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A health-care model of emotional labour: An evaluation of the literature and development of a model

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Abstract

Purpose – This paper aims to evaluate the literature on emotional labour in the health-care sector and the benefits and costs of such performance for both the carer and the patient. The aim is to develop a new health care model of emotional labour that has implications for health-care management in terms of policy and education as well as for future research in this field.

Design/methodology/approach – A new model to explain the antecedents and consequences of emotional labour within a health-care setting is developed that builds on existing research.

Findings – The model distinguishes between types of emotional conflict to which emotional labour-inducing events in health-care settings might lead. The negative and positive consequences, specific to health-care settings, of emotional labour performance are also outlined.

Practical implications – Emotional labour should be formally recognised as a key skill in facilitating the patient journey, with emotional skills being taught in innovative ways outside the formal classroom setting. Health-care professionals should be offered training on coping with the effects of emotional labour performance. Finally, more research should be carried out to further develop the model, particularly in identifying causes of emotional labour within health-care settings and in differentiating the effects that different kinds of emotional labour performance might have.

Originality/value – The paper draws together previous research on emotional labour within health-care settings to develop a coherent model that can be used to guide future research and practice.

Keywords Health services, Carers, Patients

Paper type Literature review

Introduction

Emotional labour was first defined by Hochschild (1983) and has more recently been described as the effort involved when employees "regulate their emotional display in an attempt to meet organizationally-based expectations specific to their roles" (Brotheridge and Lee, 2003, p. 365). These "expectations", or display rules, specify either formally or informally, which emotions employees ought to express and which ought to be suppressed. Whilst many employees want to portray emotions in accordance with display rules because they care about their clients (or perhaps simply wish to retain their job), there are likely to be many occasions when genuinely felt emotions do not concur with desired emotions. It is this emotional dissonance that leads to emotional labour.

Hochschild (1979, 1983) argued that emotional labour is performed through either surface or deep acting. Surface acting involves managing the expression of behaviour rather than feelings. This is accomplished by careful presentation of verbal and non-verbal cues such as facial expression, gestures and voice tone in a way in which the person knows that are only acting. Deep acting, on the other hand involves the

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actor attempting to actually experience or feel the emotion that they wish (or that they are expected) to display. Feelings are actively induced as the actor "psyches" him/herself into the desired *persona*.

Emotional labour is thought by many to be an important part of the role of many health care professionals and it has been the focus of much debate and empirical enquiry within a range of health care settings, especially within nursing. However, the research to date is limited in a number of important ways. First, as mentioned, much of the existing focus is limited to the nursing profession, despite the recognition that emotional labour is likely to be an important feature of other health-care settings. Second, a theoretical model driving the research direction seems to be lacking, resulting in a range of varied and interesting studies that are difficult to relate into a coherent whole.

The aim of this paper is to evaluate the extensive literature on emotional labour within health-care settings in order to develop a health care model of emotional labour. This model should be able to drive future research enquiry (including that examining professions other than nursing) as well as highlighting those parts of the process into which health-care management interventions might best be placed.

The current paper will begin with an evaluation of the literature on emotional labour, particularly within the health-care sector, before the new model is proposed. Implications of the model for research and practice will be outlined.

Emotional labour in health care

Although emotional labour has been the focus of much debate and empirical enquiry within a range of health-care settings over the past decade or so, the most prominent of these is nursing with studies conducted in the context of general nurses (de Castro, 2004; de Raeve, 2002; Smith and Gray, 2000; Kelly *et al.*, 2000; Henderson, 2001; Staden, 1998; Rafaeli and Sutton, 1987), learning disability nurses (Mitchell and Smith, 2003), mental health nurses (Mann and Cowburn, 2005; Majomi *et al.*, 2003), midwives (Hunter, 2001), gynaecology nurses (McCreight, 2004; Bolton, 2000) and hospice nurses (James, 1989). The reasons for the preoccupation with nursing in this context are well-defined (and will be expanded upon next), but it is worth mentioning that other health care professions examined have included medical students (Smith and Kleinman, 1989; Lief and Fox, 1963) and clinical psychologists (Mann and Jones, 1996).

Emotional labour and nursing

> Perhaps one of the most enduringly popular conceptions of an occupation requiring extensive emotion work is nursing (Bolton 2001, p. 85)

Emotional labour has been an important topic of debate in nursing because of its perceived importance to those involved in the delivery of health care and to the patients who receive that care (Phillips, 1996). Mitchell and Smith (2003, p. 111) in their review of emotional labour within learning disability nursing add that emotional labour has always been "part of the image of nursing". A range of reasons for this is offered; according to Smith and Gray (2000), within nursing, the length and uncertainty of some treatments, together with the often repressed feelings that the patient and nurse may have about a very difficult medical experience, mean that professionals inevitably have to adopt strategies to manage emotions. In addition, nurses may well at times feel

negative emotions such as disgust, irritation and anger, the expression of which would not be conducive to the patient experience. If the patient is to feel cared for then these latter emotions must be controlled, managed, or suppressed (McQueen, 2004). Thus, when nurses do not feel as they think they ought to in a particular situation they engage in emotional labour to ensure that their emotional displays match patient or social expectation (display rules). For example, interactions with angry, hostile or uncooperative patients are emotionally charged and pose a "great demand on nurses to suppress or alter their emotions" (de Castro, 2004, p. 120); as one nurse commented in Smith and Gray's (2000, p. 48) study, "some patients are really horrible and even disgusting, which means you have to really emotionally labour".

Despite the examples of emotional labour inducing events provided by the above review, there is a lack of clarification in terms of why such events are emotionally charged. For example, why and under what circumstances are patients hostile or uncooperative? What kind of things do elicit disgust in nurses or health carers? Why do nursing staff get irritated with patients? It is the lack of this kind of clarification that makes managerial attempts to control emotional labour performance more difficult; if the general categories of emotional labour inducing events were documented, it would be somewhat more realistic for health-care managers to try to implement interventions at this stage. This issue will be returned to with the development of the health-care model of emotional labour.

Nurses themselves acknowledge the centrality of emotional labour to the concept of caring within their job role. In their qualitative study of nurses' experiences of emotional labour, Smith and Gray (2000) comment that all of the nurses identified emotional labour as a chief part of the nurse's role in making patients feel "safe", "comfortable" and "at home". Bolton (2001, p. 86) describes nurses as "emotional jugglers" who are able to match face with situation but not necessarily with feeling; she talks of nurses being able to present a "sincere face" whereby feeling matches face, or a "cynical face" to mask feelings they believe should not be displayed (during an interaction of sorrow, for example). She takes this idea further in her own study of 45 nurses by distinguishing the "professional face", the "smiley face" and the "humorous face" which she feels nurses use to manage some of the emotional demands made of them.

Various studies highlight the importance of a nurse's ability to manage emotion and to present the desired demeanour in a number of health-care settings; for example, James' (1989, 1992) study of nursing the dying shows how working on one's emotions can be described as "hard" and "productive" work; Staden (1998, p. 149) used three case studies to "recognize and value emotional labour" whilst Phillips (1996) commented on the gap that seems to have appeared between the supposed elevated status since the 1970s of the emotional components of nursing and the reality; Smith (1988, 1991, 1992) notes how student nurses have to learn to be competent emotional labourers and Strauss *et al.* (1982) were one of the first to coin a phrase, "sentimental work", in recognition of the emotional component of the role.

More recently, attention has been drawn to the changing organisational context of nursing work in the UK (Bolton, 2001, p. 86) where the introduction of a "managerialism and markets mentality" means that nurses now have an added dimension to their work and are being asked to manage their emotions in much the same way as those in the private sector. Charles *et al.* (1999) suggest that an increasing

interest in partnership in patient-professional relationships is associated with the rise in consumerism with patients seeing themselves as consumers with associated rights and expectations. McQueen (2000) highlights that the changing terminology reflected in the medical literature from patient to client implies participation and the "buying" of a service with the expectation, by patients, of certain standards; these standards usually include an expectation with regard to the emotional way in which the medical care is carried out.

Nurses of course, may well perform emotional labour because they want to (in which case display rules give way to feeling rules) rather than because of organisationally prescribed display rules. That is, they want to offer authentic caring behaviour because they feel that this is a desirable skill of their job-role and because they derive satisfaction from doing so. However, this desire to feel certain emotions (hence, feeling rules) does not necessarily preclude the performance of emotional labour, since there must be many occasions when such people are unable to genuinely offer appropriate emotions (perhaps because of competing distractions from their personal lives, or due to depersonalisation effects of burnout – see later section). In these cases, it could be that performance of emotional labour has quite severe negative consequences on their mental well-being (see later section too) since the dissonance is such that they want to genuinely feel emotionally appropriate but simply cannot. If feeling the right emotions is intimately linked in their minds to being good at their job, how will they feel when they do not feel these emotions but have to, instead, rely on faked expression in order to fulfil their own criteria of doing their job well? It is possible that this could effect their self-esteem and self-efficacy more than the worker who is performing emotional labour only to meet organisational demands (and who thus does not expect that genuine feeling is an indication of being good at the job).

Emotional labour and other health-care providers

Perhaps surprisingly, there have been few empirical studies examining the role or presence of emotional labour in health-care settings outside of nursing. This is probably due to the assumed centrality of emotion to the nursing role, which perhaps distracts from that in other health care areas. In addition, emotional labour has traditionally been seen as "female" work which is an extension of the emotional caring within family life. Thus, the "maleness" of other health professions, such as doctors, excludes this type of work (Smith and Gray, 2000). Another reason that the study of the emotional arena within the medical profession is very underdeveloped is probably because doctors have traditionally been involved in the communication of technical procedures and interventions – leaving the more emotive aspects of caring to nurses (McCreight, 2004); as one nurse commented "doctors are detached from that sort of thing and leave nurses to pick up the emotional pieces" (Smith and Gray, 2000, p. 49). This is confirmed by a general practitioner in the same paper who observes that "feelings can get in the way if you're trying to make a diagnosis. . .you've got to try and remain objective. It's better to get on with the medicine and let the nurses deal with the emotions" (p. 49).

Because of the degree of potentially heightened emotion that can occur within the medical relationship, doctors and consultants often attempt to limit their emotional investment with precautionary or protective strategies (Lupton, 1997). An example of

this is given in McCreight (2004) who noted that although the consultant tends to deliver bad news of pregnancy loss, it is left to the nurses to deal with the patient's subsequent emotional distress.

One study that did look at emotion management amongst doctors (albeit medical students) was that of Smith and Kleinman (1989). They note that there are no courses in the medical curriculum that deal directly with emotion management, yet the culture of medicine does support certain unspoken rules with regard to emotional display. Smith and Kleinman note that emotion management is vital for helping doctors deal with unwanted feelings such as disgust or even sexual arousal, and that medical students draw upon a range of strategies to help them perform this work; including transforming the patient or the procedure into an analytic object or event, empathising with patients and use of humour.

Another study that has examined emotional labour outside of the nursing arena involved assessing the degree to which clinical psychologists performed emotional labour during patient sessions. Using a questionnaire the study revealed that 80 per cent of patient interactions involved the performance of emotional labour by the clinical psychologists (Mann and Jones, 1996).

Clearly, although studies examining emotional labour outside of the nursing professions are rare, the evidence that there suggests that emotion management is just an important part of these health-care settings and should be considered just as much within health-care management.

Emotional labour and the patient experience

> The aim of emotion management is to facilitate the best possible outcome for patients. (McQueen, 2004, p. 104).

Emotional labour in health care has considerable significance for the patient who experiences pain, fear, anxiety or even panic (Phillips, 1996). The nurse who performs emotional labour is able to manage the reaction of her patient by both providing reassurance and allowing an outlet for their emotions – thus directly impacting on their psychological and physical well-being and recovery. At its simplest level, emotional labour performance maintains a "cheerful environment" (Mitchell and Smith, 2003, p. 114) which makes patients feel safe and comfortable. Many nurses in Smith and Gray's (2000, p. 41) review point out that emotional labour makes the nurse and patient contact easier in "moving things along" and in "oiling the wheels of nursing work". Emotional labour, they say, is the "almost invisible bond that the nurse cultivates with the patient" and many nurses felt that their emotional labour performance even helps the patient to manage disclosures of an emotional nature.

Within the caring professions, expressing genuine emotion is not always the most helpful response – in some cases performing emotional labour might be more beneficial to the client. For instance, a maternity nurse reported by Henderson (2001, p. 132) is reported as saying "You have to have a rational detachment otherwise you could become involved...and then it would not benefit yourself or this woman". As McQueen (2004, p. 104) puts it, "if one is overcome with emotion, cognition and behaviour can be adversely affected".

Existing models of emotional labour

An examination of the literature reveals very little in the way of causal frameworks or models of the origins, consequences or moderators of emotional labour. One model, that of Harris (2002) that has been proposed is in the specific context of barristers and suggests a framework of the origins, content and consequences of emotional labour for barristers. Within this model, origins include "structural change", "audience expectations", "occupational acculturation", "self-image" and "nature of the work". These contribute to either private (during interactions with solicitors, barristers and court clerks) or public (during interactions with clients, witnesses and judges) emotional labour, or to emotional suppression. The consequences proposed by the model include negative impacts (such as stress and fatigue) and positive effects (such as efficiency and professionalism).

Whilst this is undoubtedly a useful model, it is limited in its application to a certain client group. Interestingly, it makes the distinction between private emotional labour (performed with colleagues or others within the same profession) and public emotional labour (performed with clients or those outside of the profession). Whilst this distinction is likely to apply within the health-care setting too, it is probably a less important feature as the existing literature suggests that most emotion management in this setting occurs at the interface with patients. The fact that the barrister model also distinguishes between positive and negative outcomes of emotional labour is also clearly important for a health care model.

A new model of emotional labour

A health care model of emotional labour then attempts to incorporate the relevant features of the "barrister model" with the salient concepts gleaned from the literature and is shown in Figure 1.

Emotional labour-inducing event. These events include uncertainty of treatments, dealing with pain, bodily functions or abnormal body appearance, the presence of external pressures, emotional patients and patient expectation. However, this box in the model is incomplete as there has been no comprehensive audit of emotional labour origins within the health-care setting; it is recommended that further research in this area could allow development within this part of the model.

Emotional conflict type. It is hypothesised from the literature review that emotion management for nurses typically takes two alternative forms; first, emotional dissonance, when they must suppress instinctive emotions such as disgust, annoyance or frustration from the patient (and replace them with emotional displays that convey caring and concern) and second, emotional harmony, whereby they instinctively identify with and feel for a patient's suffering and must manage their emotions so as to be detached enough to carry out their role. Within "emotional dissonance" there is a distinction between the emotions being dissonant with display rules (i.e. societal or organisational expectations about appropriate display) and dissonant with feeling rules (i.e. the carer's own expectations about appropriate feeling).

Emotional labour performance. It is suggested within the model that the three kinds of emotional conflict contribute to distinct types of emotional labour performance. Emotional dissonance can lead to:

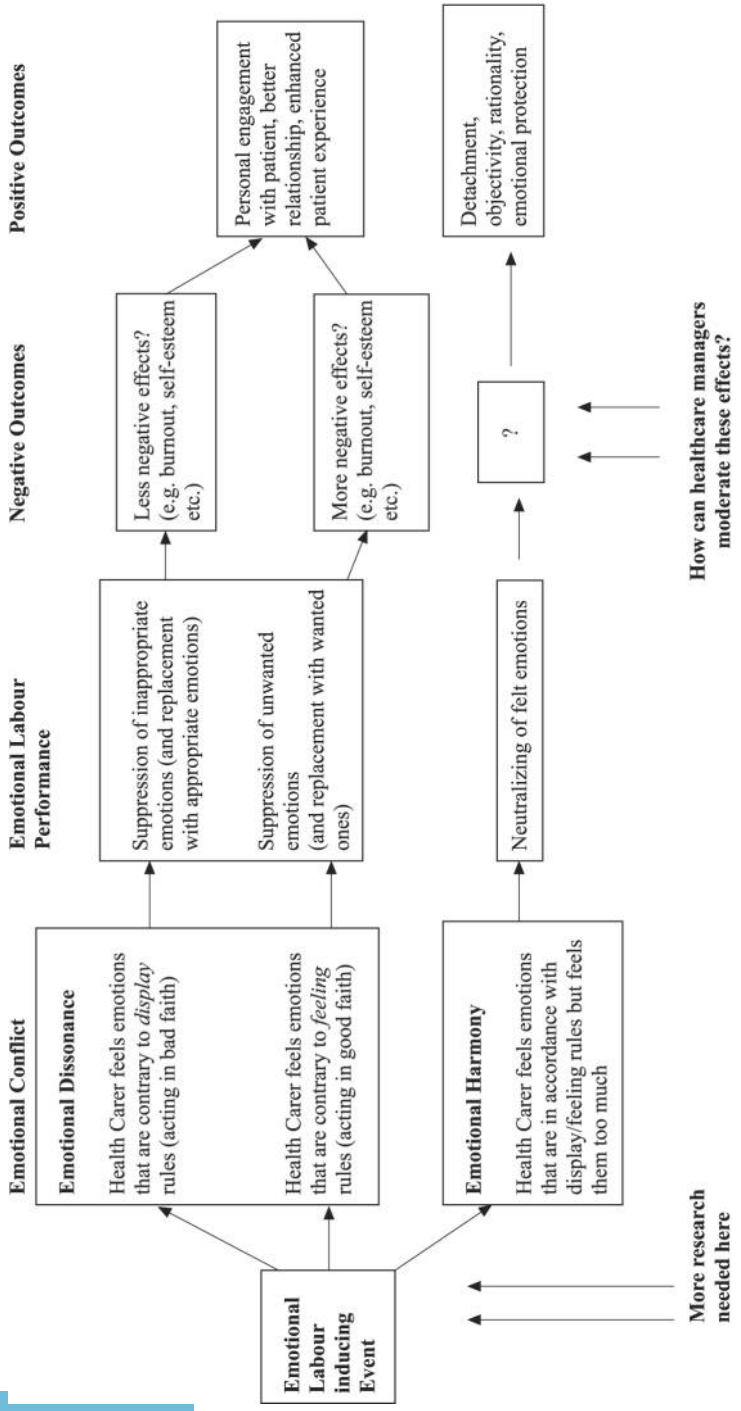

Figure 1.
A health care model of emotional labour

(1) acting in bad faith when felt emotions conflict with display rules and thus, the actor performs emotional labour because they have to rather than because they want to; or

(2) acting in good faith when felt emotions conflict with feeling rules and the actor performs emotional labour because they want to and think it is the right thing to do.

Whilst both of these produce the same emotional labour (suppression of unwanted emotions and/or replacement with wanted ones), the consequences could well be different (see next section).

Emotional harmony leads to a different kind of emotional work, that of masking or dampening felt emotions rather than supplanting them with different ones.

Outcomes: negative

> Intense or continuous emotional work can be stressful and exhausting (McQueen, 2004, p. 104).

The negative consequences of emotional labour are well documented and need not be reproduced in great detail here. It is argued (Hochschild, 1983) that portraying emotions that are not felt creates the strain of emotional dissonance, akin to Festinger's (1957) theory of cognitive dissonance which maintains that whenever an individual simultaneously holds two cognitions that are psychologically inconsistent, they experience a negative drive state called dissonance, which is a state of discomfort or tension. Ultimately, such dissonance can lead to personal and work-related maladjustment, such as poor self-esteem, depression, cynicism and alienation from work (Ashforth and Humphrey, 1993).

Other negative consequences associated with emotional labour include general dissatisfaction and stress. Research has also shown links between emotional labour and estrangement between self and true feelings (Hochschild, 1983), feeling robotic and unempathetic (Albrecht and Zemke, 1985), role overload (Wharton and Erickson, 1993), lack of work identity (Van Maanen and Kunda, 1989), lack of openness with co-workers, (Kahn, 1990) and "burnout". Burnout, a unique type of stress reaction, is most commonly conceptualised as a tripartite stress syndrome (Maslach and Jackson, 1981) and is associated with jobs that "emphazise contact with people" (Maslach, 1983, p. 32).

Research has identified a number of other potential negative consequences on health that chronic emotional labour requirements can have. From Freud (1961) to the present (Fridlund *et al.*, 1984; Pelletier, 1985) "bottle up emotions" have been blamed for symptomology, both psychological and physical. For instance, people who continually inhibit their emotions have been found to be more prone to disease than those who are emotionally expressive (Alexander, 1939; Freud, 1961; Beutler *et al.*, 1986; Pelletier, 1985; Udelman and Udelman, 1981). Contemporary researchers are finding that there is a close link between the physiology of emotion and that of the immune system. For instance, the chemical messengers that operate most extensively in the immune system have been found to be those that are most dense in those neural areas that regulate emotion (reported in Goleman, 1996). This suggested that there could be a direct physical pathway allowing emotions to impact on the immune system and further research has identified physical contact points between the ends of nerves of the ANS

and cells of the immune system. These physical contact points allow the nerve cells to release neurotransmitters (chemicals released from nerve cells that stimulate or inhibit action on the receiving cells) to regulate the immune cells. Another key pathway linking emotions and the immune system is via the influence of hormones released during emotional arousal, which can hamper the performance of immune cells (Goleman, 1996).

Whilst the consequences of emotional labour are well-known, less is known of the differential effects of different types of emotional labour. In the model, it is suggested that acting in bad faith produces less negative outcomes due to the reduced impact on self-esteem and self-identity; the actor is aware that they are only faking displays because of their job requirement. Acting in good faith, however, might have more of an impact because the individual feels bad that they do not feel as they think they ought to. However, this differential needs further exploration in future research. Similarly, in terms of "masking", it is not known whether this type of emotional labour performance is associated with a qualitative or quantitative difference in negative outcome compared to the other types of labour in the model.

Outcomes: positive. For the caregiver who is masking emotions through emotional harmony, emotional labour can protect them from getting too involved and weakening their clinical judgement. It has been suggested (Lief and Fox, 1963; Ashforth and Humphrey, 1993) that the emotional labourers can distance themselves cognitively from the situation by acting rather than experiencing the required emotion. This allows them to maintain objectivity and retain their own emotional equilibrium; as Mahan and Calica (1997) suggest, repeated exposure to loss may not be emotional healthy. Being able to detach or engage emotionally according to circumstances may protect workers from "undue emotional stress" (McQueen, 2004, p. 104).

For the emotional labourer who is experiencing dissonance, emotion management allows them to engage with patients on a more personal level, which is thought by many to be a particularly satisfying part of their job role. Job satisfaction is also achieved when appreciative feedback from patients is received – and this is likely to happen because many patients perceive emotional engagement as a requirement of health care practice, especially in nursing (McQueen, 2004). Thus, emotional engagement (even when faked or managed) can contribute towards the self-esteem of carers.

The positive outcomes for the patient of emotional labour performance have been outlined in an earlier section of this paper.

Implications of the model for health-care management

The aim of health-care managers in respect of emotional labour must be to attempt to reduce its negative consequences whilst retaining the positive outcomes for both patient and carer. There are thus two parts of the model where input from managers would be most valuable. First, at the "emotional labour inducing event" stage; what can health-care managers do to reduce either the number or impact of such events? Second at the "outcomes" stage; what can they do to moderate the negative consequences of emotional labour performance?

The answer to both questions must lie within the range of educational and training initiatives currently offered to health carers. Emotional labour still remains largely implicit within most health services; emotional labour is rarely being explicitly

recognised or taught (Smith and Gray, 2000). Still today, the tendency in research and in nursing practice is to concentrate on more visible, measurable aspects of care and medical procedure. After all, as one nurse commented, "you can't put feelings of intimacy in the patient's notes or record" (in Smith and Gray, 2000, p. 41). Emotions continue to be professionalised in order to present a detached, impersonal image of medicine. If emotional labour continues to be devalued then the health service risks becoming blind to the emotional needs, not only of its patients, but also of its staff, with the associated negative implications on patient outcome and staff health and well-being.

Acknowledgement of the role of emotions in terms of education within health-care training certainly appears to be patchy, with some provision better than others. A gynaecological nurse in Northern Ireland comments in McCreight's recent paper that she was not given guidance on dealing either with her own or her patient's emotions and consequently felt that she was inadequately prepared for a part of her job that is central to her role; for example, nurses were trained in recognising symptoms of miscarriage as well as appropriate forms of medical intervention, but not in the emotional aspects of such incidents. Nurses in Henderson's (2001, p. 134) study also frequently expressed their "profound disappointment in the failure of nursing education to address the emotional requirements of the work"; none of Henderson's nurses felt that their nursing education has "in any way" prepared them for the emotional cost of nursing. In a similar vein, a psychiatrist in the *British Medical Journal* laments that "much of medical training seems to be focused on how to deal with things . . . rather than how to cope with people" (Persaud, 2004, p. 87).

But how might this emotional training be achieved? Many nurses feel that these skills are best learned vicariously from more experienced colleagues: "there are very experienced staff here. . .and basically what you do is you learn from them" (Katlin, in McCreight, 2004, p. 6). This seems to reflect little change from the views of student nurses in 1992 who suggest that the skills needed to perform emotional labour are most frequently learnt informally in the workplace (Smith, 1992). This suggests that placements and other *in situ* elements of the training process are the best place to learn the emotional requirements of the job. Another suggestion is offered by McCreight who notes that training for gynaecological nurses which involved visits from bereaved parents was regarded as very helpful in helping nurses see things from the patient's perspective; this idea of "patient-centred" emotional skills training could be delivered across a wider range of disciplines; recovered patients, for example, could attend formal training days to share their experiences on the emotional aspect of the care delivery. McQueen, in her 2004 meta-analysis of emotional intelligence in nursing work, suggests that the training focus on self-awareness, self-regulation and social skills, whilst Cook (1999) points out that the current financial pressure on universities to teach in large groups is not conducive to these aims. Smith and Gray (2000) advise that reflective learning (including mentoring and storytelling techniques) is a useful way to learn these skills (although the emotional labour inherent in these learning processes themselves must be recognised).

Initiatives leading to changes in the organisation of care in recent years may inadvertently effect the levels of emotional labour performed by care workers and this

should be considered when considering future policies. For example, a drive to provide "continuity of care" from midwifes in the Department of Health's Changing Childbirth report (1993) may have important implications for a midwife's personal life that can result in increased emotional labour as they attempt to juggle home and work roles (Hunter, 2001).

This leads to the issue of the effects of emotional labour on the labourer which have been outlined in detail earlier in this paper. It seems undisputed that continuous and chronic emotional labour performance can have significant negative outcomes on the health and well-being of the labourer, yet if emotional labour is barely acknowledged in the health service, how can its effects be monitored and treated? Thus, it is not just performance of emotional labour that needs to be taught in a formally recognised way, but also coping with the effects. Strategies that could be introduced to counteract the negative effects of emotional labour performance need to be both training and policy-led; for example, peer support programmes, changes in patient and resource allocation systems, stress management interventions, "downtime" schedules, work rotation schemes and debriefing programmes (see Mann (2002) for review).

Conclusions

> There is a profound need to bridge the gap between medical and emotional aspects of care (Smith and Gray, 2000).

The aim of this paper was to develop a health-care model of emotional labour that could be used to help health-care managers better deal with the causes and consequences of emotional labour for staff and patients. It has been shown that emotional labour is a crucial part of the role of many health care professionals, especially nurses, and that these skills are not adequately taught within health-care education programmes. Similarly, the stress and effects of mental health of emotional labour performance have also not been sufficiently acknowledged or addressed. Specific recommendations from this review include the following:

- The study of emotional labour should be widened to include other professions outside of nursing such as doctors, counsellors (Mann, 2004), clinical psychologists and other health-care providers.
- Emotional labour and emotion management should be formally recognised as a key skill in facilitating the patient journey and training, policy and education within health-care systems should reflect this recognition.
- Emotional skills should be taught in innovative ways outside of the formal classroom setting and in small, appropriate groups encompassing reflective learning, mentor-led experiences and patient-centred sharing.
- Health-care professionals should be offered training on coping with the effects to themselves of emotional labour performance both as part of initial entry-level training and as part of continuing professional development.
- More research should be carried out to further develop the model, particularly in identifying causes of emotional labour within health-care settings and in differentiating the effects that different kinds of emotional labour performance might have.

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