating effect of personality traits within this relationship. The theoretical significance of this research is fourfold: 1) the perception of the work environment is negatively associated with one of the emotional labor strategies, that is, when nurses have a positive perception of their workplace they do not tend to adopt a deep acting strategy; 2) this statistically significant association happens when individuals score high in conscientiousness and openness; 3) we found a statistically negative association between extraversion and deep acting and positive association between extraversion, agreeableness and surface acting; and 4) job tenure is negatively associated with surface acting, wherein the more years of work as nurses least they fake and hide their true emotions.

Our results meet the idea that emotional labor is synonymous of fake emotions, so we can assume that when we are in an environment that we consider positive we do not fake our emotions so much. Also, we may assume that emotional regulation is somewhat subjected to different personality traits. Extraverted individuals need less effort to exhibit positive emotions during service interactions. Thus, it is proposed that extraverted individuals face less emotional labor as they are social and ambitious. Individuals who score higher on agreeableness also express positive emotions easily because of their sincere disposition. So, it is proposed that individuals with agreeable personalities face less emotional labor in management of emotions. Individuals with neurotic characteristics are not suitable for service sector. They require more effort to regulate the organizationally required display emotions to fulfill the job tasks. Thus, it is proposed that they will face more emotional labor to manage emotions. Conscientious individuals are careful in carrying out their job tasks and may thus be more appropriate to adhere and display rules for emotional

expression. Therefore, results support the argument that these individuals are good in interpersonal transactions.

For now, these findings have led to a deeper and fuller understanding of the impact of work environment perceptions and personality traits on the management of emotions at work. When healthcare institutions offer a good work environment, nurses try to do their utmost to make their emotions correspond with what is expected of them. Thus, healthcare managers need to examine how organizational policies and practices are translated into the work environment. Also, if we can better understand how nurses perceive their work environment and how that will affect, along with their personality, the way they manage emotions and present themselves to patients, we design better work environments that make nurses feel more comfortable on their own skin. Nurses' roles within healthcare services are sensitive to their personality traits and life experiences.

### **PART III: GENERAL DISCUSSION**

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## **CHAPTER I – MANAGING EMOTIONS IN HEALTHCARE. PRESENT AND FUTURE**

The purpose of this chapter is not to repeat extensively the implications and conclusions already made throughout the three papers, but rather we intent to summarize the main contributions to the following emergent themes: service recovery and emotional labor. And also, to debate the present and future of managing emotions in healthcare.

### **1. Main findings and theoretical implications**

With the research questions previously formulated in mind, the studies that integrate the present thesis make several contributions to the existing body of literature. Study 1 provides a clear insight about the value, meanings, attitudes and strategies of emotional management by healthcare professionals and patients. In this sense, we concluded that emotional labor is a two-way process. That is, the results suggest two different approaches, which are associated with what individuals identify as a good-quality service. The “relational engagement” occurs when service providers rely on emotions to develop connections with customers, which are considered crucial in providing a personalized treatment and creating trust, confidence and hope among patients. The “performative engagement” occurs when service providers try to control their emotions, which are considered damaging to relationships between service providers and customers, deflecting attention to the technical skills.

This study is also the first qualitative study that focuses on the perceptions that healthcare professionals and patients have about the display of emotions during service interactions. Lastly, our findings provide specific and novel information to help healthcare managers define and implement strategies to achieve service quality and customer satisfaction. Managers should focus on the experience and expression of emotion during service encounters to know how to train healthcare professionals to deliver a better service.

Study 2 highlights the importance of empowering employees to manage their emotions the way they find most appropriate. Through a critical analysis of the literature on emotional labor we came up with the concept of *employee emotional empowerment*, which is based on the research streams of empowerment and authenticity. This research contributes to the ongoing debate and discussion about emotional labor by exploring the surface acting and deep acting strategies and proposing a better alternative to both.

Finally, regarding study 3, to the best of our knowledge, no research to date has examined the impact that the perceptions of work environment may have regarding the choice for one or another strategy (surface acting and deep acting) to manage their emotions during service interactions. Also, we explored the moderation effect of the personality characteristics based on the theoretical rationale of the job demands-resources (JD-R) model.

Our findings confirmed some studies but also provided specific and novel information about the relationship between work environment perceptions, personality traits and emotional labor strategies. When nurses score high in extraversion and agreeableness they are more likely to suppress and fake their emotions. Also, the perception of the work environment is negatively associated with deep acting. In other words, when nurses perceive their workplace as positive and satisfactory they do not tend to use a deep acting strategy. This means that in this type of work environment experienced by nurses they tend to do their utmost to make their emotions correspond with what is expected of them. They are willing to display positive fake emotions to fulfill their job responsibilities.

## **2. Practical implications**

The emotional management at work has gained prominence in the scientific community for its direct association to stress and to changes in mental and behavioral health of the employee. Healthcare professions are one of the job categories with the highest emotional workload (Jennings, 2008). The

nursing team, consisting of nurses, technicians and auxiliaries, is the one that is more predisposed to the development of burnout because of the proximity they maintain with patients and their families. The intense and frequent interactions contribute to this description. The social expectations also create pressure and stress on this group of professionals. They are expected to have a permanent concern for others, constant feelings of solidarity, permanent improvement of communication channels and restraint of their own personal feelings (Hallam, 2002; Bolton, 2001). Several authors are unanimous in considering that healthcare professionals that face the great challenge of working closely with patients and their families are at the mercy of a high emotional load and great stress, which can lead to burnout (Portoghese et al., 2014; Jennings, 2008).

Our results hold several practical implications for healthcare organizations that wish to promote high emotional labor performance and reduce stress and burnout among employees. Managers should be encouraged to involve employees in a positively-biased work environment and organizations should take various steps to enhance acts of compassion, empathy, gratitude and interest. The first study focuses on the perceptions that healthcare professionals and patients have about the management of emotions. From this study we proposed that organizations may consider the experience and expression of emotion during service interactions in order to be aware of how healthcare professionals should be trained to deliver a good service quality and on which conditions healthcare professionals avoid doing emotional labor. By doing so they are not only fostering employees' self-efficacy and job satisfaction, but also minimizing the negative effects of poor management of emotions at work.

The study 2 offers some insights for managers by presenting an alternative strategy of managing emotions that minimizes employees' burnout, stress and job turnover; it contributes to a new perspective over emotional labor by demonstrating that employees should be empowered to manage their emotions in a way they found more appropriate considering the service context and the customer. For an effective implementation of employee empowerment there should be a shared

vision of the goals of the organization, employees should have organizational support, there should be an improvement of employees' skills, and the recognition and appreciation of employees' performance is also crucial for their motivation.

From study 3 we concluded that healthcare organizations might benefit from creating a healthy work environment that promotes a high emotional labor performance. It is becoming clear that strategic human resource practices that result in high performance work environments are linked with important organizational outcomes, such as service quality, customer satisfaction, and loyalty. Further on issues about nurses' recruitment and education, managers should consider that nurses' roles and personality traits and life experiences may blend as time passes by. The organization should prioritize individuals with high levels of extraversion.

In sum, this research contributes to a new perspective over managing emotions at work by demonstrating that healthcare providers and patients still have a skeptical vision about the display of emotions. Our data pointed to the need for developing a type of intervention that promote the managing of emotions. Listening to employees seeking to identify their concerns, difficulties, ideas and potential is key to preventing stress. Other strategies to minimize risk factors are institutional integration, a healthy and pleasant work environment (physical and psychological), free circulation of information, recognize the work done, reduction of working hours, attractive and rewarding working conditions, recognition of the need for constant training and investment in professional development, social support for teams and participation in decision-making.

### **3. Directions for further research**

Future research should try to provide a more holistic view to emotional labor within healthcare services by including the interaction between professionals, patients and work contexts. For example, future studies may examine the characteristics of nurses and physicians (such as emotional stability



and emotional intelligence), patients (e.g. how they deal with their feelings and the feelings of others), and work contexts (e.g. leadership, working conditions such as salaries and working hours).

Researchers may want to investigate longitudinally how nurses and physicians manage their emotions and how patients react to it. For example, as time passes by, healthcare employees that care for the same patient may become accustomed to him/her and change the way they manage their emotions. Also, patients that go to hospital regularly can react differently to healthcare professionals' behavior over time. This would help to answer questions related to how the interactions between professionals and patients change over time regarding the balance between expressing and suppressing emotions and negotiating closeness vs distance.

Resulting from study 1, it would be also interesting to explore if this phenomenon occurs among a variety of clinical specialties and compare it in private and public healthcare institutions. Further studies targeting specific emotional labor strategies, namely observational studies, would bring much needed information on the efficacy and well-being correlates for both patients and professionals. Also, in-depth interviews that explore the individual psychological mechanism underlying such specific strategies should shed light on a much understudied subject. We could also apply the new approaches – relational engagement and performative engagement – in other types of services, where there is an intense interaction between service providers and customers.

Regarding study 2 more research is necessary to explore the relevance, conditions and success factors of the new construct *employee emotional empowerment*. The inclusion of this construct in future research is highly promising, as it might offer a more comprehensive view of the process of managing emotions in the workplace. Therefore, the usefulness of this construct should be empirically studied.

Finally, about study 3, future studies might collect data from different sources and replicate it to different work populations and organizations. To deepen the issue within healthcare services a sample of physicians should be analysed.



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## **APPENDIX**

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## Research project about healthcare professionals' emotions

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A group of researchers from the Nova School of Business and Economics of the University Nova in Lisbon is seeking to understand how the emotions of healthcare professionals influence their patients' emotions.

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### Informed Consent

We would like to know if you accept to collaborate with us on this project, answering to a brief interview.

Your answers are strictly confidential, and the results are only used for research purposes. There are no right or wrong answers; answer truthfully to all questions. In this sense, we ask your permission to record the interview. This participation is voluntary, so you can stop it at any time.

Your support is very important and essential in the whole process. Without it we cannot know the Portuguese reality and thus contribute to the management of emotions of healthcare professionals.

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Researcher signature

\_\_\_\_\_

Participant signature

\_\_\_\_\_

---

**Thank you for your collaboration.**



**Table 7** Interview script for physicians and nurses

- 
- (1) How would you describe your experience/interaction with your patients?
  - (2) Which emotions do you feel at the different stages of patient follow-up?
  - (3) Can you report any situations/stories that affected you in a professional and personal level?
  - (4) How do you manage your emotions when you are with a patient?
  - (5) Do you think that there is some emotional influence between healthcare professionals and patients?
  - (6) Do you think that patients' perceptions of hospitals' service quality can be influenced by the relationship between healthcare professionals and patients?
  - (7) Which are the main factors that you think are important for hospitals' service quality?
- 

**Table 8** Interview script for patients

- 
- (1) Describe your emotions when you enter and when you leave the hospital.
  - (2) How healthcare professionals should manage their own emotions when they are with a patient?
  - (3) Do you think that there is some emotional influence between healthcare professionals and patients?
  - (4) Do you think that patients' perceptions of hospitals' service quality can be influenced by the relationship between healthcare professionals and patients?
  - (5) Which are the main factors that you think are important for hospitals' service quality?
-



Appendix 3 *Quotes from Interviews*

**Table 9** Additional Quotes for Theme 1: Identification with the task and engaging with relationships

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Theme 1: Identification with the task and engaging with relationships

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- “Emotions can and should be passed on to patients, so patients feel they are being monitored by a physician who understands them and feels their problems.” (Ph7)
- “I try to be as I am, sincere and open. But sometimes in some situations I get affected emotionally, not to the point of crying or showing emotions, but I am affected.” (Ph10)
- “Often patients do not want to sound technical, or too technical. They value the relationship and professionals are the image of who receives them. In other words, to patients a good professional, friendly and respectful is a good picture of the service.” (N10)
- “I believe that the nurse is the person closest to the patient since the admission to discharge and consequently the quality of nurse-patient relationship influences the perception of the patient about the quality of service”. (N12)
- “If the nurse when implementing your care is arrogant, unavailable, unsympathetic, among so many other negative attitudes, to the patient, this will undermine the quality of the services provided. However, if both maintain a good therapeutic relationship based on respect, understanding and concern for the other, the patient realizes that, even if his/her condition worsens, the nurse did everything possible to ensure their well-being.” (N16)
- “All interpersonal relationships have an emotional influence on both sides. Being the nurse/patient relationship so interdependent and more permanent will have more emotions of each side.” (N20)
- “In my case, considering my illness, realize that physicians and nurses also have their problems, it is good. I think that they can understand us better, know us better and give us value.” (P6)
- “Yeah! I always prefer to be attended by the same physician because he has the chance to know me, so he can minister the therapy better, depending on the knowledge he has about me.” (P16)

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**Table 10** Additional Quotes for Theme 2: Job detachment and engaging with performances

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Theme 2: Job detachment and engaging with performances

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- “The factors that contribute to the service quality are job satisfaction (either work schedules or wages), recognition and proper workload to working hours.” (N11)
- “I think there is no emotional influence. I can distance myself from what they (healthcare professionals) feel and demonstrate.” (P1)
- “There are people who will want to get some feedback from the physician in terms of emotions. In fact, it makes them more human, more sensitive to the patients’ eyes, but I do not know if this physician is very professional.” (P23)
- “It is irrelevant for me. I’m more concerned about being treated by a competent professional who knows what he is doing and who treats me nicely.” (P24)
- “Since my relationship with the patient is strictly professional, there is no need to manage emotions.” (N29)
- “Factors determining the service quality should be a good superior coordination, consistency, assertiveness and organization. Satisfied professionals perform their duties better.” (N30)

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## RELACIONAMENTOS EM SAÚDE

O objetivo desta investigação é explorar a associação entre a abordagem de relacionamento enfermeiros /doentes e alguns factores demográficos. Este questionário insere-se no âmbito do Doutoramento em Gestão conduzido pela investigadora Joana Dias, orientada pelo Professor Doutor Miguel Pina e Cunha, da Universidade Nova de Lisboa. O seu preenchimento é anónimo e confidencial. As suas respostas sinceras são essenciais para este projeto, pelo que pedimos que leia com atenção as perguntas, e que assinale a opção de resposta que considera mais adequada, tendo em conta a sua experiência pessoal. Depois de responder a todas as perguntas, clique no botão "Enviar". Em caso de alguma dúvida ou interesse pelo estudo pode contactar jo\_dias@portugalmail.pt, onde procuraremos responder às suas questões.

---

### Dados demográficos

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1. Idade \_\_\_\_\_
2. Género:  
Masculino \_\_\_  
Feminino \_\_\_  
Outro \_\_\_
3. Tempo de exercício profissional (em anos) \_\_\_\_\_
4. Habilitações académicas:  
Bacharelato \_\_\_  
Licenciatura \_\_\_  
Mestrado \_\_\_  
Doutoramento \_\_\_

Outro \_\_\_

5. Habilitações profissionais (especialização em enfermagem):

Saúde Comunitária \_\_\_

Saúde Materna e Obstétrica \_\_\_

Saúde Infantil e Pediátrica \_\_\_

Reabilitação \_\_\_

Saúde Mental e Psiquiátrica \_\_\_

Medico-cirurgica \_\_\_

Outro \_\_\_

6. Considera que tem as condições de trabalho adequadas ao exercício da sua profissão?

Sim \_\_\_

Não \_\_\_

7. Se respondeu Não, por favour justifique.

---

8. Instituição de saúde onde trabalha:

Hospital público \_\_\_

Hospital privado \_\_\_

Clínica \_\_\_

Centro de saúde \_\_\_

Outro \_\_\_

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## Parte I

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### Gestão Emocional

**Avaliação da Gestão Emocional, escala de ELS (Emotional Labor Scale) traduzida e adaptada para a população portuguesa por Celeste (2009).**

A fim de fazer o seu trabalho de forma eficaz, indique o quanto segue os seguintes comportamentos quando interage com os pacientes:

	Nunca	Quase Nunca	Às Vezes	Quase Sempre	Sempre
1. Resiste em expressar os verdadeiros sentimentos.					
2. Tenta de facto sentir as emoções que tem que exibir como parte do seu trabalho.					
3. Esconde os seus sentimentos.					
4. Tentar experienciar realmente as emoções que tem de manifestar.					
5. Finge ter emoções que realmente não tem.					
6. Faz um esforço para realmente sentir as emoções que precisa de demonstrar para os outros.					

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## Parte II

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### Características da Personalidade

**Avaliação da Personalidade, escala de BFI (Big Five Inventory Scale) traduzida e adaptada para a população portuguesa por Brito-Costa et al. (2015).**

Em seguida encontram-se algumas características que lhe podem, ou não, dizer respeito. Por favor escolha uma das opções da escala que melhor expresse a sua opinião em relação a si mesmo. Não existem respostas certas, nem erradas!

	Discordo Completamente	Discordo	Não Concordo Nem Discordo	Concordo	Concordo Completamente
1. É conversador, comunicativo					
2. Às vezes é frio e distante					
3. Tende a ser crítico com os outros					
4. É minucioso e detalhista no trabalho					
5. É assertivo, não teme expressar o que sente					
6. Insiste até concluir a tarefa ou o trabalho					
7. É depressivo, triste					
8. Gosta de cooperar com os outros					
9. É original, tem sempre novas ideias					
10. É temperamental, muda de humor facilmente					
10. É inventivo,					



criativo					
12. É reservado					
13. Valoriza o artístico, o estético					
14. É emocionalmente estável, não se altera facilmente					
15. É prestativo e ajuda os outros					
16. É, às vezes, tímido e inibido					
17. Pode ser um tanto descuidado					
18. É amável, tem consideração pelos outros					
19. Tende a ser preguiçoso					
20. Faz as coisas com eficiência					
21. É relaxado, controla bem o stress					
22. É facilmente distraído					
23. Mantém-se calmo nas situações de tensão					
24. Prefere trabalho rotineiro					
25. É curioso sobre muitas coisas diferentes					
26. É sociável, extrovertido					
27. É geralmente confiável					
28. É, às vezes, rude (grosseiro) com os outros					
29. É cheio de energia					
30. Começa discussões, disputas, com os outros					
31. É um trabalhador de confiança					
32. Faz planos e segue-os à risca					

33. Tem uma imaginação fértil					
34. Fica tenso com frequência					
35. É engenhoso, alguém que gosta de analisar profundamente as coisas					
36. Fica nervoso facilmente					
37. Gera muito entusiasmo					
38. Tende a ser desorganizado					
39. Gosta de reflectir, brincar com as ideias					
40. Tem capacidade de perdoar, perdoa facilmente					
41. Preocupa-se muito com tudo					
42. Tende a ser quieto, calado					
43. Tem poucos interesses artísticos					
44. É sofisticado em artes, música ou literatura					

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### Parte III

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#### Ambiente de Trabalho da Prática de Enfermagem

**Avaliação do Ambiente de Trabalho da Prática de Enfermagem, escala de PES-NWI (Practice Environment Scale Nursing Work Index) traduzida e adaptada para a população portuguesa por Amaral, Ferreira e Lake (2012).**

Avalie a perceção de caraterísticas organizacionais presentes na prática de enfermagem:

	Discordo Completamente	Discordo	Não Concordo Nem Discordo	Concordo	Concordo Completamente
1. Enfermeiro chefe apoia a equipa de enfermagem					
2. Enfermeiro chefe é bom gestor e líder					
3. Enfermeiro chefe apoia a equipa na tomada de decisões					
4. Enfermeiro chefe consulta enfermeiros no que respeita a problemas e procedimentos Diários					
5. Tempo e oportunidades para discutir com outros enfermeiros os cuidados ao cliente					
6. Enfermeiros suficientes asseguram a qualidade dos cuidados					
7. Enfermeiros envolvidos na gestão interna do hospital					
8. Mérito e reconhecimento					

para o trabalho bem realizado					
9. Trabalho conjunto entre enfermeiros e médicos					
10. Médicos e enfermeiros têm boa relação de trabalho					
11. Enfermeiro diretor possui poder e autoridade enquanto executivo					
12. Programa de acolhimento aos enfermeiros recémadmitidos					
13. Enfermeiro diretor acessível, visível para os colaboradores					
14. Oportunidade de subida na carreira					
15. Oportunidade do enfermeiro participar nas decisões políticas					
16. Administração ouve e responde às preocupações dos trabalhadores					
17. Gestão de cuidados promove continuidade dos cuidados					
18. Trabalha com enfermeiros competentes					
19. Os cuidados de enfermagem são baseados num modelo de enfermagem					
20. Oportunidade do enfermeiro participar em comissões e departamentos					



**Table 11** Emotional Labor Scale (ELS)

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**Duration**

1. A typical interaction I have with a customer takes about – minutes.

**Intensity**

2. Express intense emotions
3. Show some strong emotions

**Frequency**

4. Display specific emotions required by your job
5. Adopt certain emotions required as part of your job
6. Express particular emotions needed for your job

**Variety**

7. Display many different kinds of emotions.
8. Express many different emotions.
9. Display many different emotions when interacting with others.

**Surface Acting**

10. Resist expressing my true feelings.
11. Pretend to have emotions that I don't really have.
12. Hide my true feelings about a situation.

**Deep Acting**

13. Make an effort to actually feel the emotions that I need to display to others.
14. Try to actually experience the emotions that I must show.

Really try to feel the emotions I have to show as part of my job.

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Source: Brotheridge and Lee (2003)

**Table 12** Big Five Inventory Scale (BFI)

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1. Is talkative
2. Tends to find fault with others\*
3. Does a thorough job
4. Is depressed, blue
5. Is original, comes up with new ideas
6. Is reserved\*
7. Is helpful and unselfish with others
8. Can be somewhat careless\*
9. Is relaxed, handles stress well\*
10. Is curious about many different things
11. Is full of energy
12. Starts quarrels with others\*
13. Is a reliable worker
14. Can be tense
15. Is ingenious, a deep thinker
16. Generates a lot of enthusiasm
17. Has a forgiving nature
18. Tends to be disorganized\*
19. Worries a lot
20. Has na active imagination
21. Tends to be quiet\*
22. Is generally trusting
23. Tends to be lazy\*
24. Is emotionally stable, not easily upset\*
25. Is inventive
26. Has an assertive personality
27. Can be cold and aloof\*
28. Perseveres until the task is finished
29. Can be moody
30. Values artistic, aesthetic experiences
31. Is sometimes shy, inhibited
32. Is considerate and kind to almost everyone

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33. Does things efficiently
  34. Remains calm in tense situations\*
  35. Prefers work that is routine\*
  36. Is outgoing, sociable
  37. Is sometimes rude to others\*
  38. Makes plans and follows through with them
  39. Gets nervous easily
  40. Likes to reflect, play with ideas
  41. Has few artistic interests\*
  42. Likes to cooperate with others
  43. Is easily distracted\*
  44. Is sophisticated in art, music, or literature
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Source: John and Srivastava (1999)



**Table 13** Practice Environment Scale for Nursing Work Index (PES-NWI)

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**Management and leadership of head nurse**

1. Head nurse supports the nursing team
2. Head nurse is a good manager and leader
3. Head nurse supports the team in decision making
4. Nursing supervisors use errors as learning opportunities
5. Head nurse consults nurses in relation to problems and daily procedures
6. Time and opportunities to discuss customer care with other nurses

**Adequate human resources to ensure the quality of care**

7. Enough nurses ensure the quality of care
8. Enough nurses carry out the work
9. Active development of staff
10. Nurses involved in the internal management of the hospital
11. Merit and acknowledgement of the work well done
12. Quality assurance program

**Nurse-physician relationship**

13. Lots of work between physicians and nurses
14. Group work between nurses and physicians
15. Physicians and nurses have good working relationship
16. Nurse director has power and authority as an executive
17. Programs of embracement for newly hired nurses
18. Nurse director is accessible and visible to employees

**Nurse participation in hospital affairs**

19. Opportunity of career growth
20. Opportunity of progression
21. Opportunity of nurses to participate in political decisions
22. Management listens and responds to the concerns of workers

**Nursing foundation for quality of care**

23. Written and updated plan of care for all clients
  24. Use of nursing diagnosis
  25. Care management promotes continuity of care
  26. Works with competent nurses
  27. Nursing care are based on a nursing model
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28. Opportunity of nurses to participate in committees and departments

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Source: Lake, 2002