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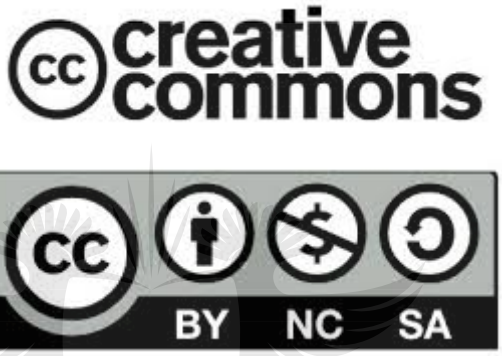

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The Interplay between Emotional Labour and Work-Family Balance among Black Women Nurses in Johannesburg

by

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Abstract

Nurses are essential to health care system in South Africa. They ensure that patients receive healing through the provision of health care. Nurses working in the South African public health care system face many challenges including poor practice environments, poor working conditions, lack of resources and staff shortages. Additionally, they are exposed to diseases and they experience traumatic events at work, for example the death of patients. As a result, nurses experience emotional exhaustion more than other professions. Along with dealing with the emotional encounters they experience at work nurses have families who also demand emotional support from them as well. These work and home demands require nurses to strike a difficult work life balance. Using a qualitative approach, this study aimed to understand the interplay between emotional labour and work family balance among Black women nurses in Johannesburg. The study findings indicate that emotional labour impacts on nurses' ability to deal with home related stresses and leads to an imbalance as work drains their ability effectively deal with family demands. In the same view, this lack of balance is visible in their quality of life and their low job satisfaction and 'ineffective' patient care.

Key Words: Nursing, Work-Family Balance, Emotional Labour, Intersectionality.

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Chapter 1: Introduction

1.1. Overview

The nursing profession has been the backbone of the health care system for many years. When an individual enters a hospital or clinic, they meet nurses. Some of these nurses face challenges that include poor working conditions, staff shortages, inadequate medical resources and an imbalance in the nurse-patient ratio. Nurses also face extreme situations everyday which include having to suppress their real emotions to meet hospital or clinic requirements or witnessing the death of a patient. These daily experiences affect nurses emotionally, impacting their service delivery and patient care. Perhaps one of the greatest challenges faced by nurses is that of striking a balance between their emotions, their work and their families.

1.2. Problem Statement

Most research that has been conducted on nurses focuses on job satisfaction and the factors contributing to job satisfaction for nurses (Lane, Esser and Holte et al., 2010). Scholars found that job satisfaction among nurses was influenced by the working environment, workload, and the support available to them (Lake, 2002; Mahmoud, 2008; Pearson, O'Brien-Pallas and Thomson et al., 2006; McHaugh, Dikutney-Lee and Cimiottie et al.., 2011; Natsupawat, kunaviktikul, Nanstupawat et al., 2017). Job performance and patient care that is offered by nurses was also found to be influenced by the abovementioned factors (Ullah, Sehrish, Anwar et al., 2018). Job dissatisfaction has been explored and is found to be a leading cause of anger and anxiety that is sometimes exhibited by nurses (Kronsber, Bouret and Brett, 2018). For women nurses, job dissatisfaction impacted their ability to balance family life and work life (Brough and Kalliath , 2009).

Experiences of nurses are impacted by their practice environment, working conditions and staffing issues. When the practice environment is healthy, it leads to nurses feeling satisfied and fulfilled (Pearson et al., 2006). However, in the South African context, there are bad working conditions and staff shortages (Hall, 2004); meaning that the practice environment is stressful for nurses working in the South African public health system (Pillay, 2009). These conditions influence the ways in which nurses balance work life and family life and contributes to emotional exhaustion and thus an emotional imbalance.

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Work-family balance is when an individual can strike a positive balance between work responsibilities and family responsibilities. Jobs characterised by sizeable workloads and long and “inflexible” working hours such as nursing make balancing work and family a challenge (Cooklin,Westrupp, Srazdins et al., 2014: 273; Charlesworth, Baines and Cunningham, 2015; Folbre, 2006). As demonstrated by Huynh, Alderson and Thompson (2008), there has been extensive research conducted on emotional labour and its effects on work productivity, along with how it leads to emotional distress and emotional exhaustion. Their study was aimed at understanding the concept of emotional labour amongst nursing practitioners (Huynh, Alderson and Thompson, 2008: 200-201). Quantitative research has been conducted to understand the relationship between work-family conflict and job satisfaction as illustrated by the study conducted at the University of Tarija in Bolivia by Daniel and Michel (2013). The aim of the study by Daniel and Michel (2013) was to change the policies that are related to work-family balance in order to improve job satisfaction through human resource flexibility. The study was able to indicate that work-family enrichment brings about fulfillment and balance in an individual’s life (Daniel and Michel, 2013). However, the influence that emotional labour has on this balance was not explored.

Emotional labour is an important phenomenon when looking at work-family balance. This is because emotionally taxing jobs such as teaching, nursing and social work are usually occupied by women. Due to misaligned demands in the workplace and family, women face challenges with striking a balance between marital and familial demands as well as the emotional demands at work. Because of this, women are more likely to struggle with psychological strain, stress and burnout. Though there is generally a lot of literature that speaks to and contributes to the discourse on emotional labour and work-family balance, it is mostly from American (Garey and Hansen, 2011), Asian (Noor and Zainuddin, 2011), Australian (Charlesworth et al., 2014) and New Zealand (Charlesworth et al. 2015) perspectives. Emotional labour has been studied from a South African context looking at nurses. An example of this was the study by Nel, Jonker and Rabie (2015) that looked at emotional intelligence and wellness among nurses in Potchefstroom. However, emotional intelligence and emotional labour are not the same thing. Another South African study on emotional labour looked at petrol attendants in Stellenbosch (Du Toit, 2012). However, emotional labour and its effects on work-family balance and the

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interplay between the two concepts have been understudied within the South African context.

The focus of this study was thus, to understand the influence of emotional labour on work-family balance. Considering the identified research gap, this study explored the following research question: "**What is the interplay between emotional labour and work-family balance among Black[1] women nurses in Johannesburg?**"

1.3. Study Aims and Objectives

The aim of this study was to explore the ways in which Black women working in the nursing profession balance the emotions as experienced in their workplace with their home life. Additionally, the study also aimed to understand the factors that shape emotional labour within the nursing profession. Moreover, this study sought to understand the experiences in which Black women nurses strike a healthy balance between their work lives and their home lives, while ensuring that the one domain does not negatively influence the other.

The following objectives were used to guide the study:

- To understand the family-related emotional encounters that Black nursing practitioners experience.
- To comprehend the work-related emotional events that Black nursing practitioners experience.
- To examine Black nursing practitioners' family dynamics.
- To assess the interplay between emotional labour as experienced at work and within the family.
- To analyse Black nursing practitioners' personal and professional coping mechanisms.

[1] "The term Black generally refers to a person with African ancestral origins. In some circumstances, usually in politics or power struggles, the term Black signifies all non-White minority populations" (Agyemang, Bhopal and Bruijnzeels, 2005: 1016). For the purpose of this study, the term 'Black' is used to refer to women with African ancestral origins.

1.4. Main Study Concepts

Gender: An identity category experienced by a person who possess the identity of either a male or a female (Shields, 2008).

Black: "The term Black refers to a person with African ancestral origins. In some circumstances, usually in politics or power struggles, the term Black signifies all non-white minority populations" (Agyemang, Bhopal and Bruijnzeels, 2005: 1016).

Practice environment: The working environment of an individual working in the healthcare profession (Lake, 2002).

Work-Family balance: A balance found by an individual between their work and their family life (Clark, 2000).

Emotional labour: Ways in which an employee supresses their emotions to fulfil the requirements of their role (Hochschild, 1983).

Intersectionality: "The way of understanding and analysing complexity in the world, in people and in human experiences" (Collins and Bilge, 2016:27).

1.5. Structure of Study

- **Chapter 1: Introduction -** This chapter has introduced the study, provided a discussion of the significance, aims and purpose of the study. The objectives of the study were clearly stated as well.
- **Chapter 2: Literature Review -** This chapter will discuss the existing literature that was found on emotional labour and work-family balance, looking into both concepts separately and how they are understood sociologically.
- **Chapter 3: Methodology -** This chapter focuses on the type of methods that were employed for the research, including sampling, data collection and data analysis.
- **Chapter 4: Findings -** This chapter provides a discussion on the findings of the study and offers responses to the objectives that were set for the study.
- **Chapter 5: Conclusion -** This chapter provides a conclusion based on the key findings of this study. It also provides recommendations for future research.

1.6. Conclusion:

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Chapter one has provided an overview of the ways that nurses are the backbone of the healthcare system. They are the ones that essentially care for individuals whether at a clinic or a hospital. Although this is the case, nurses face numerous challenges which include poor working conditions, staff shortages, inadequate medical resources and an imbalance in the nurse-patient ratio. These challenges lead nurses into suppressing their emotions when they are in the presence of their patients because they are being professional. By suppressing their real emotions nurses are emotionally affected. Globally, most research that has been explored in the healthcare sector focuses on job satisfaction or job dissatisfaction and the factors that influence a nurses' practice environment. Within the South African context, nurses' working conditions and the shortage of staff are the topics which have been explored in research. The aim of this study was to explore what the interplay between emotional labour and work-family balance is among Black women nurses in Johannesburg. This was done through the identified objectives which aimed to understand the factors that influence emotional labour within the nursing profession. Additionally, this study sought to understand the ways that nurses strike a healthy balance between their work and their families. The following chapter will provide an overview of the literature that was consulted for this study.

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Chapter 2: Literature Review

2.1. Introduction

Nursing is viewed as one of the most critical professions in society. This is due to the roles and contributions that nurses make to individual and societal health as well as well-being. In most countries, the strength and sustainability of the health system depends largely on having significant numbers of well-trained, highly skilled nurses that are supported by a well-oiled and fully resourced health infrastructure. Notwithstanding the valuable contribution of this profession, nurses operate in complex, challenging and often dangerous conditions. On top of the challenges nurses face, the nursing profession occupies low status as opposed to other professions. Nursing is a low status profession because of the nature of the job which entails taking care of the sick and doing administrative work. Furthermore, the majority of nurses who are women often find themselves navigating between work duties, emotions, and family responsibilities. As far as my literature search has shown, there is an extensive body of work on the nursing profession. However, one of the areas that is relatively less explored, particularly in the South African context, is that of balancing work duties, emotions and family demands among Black women nurses.

This chapter reviews literature with a focus on gendered experiences in nursing and the advancements of women, both White and Black in the profession. The link between the working environment of nurses and job satisfaction is then highlighted. This is followed by a discussion of work family balance in nursing and the effects it has on the nurses themselves. Emotional labour is then discussed in detail, particularly looking at its existence within the nursing profession. The coping mechanisms used by nurses to manage and cope with their challenges are then discussed. Lastly, intersectionality as the theoretical framework for this study is explained.

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2.2. Conceptions of a Gender

2.2.1. Gender and Nursing:

Within society, there are different views and descriptions of what constitutes gender. West and Zimmerman (1987: 125) defined gender as “an achieved status that is 0constructed through psychological, cultural and social means”. The definition given by

West and Zimmerman (1987) suggests that gender is a social construct that is shaped by culture as well as psychological conditioning. This study however uses an intersectional definition of gender. Shields (2008) uses feminist theory and intersectionality to better define gender. She describes it as being shaped by culture and society based on an individual's social location and lived experiences (Shields, 2008).

The definition given by Shields (2008) gives way to exploring gender as an identity category, experienced by the person who possess the identity of either a male or a female rather than an achieved status as described by West and Zimmerman (1987). Furthermore, Shields' (2008) definition allows for the understanding of different factors that contribute to the experiences of the two different genders, as well as how they intersect with each other to make up the experiences of nurses (Shields, 2008). These factors include the power relations that exist within the nurse's working environment based on their gender (Collins, 1990: 2000), the ways in which patients treat the nurses (Hart, 2005; Harding, 2007; Rajacich, Kune, Willston et al., 2013) and the psychological effects thereof (Kronsber, et al. , 2018).

Nursing used to be a gendered profession in that it was for women more than it was for men (Meadus and Twomey, 2011). This was mainly due to the feminine traits that were required for the job (Meadus et al., 2011; McDonald, 2012). Some of these traits included communal traits such as friendliness, compassion and care (Nolte , Downing, Temane et al., 2017). In the United States of America, men made up 5.7% of registered nurses in the year 2007 (Ahmad and Alasad, 2007). Similar to South Africa, the province of Gauteng being comprised of 7,4% male nurses in the year 2019(South African Nursing Council, 2019). This is due to the gendered stereotypes associated with the profession that have now posed a challenge for men and women (Ahmad et al., 2007; Buthelezi, Fakude, Martin et al., 2015; Galbany-Estragues and Comas-d'Argemir, 2017). The challenge is that male nurses are expected to demonstrate communal traits when they are at work, the same way women nurses do.

The entering of women into male-dominated professions was met with shock, and this proved the same for men who joined female-dominated professions such as nursing (Liu and Li, 2017). Gender preferences of nurses within hospitals have been said to be expressed by women more than men and this is due to reproductive reasons (Kerssens,

Bensign and Andela, 1997).One's gender preferences and requests are often influenced by their own gender identities, their attitudes and how comfortable they are (Greenwald and Farnheim, 2000). Gender preferences are seen in a quantitative study by Ahmad and Alasad (2007) that looked at patients' preferences for the nurse's gender. Ahmad and Alasad (2007) found that 67,7% of female patients preferred to be cared for by female nurses due to their 'reproductive matters, sexual and intimate psychosocial issues'. Their findings also indicate that 90% of male patients do not mind what gender their nurse is. Supervisors have also expressed gender preferences when they ask patients whether they are comfortable with a particular gender of nurses treating them; patients expressed their preference of being treated by a particular gender (Kronsber et al., 2018).

The gender experiences of male nurses globally differ from those of female nurses. This is evident in countries such as the United States of America (Hart, 2005), Taiwan (Liu and Li, 2017), Canada (Rajacich et al., 2013) and New Zealand (Harding, 2007). It is evident by the way in which they are interviewed upon entering the profession. Male nursing students who want to enter the nursing profession undergo rigorous interviews to be accepted (Kronsber et al., 2018). They are also often questioned about their reasons for choosing nursing rather than being doctors by their patients (Hart, 2005). Due to the attributes of a nurse requiring communal personalities, male nurses are often called gay (Harding, 2007), which leads to them feeling emasculated (Liu and Li, 2017). Additionally, they struggle to find a sense of belonging in their workplaces because they are so few and they are often discriminated against (Sedgwick and Kullet, 2015). Moreover, they are viewed by their patients, their families and the public as though they are promiscuous or as though they are perverts because of the physical contact required for the job (Harding, 2007).

Women nurses have different gender experiences because more women are entering paid employment (Geldenhuys, 2011) which challenges gender roles and expectations set by society. In South Africa, women occupy the lowest paid sector, which shows how most working women are poorly paid due to them finding or opting for jobs that make it easier for them to balance their home life and work life (Geldenhuys, 2011). Finding jobs that assist them in striking a balance is one of the consequences faced by working women as some, if not all tasks associated with the home such as housework, cleaning

and child-care are still regarded as 'women's work' (Lombert and Webster, 2010). Challenges that women face in the nursing profession include being expected to have a caring nature (Gray and Smith, 2009).

The perception that women are more compassionate and empathetic can be attributed to the number of nurses that occupy departments such as midwifery in the nursing profession (Bolton, 2000). Society and culture have shaped the different gender stereotypes that exist within health care settings by equating the hospital organisation to the home settings within societies (Gray et al., 2009). This is seen by the way that women nurses are treated in comparison to male doctors. Feminist scholars are of the view that the nurse-physician relationship reflects that of a husband and a wife within a home, thus emphasising a patriarchal system (Sweet and Nowman, 1995). An example would be the way that nurses are the ones who have the responsibility of caring for the patient which is parallel to childcare. Whereas the physician is the one who controls what should be done and how it should be done, which is parallel to what a husband is expected to do within the home. The nurse also has the task of providing physical and emotional support and availability for the patient, while the doctor is somewhat absent and provides the important duties and medicine like that of a father in the household (Sweet et al., 1995). Although these experiences for women are general, the experiences of Black women and White women also differ due to their race.

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2.3. Race and the experiences of Women in Nursing

South Africa's racial history is one that is dominated by racial segregation. During apartheid, racial segregation was allowed by the government (Ndinda and Okeke-Uzodike, 2012). Apartheid was the ruling ideology for the period 1948 to 1994 where White people were viewed as superior to Black people. White people's superiority was characterised by White people having privileges in areas such as education, work, residential areas and economic freedom. The privilege of White people in these areas meant that Black people were disadvantaged (Horwitz and Jain, 2011).

Segregation was also present in the workplace as there was a racial hierarchy that existed in organisations (Haslanger, 2000; Nash, 2008). The racial hierarchy was White people at the top, followed by Indians, Coloureds and then Blacks. White people were the most privileged and occupied the top managerial positions. Coloured people and

Indian people had fewer privileges and Black people had little or no privileges (Republic of South Africa, 2015; Horwitz et al., 2011). Black people had to be supervised by White people because they were viewed as more knowledgeable and had exposure in their managerial positions unlike Black people (Msomi, 2006). This gave White people an advantage over Black people in the workplace, giving way for the racial hierarchy to exist (Fletcher, 2013; Ndinda et al., 2012).

The history of nursing was influenced by apartheid and the racial hierarchy that existed during that time. White women nurses were at a greater advantage than Black women nurses. The privilege of White nurses stemmed from their association with White male doctors who, at the time, dominated the nursing profession (Schultheiss, 2010). Black women nurses emerged and started being trained when White men expressed their disapproval and uneasiness caused by the thought of White women being treated by Black male nurses (Marks, 1994). Even so, Black women nurses were not allowed to supervise White women nurses (Marks, 1994).

The tasks that were performed by Black women nurses in hospitals included taking care of the sick and the poor along with being midwives. They continue to do so as they dominate the public sector of nurses more than their White counterparts in post-apartheid South Africa (Van der Heerver, Van der Merwe and Crowley, 2019). Black women in nursing experience racism and discrimination in their workplaces because of the racial stereotypes which exist within communities (Jean-Marie, Williams and Sherman, 2009; Likupe and Archibong, 2013). Some of the racial stereotypes are seen in the way that Black women nurses could not treat White men, along with their English competency being questioned and experiences of language barriers when providing care for patients (Mapedzahama, Rudge, West et al., 2012). These experiences all contribute to the working environment of nurses and their job satisfaction.

2.4. Influences of Job Satisfaction

There are factors that contribute to the definitions of both job satisfaction and dissatisfaction. Job satisfaction is defined as the positive mental and physical setting experienced by an individual in the role they play at work (Khunou and Duvhana-Maselesele, 2014). The mental and physical setting can bring about negative or positive feelings about a job (Buitendach and Rothmann, 2009). In simple terms, job satisfaction is based on what you think, the role you play and what you feel which leads to the enjoyment of and contentment in a job. There are factors that contribute to job

satisfaction of employees. These include the working environment, working conditions, the quality of relationships with colleagues and the salary received (Parvin and Kabir, 2011). Other factors include communication and commitment from the organisation of employment (Lane et al., 2010). Nurses experience job satisfaction when they are paid well and when the environment in which they work is healthy (Mchaugh et al., 2011). When the working environment is healthy, nurses are more focused on their work and they are relaxed which leads to increased job performance and patient care (Ullah et al., 2018). Nurses' work is characterised by their care for patients and helping to heal them. For this reason, nurses have great self-esteem, joy and fulfillment. However, job satisfaction is not only dependent on the kind of work that nurses do. It is also dependent on the workload and nursing support available in the workplace (Mahmoud, 2008; Pearson et al. 2006; Lake, 2002). When nurses feel overwhelmed by their workload and a lack of nursing support, they experience job dissatisfaction (McHaugh et al., 2011; Nantsupawat et al., 2017).

Experiences documented by males to influence their job dissatisfaction may include factors that differ slightly from women's experiences. Males being discriminated against in their workplace leads to feelings of "anxiety, sleepless nights, anger and trepidation wondering what negative issue would occur in the future" (Kronsber et al., 2018: 49). Women nurses have different experiences which influence their ability to balance their family life with work (Brough et al., 2009), such as sexual harassment (Nelson, 2018) and dealing with high expectations to show care and compassion for patients (Cottingham, Erickson and Diedendorff, 2015). Even though the experiences of male and female nurses differ slightly, their experiences are similar in that they all lead to burnout, stress and job dissatisfaction (Nolte et al., 2017). This is usually the case within the South African nursing field.

2.4.1. The practice Environment of Nurses

Tregunno (2004) described a working environment as characterised by the views and experiences of workers within an organisation. These views and experiences are shaped by physical and emotional connotations tied to that organisation (Dormann and Zapf, 2001). A nurse's working environment or practice environment is influenced by factors

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like how well it is staffed, the support that is available for nurses and the availability of resources (Lake, 2002).

South Africa's public health sector provides health care and facilities for most of the population in South Africa. Patients who go to public health facilities are dependent on the free health care provision (Pillay, 2009). Whereas the private health sector provides health care and health facilities to individuals that are financially stable. This means that patients that go to a private facility are financially able to pay for their health care using medical insurance or their own personal funds (Hospital Association of South Africa, 2017; Pillay, 2009).

Such differences between the private and the public sector illustrates how nurses working in the public sector have greater challenges than nurses working within the private sector. The challenges that are faced by nurses working in the public sector include shortages of staff, lack of resources and over population, leading to imbalances in the nurse-patient ratio (Lake, 2002; Hall, 2004). Nurses in the public sector experience increased workload and possible burden of disease (Maestad, Torsvik and Aakuik, 2010).

A positive practice environment can increase the positive collegial relationship between nurses and the patient-nurse relationship. It can also contribute to good patient care and good job performance. Thus, a healthy practice environment for a nurse would be one in which nurses feel a high sense of fulfilment (Pearson et al., 2006). Therefore, nurses judge their practice environment based on whether the job provides them with a sense of satisfaction (Ullah et al., 2018). This would include nurses feeling well and positive about their work resulting in high quality patient care (de Melo, Burbosa and de Souza, 2011; Ullah et al., 2018), as opposed to nurses feeling burned out (Nantsupawat et al., 2017) and emotionally exhausted (Maslach, Jackson and Leiter, 1996). Most importantly, it leads to job satisfaction for nursing practitioners (Ritter, Matthews, Ford, et al., 2016).

2.4.2. Working conditions of Nurses

The experiences of nurses in the South African healthcare sector are characterised by working conditions that lead to stress and burnout (Hall, 2004). This is often the case in the public sector due to long working hours, staff shortages, insufficient resources and high ratio of population to nurse statistics (Hall, 2004; Khamisa, Oldenburg, Peltzer et

al., 2014). In the South African public health sector, 'stressful working conditions' are the most prevalent and although nurses love providing care and love their jobs, they often make the decision to leave their workplaces due to poor working conditions (Taylor, Fair and Nikodem, 2013). Again, nurses state that they leave work due to several other reasons, like 'lack of competitive incentives, work pressure, inadequately resourced working environments and loss of professional skills' (Hall, 2004; Songstad, Rekdal and Massay et al., 2011). For example, nursing staff working at the Baragwaneth Hospital in Soweto reported that they felt as though their working environment not only escalated their anxiety and stress, but that it was also 'unacceptable and unsafe' (Horwitz, 2013).

Alongside the workload and working conditions, nurses also voiced their concerns about the low pay. This complaint and concern cuts across the public and the private sector (Taylor, Fair and Nikodem, 2013).

2.4.3. Shortage of Staff in Nursing

In 2002, there were 155 484 practicing nurses in South Africa and the ratio of nurses to population was 343 nurses: 100 000 population (Statistics South Africa, 2002; Hall, 2004). However, these statistics have since changed wherein, the province of Gauteng alone is comprised of a total number of 74 044 nurses where 68 535 are female and 5 509 are male (South African Nursing Council, 2020). Due to rapidly changing health needs of people, professional health care is required (Hall, 2004).

The shortage of nursing staff is a problem globally within the public health care sector. South Africa is no exception to the problem as there are a lot of issues surrounding shortages of nursing staff. Shortage of nursing staff can be attributed to the decreased levels of job satisfaction within the profession. There is a prevalence of shortage of staff in the public health care sector because nurses must assist many patients a day. (Holmberg, Caro and Sobis, 2017). Factors influencing the shortage of nurses include unsatisfactory working conditions, low pay and the lack of professional development within the nursing profession (Songstad et al., 2011; Taylor, Fair and Nikodem, 2013).

In the South African public health sector, low remuneration, poor working conditions and the practice environment of nurses influences job satisfaction and nurse shortages

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(Mokola, Oosthuizen and Ehlers, 2010). Nurses are unable to thrive and deliver exceptional service in an environment where they receive little or no respect, are not appreciated and honoured for their skills and abilities (Oulton, 2006). Nursing ought to provide an environment where nurses have financial security, professional and personal growth, workloads that leave room for adequate patient care and a local environment that allows for appreciation for nurses and the work they do (Oulton, 2006; Mulenga, 2010) — resulting in nurse retention rather than resignation. However, in the South African public sector, this is not the case. Nursing shortages are the result of nurses receiving unsatisfactory pay, where they cannot adequately provide for their families or meet some of their basic needs like security (Oostheizen et al., 2007). Nurses work under poor working conditions, have excessive and unmanageable workloads, and they have limited opportunities to grow within their profession (Khunou et al., 2016), leading to work burnout, stress and job dissatisfaction (Yang, Zhou and Liu et al., 2017). Consequently, nurses in South Africa are emigrating and working in foreign countries like the United States of America where they can earn more money while working under better conditions with better and more resources (Egerdahl, 2009). Increasing the remuneration and improving the working conditions of nurses could result in decreasing nursing shortages in South Africa (Magana and Damons, 2013).

2.5. Work Family Balance and Nursing

Work-family balance has been used to understand and explain how individuals aim to balance their work life and their home life (Garey and Hansen, 2011). Here, the work life and the home life both have requirements and expectations that need to be met by the individual (Lee, Reissing and Dobson, 2009). For one to say that they have a balance between their home and work life, it would mean that they have a way of balancing these spheres in ways that reduce stress, ways that are satisfying and ways that have very little conflict with each other (Clark, 2000). The roles of the individual would not be in conflict in any way and there would be no evident work-family imbalance (Crompton and Lyonette, 2006). Work family imbalance is when an individual fails to find a harmonious balance between their work life and their home life (Gropel and Kuhl, 2009). This leads to tension as work and family roles compete. Hence, negative consequences may occur on health, professional performance as well as on the family and home dynamics of the individual (Daniel et al., 2013). This is congruent with the definition of work family conflict which is when the different roles that individuals occupy in their lives begin to clash with

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one another, that is, the work life and the home life (Daniel et al., 2013; Michel, Kortrba and Mitchelson et al., 2011; Parasuraman and Simmer, 2001).

Work-family balance is influenced by the socially constructed expectations of what duties a woman should fulfill in the household, in the community, and at work. Even women who engage in paid labour go home and perform a second shift. This entails the women having duties and responsibilities within their home such as taking care of the children, cooking, cleaning, and ensuring that the house is well-kept. However, striking a balance between work and family life is a challenge for career-driven women (Cannold, 2014; Byrne and Canato, 2017). As a way of striking a balance, some women resort to employing another person for assistance with household related responsibilities. In such cases, women are employed to babysit or help with the domestic related duties (Cannold, 2014).

The possibility of work-family balance is the provision of social support to working women. Social support can be in the form of spousal or familial support (Miyoung, 2012; Alazzam et al., 2017). Consequently, in Black families, this can be a challenge because of the expectation of women to take care of extended family members. Providing care for extended family members makes it challenging for women to strike a balance because the familial support needed is relying on them for support (Parry and Segalo, 2017). Relying on the women for support leads to a work-family imbalance because one role takes precedence over another, causing the two roles to clash (Amoateng, 2007). Due to Black men maintaining the traditional belief that household duties are a woman's job, spousal support among Black households is a challenge (Osezua and Agbalajobi, 2016).

The work-family theory describes how an individual's work domain and their family domain are bound to intersect because they occupy both spaces daily (Clark, 2000). The borders of the two domains will cross because they are in constant interaction with each other due to the individual actively participating in both domains (Clark, 2000). To achieve a balance, individuals need to understand where the borders cross daily and to understand what contributes to the crossing. Understanding where the borders cross and what influences their crossing is possible through understanding that the restrictions of work and home life have changed (Kelliher, Richardson and Boiarintseva, 2019). Understanding work hours, the flexibility of life and more support in the family life, work-family balance is possible.

It is essential for nurses to have a balance between their work and family because it has an impact on their job performance as well as their physical and mental health (Brough et al., 2009). When nurses feel as though they have found a balance between their work and family, they have increased self-confidence and they work better. Additionally, they find their jobs satisfying and fulfilling (Brummelhuis and Bakker, 2012), showing alignment between work-family balance and job satisfaction. Work-family balance and job satisfaction go hand in hand because when nurses cannot find a balance between their work and family roles, work-family conflict occurs (Alazzam et al., 2017). The occurrence of work-family conflict leads to them needing additional support from their spouses and family members (Miyoung, 2012). This leads to the alteration of gender roles within a household where spousal and familial support become essential (Miyoung, 2012; Alazzam, et al., 2017). In such cases, childcare, elderly care and other family related responsibilities would then need to be fulfilled by the spouse. However, supportive working environments and demands also assist nurses in striking a better balance between their work life and family life (Cortese, Colombo and Ghislieri, 2010). Miyoung (2012) indicates how age is a factor when it comes to work family balance among young nurses. This is because their age increases difficulties in accessing social support from family or friends. Additionally, the number of children that the nurse has impacts the ways in which the family can have an impact on work (Alazza, et al., 2017). In cases where nurses have a high number of children, they would need additional help from family members and friends. Additional help is not always available to them resulting in them having to take time off work to take care of their children or leaving the children home alone. This can result in the nurse feeling stressed which impacts her emotions when she is at work (Alazza, et al., 2017; Bakker, Du and Derks, 2019). Social support and the working environment also play an essential role in cases whereby the nurse is being emotionally or physically abused at home. This would mean that their work would need to contribute to their well-being and being able to strike a balance between their work and their home (Henderson, 2001), whilst not letting the family impact the work domain.

2.6. Emotional Labour in Nursing

Kenny (2004) describes the retail sector as being characterised by emotional suppression and it is gendered because most educated young Black women dominate the retail industry. Some men work in the retail industry, but there are more Black women in the frontline of the industry. This is because women can sell the brand and the

products much better than men (Kenny, 2004). Although these young Black women face labour struggles that include discrimination and low working environments, they offer a smile to the customer and ensure that they offer the best service (Kenny, 2004). Offering a smile and the best service is no different from the emotional labour and gendered work that characterises the nursing profession.

Employees in the nursing profession experience high emotional demands (Coetzee, Klopper and Ellis et al., 2013). Due to nurses having to deal with events that affect them emotionally such as death and adverse situations they face daily (Theodosius, 2008), the profession is highlighted by immense stress, burnout and is emotionally draining (Firth, McKweon and McIntee et al., 1987; Taylor , 1985). Therefore, it is essential to understand the concept of emotional labour in nursing and its effects as a part of this research study.

Emotional labour has been described and explained in various ways by different scholars. Some describe it as the expected job requirements that characterise a role one needs to fill in the workplace (Morris and Feldman, 1997). Similarly, it is the expected ways in which an individual must shape their emotional responses to fit the emotional expectations of their working roles (Grandey, 2000; Glomb, Miner and Tews, 2002). Emotional labour has also been explained as being the expressed emotions of the employee when they encounter a client or patient (Ashforth and Humphrey, 1993). Hochschild (1983) referred to emotional labour as the required ways in which an employee suppresses their emotions to fulfill the requirements of their role. Additionally, Hochschild (1983) explains how emotional labour in an organisation ensures a safe environment and atmosphere for the client or patient benefitting both the organisation and the patient. As a result, employees must watch their emotional responses which are shaped by the organisational culture. These emotional responses are viewed as important because they boost morale and client or patient satisfaction which is regarded as good for the organisation (Rafaeli and Sutton, 1987).

The continuous need for nurses to suppress their emotions in the workplace leads to them pretending to meet the emotional requirements of their job (McQueen, 2004). This pretending is referred to as either deep acting or surface acting where both are equally emotionally demanding on the person performing them (Debesay, Harslof and Rechel et al., 2014). Deep acting includes pretending and showing emotions that must accommodate and are consistent with the emotional standards set by the organizational

culture of the workplace or hospital (Hoschild, 1983). It often results in positive outcomes that lead to the nurses feeling an increased level of job satisfaction, as well as patients feeling satisfied with the care that they receive because nurses would show compassion and have a greater connection with them.

Subsequently, surface acting entails an individual expressing themselves in carefully controlled and rehearsed ways such as smiling to show the most appropriate emotions for the situation (Hoschild, 1983). This kind of acting can be associated with emotional dissonance (Cheng, Batram and Karimi et al., 2013) which is the tension an individual experiences when they have to show emotions that are appropriate for their workplace rather than showing their true emotions (Andela, Truchot and Borteyrou, 2015).

Emotional dissonance is often seen in the negative effects that it has on nurses. These negative effects include nurses feeling emotionally exhausted, having increased levels of burnout, stress and their general well-being being compromised (Schmidt and Diestel, 2014). Additionally, emotional labour has negative impacts on the personal lives of the nurses. An example of this would be in the way that their deep acting, which involves suppressing their emotions affects their familial and personal relationships (Bechotoldt, Rohrmann and Der Doter et al., 2011; Gimlin, 2007). One impact that can be seen is in the way that they fail to respond to the emotional needs of their loved ones as a norm of what they have been accustomed to do at work (Mann, 2004). Due the emotional exhaustion caused by the suppression of emotions, nurses often project and misdirect their frustrations or disappointments from work onto their family members and friends. They could lash out in anger towards their spouse because he or she does not understand how difficult their work is. They could also refuse to assist their children with their homework due to a lack of patience (Mann 2004). This leads to nurses not only being isolated within the society but also being alienated and isolated in their own homes (Mann, 2004; Gimlin, 2007).

After immense observations of nurses and the healthcare profession and environment, Theodosius (2008) points out three types of emotional labour. These three types of emotional labour exist within the nursing profession and are connected to the general healthcare of people. Firstly, Theodosius (2008) discusses therapeutic emotional labour, which entails the interactions and relationships that nurses have with their patients and their families. Examples of therapeutic emotional labour can be seen in the need for compassion and empathy in nursing (Engel, 1977). For a patient to receive the patient-

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centred treatment, they would need to be treated holistically. Holistically treating a patient entails the nurse having a positive interpersonal relationship with the patient andcaring for them with kindness, empathy and compassion (Halpern, 2007; Warmington, 2012).

The second type of emotional labour identified by Theodosius (2008) is Instrumental emotional labour. This is the belief of the nurse in her education, skills, abilities and resources to be able to treat a patient holistically, resulting in positive healing and well-being. Instrumental emotional labour is a challenge in hospitals where there are limited resources and staff shortages. It becomes a battle for nurses to maintain positive beliefs in their abilities and their passion for nursing and healing patients when they do not have sufficient resources (Msiska, Smith and Fawcett, 2013).

Thirdly, Theodosius (2008) refers to collegial emotional labour which is the relationship that the nurses have amongst each other as colleagues, and the interaction that takes place between the doctors and the nurses. Additionally, collegial emotional labour is also the interactions and relationships that exist amongst all the working staff in a healthcare organisation as this has an impact on patient care (Theodosius, 2008). This can be seen in the different ways in which nurses treat each other and other peers such as doctors. At times, conflicts arise because of disrespect in the workplace such as doctors not acknowledging the nursing profession enough (Matziou, Vlahioti and Perdikaris, 2014; Tang, Chan and Zhou, 2013). However, Regan and Rodriquez (2011) note that when nurses and other staff within a healthcare facility have a positive relationship with one another, there is an improvement in patient care.

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Drawing from the work of Theodosius (2008), this part of the literature review has explored literature that speaks to these three types of emotional labour within the nursing profession from an African perspective. Exploring literature focusing on an African perspective using the work of Theodosius (2008) was due to studies on emotional labour in the African context being rare, particularly those looking at the emotional labour in the nursing profession. The shortage of nurses in African countries such as South Africa has caused a significant level of emotional strain on nurses (Hall, 2004). This is especially true in cases where nurses must care for patients that have diseases such as HIV/AIDS and tuberculosis (Dworzanowski-Venter, 2010; Msiska et al., 2014). Nurses working with patients that have HIV tend to be less emotionally available for their patients in the fear of contracting the disease. However, over time they begin to trust in their abilities and

training, and effectively help their patients (Msiska et al., 2014). By trusting in their training and abilities, and being emotionally available for their patients, nurses are showing an example of emotional labour as discussed by Theodosius (2008). Nurses in Malawi have reported that working shifts has a great effect on their everyday lives due to the disorientation caused, along with the strain that the long hours have on the body (Vermaak, Gorgens-Ekermans and Nieuwenheize, 2017). Although this is the case, nurses in Kenya felt that shift work assists nurses in managing their workload and the quality of care that is received by patients (Nzinga, McKnight and Jepkosgei et al., 2019). Additionally, nurses that need to suppress their emotions such as those who experience emotional abuse at home rely on their colleagues for social support and assistance during their working hours (Henderson, 2001). This is an indication of the importance and existence of collegial emotional labour in nursing (Theodosius, 2008).

2.7.Coping Mechanisms for Nurses

Throughout the literature that was consulted, it is shown that nurses did not indicate direct ways in which they coped with the challenges they faced daily. However, there are a few ways that have been mentioned as to how they attempt to deal with their challenges. Some of these ways include talking about their problems with their colleagues and friends about their work (Loo, 2012). Others, especially those working with patients that have long-term diseases, like HIV/AIDS, tend to make jokes about their work due to the stigma attached to these diseases (Dworzanowski-Venter, 2010). They often do this by making jokes about their work or not disclosing that they are nurses at all. Some would not even share their working experiences with others because they feared the reactions they would get (De Lobelle et al., 2009). This is largely due to the negative public image and perceptions that people have about nurses and what their work entails. This includes undermining their education, skills and abilities (Hoeve, Jansen and Roodbol, 2013).

Additionally, media often portrays nurses in a negative light making it difficult for nurses to avoid being socially isolated and stigmatised (Likupe et al., 2013; Likupe, 2013). Nurses also rely on spousal and familial support to manage their work, family and their emotions in a healthy way (Makola, Mashegoane and Debusho, 2015). Spirituality, having faith and religiosity has been viewed as a healthy coping mechanism among nurses. Due to nurses facing the death of patients and challenging working conditions daily, praying to a higher power like Buddha or God has been seen as helpful (Dill, 2017;

Shiri, Sohrabi an Jafari et al. 2008). It assists nurses to give meaning to their lives and increases their psychological well-being and job satisfaction (Butler-Barnes, Martin and Hope et al., 2018). Having healthy coping mechanisms ensures that nurses consider their mental health to increase their patient care and self-care (Shah, 2012; Teffo and Rispel, 2020).

2.8. Intersectionality: Work Family Balance, Emotional Labour and Nursing

Intersectionality was used as the theoretical tool for this study. Intersectionality has been a constructive way for feminists to be able to transform the misconstrued views of gender and how it has been conceptualised in research (McCall, 2005). Intersectionality is described as "the way of understanding and analysing complexity in the world, in people and in human experiences" (Hill, Collins and Bilge, 2016:27). This term was first coined by Kimberley Williams Crenshaw as a way of giving a voice to Black women. The main aim of this theory is ensuring that Black women can share their experiences while looking at factors that intersect, such as their race, identity and power dynamic in their lives (Crenshaw, 1989). It has contributed immensely to feminist theory and the broader understanding of gender. Feminist theorists challenge the assumptions that underlie gender and gendered expectations. Through the intersectional perspective, the researcher was able to understand the underlying and beyond the surface 'social identities' that influence the ways in which nurses conceptualise, understand and experience their gender, work and family roles.

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The work of Crenshaw was essential for this study as it aimed to give Black nursing practitioners a voice by trying to understand their lives and the world in which they live. The aim of the researcher was to see how their race intersects with their work, their family responsibilities and their emotional selves. Intersectionality was used to understand that there are several factors that intersect when speaking of women of colour. The concept of work-family balance needs to consider these factors because their intersection influences the ways in which women experience their lives (Shields, 2008). These factors include race, gender and class. Additionally, they also include the ways that cultural and traditional practices intersect and determine the ways that a Black woman in South Africa needs to uphold herself (Kamenou, 2008).

Using intersectionality in this study allowed for the analysis and understanding of the different concepts and how they intersect with each other. Feminists understand one's social location 'as reflected in intersecting identities and must be at the forefront investing

gender' (Collins, 1990: 2000). Additionally, intersectionality allowed for the understanding the experience of being a Black nursing practitioner working for the state, and what factors contribute to the work-family balance that may or may not be present (Hill Collins and Bilge, 2016). For this study, it was essential to understand the interplay between emotional labour and work-family balance as well as the interlink between Black women nursing practitioners, the society and the relationship that exists amongst them. Understanding the biography and history of work, family, emotional labour, race, the nursing practitioners as their own self and their relation to the greater world was also important.

As a theoretical tool, intersectionality was effective in providing a tool for analysing the responses of Black women nurses to the challenges that they face. To be able to gain greater understanding and insight of emotional labour and work-family balance that have been studied as separate concepts however, they in fact are intertwined and build on each other (Hill Collins and Bilge, 2016). Moreover, it allowed the researcher to see how work-family balance intersects with emotional labour and how these two concepts intersect with race as the researcher looked at Black women nursing practitioners and their experiences. By using intersectionality as a theoretical framework for this study, it allowed for the representation and understanding of 'complex and dynamic' associations between factors which are allowed in an intersectionality perspective.

2.9. Conclusion

This chapter highlighted the importance of nurses in our communities and the work that they do in hospitals and clinics. The chapter has provided literature that gives an outline of the challenges faced by nurses. This included the gendered experiences of nurses. Men and women experience the nursing environment differently from each other. There are also differences in experiences for Black and White women due to the underling racial histories that are prevalent in countries like South Africa. The working environment influences how nurses experiencetheir work and whether or not they experience job satisfaction or dissatisfaction. Work family balance is a challenge for nurses as they work long hours and are often not available for their families, which leads to them having to rely on extended family members and their spouses for support. Emotional labour is most prevalent within the nursing profession where nurses have to act according to their job requirements in orderto ensure adequate patient care and healing. The chapter has also explored the different

coping mechanisms that nurses use to deal with the demands that they face at work and at home. The next chapter discusses the research methodology that was used in conducting this study.

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Chapter 3: Methodology

3.1. Introduction

Emotional labour is a reality in nursing because nurses face emotional challenges from working in stressful environments (Coetzee et al., 2013). Due to long working hours, nurses must balance their work and their families in ways that will be beneficial for them. (Cortese et al., 2010). This study intended to comprehend the work-related emotional experiences that Black women nurses experience and to examine their family dynamics in order to understand the responsibilities that they have at home. This study aimed to explore the interplay between emotional labour as experienced at work and within the family. To meet the aim of the study, factors such as coping mechanisms that Black nursing practitioners use needed to be understood (Cortese et al., 2010; Mulaudzi, Pengpid and Peltzer, 2011).

Epistemology refers to the theories that people believe to contribute to the nature of knowledge (Richards, 2003; Bryman, 2008). In other words, it is the different ways that people make sense of the world they live in (Crotty, 1998). The researcher used an interpretivist epistemological approach in conducting this study. This chapter provides a detailed discussion of the research design, methods of data collection and research instruments. The chapter also justifies the selected methods and instruments. Furthermore, the chapter discusses the descriptions of the population, sampling techniques and the rationale for choosing the research site. The discussion in this chapter also highlights the sources of data, discourse data analysis through the thematic procedure. Lastly, the chapter highlights the researcher's reflexivity.

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3.2. Research Design and Approach

This study adopted the qualitative research approach. The qualitative approach uses several methods that focus on descriptions to record and analyse certain features in society (Bless and Higson-Smith, 2000). A qualitative approach makes use of non-numeric interpretations of analyses and examinations to discover “underlying meanings and patterns of relationships” (Babbie, 2013: 390). A qualitative approach is an exploratory form of research which assists the researcher to acquire and exploredifferent life worlds, experiences and opinions. It also provides insight and allows one togain a deeper understanding of the problem or the lived experiences of others. As seenin this study, the researcher was able to amplify the voices of nursing practitioners on

how they perform emotional labour and how this has an impact on the way they strike a balance between their work and family responsibilities. The advantage of using the qualitative approach was that it enabled the researcher to understand the nursing practitioners' experiences and the research topic in detail. Furthermore, it allowed participants to share their lived experiences and opinions in depth (Babbie, 2014).

3.3. Research Site

The research population was the public healthcare sector in Johannesburg. Johannesburg was the research site for this research. Johannesburg, also known as Jozi, is located in the Gauteng Province of South Africa. It is the capital city of the province and it is also the largest and wealthiest city in South Africa. Arguably, Johannesburg is the largest city that is not near the coast (Statistics South Africa, 2012). In 1896, gold was discovered in Johannesburg thus causing the influx of people from across the world. By the year 1931, Johannesburg's population was sitting at 400 000, which doubled during the Second World War (WWII) (Statistics South Africa, 2012). The United Nations estimated that the Johannesburg metropolitan population was about 1.8 million in 1995, which slowly decreased in the following years. However, the population has increased and continues to do so gradually. Currently, it is estimated that the population in 2016 was 4.4 million. From this estimated population, Black Females make up 47.2% of the population in Johannesburg which would coincide with the statistics showing majority of nurses being Black Female (Statistics South Africa, 2012) which account for 50% (Hospital Association of South Africa, 2017). The map below is an illustration of the city of Johannesburg:

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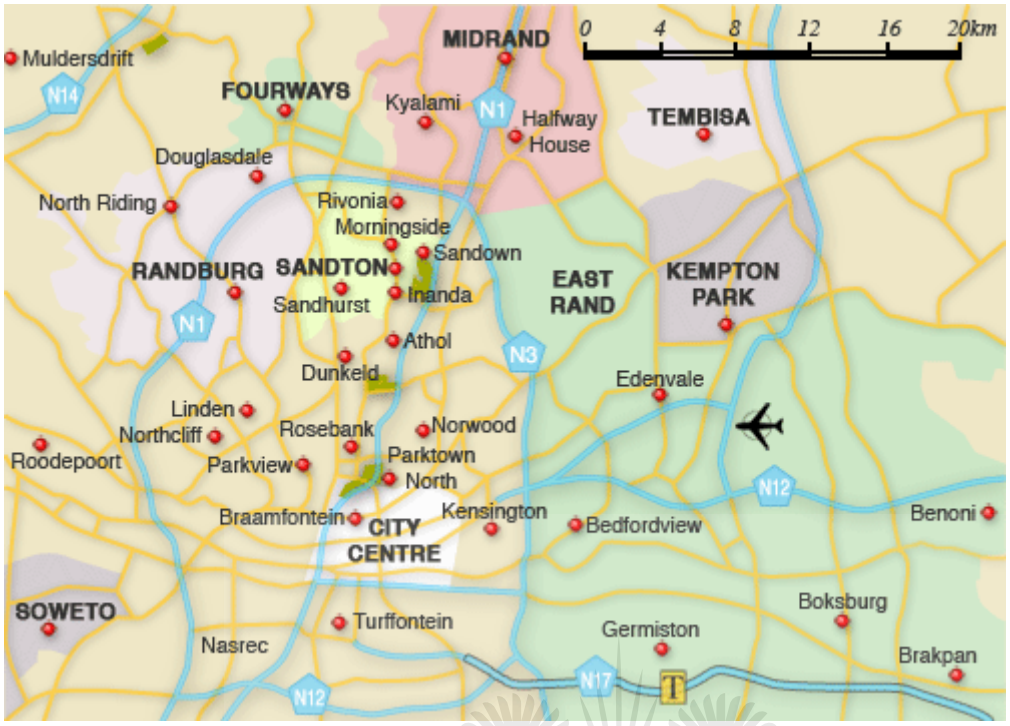
Image 3.1.



The population density of the city of Gold is 2,900 people per square kilometer and when one includes the more terrific metropolitan West Rand and Lenasia, the population of Johannesburg would be 10,5 million. The most prevalent group residing in Johannesburg are Black Africans who account for 76.4% of the population. White peopleaccount for 12.3%, Coloureds for 5.6% and Indian/Asian people account for 4.9% of the city's population. The majority of the population in this city speak the Nguni languages which comprise of isiZulu, isiXhosa, isiSwati, isiNdebele and xiTsonga (Statistics SouthAfrica, 2012). The smaller language groups include Sesotho, English, Afrikaans and TshiVenda. Seven percent of the population living in Johannesburg are illiterate, and only 3.4% have at least a primary school level of education. Single parent headed households make up 66% of the Johannesburg population and a significant 29% of the population reside in "informal dwellings" (Statistics South Africa, 2012).

3.4. Population for Study

The choice of the study population was influenced by the number of male and female nurses that work in the nursing profession. The table below indicates the provincial distribution of nursing manpower versus the population in South Africa.

Table 3.1

SANC Geographical Distribution 2018

Provincial Distribution of Nursing Manpower versus the Population of South Africa

Population	Nursing Manpower as at 2018/12/31				In Training as at 2018/12/31				
Province		2018	Registered	Enrolled	Auxiliaries	Total	Students	Pupils	Pupil N/A
Gauteng	- Females	7 282 657	35 031	16 846	16 658	68 535	4 311	1 304	805
	- Males	7 434 382	2 939	1 462	1 108	5 509	994	147	76
	- Total	14 717 039	37 970	18 308	17 766	74 044	5 305	1 451	881
	- Total	57 725 606	146 791	70 552	68 361	285 704	21 280	3 502	2 310

The Gauteng province is comprised of a total number of 74 044 nurses, wherein 68 535 are female and 5 509 are male (South African Native National Council, 2019). It is because of these statistics that the researcher decided to research women for this study. Additionally, Black women make up more than half of the nursing population that occupy the public health sector (Hospital Association of South Africa, 2017). Black women were therefore the target population for this study. Through these statistics, one can see that nurses in Gauteng experience an increased workload as there are so many patients that need to be assisted by a single nurse (Hospital Association of South Africa, 2017). Drawing from the above statistics, the population for this study was made up of Black women who work as nursing practitioners for state hospitals in Johannesburg.

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3.5. Selection of Participants

The snowball sampling technique was used to allocate participants for this study. Snowball sampling technique is a purposeful sampling method used to provide a criterion set by the researcher to find participants (Noy, 2008). Snowball sampling allows for the researcher to access the participants better through the recommendations of others (Naderifar, Goli and Ghaljaie, 2017). Snowballing allows the participants to refer the researcher to other people with similar characteristics who would be willing to take part in the study. Snowball sampling was the most appropriate sampling technique for this study as the researcher intended to locate six participates outside of their hospital working hours. The nurses made the decision to meet outside of their workspaces because they wanted a space where they would not be busy. Additionally, they wanted to offer attention and information without being distracted by their patients and their duties. The researcher gained access to my participants through my personal nurse and my parents. They were the people with whom the participants had contact with before the researcher spoke to them.

To qualify for participation in the study, prospective participants had to meet the study's participant criteria as set by the researcher (Neuman, 2011) which included over 3 years working experience in a public hospital or clinic located in Johannesburg. The hospitals and clinics that the participants worked in included Daveyton Main Clinic, Far East Rand Hospital, Geluksdal Clinic, Helen Joseph Hospital and Pholosong Hospital.

Participants also had to be over the age of thirty and had to be a Black woman. Age was used in the selection criteria because women over the age of thirty are more likely to have enough working experience as nursing practitioners (South African Nursing Council, 2016). The participants could either be married or single with children as this would enable the study to explore their family dynamics better and make their lived experiences unique to them, making for rich data. Over three years' experience ensured that participants had enough experience and knowledge to be able to answer the questions posed in this study (Hoeve, Jansen and Roodbol, 2013).

The table below provides a breakdown of the study participants. The description includes the language(s) that the interview was conducted in, the ages of the participants, their marital status and the number of children the participants had. In order to protect their identities, all the participants were assigned pseudonyms (Bless, Higson-Smith and Sithole, 2014). Additionally, the table includes the participants' occupation, working experience and the sector they have worked in and currently work in.

Table 3.2.

Participant Pseudonym:	**Language of Interview:**	**Description:**
Meme Mvelase	English and Sesotho	**Age:** 35 **Marital Status:** Single **Children:** Two **Occupation:** Professional Nurse **Working Experience:** 10 years **Sector:** Public clinic and hospital

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Vivian Nxumalo	English and IsiZulu	**Age:** 47 **Marital Status:** Married **Children:** Two **Occupation:** Professional Nurse **Working Experience:** 25+ years **Sector:** Public clinic and hospital.
Randzo Khosa	English and IsiZulu	**Age:** 49 **Marital Status:** Single **Children:** Two **Occupation:** Professional Nurse **Working Experience:** 17 years **Sector:** Public clinic and hospital
Busisiwe Khambule	English and IsiZulu	**Age:** 47 **Marital Status:** Single **Children:** Two **Occupation:** Professional Nurse **Working Experience:** 18 years **Sector:** Public clinic and hospital
Nomkhita Shabangu	IsiZulu	**Age:** 43 **Marital Status:** Single **Children:** One **Occupation:** Registered Nurse **Working Experience:** 8 years **Sector:** Public hospital

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Bridgette Sibiya	English and IsiZulu	**Age:** 36 **Marital Status:** Single **Children:** One **Occupation:** Registered Nurse **Working Experience:** 3 Years **Sector:** Public hospital

The criterion provided in the above table was used because in state hospitals, women make up majority of the nursing staff. Additionally, state hospitals have more Black women than women of other races in their working staff (van der Heever et al., 2019). Moreover, Black women nurses receive little to no extra support from their families and their workplace (Henderson, 2001).

3.6. Data Collection

To collect the necessary data that was needed for this study, a total number of six interviews were conducted. Six nursing practitioners who worked in the public sector were recruited for individual interviews. The nursing participants for this study were selected based on a criterion of age, race and working experience. The following table gives a brief introduction and a description of the nurses that were interviewed.

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Table 3.3.

Meme Mvelase: A quiet and reserved 35-year-old Black woman. She is a single mother of two and is a professional nurse. She started lecturing at a nurses' college four months prior to the interview but continues to work as a nurse. She has ten years working experience in both public hospitals and clinics.
Vivian Nxumalo: An outspoken and opinionated 47-year-old married Black woman. She has two children and has been working as a professional nurse for over twenty years. She has worked in both public hospitals and clinics.

Randzo Khosa: A spirited and conversational 49-year-old single Black woman. She is a mother of two, oneof which is adopted from a family member. She has been a nurse for seventeen years and has experience working in both public hospitals and clinics.
Busisiwe Khambule: A reserved yet strict 47-year-old Black woman. She is a mother of two and has been a professional nurse for eighteen years. Her working experience is in both public hospitals and clinics.
Nomkhita Shabangu: A soft-spoken and sensible 43-year-old Black woman. She is a single motherof one. She has been a registered nurse at a public hospital for eight years.
Bridgette Sibiya: A benevolent 36-year-old Black woman. She is a single mother of one. Shehas been a registered nurse for 3 years in a public hospital.

Although the researcher did not perform a pilot study due to time constraints that the nurses had with their schedules at work and my own feasibility, the first interview was treated withan amount of caution. The reason for this was because the researcher was practicing her interviewing skills and assessing whether the questions that she had would collect the necessary data that the researcher needed to complete this study (De vos, Strydomand Schulze et al., 2011). In a nutshell, the first interview assisted in ensuring that the interview skills of the researcher were on par and that sufficient notes were made. It alsoensured that rapport was built as it was needed from the participants. This was done with the intention of being able to discover the strengths and weaknesses of the technique used to ask questions as well as to test the interview guide. No questions were changed as they proved suitable for the study.

Semi-structured interviews with open-ended questions were used to conduct the interviews. Open-ended questions allowed the researcher to ask further questions to better understand the participants' views. Interviews allowed the researcher to understand participants' experiences and views of the nursing profession (Babbie and

Mouton, 2013; Wilson and MacLean, 2011). Using semi-structured interviews gave room for participants to explain themselves, to paint scenarios and extend their answers as they told their stories (Ryen, 2016). The use of open-ended questions such as 'Can you count on your colleagues when you come across difficulties in your home?" allowed participants to give broad answers (see appendix C for the interview guide). The interviews took roughly anhour and a half. The questions included in the interview guide were meant to assist in understanding and examining the nursing practitioners' lived experiences and to comprehend their live worlds while understanding underlying patterns of relationships and meanings of these underlying patterns. All interviews were recorded at the permission of the participants. Interviews took place at a time and place that was most suitable for the participant. For example, the researcher met with the nurses at their offices at the colleges where they gave lectures, at the KFC inside the Mall @ Carnival or at their homes. These are the places they had suggested and felt most comfortable in.

The interviews were conducted mostly in English. IsiZulu and Sesotho were also used in some cases where there was need for further explanation and understanding, or where the participant was conversant in either language. In some cases, these native languages were used when the participants wanted to fully get their point across. Using isiZulu and Sesotho to explain to the participants showed my ability to communicate fluently in both the languages as my home language is isiZulu, but I also grew up in Sesotho dominated provinces like the Free State.

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3.7. Data Analysis

For the data analysis process, thematic content analysis was employed. This method allowed the researcher to identify and examine the data and enabled her to see the common patterns and themes emanating from the data (Braun and Clark, 2006). By using this data analysis technique, the nursing practitioners were given a voice. This was done through various selections from their narrations that took place before, during and after the interviews. Additionally, the researcher paid attention to the verbal and non-verbal cues to broadenthe argument and support the findings of this study (Fine, 1992). The recorded interviewswere transcribed verbatim and then read several times thus allowing the researcher to understand and comprehend the responses fully. Thereafter the interviews were categorised and labeled accordingly (Beazley, 2009).

An audit trail, which is the documentation (notepad, journal or diary) that the researcher

keeps throughout the data collection process was kept (Rodgers and Cowles, 1993). The researcher kept an audit trail throughout the study to account for any changes, feelings and observations during the data collection and analysis phase of the study. An audit trail is also used to assist the researcher with clarity on some of the information that the researcher might have recorded during data collection (Robinson, 2003). The researcher did this especially with information that the participants shared once the recorder had been turned off. The researcher then had to make additional and more detailed notes in my notepad. From the combination of the interviews, the recordings and the audit trail, the researcher was then able to get enough details to accurately analyse the data and draw findings thereafter (Wilson and MacLean, 2011).

The researcher began the data analysis process by reading through each transcript with the aim of becoming familiar with the data. The researcher analysed each interview looking for points and words that would potentially assist me in answering my research question. I highlighted quotes that I thought would be useful. I tried to be as inclusive as possible by looking for data that was most relevant to the objectives of this study. I then moved onto systematically coding the quotes that I had highlighted. According to Braun and Clarke (2006), coding is when the researcher names and labels all the points they found relevant when they were reading through their interviews. Using different colours (blue, pink, red and yellow) to highlight different points, I then separated them by colour into different word documents. This is as far as I went in using the computer software that was available to me. Separating the different points the researcher had spotted into separate documents was sufficient for this study as it assisted me in organising the data properly to draw the appropriate themes (Guest and Eleanor, 2003). After separating the points of interests into word documents as a form of coding them, the researcher then began searching for themes.

A theme is described by Braun and Clarke (2006) as the essential details from the data that assist the researcher in answering the main research question. The identified essential details show recurring patterns and occurrences that are significant to the study (Vasimoradi, Jones and Turunen et al.., 2016). In searching for themes, I made clusters of codes that had the same colours (Henry, Dymnicki and Mohatt et al., 2015). For example, the blue cluster had details about nurses feeling as though they are human as well as social stigma. From there I began examining my themes to see whether they were valid. The validity of each identified theme was dependent on whether the theme

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contributed to or answered the overall objectives of the study (Nowell, Norris and White et al., 2017). If not, the theme was then removed. Thereafter, the remaining themes that were valid and essential to the study were given names to contribute to the story of the overall findings in Chapter 4.

3.8. Reflexivity

Reflexivity is defined as the way in which a researcher understands their positionality, self and criticism when in the field. It allows the researcher to look back and examine their experiences when they were in the field. Reflexivity also allows the researcher to understand and make sense of any biases they may have had during the data collection process (Alvesson and Skolberg, 2000). In essence, reflexivity was the process through which my social background, race, sex and educational background influenced the ways in which I conducted myself in the field. Additionally, it was the predictor of how the participants treated me and it was the dictator of the relationship between us (Alvesson et al., 2000; Berger, 2013).

Entering the field, the researcher was a 23-year-old master's student at the University of Johannesburg. She was a respectful and young Black woman who sought out to understand the lived experiences of nursing practitioners. I went into the field with my head full of literature that she had read and questions that needed to be answered by my participants. However, on the other hand, the researcher was the daughter of a Black mother who worked in a job characterised by emotional labour. Shealso saw herself as the daughter of these nursing practitioners because she grew up ina culture in which every elderly Black woman was her mother, whom she had to show respect as such. This entailed respecting her time and her space. To ensure that the experiences that were shared with me would remain private and would not be shared beyond us, the researcher made sure that she kept all the ethical considerations in mind.This meant that the researcher informed the participants about what the research entailed. The researcher provided them with a consent form, and she did not force them into participating in the research. I kept their identities and their information anonymousand confidential. The researcher respected the nursing practitioners and their field of work because she was an outsider to it. This was an important part of the way that the researcher conducted herself in the field as she was entering a world in which she had never belonged to. Moreover, the researcher was entering the field with her own reality, and therefore, it was important that she was always aware of her positionality and self (Lombart, Jombeen and McSherry, 2010).

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The researcher began contacting potential participants between November and December 2019. Her parents and her personal nurse who works in a private pharmacy were the main people who provided her with information on potential participants. This information included where she could get participants. In mid-January 2020, the researcher started directly communicating with the prospective participants using text messages and WhatsApp. She used these forms of communication because she did not want to call at the time out of respect and in case, they were busy; and her call would have been a disturbance. Additionally, the researcher wanted to create a safe and respectful relationship with the participants, which is why texting was the better option as compared to calling. However, others did not respond to the text messages which led to her calling them directly. When she called, the researcher made sure that her caller identification was visible as some people would not pick up an unknown number. Two of her participants responded days after receiving her texts and this was due to them having tight schedules and being busy at work. This turned out to be an issue because the participants all showed a concern of having to clear up time to meet with me due to their tight work schedules. This potentially indicated the challenges that nurses faced with balancing their work and life.

The researcher went into the data collection process having made a conscious decision to make sure that she was available to meet with the participants of the study at the time that suited them. The reason for this was that these would have been the only available times in their tight work schedules. The researcher ensured that, for the duration of the data collection process, she had free weekends. Additionally, the researcher made sure that she had a full tank of fuel so that she was able to drive to the places chosen by the participants.

The most uncomfortable part of the data collection process was the uncertainty that accompanied it. Most times, the researcher was uncertain about the participant's ability to participate even after they had committed. Although they had made a commitment to the study, it did not take away the fact that their participation was voluntary, and that they could choose to stop at any time. The researcher was also uncertain whether their participation was because they were interested in the study, or they were afraid to disappoint the people who had referred me to them.

The researcher met with the first three participants on the 22nd and the 23rd of January 2020. She met with the first participant, Meme, at her office at the nurses' college where

she lecturers a few times a week. Meme was a quiet and reserved woman. She thought about every answer she gave the researcher and made sure that she made sense after each answer. Meme felt that she and the researcher had common ground because they were both students. The researcher was doing her masters degree and she was, at the time, applying to do her masters. That is how I established rapport and trust with her. It made her more relaxed to know that two educated women were sharing a conversation.

It was during the interview with Meme that Vivian, the second participant, walked in. On that day she was not yet a participant. The two practitioners shared an office and Vivian was interested in knowing what the researcher was doing there as she was not a nursing student. Meme and the researcher simultaneously explained the reason for the researcher's visit. Vivian then asked where the researcher was from, and when she realised that they were from the same area, she showed interest in participating in the study. Vivian was more outspoken and opinionated than Meme. She was funny and wanted to get a very strong point across that nurses are people too. Nurses have lives beyond those hospital gates. It was interesting and fun interviewing her.

The third participant, Randzo, was a spirited, conversational woman. The researcher and Randzo met on the 23rd of January 2020 at KFC. She had chosen this meeting spot because she felt that it was halfway between where she lived and where the researcher lived. It was also convenient for her to meet the researcher there as she had a car and could drive herself there. She could also go to the gym after the interview. When the researcher arrived, Randzo was already seated. She had bought herself something to eat. Being the one who had invited her to this meeting, I felt the need to buy her something to drink although she declined my offer, saying that the researcher was still in school and that it was okay. She also added that due to health reasons she does not take any fizzy drinks, so water was fine. From the beginning to the end of the interview, Randzo expressed herself in isiZulu which was her home language. She was more comfortable as this was seen in the detail that she gave throughout the interview. This was different from the other interviews the researcher had conducted. Having to translate data from isiZulu to English could result in the misinterpretation or loss of information during translation (van Nes, Runge and Jonsson., 2010). To keep the richness and validity of the data, metaphors and translations that were closest to the original explanation as possible were used (Polkinghorne, 2005; Polkinghorne, 2007). This interview turned out to be the longest interview and essentially, my favourite. Throughout

the interview the researcher felt as though her mother was telling an African story of an amazing Black woman.

Busisiwe, a reserved yet strict woman was my fourth participant. We met on the 12th of February 2020 at her home. She had been strict about the time that we had to meet because she was working that night. In the beginning she made a fuss over how comfortable the researcher was and how she could accommodate her. After the researcher had explained how the interview would go and she had read the information sheet and signed the consent form, she became a bit relaxed. We started off the interview with her being a bit shaky and very shy, but as we continued, she found out that her daughter and the researcher were of the same age. This made her very comfortable in knowing that young girls are getting an education and working. She felt as though we were conversing as mother and daughter, and that is when she became more expressive and open. It was a pleasing interview.

Nomkitha and the researcher met at a local restaurant down the street from where she worked and not far from where the researcher lived. The interview was on Friday the 14th of February 2020. Upon meeting, she asked the researcher what her valentine thought of her conducting interviews on the day of love. The researcher laughed and toldher that "my masters is my first love". The pleasant laughter created a comfortable environment for both of them. From the beginning she asked if she could speak isiZulubecause of her Bantu education[2]. The researcher assured her that it was fine. She expressed herself well and in full detail. Nomkitha got emotional when they had to talk about her son because she had to send him to Kwa-Zulu Natal (KZN) where she owns a house. She sent her son to KZN after an accident that he had, and because of work, she could not fully care for him. The researcher then had to ensure that she was okay and asked if she would need to get in touch with a counsellor. She assured the researcher that she was fine and would go shopping after the interview and feel much better. Thereafter, she expressed her passion for nursing, sounding and looking much better after the emotional moment. The researcher called her a few days after the

[2] The education system during the apartheid era was Bantu Education. Black South Africans were limited in this education system as they did not have access to quality education (Gallo 2020). Many Black South Africans have been affected especially when it comes to language. Reason being, English was not a language of instruction during the apartheid period (Klu 2017). Meaning it was not necessary for it to be known which has now caused language barriers. Especially when Black South Africans who were taught under Bantu Education need to express themselves in adulthood.

interview to check on her and she was indeed fine. The researcher gave her the helpline numbers for counselling just in case. She gladly accepted them.

The final participant, Bridgette, was benevolent. The researcher and Bridgette met on the 22nd of February 2020 in her home as this was most convenient for her. It was a rainy Saturday and she had to stay at home with her mother and daughter that day. She shared her experiences in a very care-free way and made sure that the researcher understood what she meant. In answering, she not only shared her experiences, but also made examples using her friends and colleagues' experiences toemphasize her points. Bridgette was very comfortable talking to me and even ensured that if the researcher needed more help with the study, she was always there to assist.

Although the interviews were in English, some of the participants were comfortable using either isiZulu, seSotho or seTswana when emphasizing a point or for expression due to educational background. Where this was the case, the researcher translated the interviews into English during transcribing. Translating data from one language like from isiZulu into English to accurately present the findings affects the trustworthiness of the data (Chen and Boor, 2010). The researcher felt that nurses who used vernacular languages to articulate their answers gave more in-depth answers. They were also able to explain and describe their experiences well. To maintain the trustworthiness, the researcher ensured that she gave metaphors and narratives that were as close to the original expression as possible (Polkinghorne, 2007).

The explanation of questions in the interview guide advanced as the data collection process progressed. This was due to some nurses needing more probing than others. In some cases, some participants needed the questions to be phrased a bit differently for the researcher to gain a proper understanding of their answers. Every interview was its own experience because at times, the researcher would have to explain herself more and at other times, she would not be required to explain herself at all. The researcher enjoyed each interview as it taught her different perspectives, opinions, views and daily experiences. The researcher entered a world she had never entered before and she left it being more educated and knowledgeable than when she had entered the field.

3.9. Ethical Considerations

Ethical clearance and approval for this study was granted by the Faculty of Humanities Ethics Committee at the University of Johannesburg (see appendix D). Only after ethical

clearance had been granted did the data collection process begin. When conducting a sociological study, it is essential to consider ethics because they aim to prevent the violation of human rights of participants (Creswell, 2009; Bless, Higson-Smith and Sithole, 2014). For this reason, the research adhered to all aspects of ethical considerations. On recruitment to participate, potential participants were informed about the aim of the research. This was done through the study information sheet (see appendix A); the information was provided to ensure that participants understood that their participation was entirely voluntary and that they could withdraw at any time without negative consequences. Participants understood that they could stop during the interview when they felt uncomfortable. By participating in this study, they would not experience any harm. Confidentiality was maintained using pseudonyms. No personal information and shared experiences wouldbe traced back to the participants because of the use of pseudonyms, ensuring anonymity (Neuman, 2014). Once they understood the study's objectives and agreed toparticipate, the prospective participants were required to sign a consent form (see appendix B). The participant information sheet (see Appendix A) included information about participants' rights to withdraw from the study at any given time (Ryen, 2010; Neuman, 2014).

As nurses work with cases that may be of a traumatic nature and can evoke negative emotions and memories, they are considered vulnerable participants in research. Doing research with vulnerable groups has the potential to psychologically harm them especially when participants are asked questions that would make them recall sensitive experiences that may cause them to be re-traumatised or experience excessive emotions. In cases where I thought professional intervention was needed, I referred the participants to the National Counselling Helpline on 0861-322-322. This was for them to receive professional psychological counselling and help as I am not qualified to assist them.

3.10. Conclusion

This chapter detailed how the research was executed. The research adopted a qualitative research design. The reason for this being that qualitative research allowed for the adequate documentation of the lived experiences of the nurses. Due to the majority of the population being Black people, the city of Johannesburg in the Gauteng province was the research site chosen for this research study. The population for this study was Black women nurses who worked in public hospitals and/or clinics. The

sample was made up of six participants who met a set criterion based on age, gender, race and working experience. Ethical clearance and approval for this study was received from the Faculty of Humanities Ethics Committee at the University of Johannesburg. Data collection took place during January and February 2020. Thematic content analysis was used to analyse the data and to formulate the necessary findings. The researcher was reflexive throughout the time that she was in the field. The next chapter will discuss the findings and provide an analysis of the findings.

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Chapter 4: Findings and Discussion

4.1. Introduction

The focus of this research was on Black women nursing practitioners. These women could be assumed to be part of the working force whereby they also have to perform "double-shifts" because they work and they also have homes or families that need to be cared for outside of work. There was an evident need to balance both household responsibilities and workplace responsibilities amongst these women. Within the findings there were some similarities found amongst the practitioners which were mainlywork related. However, to indicate differences in the way that women strike a balance, there was a significant focus dedicated to analysing the differences between theexperiences of each of these women. This study aimed to explore the interplay betweenemotional labour and work-family balance amongst Black women nurses in Johannesburg.

In an attempt to answer the research question, this chapter discusses themes that emerged from the data analysis. The themes include '*My uniform and social stigma'* which discusses the stigma that nurses go through at work and within their communities when they are in uniform. '*Shortage of nurses, targets and patient care',* focuses on discussions surrounding the ways in which the shortage of nurses impacts the nurses and how they interact with patients. The section on shortage of nurses also discusses the ways in which public hospitals are run by the government and how this has an impact on the quality of service delivery from the nurses and essentially patient care. The third theme discussed in the chapter is on '*Holistic healing of patients'.* This focuses on the fact that nurses feel that they need to heal a patient holistically and the factors that are considered to ensure that a patient is fully healed in a context with limited medical resources for effective healing. The fourth theme "*Your child is my child'* is based on the ways that nurses build emotional bonds with patients and the effects that this has on them. *'Taking my feelings home'* focuses on the way that nurses may express suppressed emotional frustration onto their loved ones at home. The sixth theme, *'As a nurse, I am also human'* focuses on the ways in which nurses neglect themselves to

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ensure that their patients receive the patient care that they need. Finally, the chapter discusses '*Coping mechanisms'* which is based on the ways in which nurses find ways to cope at home and at work.

4.2. 'My uniform and the dynamics of social stigma and positive recognition'

To comprehend the work-related emotional events that Black nursing practitioners experience; it is important to understand that nurses work within communities to provide adequate care to those who are ill and needmedical help (Hoeve et al., 2013). People living in these communities have negative and positive views about nurses. Some of the negative views from the community are often experienced by the nurses when they are in uniform outside of work. This includeswhen they are in a mall, shopping center or when they are walking home or to a taxi after work. When I interviewed my participants, they spoke about the community's views towards their profession. The views towards nursing as a profession by the community are both negative and positive. However, the negative views outweigh the positive ones.This is due to the history of nursing and the negative depiction of nurses portrayed in themedia (Likupe et al., 2013; Likupe, 2013; Patidar et al., 2011). Randzo, the 49-year-oldBlack women working in a public clinic expressed how she had gone home to change out of her uniform after work before she came to meet me. She went on to make examples of some of the remarks she would get had she not changed. These examples included:

> "*Look, she probably ditched work to come to KFC instead of helping people that are in need! She is only thinking of herself*". (Randzo, Interview 23 January 2020).

These would be remarks coming from individuals in the community. The expression on Randzo's face indicated that the remarks were not something she could ignore yet it is her reality. Randzo's expression indicates that nurses need to be aware of how they always represent themselves and their profession. This includes times when they are meant to be relaxing outside of their workspaces. Meme, 35-year-old Black woman who works at a public hospital in Johannesburg and lectures incoming students, made a similar comment saying:

> "*You know, when I used to work until late at the hospital and had to take public*

> *transport I was always scared. This is because we get attacked by the community when we are walking in the streets with our uniform on. They think that we are the bad guys, they think we do not want to help people. And I think it is because of what is in the media about us. Have you ever seen anything positive about a nurse in the papers? Never! They don't have anything good to say about us. Even the government. Doctors are protected and nurses are blamed for the things that happen to the patients*". (Meme, Interview 22 January 2020).

The expressions made by Meme referred to how the media depicts nurses which is not always positive. She shows that being fearful when in uniform as a nurse is common because unlike other professions, nurses cannot hide their profession (Patidar, Kaur and Sharma et al., 2011). This is because factors outside their control such as the shortages of nursing staff, shortages of resources and the picture given by media has often portrayed nurses in a negative light. They are often portrayed as an undignified profession that lacks respect and has no regard for the people they work with. However, this is not the case and could be the reason why both Randzo and Meme expressed a sense of frustration over the community not highlighting the positive views of the nursing profession. These expressions show some of the difficulties that nurses endure as the views of the community and the media hinder them from enjoying what they do.

Additionally, they struggle with helping their communities because they are not seen as helping but as unwilling to help. This is congruent with the literature found that nurses are treated the same way as women in society where the husband gets recognition for providing for the family whilst the wife stays at home and takes care of the children and does not receive any credit for it (Sweet et al., 1995). It also shows how nurses are marginalised and isolated in the society due to their work, along with the stereotypes in the society on how nurses should always be tending and caring for patients (Net al., 2017). The social stigma and isolation that nurses face indicates the ways in which it is difficult for them to defend their abilities, skills and education (Hoeve et al., 2013). This is due to people believing the negative views and perceptions that are provided in the media about nurses (Likupe et al., 2013; Likupe, 2013).

Although the media portrays nurses in a negative light, there are factors that influence the negative views that the community has towards nursing as a profession. Some of these factors are not beyond the nurses' control as they are based on the way in which nurses treat their patients (Nesengani, Downing an Poggenpoel et al., 2019). Patient care is an essential element in the nursing profession, and it determines whether the

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patient will have a positive or negative experience at the clinic or hospital (Randall, Crawford and Currie et al., 2017). Bridgette, a bubbly 36-year-old describes the reasons why the community has a negative view towards nurses due to a bad experience with a nurse in a clinic or hospital. Her description was as follows:

> "*Because you know with other people, they know the particular nurse that treated them badly so, you don't fall into that category. If you didn't do anything wrong to someone, you didn't do anything wrong. It's not always thatyou are dressed as a nurse, you fall under all bad nurses, NO! They will say "there is this other nurse at the clinic" even if they don't know the name of thatparticular nurse but they know who they are targeting, who did what to them.So, I don't get that bad reaction, no I actually don't feel shame, not at all. I don't".* (Bridgette, Interview 22 February 2020).

Bridgette's answer indicates the importance of therapeutic emotional labour in nursing. This shows the ways that nurses treating their patients with care and compassion can have an effect on them (Theodosius, 2008). It also shows the ways in which the treatment that nurses give their patients and their families can actually change the negative outlook that the public has on nurses into a positive one (Hoeve et al., 2013). Additionally, this will increase the belief and understanding of the nurses' training and education which is their instrumental emotional labour (Theodosius, 2008).

Although this is true, the ways in which nurses treat their patients is influenced and determined by other factors as well. These factors include their job satisfaction, the resources that are made available to them, the amount of patients that they have on that day and the amount of staff members that are on duty. Nurses' well-being is another factor that negatively influences their attitude and their service delivery. On the contrary, Bridgette had a different view of wearing her uniform in public and how she would be viewed. She had a much more positive response and experience with how people view the nursing profession. She shared the following:

> "*Some, especially for the children….kids would actually ask me how I got into nursing because they will be interested in doing nursing. …so they will ask questions seeking information. So, it's actually positive than it is negative*". (Bridgette, Interview 22 February 2020).

Bridgette shines light on the positive views that the community has towards nursing. Her experience shows how nurses that are new to the nursing profession have different experiences to those who have been working in the profession for years like Randzo and Meme. This is seen in how Bridgette feels that by wearing her uniform in public, sheis

able to inspire young children to join the profession and to positively represent the profession. Unlike Randzo and Meme, she is not fearful of wearing her uniform and does not feel the need to hide that she is a nurse. Instead, she is encouraged and inspired to wear it. Wearing her uniform gives her a sense of pride and gives her an opportunity to change the negative views towards nursing into positive views. Positive views include seeing nursing as a profession worthy of positive social recognition (Patidar et al., 2011).

Similar to Bridgette, Nomkitha, a 43-year-old passionate nurse who works at a public hospital shares a positive experience of wearing her uniform in public. She feels that by wearing her uniform in public, she gains more respect than when she is in the hospital. People within the community she works in and the one she lives amongst feel more comfortable to ask her health-related questions. Thus, she feels that she makes more of a difference and a greater contribution when she is outside the hospital than when she is working in the hospital. This can be seen in the way she narrates an experience she had with an older nurse who saw her wearing her uniform:

> "*I remember a time when I was in my uniform in a mall. I was avoiding looking at people because I noticed that they would stare at me or whisper to each other about me. Then an older nurse walked up to me and she asked me if I am a nurse? I said yes. She asked me where I worked, and I told her. After that she gave me the best advice ever and I still follow it to this day. She said to me: 'Never be ashamed to wear your uniform in public because people feel free to approach you'. After that I felt that I could wear my uniform anywhere and be proud of it*." (Nomkitha, Interview 14 February 2020).

For Nomkitha, the advice that she got from the older nurse helped her to see her profession as not being restricted to the hospital only. She could walk in a mall with pride from that day going forward because she had an opportunity to assist even more people. By being confident and open in the public while in her uniform she is able to provide health education beyond the patients and their families that she encounters daily at work. This would be leading to more people in the community being informed and aware of health-related issues. Although this is the case for Nomkitha, she did indicate that there is a double-edged sword to wearing her uniform in public. She described it in the following way:

> "*There are times when I am discouraged to wear my uniform because should something health related happen to someone in my presence, I am legally obliged to help them. This puts me at risk of losing my job."* (Nomkitha, Interview 14 February 2020).

According to the nurses' pledge taken upon entering the profession, they pledge to honour and place human life above themselves (South African Nursing Council, 2020). This means that when a nurse is in uniform, they carry their professional identity with them. This makes them legally liable for a human life that needs medical attention, and that human life becomes their responsibility. Meaning that the person in need of medical assistance at that time becomes the nurse's patient. The downside to this is that the nurse will be liable for anything bad or good that happens to their patient. This requires the nurse to have a heightened level of attention to everything she does so that she can record everything at a later stage. This is because should the patient die, the nurse will have to answer for everything she did to the patient. Experiences of the nurses in their uniform indicate that there are positive and negative views towards nursing from the public. These views are widely influenced by the personal experiences of both the patient and the nurse.

4.3. 'Shortage of nurses, Targets and Patient Care'

Daily, nurses work in environments that affect their emotions and shape their experiences within their working environments. The practice environments that nurses work in are overcrowded and the working conditions often lead to stress, burnout and extreme exhaustion. This is due to the public healthcare sector in South Africa having a prevalence of a shortage of nursing staff (Hall and Erasmus, 2004). One of the main contributing factors to the problem of the shortage of nurses can be attributed to the imbalance in the nurse-patient ratio in the South Africanpublic health sector (Hospital Association of South Africa, 2017). Nurses that participatedin this study voiced out their frustration when it came to the shortage of nurses. The participants mentioned different experiences which were frustrating to them and how they affected them differently. These frustrations were attributed to the overcrowding and the shortage of nursing staff. Randzo expressed her frustrations in the following words:

> *"Yoh! Ntsako, you don't want to know. Yooohh! You don't want to know, 'Yazin' (you know). They say that the shortage of staff, like they don't want us to complain. It means that we have to accept because when you cry or when you complain they say that it is the same everywhere. As if it's a good thing and we must clap hands for them. The shortage… I don't want to say that it is everywhere because I am not everywhere, right? I am here so…I want when I go and complain, whoever I am complaining to should understand that I am complaining and what my story actually is."* (Randzo, Interview 23 January 2020).

Randzo's frustration is centered on not being able to express her complaints about the shortage of nursing staff to her supervisors. Randzo could not share her complaints with her supervisor about the shortages of staff because it is seen as a global problem. Therefore, she must deal with it because it is everywhere. Drawing from what Randzo said, it is clear that nurses are not heard in their workplace when they try to voice out what adds to their frustration at work. The nurses raise their concerns because they know from experience that the staff shortages could lead to negative effects in patient care and job productivity.

Like Randzo, Meme also expressed her defeat when it came to expressing the need for more nurses. She said:

> *"Because, there, the way we were working there were times where we will work till 3 o' clock, no tea, no lunch! Shortage of nurses!! And like me , I'm chronic, I take medication for blood pressure then imagine that you don't eat, you don't drink water and now you must also take your tablets and sometimes you miss, you forget to take your tablets because of the overload of work…you become so busy…you don't have time for yourself."* (Meme, Interview 22 January 2020).

Nurses working in the public health care sector face numerous challenges. One of these challenges is that nurses in the public sector experience increased workloads and possible burden of disease (Maestad et al., 2010). Meme voices out the ways that the shortage of nursing staff increases the workload because nurses are then expected to make sacrifices to assist patients. These sacrifices come at the expense of their health because they neglect themselves in the process of trying to help patients. This increases the burden they may already have from diseases like high blood pressure or it makes them more vulnerable to contracting new diseases like HIV/AIDS. Vivian's experience is similar to Meme's experience. However, she mentions other sacrifices made by nurses. These additional sacrifices include sacrificing their time with family by going home a bit later than usual to assist a patient. Vivian, an outspoken nurse with over 20 years' nursing experience, shared her experience through the following expression:

> "*There you work especially if you are on the floor for a long time like for instance if you are in direct contact with the patient… then you have to work and it's not a matter of uhm… having a choice as such because remember we are dealing with people's lives… so you can't really say, "Nooo, I have to go or I have to…"* (Vivian, Interview 24 January 2020).

Vivian, also added the following:

> *"You'll find yourself well, most of the time you are working more hours than you are supposed to because there are situations whereby you feel you can't just leave the, the ward and the unit as it is ... when it's messed up because when everything is…* (signals everywhere using gestures of sweeping them all over the table*) … because you try and help even if it's an hour before you go home. But another thing that I will tell you, right? For instance, I worked in uhm Daveyton clinic for a very long time. That clinic is so busy, I'm telling you.* (Sighs) *Like you don't have a, you don't have teatime. Like you can't say, "I'm going to tea now" or "I'm going to lunch" Because the minute you sit down to have that cup of tea then there's a patient that's going to come in bleeding profusely so."* (Vivian, Interview 24 January 2020).

Vivian expresses how nurses have to put their patients first even at the expense of their own well-being. Due to the nature of their work, being there for their patients is not always something nurses choose to do but rather what they have to do. It is their duty to ensure adequate patient care and assistance to their patients. At times assisting their patients comes at their expense such as working overtime to make sure they have fully assisted a patient.

Nurses sacrifice themselves so much for the sake of their patients because they want to heal their patients and they want to ensure that their patients are better (Makola, et al., 2015). In order to ensure adequate patient care and relieve the pressures of the disproportionate nurse- population ratio, nurses work in shifts. Shift work has proven to be a solution used in Kenya and Malawi (Nzinga et al., 2019; Vermaak et al., 2017). 47-year-old Busisiwe shares how working shifts has worked in her department at the hospital:

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> "*Eish, you know us, in our department everybody, everybody because say for instance I am working like now I am going on nights… there will be four of us. So, there will be a gunshot, which is a surgical case, there's a maternity person who's going to be delivering their cases, orthopaedic cases. So, you as the two sisters have to divide yourselves, you are going to be taking maybe two theatre cases, this one will be doing two theatres. You are going to share the job equally and within those four, the sister will have her own nurse … a sister with a nurse so, there is no way that I'm going to work without a nurse, there's no way. I can't function without him/her. So, that's why I say our workload is, is, we all share the same…. Because most of the time when you are a sister in the theatre you are a scrub. If I need something, I need to ask her. If she is not there, if she doesn't want to, how will I do things, so can you see that we work hand in hand."* (Busisiwe, Interview 12 February 2020).

Based on what Busisiwe said, it is clear that shift work does assist nurses in managing their workload better. Sharing their duties as nurses according to the cases and patients that they have relieves nurses from feeling overwhelmed. They are able to clearly see where they can assist others as well as separate the patients according to emergencies

and urgency. Above that, nurses are able to fully apply themselves to the job that they are doing so as to provide adequate patient care. Providing adequate patient care contributes to nurses feeling satisfied with their job because they have a sense of fulfillment.

Drawing from what Busisiwe shared, shift work also contributes to a healthy practice environment for nurses. A healthy practice environment for nurses results in them feeling a high sense of fulfillment (Pearson et al., 2006). A healthy practice environment seems to be the result of working in shifts. However, how a healthy practice environment is created and maintained may differ from hospital to hospital because of the people you work with. At times, the delegation of tasks and trying to assist each other where possible does not help. Meme shared her experience on how they handle the shortages of staff:

> "*Sometimes you will delegate each other… then it was. I used to, if in that unit you have a unit manager, because the unit manager must do the admin but sometimes the unit manager is up and down with meetings and stuff and the shortage of resources or whatever medication, it doesn't affect the unit manager it affects you whose doing patient care!"* (Meme, Interview 22 January 2020).

Meme acknowledges that delegation works at times. However, once someone like the unit manager who is meant to help in distributing resources is busy in meetings it becomes a challenge to delegate properly. Delegation challenges are due to the lack of resources that is prevalent in the public health care sector over and above the shortage of nursing staff (Lake, 2002). Nurses that are trying their best to deliver adequate patient care are affected by a lack of resources and shortages of nursing staff.

Busisiwe and Meme's experiences indicate the importance of collegial emotional labour. Collegial emotional labour is the relationship that the nurses have amongst each other as colleagues and the interaction that takes place between the doctors and the nurses (Theodosius, 2008). Additionally, collegial emotional labour is also the interactions and relationships that exist amongst all the working staff in a healthcare organisation as this has an impact on patient care (Theodosius, 2008). Collegial emotional labour assists the nurses to be able to alleviate the stress, exhaustion and burnout that they go through at work, along with ensuring adequate patient care (Nzinga et al., 2019).

In an attempt to alleviate nurses from their excessive workload, stress and burnout; the government has put regulations in place that nurses working in the public sector must adhere to, whether it is in a hospital or a clinic. These regulations include the placement

of targets which means that nurses must see a particular number of patients a day before they knock off. Randzo describes how this has made nurses work much longer than they are actually supposed to because they are trying to ensure that they meet their targets. They are also trying very hard not to leave any patients unattended. Randzo shared the following:

> "…*now it is always about targets. We must reach this target and we must reach that target. I must…like I would just say that the government neglects its own staff. The things that are here that we have to reach targets, we have to … and if you, if you are working and you are chasing after a target, mind you the trouble is that you can... because you are chasing a target you can miss something else on this poor child, the one you are attending to, you understand?"* (Randzo, Interview 23 January 2020).

Randzo's experiences indicate how the strategy of targets has proven counter-productive for nurses because instead of alleviating the stress and burnout, it has increased it. This is because nurses are no longer applying themselves to patient care by paying attention to their patients. Instead, they are now paying attention to the numbers that are being requested by the government (Msiska et al., 2014). The job becomes challenging for the nurse when they are focusing on numbers. By focusing on the target number of patients, the nurse is not able to fully give the patient a proper assessment. By focusing on targets and numbers, there is also a high possibility of them missing certain assessments that would assist them in better treating the patient. The nurses also voiced how the focus on targets hinders them from advocating for their patients when the situation calls for it which might have a lasting effect on the care that the patient received.

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4.4. 'Holistic healing of patients'

Nurses experience emotional labour daily both at work and at home. To better understand their experiences of emotional labour at work, there are three different types of emotional labour that explain how it can be experienced in a work environment. Instrumental emotional labour is the belief of the nurse in her education, skills, abilities and resources to be able to treat a patient holistically resulting in positive healing and well-being (Theodosius, 2008). Nurses believe in putting their patients first and this includes healing them on a holistic level (Theodosius, 2008). Their patients' health remains the main priority. However, there are factors such as social, psychological, mental and spiritual factors that also contribute to the well-being of the patient. A lack of support for and to nurses and the lack of resources in the public health care sector makes

it difficult for nurses to believe in their resources to be able to holistically treat their patients (Lake, 2002). Experiences that have been shared show the ways in which nurses believe in their abilities to heal a patient. These abilities have been built on their experiences with patients, their skills and education. Additionally, the nurses expressed the difficulties of having to holistically heal their patients in similar ways. Meme expressed her experiences by saying:

> "*For me as a nurse, patient first other things shall follow."* (Meme, Interview 22 January 2020).

From this, it is clear that Meme puts herself second to her patients. This demonstrates the essential need for nurses to always think of their patients before anything else in their lives, especially when they are within their practice environment. Due to a patients' surroundings determining their mindset and affecting the way they process their health conditions; nurses expressed how the social life of a patient influences how quickly they heal. The importance of the social life and social surroundings of patients is illustrated in Vivian's experiences. She voiced them out by saying:

> "…*because remember as nurses, we nurse this patient holistically. So socially and… because the social life will affect the health one way or another if it's not healthy enough, you know what I mean? So, it's one of those things."* (Vivian, Interview 24 January 2020).

Vivian is explaining that the social life of patients affects their health. Vivian shines light on the importance of health in all spheres in the life of patients. The health of one sphere impacts the other, which then influences the overall healing of a patient. Vivian uses social life as an illustration to show that if one's social life is not healthy enough, then the physical health of the patient will be affected. She said:

> "…*because I believe that when you nurse a person, you are nursing them holistically, you understand? Touch or talk about other aspects, you understand? Because you need to, to, to refer them in the correct manner."* (Randzo, Interview 23 January 2020).

Although nurses trust in their education, abilities, skills and resources to ensure adequate patient care and holistic well-being of the patient, it is clear by what Randzo has shared that there are times where nurses need to make the necessary referrals to ensure that their patients are being treated properly. Due to the communal traits that nurses possess which include friendliness, compassion and care (Nolte et al., 2017), the nurse also has the task of physical and emotional support, and availability for the patient.

As a result, nurses can offer emotional support to patients through guiding patients through their treatment programs. However, they cannot counsel the patients because it is beyond their expertise to do so. In some instances, this may not be the case due to the lack of emotional support staff in the South African public health care sector. However, this is possible in the South African private health care sector as they have emotional support staff at their hospitals as a result of the patients having medical insurance or them affording private care (Hospital Association of South Africa, 2017; Pillay, 2009). Patients in the private sector are able to get the best medical care, which is different from patients who rely on the free resources that are provided by the public health care sector (Pillay, 2009).

Nurses can believe in their education, skills, abilities and resources but the patients' belief in the abilities and skills of the nurses is more important. From her experience, Nomkitha explained what it means to holistically treat a patient:

> "*Isn't it they are coming to get life and healing? So, if and when they see you, they have that small glimmer of hope that the nurse will help them with the pain that they are experiencing at that time."* (Nomkitha, Interview 14February 2020).

Based on what Nomkhita said, it is evident that patients trust nurses to heal them. Due to the communal traits that nurses possess which include friendliness, compassion and care (Nolte et al., 2017), patients view the nurse the same way children view their mothers. This is due to the gendered stereotypes associated with the profession that nurses perform similar roles to that of a mother, in that she is the one who provides care for her children like a nurse provides care for her patients (Ahmad et al., 2007; Buthelezi et al., 2015; Galbany-Estragueset al., 2017).

The above responses from Meme, Vivian, Randzo and Nomkhita explain how they perceived holistic healing of patients. Additionally, they gave an illustration of instrumental emotional labour. However, Busisiwe and Bridgette had different views of how holistic healing can occur. Busisiwe described her different view of holistic healing in the following way:

> *"You know there is nothing as nice as having…once you start talking to a patient they first, patients look at the attitude, wow they look at your attitude. If you are an approachable person, you know healing does occur, without having done anything. They become relieved thinking that, "oh this one" they begin to have this trusting relationship with you just because you were okay.*

> *The rest follows, you see the issues of medication helps but remember your mindset as well. It also helps you in your healing process as well so, it, it is like that. Like do you maintain a good relationship with… do you explain each and everything that happens? Do you consider their feelings? Do you consider their religious beliefs? Once you have considered all those things it becomes okay, you see?"* (Busisiwe, Interview 12 February 2020).

Therapeutic emotional labour is interactions and relationships that nurses have with their patients and their families (Theodosius, 2008). Therapeutic emotional labour can be seen in the need for compassion and empathy in nursing (Engel, 1977). Based on what Busisiwe described, one can understand that therapeutic emotional labour can occur before the nurse and the patient even have a conversation. This is because nurses' attitudes precede their skills and abilities. This entails the nurse having a positive interpersonal relationship with the patient and caring for them with kindness, empathy and compassion (Engel, 1977; Halpern, 2007; Warmington 2012). Therefore, nurses need to ensure that their attitudes are positive to build a positive relationship with their patients. When the nurse is approachable there is a higher chance that the patient will be more open about their health challenges. This leads to better patient care, patient satisfaction, while the nurses also have great self-esteem, joy and fulfillment (De Melo et al., 2011).

Similarly, Busisiwe indicates the ways in which healing can occur through the treatment and kindness that a nurse gives to you:

> *"Obviously you must have compassion… you need to be compassionate because you have to feel the other person's pain, you need to know and understand that you are there for a reason and to serve a purpose. So, I think then they see a nurse they just see that helping hand.*" (Bridgette, Interview 22 February 2020).

Bridgette expresses how a simple act of kindness can go a long way. This is seen in nursing literature. For a patient to receive patient-centred treatment they would need to be treated holistically. This entails the nurse having a positive interpersonal relationship with the patient and caring for them with kindness, empathy and compassion (; Engel, 1977; Halpern, 2007; Warmington, 2012). These are communal traits such as friendliness, compassion and care (Nolte et al., 2017). Moreover, according to the nurses in this study, nurses are essential to the holistic healing of a patient.

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4.5. 'Your child is my child'

Nurses have families of their own and they experience family-related emotional encounters during their workday by interacting with their patients. Human interaction is at the core of the nursing profession. Nurses need to know how to interact with their patients to ensure adequate patient care and support for their patients (Theodosius, 2008). The nature of their work includes them providing their patients withcare and helping them to heal, as well as being compassionate, kind and friendly to them(Halpern, 2007; De Melo et al., 2011; Warmington, 2012). Nurses build emotional bondswith their patients because of the daily interaction and the reliance of patients on the aidof their nurse (Kleinman, 1988). When asked whether they experience events at work that affect them emotionally, nurses in this study all indicated how they develop 'soft spots' for their patients. Soft spots make the job a bit more complex than just treating a patient based on their health problems. Nurses become emotionally invested especiallywhen they personalise their patients' conditions. The emotional attachments and the ways in which patients were personalised differed amongst the nurses. Bridgetteexpressed that she gets extremely emotional when a woman with children passes on. She said:

> "*I get affected every day. So, it's not particularly one day, it's just an everyday thing especially for me when a woman passes away. Like when a female passes away it affects me because the first thing, I think about are the children. So, I just assume that she left her children behind… I don't know if she has them or not, but I would assume that it's obvious she has children. So, that's what affects me*." (Bridgette, Interview 12 February 2020).

Bridgette's explanation is not based on the interactions she has had with the deceased woman but rather it is based on her assumption that the woman might have children and how they will be left without a mother. This emotionally affects Bridgette even though she experiences this every day. Bridgette has a 10-year-old daughter that lives with her and her mother. By looking at the description Bridgette has given, it is clear that she personalizes the death of women because she mentally asks herself what would happen to her child should something unexpected happen to her. By thinking this way, Bridgette has an increased level of empathy and compassion towards the patient's family (De Melo et al., 2011). This also leads to job satisfaction for Bridgette as she feels she has done her part as a nurse of providing comfort for her patients and their families by being empathetic.

Busisiwe has a 23-year-old daughter with whom she lives with and they have a close emotional bond with one another. Due to her close relationship with her daughter, Busisiwe is mostly affected by young adults because she gets emotionally attached and affected when the patients are of the same age as her daughter. This is because she draws similarities between them as she shared the following:

> "*You know sometimes you become so attached, you know there are patients when they come you feel that you know. Let's say if you came in, I would say: "Oh, here comes Khanyi" Khanyi is my daughter. "She's my daughter's age" I will draw similarities between the two of you, you know. Should anything bad happen to you, wow! I would be emotionally attached, you see. I would over sympathise to a point where I would now begin to put myself in your parent's shoes that if it was me and that was my child, I would also do this and that. And really, wow! It's not nice, I must say. It's really hard, very young kids, they come, and the child passes away then you ask yourself, 'why? She is very young, why?' You see? You don't wish for those things to happen to, I'm not saying that we want grannies to die but you just think that, 'at least this one has lived this young one…"* (Busisiwe, Interview 12 February 2020).

Due to the nature of a nurses' job, Busisiwe's thoughts and experiences indicate the way that nurses cannot leave their family life at home. She works with people therefore she always needs to be empathetic because this increases her dedication to her patient and work. By drawing these similarities between her family members and her patients, she can increase the quality of her patient care. She thinks beyond just the health conditions of her patients and goes the extra mile to make sure that every aspect of the patient's healing process goes well, including the family aspect as well. However, drawing these similarities has its disadvantages as Busiswe may become overly invested in her patients and their lives. This is problematic because she cannot detach herself from herpatients which has an impact on her job performance, her physical and mental health (Brough et al., 2009).

The nurse-patient relationship is different for every case. When nurses interact with patients over a long period of time they tend to be more emotionally invested. Nomkitha and Randzo shared their experiences in this regard because they treated patients who had chronic diseases such as HIV/AIDS, tuberculosis (TB) and diabetes. Working with patients with chronic illnesses led to them feeling a strong emotional connection with them due to the amount of time they spent treating the patient.

> *"…you know when you when, when you are there at work, you bond with the patients even if you don't know the person, you bond with them, you see? As you continue to help them and take care of them that bond begins to build.*

> *So, if it happens that you have been helping this person for a long time, you've been trying to get them healed and okay again and then in the end they pass on…that becomes very difficult."* (Nomkhita, Interview 14 February 2020)

Nomkitha described the effects that working with a patient for a long time could have on a nurse. Nurses end up building relationships with their patients and their families because of the frequent interaction. Emotional bonds become slightly more personal and this could have long lasting effects should the patient die. This could lead a nurse, like Nomkitha, to doubt her abilities and skills to be able to treat a patient to the point of healing, thus leading to poor job performance. Above that, nurses feel an emotional loss when a patient dies due to a long-time illness. Because they would have been working with each other for so long, the nurse will feel as though they lost someone close to them.

Randzo expressed a similar expression to Nomkitha. She explained that she works with TB, HIV/AIDS patients, women and children. Randzo's experiences with the programs that she was heading at work were what drained her emotionally. She shared the following:

> "*All the things that I have named drain me emotionally. I, we have to, to…. truth be told, we have to tell the truth… it doesn't matter how much passion you had or how dedicated you are but emotionally they drain me. You… I want to make an example…"* (Randzo, Interview 23 January 2020).

Randzo highlights that passion and dedication to nursing as a profession is important. However, because of the investment that you must put in doing your job, you will be emotionally drained. To make me understand what she meant, Randzo went on to explain her experience with a teenage girl who had given birth to a stillborn baby. She expressed her anger as to how the mother missed all the signs and how something could have been done earlier. This affected her emotionally. She said:

> *"It's, its painful. Yoh, I was heartbroken for… for two days. And with, with, with, with my patients, you get attached. Isn't it they are on treatment for six months, from six months up to a year. You become so attached to them, you understand? In such a way that they end up sharing their household issues… and you take them and carry them with you."* (Randzo, Interview 23 January 2020).

Randzo's experiences demonstrate the way that there is a need for nurses to suppress their emotions (McQueen, 2004). Suppressing their emotions as nurses can either make them seem emotionally detached or emotionally invested based on the way in which

they respond. Literature explains emotional suppression of an individual in their workplace to meet job requirements as either deep acting or surface acting. Deep acting is showing the emotions that would be suitable for the situation (Hoschild, 1983), for example, a nurse showing compassion to the children of a deceased woman. That would give the impression that the nurse is empathetic and understands what the family of a patient is going through. This leads to job satisfaction and patient satisfaction.

Surface acting is responding in a way that has been rehearsed prior to the time of the encounter so as to make the patient feel more comfortable around the nurse (Hoschild, 1983). An example is when Randzo had to hide her anger and shock to the details she was being given by the teenage girl. She had to rather show an increased level of concern rather than worry. This leads to emotional dissonance which makes the nurse seem as though they lack compassion and kindness needed for patients to feel satisfied. Drawing from the experiences shared by the nurses, surface acting seems to be more prevalent in nursing than deep acting. Although both deep acting and surface acting are emotionally demanding, surface acting leaves nurses feeling more emotionally exhausted, having increased levels of burnout and stress, and their general well-being being compromised (Schmidt and Diestel, 2014).

4.6. 'Taking my feelings home'

Black nursing practitioners are mothers, wives, friends and family members. They have homes they need to return to after working their daily shifts. This theme will explain the family-related emotional encounters that Black nursing practitioners experience. Nurses are required to emotionally invest themselves in their work (Coetzee et al. 2013),and thereafter they go home. At times, the challenge of detaching their emotions from their workday to the family begins to affect them when they return home after work (Gimlin, 2007). It is important for nurses to strike a balance between their home life andtheir work life because it can affect them in both ways. This is whereby work begins to interfere with the home life or the home life interfering with the work life (Brough et al., 2009). Nurses deal with a lot of emotion at work and thereafter they have to go home totheir own families. They are not always able to detach from these emotions directly afterwork as Randzo explains,

> *"Phela' all your strength, all your… what can I say… you! Meaning you, you are drained at work, right? When you reach home you are untouchable, you understand? When you reach home you are tired, you are actually exhausted.*

Your brain is as if it is not working well." (Randzo, Interview 23 January 2020).

The explanation provided by Randzo demonstrates the way that nurses must invest their entire selves to their work. Being a nurse requires more than applying the theoretical aspect by making it practical. It also requires nurses to think beyond the physical health of the patient and consider other forms of health. Nurses need to step outside themselves and the physical health of patients to provide adequate care (Cheng et al.,2013). This leads to immense emotional burnout and exhaustion on the nurse becauseshe has invested and used her brain, strength and skills in order to provide good patientcare (Schmidt and Diestel, 2014). This could affect their familial and personal relationships because they are too exhausted to be emotionally present in their homes, for their friends and family (Mann, 2004).

Nurses' job performance, physical health and mental health are the result of how well nurses balance their work and family, indicating the importance of having a balance (Brough et al., 2009). If they do not have a balance between work and family, it affects their familial and personal relationships (Gimlin, 2007). Vivian, Bridgette, Meme and Busisiwe expressed their difficulties when it came to balancing their family life and their work life. Vivian shared her experiences with work family balance in the following ways:

> "*I mean uuhh when I was young, I used to come back home after a twelve-hour shift and cook or prepare food. But I find now I can't do it anymore. I think when, when you start and you are still young and nursing, right? you stillhave got energy… because one, you are young, two, you are not as exhausted. Now when you are older… you do this exhaustive or uuuhhh job for a long time then you become more exhausted and you'll find that you become more and more exhausted."* (Vivian, Interview 24 January 2020).

Experience within the nursing profession has an impact on how nurses encounter and make sense of their emotional exhaustion. What attributes to this would be the exposure to patient deaths and having to perform tasks that are emotionally taxing over a long period of time (Zheng, Lee and Bloomer, 2017). Vivian illustrates the ways in which balancing being a nurse and having a family is easier when you are younger rather than when you are older. This is because of the experience within the nursing profession and the energy that younger nurses have. Due to the energy that younger nurses have; they can strike a balance better than older nurses. This can be seen in Bridgette's response.

> *"No, in a way you need a balance in life because it's not like your family needs you the whole day. So, you can work then knock off in the afternoon, come home and cook and go on with life as usual."* (Bridgette, Interview 22 February

2020).

There is a need to be able to strike a balance between your work life and your family life (Brough et al., 2009). Bridgette gives a picture of how she balances being a working mother and being a nurse. She explains that your loved ones will need you, but it would be impractical not to work. She feels that there will be time to engage with them when you return home from work. You will be able to care for them by cooking for them and ensuring that everyone is well. Bridgette is a young mother who has her mother's assistance with household chores as well as taking care of her daughter. However, Bridgette's response differs from literature. Literature indicates that young nurses that are mothers struggle to find support from their family members and find it more challenging to balance work and their family (Miyoung, 2012). Although Bridgette has support, on the other hand Meme struggles with not having enough time with her children. This is indicated by the experience she shared:

> *"I didn't have enough time with my kids. Or to myself nje… mhmmm. Cause also like you need to study; you need to develop yourself and you don't have time to do those things. Everything now when you are a professional nurse is just you and the patient. You and the patient… then in improving your academics …hai it was hard."* (Meme, Interview 22 January 2020).

Meme, who is a 35-year-old mother of two young children felt that as a working mother who is still trying to improve her practical skills at work, she did not have enough time for her children. This is problematic because the work is interfering with her home life which indicates that she does not have a good balance between her work and her family. Meme's experiences are congruent with literature that states that mothers find it difficult to strike a balance between work and life (Miyoung, 2012).

Because of the imbalances caused by work requirements, nurses who are also mothers have to find creative ways to balance their lives. Busisiwe indicates the ways in which social support plays a significant role for a young nurse with a baby. She details how she managed:

> "*So, those were… but just in general my mom, you get relieved that she is staying with someone that won't harm, you know very well that this one would never, never… isn't it this , is my mom and it's my mom I know her, you know? So, those are the challenges that are there but then it also depends on the support system that 'do you have a support system?' Yes or no?"* (Busisiwe, Interview 12 February 2020).

Busisiwe started practicing nursing when her daughter was just over a month old. The

baby stayed at home with Busisiwe's mother in a township called Tsakane, located in the far East Rand of Johannesburg. Meanwhile, Busisiwe was in Johannesburg central where she lived, worked and studied. She felt guilty as a mother that she was helping other people and investing all her emotions into her job when she has a small baby at home. She explained that this affected her immensely because when she was at work she would worry and be stressed about her small baby that she left at home. This was not beneficial to Busisiwe because it affected her job performance and mental health which demonstrates how the home life interferes the work life (Brough et al., 2009). Although the interference of the home life on the work life was the case, Busisiwe shows the importance of a strong support system. She shares that her mother was a great help to her. She was able to feel more at ease knowing that her baby was safe and well taken care of.

Vivian shares similar sentiments, as she expressed the ways in which she relied on her husband for assistance. She said:

> *"To be honest with you, he's one of the people who are very uh… helpful when it comes to those things. I remember, there's one thing... one thing that I….I was not fond of doing… is… even when I was still in hospital you know as a nurse in a ward situation, is to bath people, so my kids when they were still young… my husband used to bath them every day, like he enjoyed that. He will enjoy doing ironing but then he won't iron the whole washing, but he will iron the shirt... he'll say, "Ooo, I need a shirt to iron…Then he will do it. So, he's helpful, it's just that some of the things uhm… most of the household things he can't do because he was not taught how to do them."* (Vivian, Interview 24 January 2020).

Vivian's experience indicates the importance of spousal support and the ways in which it can assist in striking a balance between the two roles occupied by a nurse. This is due to the shift in the gender roles within the household. Men are more willing to assist their working wives with their second shift. They do this by assisting with household chores such as childcare and ironing. (Miyoung, 2012; Alazzam et al., 2017). Busisiwe and Vivian's shared experiences demonstrate the ways in which spousal and familial support is essential and needed for nurses. This is because they can depend on their loved ones for assistance especially in striking a balance between work and home responsibilities (Cortese et al., 2010; Miyoung, 2012).

When at work, nurses perform both deep and surface acting (McQueen, 2004; Debesay et al., 2014.). Deep acting involves suppressing what the nurse really feels in order to act in accordance to the situation at hand. Surface includes nurses performing in ways

which are rehearsed and are appropriate for the hospital or clinic and will ensure the best patient care (Hoschild, 1983). Deep acting and surface acting has negative effects of the nurses' well-being as it leads to stress, emotional burnout and exhaustion. Additionally, it leads to depression, reduced job satisfaction and it has an impact on their personal and familial relationships (Schmidt et al., 2014). The ways that suppressing emotions can be detrimental to the family life and environment can be seen in Randzo's explanation:

> *"Sometimes you did not get the chance to snap at work, so you go home and snap there. Whoever decides to touch you, you are already on the roof, you will fetch all of the issues. It's like those patients in Geluksdal that arrive at 16:15* (Zabby chuckles) *the poor guy, if you have a husband or your children, where were they?*
>
> *"You know you irritate me, you are just like those people, you would ask a question and they would give you an answer that does not have any direction…"* (Randzo, Interview 23 January 2020).

Randzo paints a picture of how nurses carry their suppressed emotions home. According to Randzo, this is usually the case when you were not able to find an emotional release at work. As a nurse frustrated by all the emotions you have had to suppress all day, you then get home and let the appropriate responses spill over into your family life (Schmidt et al., 2014). Remarks such as "you irritate me, you are just like those people" demonstrate ways that nurses could draw parallels between their patients and their family members. This is unfair on the family members because they are not the cause of the frustration. Randzo continues to explain the challenges that are accompanied by emotional suppression:

> *"Can you see how challenging this is? Now you are, are, are… it just becomes hectic and it becomes challenging for the people that you live with because all that frustration, all that anger, all those things you are now taking them and dumping them on your family members. You are expecting them to say,*
>
> *"Oh no yes, we understand today you had a hectic day at work",*
>
> *But they were not there, and it was not their fault."* (Randzo, Interview 23 January 2020).

It is clear by reading Randzo's explanation that nurses have challenges in managing and balancing their emotional experiences. They end up transferring the emotional frustrations that they experience at work into the home which is detrimental for the overall wellbeing of the nurse (Gimlin, 2007; Bechotoldt et al., 2011). Suppressed emotions include their anger and frustrations that were meant to be expressed to the patient but

are now being expressed to the family members. There is also a high expectation that they will show empathy and understanding that the nurse had a hectic day at work. However, this cannot occur when the nurse does not communicate with her family, resulting in a negative home environment. This shows the way that nurses need to be considered as human and not only members of the community that care for others.

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4.7. ‘As a nurse, I am also human’

Nurses are human beings that are members of the society who decided to serve the community as well. Nursing practitioners pledge their services to the community and they are celebrated for their commitment of helping the community. However, due to this commitment and pledge. Members of community often negate that nurses are also human being. The 12th of May is International Nurses’ Day, which is globally acknowledged and celebrated. This day is in remembrance of the legacy of the mother of nursing, Florence Nightingale, who made the nursing profession one that is independent, valued and needed in the health care system (South African Nursing Council, 2020). Adopted fromthe physicians’ pledge, the nurses’ pledge exists to ensure that nurses follow a set of principles. These principles include ‘leading by example, faithfulness, accountability, accuracy, responsibility, confidentiality, devotion and quality’ (South African Nursing Council, 2020). The South African nurses’ pledge reads as follows:

Table 4.1.

Nurses' Pledge of Service
I solemnly pledge myself to the service of humanity and will endeavour to practice my profession with conscience and with dignity.
I will maintain, by all the means in my power, the honour and noble tradition of my profession.
The total health of my patients will be my first consideration.
I will hold in confidence all personal matters coming to my knowledge.
I will not permit consideration of religion, nationality, race or social standing tointervene between my duty and my patient.
I will maintain the utmost respect for human life.

Extracted from the South African Nurses’ Council (2020)

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The nurses' pledge ensures that nurses deliver patient-centered treatment. Seemingly, it was meant to keep the principles alive within the profession by ensuring that nurses know the requirements of the work that they do. Due to the pledge that the participants of this study took as nurses to always put their patients first, sometimes they end up in positions where they compromise their own health. Meme shows the way the pledge can be used when dealing with a problem:

> *"Then they will always refer you back to the pledge, the patients' rights, the principles but they don't mention the nurses' rights."* (Meme, Interview 22 January 2020).

Meme indicate the ways in which nurses feel as though hospitals and clinics think about the patients more than they protect the nurses and their rights. This leads to nurses accepting their bad working conditions, which has negative effects on the nurses as they end up over compromising. They have to endure the comments that come from the patients as well as the pressures that come with working in the government hospital such as meeting the target and covering staff shortages (Kronsber et al., 2018). This contributes to nurses being overworked and how this has an impact on patient care (Hall et al., 2004). As a result, the nurses are dissatisfied with their work (Nolte et al., 2017).

Nurses working in the public health care sector are often exposed to long-term diseases such as TB and by putting their patients first they neglect their own health (Maestad et al., 2010). They also forget to take their medication, or they do not take it as a sacrifice to take care of their patients. This then puts the nurse's health at risk as their health conditions could deteriorate. When asked about what they thought their patients expected of them, the participants' responses indicated that they wanted to be seen as human too. Meme said:

> "*You just work! Yes, it's like the truth is, as a nurse you don't have rights of humanity. You as a human being, you are just a nurse! Like, as a nurse you are allowed to die on duty. Not to be sick or feel tired uh-ah. You must just work, if you are done, you're done. You can die on duty, its fine! We can't complain, we can't say ha-uh this is too much patients, we can't huh-uh. They say patient first, isn't it there's this thing we… the pledge!"* (Meme, Interview 22 January 2020).

Meme was expressing her frustration and the way in which patients need to understand that nurses also need to have a break at times. She feels as though nurses could lose their lives whilst at work and that would be a sign of the ultimate sacrifice. This would mean that she has put her patient before herself even at the expense of her life. She

went on to detail how she is a chronic high blood pressure patient herself but at times does not take her medication because she skips meals at work:

> *"Sometimes you feel that I'm sick. Actually, I would find my BP is up cause I was not resting, I was not taking my medication properly. Then I would have to take sick leave and if I take sick leave the shortage is what?... worse! So, it's not helping, it's just making things worse. That's what is happening in our government hospitals now."* (Meme, Interview 22 January 2020).

Meme shines light on how the shortage of nursing staff impacts her because she cannot take sick leave to take care of herself. She must continue coming to work because her patients always come first, and she needs to see them through their healing process. She has built relationships with her patients and they trust her, so she feels that she cannot leave them with another nurse. This is prevalent in government hospitals where they are fewer nurses and more patients.

Randzo and Vivian shared the same frustration and anger because they felt that it is unfair how nurses are expected to go the extra mile sacrificing for a society that does not even acknowledge their efforts. Vivian expressed her frustration using these words:

> "*You'll find yourself well, most of the time you are working more hours than you are supposed to because there are situations whereby you feel you can't just leave the, the ward and the unit as it is.. when it's messed up because when everything is…* (signals everywhere using gestures of sweeping them all over the table*) … because you try and help even if it's an hour before you go home. But another thing that I will tell you, right? For instance, I worked in uhm Daveyton clinic for a very long time. That clinic is so busy, I'm telling you.* (Sighs) *Like you don't have a, you don't have teatime. Like you can't say,*
>
> *"I'm going to tea now" or "I'm going to lunch"*
>
> *Because the minute you sit down to have that cup of tea then there's a patient that's going to come in bleeding profusely so…"* (Vivian, Interview 24 January 2020).

Majority of public hospitals and clinics in Johannesburg are in the townships. Townships are known to have bigger populations and the people living in them are dependent on the free resources that are provided by the public health care sector (Hospital Association of South Africa, 2017). Due to this, public hospitals and clinics are often busy because there are more people seeking medical assistance. Vivian demonstrates how patients in the townships need the nurse to sacrifice herself more. This is because there are more emergency cases that require nurses to be constantly working with no time to even eat. Similar to Vivian's experiences, Randzo also expresses the same frustrations:

> "*The sacrifice comes in saying "don't go for tea, at least push because they arrived in the morning, push them" and then you'd rather go for lunch even so at 14:00. Then you try and get out and you find that it is full and then you tell yourself "let me push until 14:30, I will go for lunch at 14:30"*
>
> *Then you get out at 14:30 and you want to pass by with your lunchbox shame… you hear remarks. "Right now, we have been here for a long time and now they are going to eat…" blah blah blah… "because we are here…" this and that…*
>
> *What do you do? Because if you have to turn back it means that you will have to work on an empty stomach until you knock off. And then when you go and eat, you feel guilty, right? You will eat for 10-15 minutes instead of 45 minutes. You will eat for 10 minutes and then stand up quickly and go and continue and pick up where you left off. It's hectic…. Whooooo, yoh! Its hectic. It's very hectic!"* (Randzo, Interview 23 January 2020).

Randzo shares a similar experience to Vivian but however, she refers to the remarks that waiting patients make. Patients seem to lack empathy for the nurse and expect nurses to work like robots, forgetting that nurses are also human. Nurses pledge to honour human life and to practice their profession with dignity (South African Nurses' Council, 2020) and when they hear patients remarking negatively on the way nurses disrespect human life or how they may be selfishly acting when they are work, they experience feelings of guilt and regret. They begin to question whether they are indeed respecting their profession by putting their patients first.

Nurses in this study expressed their frustration with how they sacrifice themselves for their patients. They sacrifice their families and their health for their patients. They feel that patients and the government should also understand that they are also human (Makola et al., 2015). Beyond pledging that they will make the total health of their patients their first consideration, nurses also put their own health at risk. They seek to live out the pledge that they have made and maintain the dignity of their profession (South African Nursing Council, 2020). Drawing from the sacrifices that are made by the nurses, it is clear that nurses do feel overwhelmed, overworked, tired and exhausted. Both the pledge and the communities that they work in can be attributed to this. The Nurses' pledge has worked against nurses rather than reminding nurses of the importance of their profession.

4.8. 'Coping mechanisms'

Daily at work, nurses invest and apply themselves mentally, physically and emotionally (Coetzee et al., 2013). To fully assess and assist patients, they need to use their

theoretical knowledge and practical skills (Theodosius, 2008). Alongside applying themselves, they encounter traumatic events which could lead to their emotional and psychological health being affected negatively. Coping mechanisms are essential to ensure that nurses pay attention to their mental health, along with maintaining high job performance, patient care, and job satisfaction (Shah, 2012; Teffo et al., 2020). The coping mechanisms mentioned by the participants of this study differed from nurse to nurse. Their answers depended on whether or not they are social people and how they interpret their emotional strain, stress and burnout. Coping mechanisms provided by each nurse were unique to them and their personalities. For Busisiwe, coming home to her children made her feel happy and she felt a release of positive emotions when she spoke to her children. She said:

> *"Sometimes you know, it's just that nowadays people cannot be trusted but I tell these ones and I will say that "eish at work, this and that is happening" I will tell them that - 'You know yesterday Ntombi did this and that' and my daughter would say, 'wow mom, Ntombi does this…'". (*Busisiwe, Interview 12 February 2020).

Busisiwe expresses that she cannot trust people that are outside her home. She felt better after confiding in her daughter. This could be because by sharing with her daughter what she was experiencing at work, her daughter could understand and empathise with her mother. This could relieve any feelings of stress and guilt; she would feel a bit more understood. It also allows Busisiwe to spend time with her daughter. Busisiwe's ways of coping differ from those of Nomkhita. Nomkitha felt much better after watching a good telenovela as she felt that it was the best way to release her emotions and be able to cool off:

> *"As I said, I love watching TV so I love watching soaps, when I come home from work after a long day I know that the TV is there, I will watch what watch then I will go to bed."* (Nomkhita, Interview 14 February 2020).

Nomkhita lives by herself and her relatives live quite a distance from her therefore she tries to find activities that she will be able to do and enjoy on her own. These include activities like shopping and enjoying a telenovela. These are coping mechanisms that are not very costly, and she can enjoy them from the comfort of her own home as she creates a relaxing environment for herself that allows her relieve herself from the stress and exhaustion from work. Other nurses engage in more recreational activities. Randzo proudly expressed that she loves talking to her colleagues about their challenges, along with partaking in extra mural activities:

"I am a member of planet fitness; I also play golf…" (Randzo, Interview 23 January 2020).

Sharing her experiences and expressing her emotions with her colleagues makes it easier to deal with the emotional strain. Randzo also illustrates the importance of recreational therapy that could be of great help to nurses. Recreational therapy helps to stimulate the mind and the body simultaneously (Carter and Andel, 2019). It alleviates stress and allows the nurse to engage in activities that benefit her physically and mentally (Chang and Taylor, 2014). However, other nurses felt the need to ask for copingstrategies from their workplaces such as Meme and Vivian who stressed the importanceof collegial support and comfort (Theodosius, 2008). Meme shared the following:

"*At work we ask the senior doctors to have debriefing sessions. Cause there were time when we like the whole ward, we felt we were like depressed and they started like the time I was there. Then some, there were days we'll come, and we go for debriefing. You just talk from your experiences, how it was then sometimes it will help then when we discuss about that the challenges then even others… Then you hear also from others how was it cause if you sometimes you feel maybe it just you. Then when you share with other… the doctors that we ha and other, my colleagues then it was helping. Mhmmm yah."* (Meme, Interview 22 January 2020).

External psychological and emotional support could be costly on any individual. Therefore, emotional support provided by the hospital or clinic provides help to the nurses. Having emotional support being provided within their practice environment assists nurses more than other avenues would (Shah, 2012; Chang and Taylor, 2014). Meme expresses the way that having a group discussion or debriefing session with her colleagues helps them to better understand each other. Additionally, it allows them to express their challenges, frustrations and emotional strains with each other. This could be beneficial because all the nurses become each other's support systems. By relating to each other's feelings and emotions, they better understand what they are each going through (Teffo et al., 2020). This means that they have an increased level of empathy and compassion towards each other. Vivian shared similar sentiments saying that talking to her colleagues alleviates her stress:

"I have a….I mean I can speak to my colleagues actually I don't even have to go to them, they can see that you are emotional…that's what we do, we support each other. They will come to you obviously and you know, speak to you and make sure that you're calm. But I've never had a situation where I've had to go and see a professional as such." (Vivian, Interview 24 January 2020).

Hospitals and clinics are where nurses spend the majority of their time. They share a space with their colleagues who better understand their emotional state and their experiences. Although collegial support is important, supporting each other as nurses also includes task support (Shah, 2012). This means when a nurse needs to compose themselves because of something that affected them emotionally, another nurse can take over the other nurse's task. This ensures that a nurse like Vivian, who is emotional for a particular time, has enough time to calm down and return to her tasks afterwards. Along with collegial support, Bridgette indicates that her faith helps her to stay sane and not get swallowed up by her emotions at work:

> *"That's it, there's really nothing else because I don't remember us having counselling, I don't remember going to counselling. So, you just must pray about it so that you are able to cope and so that other things can come to pass. That's it, nothing else."* (Bridgette, Interview 22 February 2020). *(Bridgette Sibiya, 36).*

Religion, spirituality and faith have been indicated as ways that people can use to cope with the pressures of life (Dill, 2017). This is because having a spiritual relationship with a divine being or higher power such as God or Buddha contributes to healthier psychological well-being. It therefore makes for a good and positive coping mechanism (Butler-Barnes et al., 2018). Versano (2011) indicates the ways that either having a religion to follow or being a spiritual being can be beneficial as a coping mechanism. This is because when an individual believes and follows a particular religion or if they are spiritual, they have ways of finding meaning in the occurrences of daily life. This helps them to make better sense of the situations leading to decreased emotional distress and increased quality of life (Shiri et al 2008). This was true in Bridgette's case as she found that praying about her struggles at work helped her distress and find more reason to continue helping others. Bridgette believed that prayer helped her in going through the emotional experiences at work as they would eventually come to pass. Having this belief in her prayers to God helped Bridgette to remain psychologically healthy and maintain her positivity (Butler-Barnes et al., 2018). Additionally, Bridgette feels more at peace and feels a greater sense of comfort when she prays. Kelly (2004) indicates that prayer assists nurses to be more reflexive and conscious of the ways in which they treat people. When they feel that they have fulfilled their duties according to their faith, they feel more satisfied and fulfilled with their work and themselves (Kelly, 2004; Dill, 2017).

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The coping mechanisms that the participants shared all indicate positive ways of coping. However, there are nurses who resort to drinking and smoking to cope. Randzo described it so well in a text she sent me a day after our interview.

> "*I needed to add something with regards to coping mechanisms, yesterday I spoke about positives I didn't touch on the negative, nurses may drink alcohol in order to deal with stress and end up being alcoholics, some take drugs and end up stealing from their work place in order to feed the addiction, they end up losing their jobs that makes everything worse"* (Randzo, Interview 23 January 2020).

Drawing from the text received from Randzo, there are nurses who make use of negative coping mechanisms. Negative coping mechanisms such as drinking alcohol and stealing drugs are not beneficial to nurses because they can lead to addiction and the loss of their jobs, and this could affect them greatly. They will not be able to further support their families, and patients will also not trust nurses because they will view nurses as misusing government resources. Some of the other nurses also related to this view using their colleagues as examples of what the negative ways of coping would be:

> "*Others can also drink because they think that it will help them cope and that can end up being dangerous because they can end up being addicted to such substances, you see?"* (Nomkhita, Interview 14 February 2020).

Substance abuse is a global problem as it has greater health, social and mental consequences on any individual. Nomkitha demonstrates the danger associated with taking substances such as alcohol. Alcohol reliance can lead to alcohol addiction which could be detrimental to the nurse as her quality of life could decrease. Bridgette shared a similar view to Nomkhita however, she saw it in a positive light:

> *"Others drink, you would think they drink it off. Yes, maybe others have hobbies that they engage in just to forget a bit. Others love getting in community societies, they go to socials and maybe I think that it is a coping mechanism…yes, I think should think it is. So, others drink, and others socialise so that they can forget a bit."* (Bridgette, Interview 22 February 2020).

Bridgette indicates the possible reasons why nurses would drink or take medication. She says that other nurses want to forget about the constant emotional trauma that they experience at work. Bridgette continues to shine a light on the other reasons why nurses could be drinking. These included socialising with their family and friends which could be a way of coping with their stressors at work.

The nurses had various coping mechanisms that included going to the gym, reading and spending time with their children. Some find a patient that has healed and comes back to say thank you as rewarding and therapeutic as it gives them purpose and a reason to continue doing what they love. However, there are some nurses that indulge in destructive forms of coping mechanisms because they cannot afford the external coping mechanisms so they resort to stealing pain medication from the hospital or they drink in order to numb what they are going through. It is essential to understand both the personal and professional coping mechanisms of nurses as it helps them to strike a balance between their emotions and work and their emotions at home.

4.9. Conclusion

Drawing from the above themes, the main findings are essential and have met the objectives that were set for this study. Six Black women nursing practitioners were interviewed for this study. Their ages ranged from 35-50, their working experiences ranging from 3 years to 25 years and above. One was married, one was divorced, one was living with her partner and the rest were unmarried and single. They all had children, and all worked in the South African public sector.

Although nurses are essential for the people in our communities, they are often viewed in a negative light by the media and the government. This was seen in the expressions given by the nursing practitioners interviewed in this study. They were afraid to be seen in public wearing their nursing uniforms.

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There is a prevalent shortage of nurses in the South African public sector. According to these findings, nurses are affected differently based on the community that they work in. By analysing the above findings, shift work has shown the significance of collegial emotional labour as it alleviates the nurses from getting burned out, exhausted and stressed. Consequently, in attempts to try and reduce staff shortages and to have more patients being assisted, the South African government brought into place the target strategy. Nurses expressed how this was counter-productive for them because it brought about the challenge of inadequate patient care. So, instead of focusing solely on the patient and their medical needs, the nurse is more focused on reaching the set targets. This might lead to patients not being cared for properly and nurses being more stressed out and exhausted.

Nurses believe in the holistic healing of their patients which means patient healing is not only physical, but it includes the social, mental and psychological aspects as well. Nurses also form emotional bonds with their patients. These bonds can form in different ways as seen in the above findings. They can form through treating a patient over an extended period of time or drawing similarities between their own loved ones and the patients that they treat daily. Whichever way the nurse forms these emotional bonds, they influence her. She can become burned out and stressed, or she can be satisfied with the job she has done and feel that she gave the patient adequate care. It is importantfor nurses to strike a balance between their home life and their work life because it can affect them in both ways whereby work begins to interfere with the home life or the homelife interferes with the work life. It is also important to know how and when to detach themselves from the suppression of their emotions at work and not allow them to spill over into the family life.

Nurses in this study expressed their frustration with how they sacrifice themselves for their patients. They sacrifice their families and their health for their patients. They feel that patients and the government should understand that they are also human. The coping mechanisms indicated by these nurses involved bonding with their children, watching television, going to the gym and praying. Indications of nurses turning to destructive coping mechanisms such as drinking, smoking and abusing the use of medication were also made.

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In a nutshell, the study aimed at exploring the interplay between emotional labour and the work-family balance amongst Black women nurses in Johannesburg. The study had five objectives which guided the interviews and the study. Through six in-depth interviews, eight themes emerged. These were: '*My uniform and social stigma',* '*Shortage of nurses and patient care',* '*Targets and patient care',* '*Holistic healing of patients',* '*Your child is my child', 'Taking my feelings home', 'As a nurse, I am also human'* and '*Coping mechanisms'.* Although there were similarities that were analysed, attention was also given to the differences that were noted within the themes. Not only did the findings meet the objectives of the study, but they answered the main research question. The findings and the themes indicate the factors that contribute to the interplay between emotional labour and the work-family balance amongst Black women nurses in Johannesburg. The next chapter will discuss the main findings of the study and provide recommendations for further research.

Chapter 5: Conclusion

5.1. Introduction:

Nurses are essential for the health care system because they provide adequate care for patients to ensure their healing. In providing care, nurses face daily emotional challenges that impact their job performance and family life. This study sought to understand the interplay between emotional labour and the work-family balance among Black women nurses in South Africa.

5.2. Main Findings:

This study aimed to explore the ways in which Black nursing practitioners balanced their emotions as experienced at work and at home. Additionally, the study also aimed to understand the factors that shape emotional labour within the nursing profession. Moreover, this study sought to understand the experiences in which Black women nurses strike a healthy balance between their work lives and their home lives.

The objectives for the study were:

1. To understand the family-related emotional encounters that Black nursing practitioners experience.
2. To comprehend the work-related emotional events that Black nursing practitioners experience.
3. To examine Black nursing practitioners' family dynamics.
4. To assess the interplay between emotional labour as experienced at work and within the family.
5. To analyse Black nursing practitioners' personal and professional coping mechanisms.

By using a qualitative research approach the researcher was able to answer the research question: "what is the interplay between emotional labour and the work-family balance among Black women nurses in Johannesburg" by using these objectives to guide the study. Below will be an explanation of how each objective was met with a conjuncture to literature that was explored.

5.2.1. Objective 1:

The first objective focused on understanding the kind of family-related emotional encounters that Black women nursing practitioners experience. This research found that due to the human interaction that nurses engage in daily, building emotional bonds assists them in supporting their patients and giving better patient care. However, these

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emotional bonds lead to the nurses being affected emotionally because overtime they develop “soft spots” for their patients. They also personalise patients that have long-term illnesses or that have been in the hospital for a long time. Although the nurses all agreed they build emotional bonds with their patients and that they personlise them, the way in which they personalised patients differed. For example, Bridgette was mostly affected by women who died in the hospital because she assumed that she had children or a family that she had left behind. Busisiwe was affected by young girls who were around her daughter’s age because she would think of her own daughter while treating them. The emotional bonds and the personlising of patients between Bridgette and Busisiwe are congruent with literature in that it indicates that it is difficult for nurses to detach themselves from the emotions they experienced at work. This shows how nurses relate their family members to their patients making it challenging to leave their home live at home when they are at work.

5.2.2. Objective 2:

The second objective focused on comprehending the work-related emotional events that Black nursing practitioners experience. This is seen in the themes *“My uniform and the dynamics of social stigma and positive recognition’* and *‘ Shortage of nurses, target and patient care’.* Nurses work in communities that they are a part of. They encounter individuals daily whether at work or when they are traveling to and from work. This research found that some nurses see their uniform as a burden because individuals in their communities use it to judge them. Community members also share their views of nursing when they see nurses wearing their uniform. These views are often negative and are influenced by social media which does not portray the full view of what being a nurse entail. Participants of this study expressed their fear of walking around wearing their uniform in public due to the way they are treated by people in the community. This is congruent with literature that indicates how nurses are marginalized in society and are often judged due to their line of work along with the stigma that is associated with caring for sick people. Other nurses had positive expressions with regards to wearing their uniform in public. They expressed that they saw it as an opportunity to educate young people about the nursing profession and to also give hope to other Black children that being a professional is possible. Social media is not the only factor that influences the way in which the public view nurses, their views are also influenced by the patient care and the job performance that they receive when they visit a clinic or a hospital. These factors, the nurses explained, are often out of their control. The nurses expressed that

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their working environments are usually crowded, and they have regulations that need to be followed that hinder the way they do their jobs. They must produce the numbers because they must meet their daily targets. Nurses in the public sector experience high numbers of staff shortages which has a significant impact on the nurse-patient ratio. However, nurses are not allowed to complain about it because it is a global problem. This leads to nurses having increased workloads and they are expected to sacrifice to assist their patients. The nurses all shared a similar experience where they often did take their lunch breaks to be able to attend to their patients. This was a disadvantage for the nurses because they had no energy to fully assist their patients and some of them did not take their own medication for their chronic illnesses. This was highlighted in literature because staff shortages and increased workload contribute to nurses' job satisfaction or job dissatisfaction which influences their patient care and service delivery. Shift work in literature had been noted to bridge staff shortages and working conditions because it contributed to a healthy practice environment. This was said to have worked by two participants who expressed that shift work gave them enough time to rest and alleviated their stress and exhaustion.

5.2.3. Objective 3:

The aim of this objective was to understand the family dynamics of the nursing practitioners in order to better understand the ways that nurses balance their work and family. It was found that most of the nurses interviewed for this study had children. They were a combination of married and single nurses however, each nurse had home to return to, a family to take care of and household responsibilities to attend to after work. These responsibilities included doing laundry, cooking and cleaning. Moreover, nurses needed to attend to their families which included being physically and emotionally present for their family members. However, it is seen in the theme "*I take my feelings home"* that nurses find it challenging to detach themselves from the emotions they had experienced at work when they got home. One participant expressed how nurses invest emotionally, mentally and physically when doing their job which leads to her finding it a challenge to fully invest herself at home. Other nurses expressed challenges when having to balance their work lives and their home lives because they needed additional support especially when they had young children. Energy investments are also important in both domains of a nurses' life because it assists them in playing their roles more effectively. For example, all the nurses explained that they needed to make time for their patients in order to perform well at work. However, that compromised the time that they

spent with their children because they would not have the energy to fully enjoy their time at home. Literature indicated that working mothers found it a challenge to balance their work and their family lives and they often needed additional support. Participants explained that it is important to strike a balance because you need to show your family that you love them by providing for them and by being physically and mentally present in their lives as well as giving their patients adequate patient care and good job performance.

5.2.4. Objective 4:

The aim of this objective was to assess the interplay between emotional labour as experienced at work and within the family. Nurses spend their time acting out appropriate emotions when they are at work. Their work lives also affected their home lives because of the acting they had to do at work by suppressing their real emotions they would release inappropriate emotions at home. This would lead them to the damage of their relationships with loved ones and they would then get isolated or excluded. Their work makes them feel as though they are not human beings because they must sacrifice themselves for their patients. Literature has shown that the factors that influenced job dissatisfaction was the how their exhaustion and burnout negatively impacted patient care. Nurses in the public sector are exposed to long-term diseases like HIV and TB which meant that by nurses putting their patients first they were in turn putting their own lives at risk. Literature indicated that by over compromising by putting their patients first, nurses neglect their own health. Nurses in this study expressed their frustration because patients do not treat nurses as though they are human. They do not want to understand that nurses need to take breaks for them to perform well in their job. Due to staff shortages nurses cannot take sick leave because they would be adding to the problem meaning they do not get enough rest. The nurses expressed that if the government and the patients could understand that nurses are also human their job satisfaction, job performance and patient care would increase.

5.2.5. Objective 5:

Through the experiences shared by the nurses in this study, it was important to understand what they did to cope with the challenges that they faced daily, whether at work or at home. The nurses expressed different coping mechanisms however, there were similarities. The personal coping mechanisms included going to the gym, shopping, talking to friends and spending time with their children. Some nurses prayed and turned

to their spirituality which has been indicated been in literature to have significant healing and coping results. Professional coping mechanisms included watching a sick patient get healing because it had a therapeutic effect on the nurses. The nurses expressed that some of their colleagues used unhealthy coping mechanisms like the overuse of medication and alcohol.

5.3. Recommendations

The recommendations for future research looking at emotional labour and/or work family is to try and provide more literature focusing on the relationship between the two. This could be done from both a quantitative and a qualitative perspective. This study focused on the public health care system, further research could focus on the private sector and the differences between the two. Further research could also look at the support that nurses receive their families and the ways that the support can be improved. Professionally, nursing policies could investigate ways of making allowance for nurses to take care of themselves in a way that is not detrimental to their health.

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Appendix A:

Information Sheet

Dear Prospective Participant

My name is Zabby Ntsako Maluleka. I am a master's student at the University of Johannesburg, at the Sociology Department. I am currently involved in a study that seeks to understand the relationship between jobs that need you to manage your feelings ad expressions in a way that suits the job (emotional labour) and the way that your job and your work may be in conflict with each other (work-family conflict) I aim to understand the experiences of Black women nursing practitioners in Johannesburg andhow they balance work and family responsibilities. I kindly invite you to participate in thisstudy as your participation will be valuable and serve as a great asset to the study.

Agreeing to participate in the study means that you will be interviewed by me. As part of following the ethical standards, I will record the interviews after you have signed the consent form. The interview will be an hour and 30 minutes long and will take place at a time and place chosen by the participant. The personal information and identity of the participant will not be revealed to anyone for any reason. Your participation in this study is your choice, nothing will happen to you if you decide not to participate or to stop participating in the study. A summary of the results to the study will be made available. Should you want a summary, please contact me, Zabby Maluleka, the researcher of this study on the email address provided below.

The results of this study may be included in journal articles or conference presentations should you at any time have any questions or concerns pertaining to this research study or the interviews, please do not hesitate to contact Zabby Maluleka. Thank you for taking your time to read this information. I look forward to your participation.

Zabby Ntsako Maluleka

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ntsakolayla67@gmail.com

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Appendix B

Consent Form:

I.....have read the information provided regarding this study, I confirm that I understand what is expected of me as a participant. I agree to participate in the study and to sit in the interview.

I also give my consent for the interview to be recorded. I am aware of my rights not to answer any questions I do not feel comfortable with answering. I acknowledge that I have been informed of my rights to withdraw at any time without penalties. I understand that my identity and personal information will be kept confidential. I give consent for my experiences to be included in research reports or other academics publications or presentations which will be used to disseminate the findings of the study. I give consent to participate in the study explained in the information sheet and by the researcher.

Signature……

Date……

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Appendix C

Interview Guide:

Questions:

Basic Biographical Questions:

1. **How old are you?**

   (Participants are required to state their current age since their last birthday)

2. **Are you married?**

   (Participants are required to state their marital status)

3. **Do you have children?**

   (Participants are required to state the number of children they have and/or are living with. This includes step-children.)

4. **What is your occupation?**

   (Participants are required to state the nature of their work and possibly their workplace)

5. **How long have you been working in your field?**

   (Participants are required to mention their years in practise and their years of experience within their occupation)

Informative questions:

1. **What are the main household duties in your home?**

   (The participant is required to describe the duties that exist at home such as cooking, cleaning, taking care of the children etc.)

2. **Who assists you in carrying out these household duties?**

   (The participant is required to mention the different people that they get help from whether it be from their spouses, a domestic helper or other family members and friends etc.)

3. **Do you feel that it is still your role as a working woman to be responsible with activities associated with the household and childcare?**

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(The participant is required to share their feelings and experiences of being a working woman and having to be responsible for their household by managing work, household chores and childcare as well as other additional household responsibilities that may exist)

4. **How does your partner react with regards to assisting with childcare and household chores? *For participants that are married or cohabitating***

(The participant is required to share the reaction and responses that they receive from their partners whenever they ask or need their partners to assist with household and child related responsibilities.)

5. **How many hours do you work in a week?**

(Participants are expected, based on estimation or knowledge, to mention the hours they work daily or weekly which includes overtime and extra hours that they must work. They can also state the reasons why their work hours are as such.

Probing question: How many off days do they have?

: How do they use their off days?

They can also include how much time they have left to attend to their home responsibilities)

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6. **Do you have ranks (hierarchy) at work?**

(Participants are required to say describe the hierarchies and ranks that exit in their workplaces.

Probing questions: Does this determine the number of days worked?

: Does it determine the workload?)

(what rank are you in?)

7. **Can you count on your colleagues when you come across difficulties in your home?**

(The participant is required to provide ways in which they can count on their colleagues for help in the workplace should they need to attend to something at home.)

8. **How does your management respond to any unforeseen circumstances and emergencies that you may have to attend to?**

   (The participant can begin to explain the ways that they can attend to emergencies that may occur and refer to their personal experiences).

9. **How does the time that you spend at work have an impact on the time that you spend at home?**

   (The participant can describe the way they feel when they are at work and when they are at home. They can explain their experiences of home and work in ways that influence each other or are similar)

10. **Are you confronted in your work with things that affect you emotionally?**

    (The participant is required to describe and express in detail their work experiences and how they feel their emotions are challenged at work and how they deal with these.)

11. **What are the challenges you face being a working woman and having a family?**

    (Participants can explain and describe the kind of challenges they face in their daily lives while trying work lives and their family lives. They can also include the different expectations they encounter as Black women who are working and have family responsibilities)

12. **Do you know what your patients expect of you in your work?**

    (The participant is required to share experiences of their patients and their experiences with their patients and how their patients expect them to act at work and what they expect them to do for them as patients)

13. **Do you have enough time to get your job done?**

    (The participants are required to spread them in terms of health care, administration and record keeping as compared to the way that they spread them in reality)

14. **Do you experience conflict between the roles you have to perform?**

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(The participants are required to give a detailed description of their difficulties or lack thereof, with their work and family responsibilities. They can also describe the challenges that accompany the conflicting roles and how they cope with these challenges)

15. **How do you cope with juggling work and the home duties?**

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Appendix D

Ethical Clearance Letter:

FACULTY OF HUMANITIES RESEARCH ETHICS COMMITTEE

19 November 2019

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ETHICAL CLEARANCE NUMBER	**REC-01-162-2019**
REVIEW OUTCOME	**Approved**
APPLICANT(S)	**Ms. Z.N Maluleka (201509760)**
TITLE OF RESEARCH PROJECT	**The Interplay Between Emotional Labour and Work-Family Balance Among Black Women Nurses in Johannesburg**
DEPARTMENT	**Sociology**
SUPERVISOR(S)	**Prof. G. Khunou**

Dear Ms. Z.N Maluleka

The Faculty of Humanities Research Ethics Committee has gone through your research proposal and is satisfied that it is compliant with the approved ethical standards of the Faculty of Humanities at the University of Johannesburg.

The REC would like to extend its best wishes to you in your research project.

Sincerely,

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Prof Tapiwa Chagonda
Interim Chair: Faculty of Humanities
REC Tel: 011 559 3827
E-mail: tchagonda@uj.ac.za

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