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THE NURSE – PATIENT EMOTIONAL INTERACTION IN QUALITY OF WORK LIFE: THE ROLE OF EMPATHY AND EMOTIONAL DISSONANCE.

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Declaration

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

Letizia Dal Santo

"... I shall be telling this with a sigh
Somewhere ages and ages hence:
Two roads diverged in a wood, and ,
I took the one less travelled by,
And that has made all the difference."

(Frost. R., 1913)

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Acknowledgements

Once upon a time there was the phd student…
His adventures and troubles are well explained in the web site www.phdcomics.com.

Phd student has been described as frustrated and sad, maybe a bit depressed. He suffers from lack of recognition and his intellectual freedom is caged by severe professors and institutions.

My personal story as phd student has been pretty different …

The main theme of this doctoral work is emotions and this project has been really moving for me. It has been challenging, scaring, satisfying, overwhelming, surprising, confusing, enriching ... it has been a real opportunity for my self determination and personal evolution !

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ABSTRACT

People *are* emotions! Our behaviors, thoughts and actions are wound up with what we feel. So one key value people bring to organizations is emotion. In the recent years we have been witnesses to a rise of organized studies of emotions in the workplace. Weiss and Cropanzano (1996) advised workplace experiences comprise many work events that can be pleasing or stressful and frustrating. Doubtless, emotions are beginning an inherent part of the workplace. This perspective seems to be fundamental in health care organizations and plays an important role for helping professions as nursing. Nurses have a constant emotional involvement with patients and their relatives by listening to their complaints and dealing with suffering, helplessness and death associated issues. This *emotional labor* has found to have ambiguous correlations with nurses' well-being. Most reviews of the matter show a strong prevalence of the dark side of emotions. Emotional workload has been included in the large and well known arena of burn out, stress and dissatisfaction. Although there are some inconsistencies in these findings, emotions are at most considered as spoiling elements of workload. In this doctoral dissertation we aim to connect the emotional work during nurse/patient interactions to concepts of positive psychology. This theoretical perspective emphasizes human resources and strengths rather than deficits and problems (Seligman & Csikszentmihalyi, 2000). We aim to underscore that handling emotions with patients is nor positive neither negative. The focus is on *how* nurses manage with emotional involvement with patients. For that reason we focus on two different states of being which are involved in emotional labor and seem very pertinent in the nursing context. We examine the role played by empathy and emotional dissonance and test their role in (not) promoting quality of nurses' working life. In order to test our hypotheses three empirical researches are performed.

The main findings are as follow:

Empathy: has shown positive links with job satisfaction, work engagement and organizational citizenship behaviors (study 1, model 1). Empathy must be considered as a different component of emotional labor, which involves management of natural emotions.

Emotional dissonance: our study confirms previous observations, which have underlined that the negative effects of emotional dissonance were overestimated and can be lessened by personal and organizational moderators (study 1, model, 2).

Emotional display rules: our study focus on different aspects of perceived display rules. They are comprised in a *continuum* from prescribed rules to internalized rules. Organizationally shared display rules and internalization of display rules are found to positive relate to job satisfaction, whether prescribed rules are positive related to emotional dissonance (study 2).

Emotional support: emotional sources of support are found to be crucial for the satisfaction of employees engaged in emotional labor.

Together these results show that the management of natural emotion should be included as a different emotional labor strategy. Employers can assist employees by preparing employees for interactions and by ensuring adequate emotional support. We hope our study will contribute to highlight the fundamental importance of emotions in the nursing context and we aim to enrich the research on how health care organization could support and foster nurses in their difficult, but very challenging and important job.

INTRODUCTION AND RATIONALE FOR THE RESEARCH

Preamble

European hospitals are facing with an increasing "nursing crisis" (Hayes et al., 2006). This particular situation has moved researches to investigate nursing profession different dimensions and health care structures organizational features. This doctoral thesis's general aim consists in contributing to this perspective. In particular this study points to underline the role played by the *relation with patients* in nursing, by considering it an essential professional element. A fundamental factor of the nurses workload is thus monitoring the relationship they establish with patients and how they shape their communication (Zammuner & Galli, 2005) These interactions imply that nurses have a constant *emotional involvement* with patients and their relatives by listening to their complaints and dealing with suffering, helplessness and death associated issues. Nurses are required to express both affective neutrality and involvement toward their patients. Nurses are asked to listening carefully to their patients, to make them feel at ease, to reassure and to calm them when they are anxious or scared. The most general hypothesis of this study was the role requirements trigger emotional processes whose nature and consequences contribute to define and to better understand nursing profession. A most specific aim of this doctoral dissertation is to verify if and how emotions, in interactions with patients, may (not) promote positive experiences in the nurses profession. Most of researches have focused on detrimental effects of nurses workload in order to better understand and explain the crisis of their profession. We focus on positive aspects of nurses work, because our general hypothesis is that focusing on resources rather than problems could help in better understand nurses difficulties. This perspective is embraced by an emerging approach to organizational psychology which encourages researches to recognize the positive aspects of work (Turner, Barling, & Zacharatos, 2001) and to give more attention to human strengths and optimal functioning rather than to their deficits (Maslach, Schaufeli, & Leiter, 2001). The idea is for psychologists to find ways of increasing the positive consequences for people as a result of investing extensive time and energy into their work. In this doctoral

dissertation we aim to connect the managing of emotions in the nurse/patient interactions to the large arena of positive psychology.

In order to test our hypotheses an accurate analysis of the specific literature was performed. Emotion in the workplace is an ever-expanding field with a variety of theories and models used to describe how and why people feel and express their emotions in the workplace. The purpose of this opening introduction is twofold. First, a brief overview of the concept of emotion and the research on emotions in organization is provided, in order to point out the context of this doctoral dissertation. Emotion is defined and described through the basic traditions on psychology and furthermore on organizational settings. In the second part of this introduction, the chapters following in this dissertation are presented and illustrated.

A BRIEF HISTORY OF PSYCHOLOGICAL RESEARCH ON EMOTIONS

Recent research on emotions is almost vast and different as emotional life itself. A literature research limited to the word "emotion" using PsychInfo returned 5064 citations over the past five years and journals are now devoted to the topic and many textbooks have surfaced. Emotion is nevertheless not contemporary matter. Humans have walked the surface of the earth for about two millions years and where human is, there is emotion (Finemann, 2008). Although interest on emotions is an ancient human feature, the systematic study on emotion has been aided in recent years by the development of standardized stimulus materials and procedures for eliciting emotions and this continued to be an active area of research (Cacioppo, 1999). Different perspectives on emotion, which have roots in many diverse disciplines, try to make sense of the complex emotional process. Firstly researches started defining emotions, making some important distinctions. Emotion is a multidimensional concept which consists of a subjective element (what we *feel*) and of a displayed feature (what we *show*). Displaying an emotion is strongly influenced by social conventions and it is socially constructed. Feelings and emotions are usually short-term and linked to a particular object or occurrence (i.e. I am angry with Tom, I got surprised for the gift I received). They pass quickly and some of them are intense, ambivalent and uncertain (McBurney, 1999). Moods are linger states and they are not attached to any particular object or event, the cause or trigger is often obscure. They typically undulate over the time. Some people have steady moods, while others have moody states which frequently shift in feelings. There is one further term mentioned within emotions research: *affect*. This is an all-encompassing expression for

any emotional experience. It can be used as synonym of emotion or feeling (Finemann, 2008). These distinctions lead to a definition of emotion such as "... a complex psycho-physiological

experience of an individual's state of mind as interacting with biochemical (internal) and environmental (external) influences. In humans, emotion fundamentally involves "physiological arousal, expressive behaviors, and conscious experience..." (Myers, 2004. p.500).

In order to cover the multifaceted aspects on emotion, psychological perspectives divide studies roughly into four main domains: emotions as *biological*, as *early experiences*, as *cognitive appraisal* and as *social perspective* (Finemann, 2008). The biological domain holds that many of the basic emotional responses are wired into human body system through genetic heritage (Nicholson, 2000). Emotionally responses are preprogrammed and they are very useful for human survival. This perspective was fundamental to Charles Darwin. In his book: *The expression of the emotions in man and animals* (1872), he concluded that many emotional reactions are rooted in ancient prehistoric patterns of survival, a genetic residue of which is still with us. Darwin marked the way for subsequent biological approaches on emotions. *Evolutionary psychologists* have recently been interested in building on Darwin's insight. Emotional reactions are seen as the result of neurological programs that have developed over the ages, to meet survival demands. The prefrontal lobes and the amygdala (a small almond shaped area of the brain) are regarded as playing the most important role in programming emotional reactions (Cosmides & Tooby, 2000). These psysiological processes are not stand-alone. The cognitive parts of the brain are constantly conversing with the emotional parts. They need each other (Damasio, 1994). While some emotional responses may be "hard wired" into the brain, what make us feel in a particular way is much conditioned by learning and experience. In illustrating this process, William James (1884) posed two questions: "Does emotional experience cause body changes or is it the way round?" As we learn more about psychology and biology of emotion, we could answer that emotions provide us with key signals of how to cope with survival demands. Emotions help us to adapt and to create and share meanings. Emotions are embedded in a lifetime of accumulated experiences and learning and our actual feelings can be shaped by events of the past. These are process that intrigued Sigmund Freud and the *psychodinamic approach* to emotions. According to Freud, most part of personality is hidden and he used the metaphor of an iceberg (Freud, 1958). He called this area Unconscious and it is where our unacceptable passions and emotions are repressed. Our Conscious (the Ego) and the voice of Conscience (the Super Ego) shape

feelings in accord with moral codes. Freudian conceptual representations of emotions are dynamic and interacting (Klein, 1963). Freud showed we are prisoners of the past. Childhood

experiences mould emotional sensitivities and, if traumatic, leave their emotional marks such as painful feelings and anxiety. Unlike the psychodinamic approach, the *cognitive perspective* proposed that emotion is not 'there' in any meaningful sense until human being appraises or try and make sense of. Feeling and emotion follow the appraisal process. Richard Lazarus and his colleagues have developed appraisal theory of emotion (Lazarus, 1991). Lazarus showed two type of appraisal: primary and secondary. In the first one, the individual asks to him/her self: "Does this situation affect me personally?" in the second one the question is:" What can I do about it? How can I face it?" Together, the primary and secondary appraisal shape the quality and intensity of emotional reactions. Interpretation of the meaning of the object or event plays a fundamental role in the flow of feelings and emotions (Lazarus, 1991). Cognitive appraisal theory, however, does not point to the way the appraisals themselves are laced with feelings and body sensations, especially in social interactions (Parkinson, 1995). A net separation between thinking and feeling cannot be drawn. Thoughts and emotions interpenetrate. Appraisal theory takes little into account the social and cultural contexts of appraisals and emotions.
Social theories say, however, emotions are social and they spotlight the culture settings in which emotions are learned and expressed. Social perspectives emphasize the effects of different cultural experiences and everyday social expectations such as emotional roles and scripts. These are element of the social construct of emotion (Gabriel et al., 2000). Social constructionists believe that neither evolution nor past experiences build emotions. Emotions are built by meaning and this is a cultural artefact. The display of emotions depends on the social context and varies according to circumstances and how these ones might be interpreted. The connection between emotions, body and social meaning is especially powerful in everyday life and all these processes carry over into the workplace. Emotions are borrowed from culture values and organizational culture. The culture of organization helps creating and reinforcing emotions in the workplace (Finemann, 2008). Employees have roles to play and script attached to them. These elements contribute to emotionalizing organizations, as discussed in the following paragraph.

EMOTIONS IN THE WORKPLACE

Traditionally, researches in the organizational sciences have been based on the taylorian assumption that human behaviour follows, somehow, rational rules. Workplace was thought of as cold and rational as no place for the experience of humanity and expression of emotions. Simon (1976) was of the first researcher to recognize that a rational model doesn't provide an adequate representation of human behavior in the workplace. Weick (1979) in agreement with this perspective argued: "Where is the heart?". Mumby and Putnam (1992) suggested that organizational behavior is better characterized as "bounded emotionality" rather than "bounded rationality". In the introduction of a monographic number of the European Journal of Work and Organizational Psychology, Briner claimed:"…When we listen to others or ourselves talk about work, much of what we say involves a discussion of emotions. We talk about how our work and events at work made us feel. We discuss how we felt about particular interactions with colleagues and clients. It's quite clear that work is experienced by people in very emotional ways…Work and organizational psychology's studies failed in giving serious consideration of emotion at work" (Briner, 1999, p.321). Despite the slow start, interest in the study of emotions in the workplace settings has been growing since the late 1980s. In particular, articles by Rafaeli and Sutton (1987, 1989), Hosking and Finemann (1990), Wharton and Erickson (1993), Weiss and Cropanzano (1996) and many more have attracted significant interest. The underlying theme stressed by authors is that emotions are essential part of organizational life and cannot be ignored by researches. This new paradigm has stimulated the interest in the topic and the recent years we have witness a rise in the organized study of emotions in the workplace. Some edited books have contributed to keep on encouraging the interest in studying emotions at work: *Emotions in the workplace: theory, research and practice* (Ashkanasy, Haertel, & Zerbe, 2000) and *Understanding emotions at work* (Finemann, 2003) are important examples. Although the workplace emotions literature is growing, is still a young area of study. As such, it's characterized by different theoretical orientation and topical focus. For this reason, it's difficult to specify an all-encompassing yet parsimonious system that categorized work in the field. Four domains can be defined to summarize a good deal of the area: the Affective Events Theory (Weiss & Cropanzano, 1996), Mood Theory (George & Brief, 1996), Emotional Intelligence (Goleman, 1998), and Emotional Labor (Hochschild, 1983). The four domains will be briefly described in the

following pages; a particular emphasis will be dedicate to the aims of these different theoretical frames.

Affects Events Theory

Affective Events Theory (AET) is a model developed by organizational psychologists Howard M. Weiss (Purdue University) and Russell Cropanzano (University of Arizona) to identify how emotions and moods influence job performance and job satisfaction. The model increases understanding of links between employees and their emotional reaction to things that happen to them at work. In the affective events theory, authors argue that aspects of work constitute the affective events, which act systematically to determine affective states. These last ones, in turn, led to attitudinal and behavioral outcomes. Emotions can also directly lead to productive outcomes or pro- or antisocial actions (Weiss & Cropanzano 1998, Organ, 1990). The nature of the job and any requirements affect behaviors and attitudes, they result in positive or negative emotion experienced at work that influence work attitudes (job satisfaction, commitment…). Finally experienced emotions are affected by personal disposition such as emotional intelligence or trait affect and general tendency to be positive or negative mood. AET shows organizational characteristics and managerial policies can affect the emotional states of organizational members and, in turn, their attitudes and performance (Weiss & Cropanzano, 1998). These studies have supported the idea emotional states mediate the effect of work events on outcomes. These emotional elements include both mood (the rather generalized feelings of happiness, sadness...) and specific emotional states such as angry, joy, pride, shame, fear. AET points many emotions are transient states rather than aspects of work life that remain constant for long time. Employees can be happy for a successful outcome one moment and disappointed and maybe angry, in the next moment, when their boss doesn't seem interested in sharing this happiness. For AET studies, it is the *frequency* with which these events occur and the *accumulation* of events, rather than the *intensity* of particular events that determine the ultimate outcomes. Employees are thought to have more problems when adverse events unremittingly affect the way they work, even if these events appear to be minor. The theory states that negative emotional episodes at work can produce shocks that then produce lasting affective reactions (Freedheim, 2003). The aim of this theoretical frame is testing the impact of organizational politics on employees' affective reactions, with a special regard to negative outcomes.

Mood Effect

The second domain presented is mood/effects in the organizations. Moods differ from emotions from being more diffuse and long lasting. Researchers have shown both positive and negative mood affect the way employees think and behave at work (Isen, 1993, Rusting & DeHart, 2000). Research into mood in organization began in the early 1990s (George & Brief, 1990), when mood researchers in social psychology were beginning to have an impact (Fogars, 2000). Results of these studies have consistently addressed the pervasive effects of mood. These studies have traditionally separated negative mood from positive mood. This distinction is important because it implies emotion managements are different. The effects of both negative and positive mood are postulated to result from a mood congruence process (Bless et al. 1996). Specifically the mood state of an individual is argued to result in thoughts congruent with that mood state being more readily accessible in memory and other mental processes. Thus negative moods are accompanied by negative evaluations, whether positive mood facilitates optimism and generally leads to positive outcomes such as job satisfaction (Connolly & Viswesvaran, 2000), less turn over (Deery & Shaw, 1999) and organizational citizenship behaviors (Connolly & Viswesvaran, 2000). There are, however, some inconsistencies in these findings. George and Brief (1996) found the effect of the mood depends on the task. A central example is a task that require creativity. Here positive mood is an asset and negative mood a liability (Estrada, Isen & Young, 1994), maybe because of the criticism and the self-censoring that comes more readily in people in negative mood states. Negative mood is linked with greater accuracy and may be fundamental in tasks which require high degree of discrimination of choices (Locke & Latham, 1990). Nancy Rothbard from Warton University of Pennsylvania and Stephanie Wilk from Fischer College of Business in Ohio investigated the work of call-centre employees from different US states (2009). During 3 weeks, the authors were studying their behaviors and changes in mood depending on the situation at workplace. The experiment clearly showed that nothing effect quality of work more then a mood. Employees who were starting their day on an optimistic note were much more attentive and needed less coffee breaks during the working day. On the other hand, employees who come to work in an upset mood were less responsive. It is one example on how Mood Effects studies concentrate on the impacts of organizational polices on employees' moods and moods' influence on organizational behaviors.

Emotional Intelligence

The third domain addressed in this introduction is the recent and controversial concept of emotional intelligence. Traditionally intelligence has been kept separate from emotion. Intelligence deals with the capacity to perform abstract reasoning and solving problems. Measures of intelligence contain questions that involve reasoning and memory. Although the pure cognitive view of intelligence has dominated over the years, there is a long history of social intelligence, the precursor of emotional intelligence. In the 1920s there were academic discussion about the need of going beyond IQ, to include the ability to deal with people and the competence of judge moods and feelings (Hunt, 1928). Challenges to traditional view of intelligence came from the concepts of practical and successful intelligence, which refer to self-knowledge, recognition of one's strenght and weakness and the ability to shape or change environment (Sternnberg, 1997). The idea of multiple intelligence gave further help to put social intelligence on the map (Gardner, 1993). In particular Gardner underscores we have eight forms of intelligence; social and interpersonal intelligences are the basic ingredients of emotional sensitivity (Gardner, 1999). In the 1990s emotional intelligence began to emerge from the background of social intelligence, stimulated by new findings from neuron-anatomy and brain sciences on the role played by emotions in thinking (LeDoux, 1988). In several articles a theory of emotional intelligence was proposed. "...individuals differ in how skilled they are at perceiving, understanding and utilizing emotional information ... emotional intelligence contributes to his or her intellectual and emotional well-being and growth..." (Salovey, 2000, p.24). Accordingly to this definition, emotional intelligence (EI) is the ability to perceive and express emotions and to understand and use them to foster personal growth. From here on, however, ideas on emotional intelligence divide and different authors take diverse directions and emphases. The most popular model, introduced by Daniel Goleman (1998, focuses on EI as a wide array of competencies and skills that drive leadership performance. Goleman's model outlines four main EI constructs: self-awareness (the ability to read one's emotions and recognize their impact while using feelings to guide decisions), Self-management (involves controlling one's emotions and impulses and adapting to changing circumstances), Social awareness (the ability to sense, understand, and react to others' emotions while comprehending social networks), Relationship management (the ability to inspire, influence, and develop others while managing conflict). Goleman includes a set of

emotional competencies within each construct of EI (Boyatzis, Goleman, & Rhee, 2000). Emotional competencies are not innate talents, but rather learned capabilities that must be

worked on and can be developed to achieve outstanding performance. Goleman claims that individuals are born with a general emotional intelligence that determines their potential for learning emotional competencies. Research of EI in organizational and work psychology in particular focused on the links with job performance. These studies show mixed results: a positive relation has been found in some of the studies, in others there was no relation or an inconsistent one Emotional intelligence (EI) is an ability, skill or, in the case of the trait EI model, a self-perceived ability to identify, assess, and control the emotions of oneself, of others, and of groups. Various models and definitions have been proposed of which the ability and trait EI models are the most widely accepted in the scientific literature. Criticisms have centered on whether the construct is a real intelligence and whether it has incremental validity over IQ and the Big Five personality dimensions (Schulte, Ree, & Carretta, 2004). That's one of the reasons why Goleman's model of EI has been criticized in the research literature as mere "pop psychology" (Mayer, Roberts, & Barsade, 2008). This led researchers Cotè and Miners (2006) to offer a compensatory model between EI and IQ, that underscores that the association between EI and job performance becomes more positive as cognitive intelligence decreases, an idea first proposed in the context of academic performance (Petrides, Frederickson, & Furnham, 2003). As things stand today emotional intelligence has yet to be defined clearly, especially about the specific nature of the competences that constitute this ability. The management literature on emotional intelligence is heavily slanted towards certain concepts of good and bad emotions, successful and unsuccessful ones. For example bad feelings for Goleman include impulsiveness, arrogance and abrasiveness. Good moods are all ingredients of positive mental attitude, such as enthusiasm, optimism, hope... (Goleman, 2001). Disgust, hurt, boredom and jealousy are not addressed despite being intrinsic in many organisations, such for example health care structures. If and when emotional intelligent employees recognize them, can they simply turn away from such impulses? Should they? There are many organizations built on "less desirable" emotions to achieve organizational outcomes. Some physicians have to be inflexible with some difficult patients in order to take care of them. Also, current renditions of emotional intelligence in organizational settings are insensitive to gender, tasks and organizational culture. Emotions in the organizations are ambiguous and ambivalent and it is impossible to identify with any degree of clarity. Emotional intelligence's frame has caught the mood of the time. It has

brought emotions out of the closet, but under sufficient control to appear useful to organizational goals and to lever more performance or profit out. In doing so, it offers a

highly restrictive view of the emotionality of relationships in organizations. Most of emotional sensitivity lies in what it contributes to the quality of life in organisations and not only in how much the recognition of others' emotions in productive.

Emotional Labor

The last construct recognized in the emotions studies in the workplace is the emotional labor. It refers to emotion regulation that occurs within work contexts. For emotion theorists emotion regulation is "part and parcel" of emotion process (Frijda, 1986), potentially activated at any of its phases: when an event it to be appraised as good or bad, or a felt emotion is judged for its significance, or its degree with personal or contextual legitimacy. Assuming an emotion is a multicomponential process (Scherer, 1988) regulation can influence every component of the emotional experience: appraisal, psysiological reaction and facial expression. Regulation processes may influence the antecedent of an emotion (avoid public speaking because a person get embarrassed) or its consequences (when a person refrains from engaging in a vindictive behavior). Regulation on felt emotion, or its expression, is needed when personal emotions are in conflicts with internalized norms or contextual salient ones. Hochschild (1983), a sociologist, named emotional labor the regulation performed by employees in work setting contexts requiring interactions with customers/patients. Hochschild's first intent was to show employees must manage their feelings and their emotional expression in order to meet their organization's feeling and display rule, defining what emotion a person ought to feel and express to others (Ekman, 1992). Several studies confirm employees evaluations of interpersonal aspects of their interactions contribute to defining their judgments, attitudes and feelings about their job and their organization (Pugh, 1998, Rafaeli, & Sutton, 1987). In particular emotional labor research has contributed to better understand the crucial role emotion management plays in many work settings and the impact this has on workers (Bolton, 2000). Emotional labor is of critical significance from the perspective of this dissertation, which deals with testing the role played by sharing emotions in interactions with patients. Nursing is among the prototypical type of helping profession to perform emotion labor. According to Hochschild's (1983) classification, in fact, a significant element of nursing work

load, is the high emotional labor spent in relationship with patients (Mann, 2005). Emotional labor requires that one expresses or suppresses feelings that produce an appropriate state of mind, according to organizational *feeling rules* (Ashforth & Humphrey 1993). In nursing, in addition to organizational policies of how to behave with patients, there also exist very clear societal norms and expectations how the professionals should behave. These expectations may be implicitly or explicitly taught in occupational education and become part of one's professional ethos (Briner, 1999; Rafaeli, 1987). Emotional labor's theory and constructs are also chosen as theoretical frame of this work, because they focus on *how* employees could manage their emotions in the workplace, rather than categorised them negative or positive (Diefendorff et al. 2008). Focusing on emotional regulation strategies, the core of emotional labor, seem more useful to influences the practice of nurses, where, in spite of the increasing interest on emotions in the workplace, there is disappointingly little recognition of the importance of considering emotion a fundamental part of the work (Hunter & Deery, 2005). Emotional labor can also be used as conceptual device in order to explore the feeling rules within the health care organisations required to sustain relationships in situations that are often demanding and difficult. For example, within nursing, emotional labor is particularly required when working in distress situations, which arise when caring for terminally ill patients (James, 1992), experiencing loss (Smith, 1992) or palliative care (Kelly, 2000). The findings of these studies have shown that the emotional labor between nurses is a vital part of the quality of care (Gray, 2005). The findings suggest emotional labor needs to be more explicit and codified in order to incorporate it into policies and practice (Smith, 2005). The potential for exploiting nurses emotions needs to be countered by education and training, informed by research that make emotional labor explicit and which develops evidence base that informs best practice (Allan & Smith, 2005). According to these theoretical frame and practice implications, this doctoral dissertation aims to contribute to better understand the role of emotional labor in the nursing workload. In fact, despite of the growth of scholarly work on emotional labor, a number of important questions remain to be answered (Daus & Munz, 2005, Hulsheger & Schwe, 2011). The Hochschild's original sociological conceptualization, focused on the detrimental effects of estrangement and inauthenticity, has dominated the literature on emotional labor, which was included in the large arena of burn out (Abraham, 1999, Bakker & Heuven, 2006), was discovered to negative correlate to nurses' well being (Heuven & Bakker, 2003, Zapf, 2002) and was also found to positive correlate to job dissatisfaction and increasing nurses turn over intention, but some inconsistencies are recently discovered in these findings (Murphy, 2005). After analysing the different models used in

organizational psychology to study emotions at work, emotional labor appears the most pertinent to our study. Affect Event theory and Mood Effects focus on the impact of employees emotions on job performance and/or organizational behaviors. They consider a large variety of emotions with different source and target: customers, leaders, private life and tend to categorize them in positive or negative.
The theoretical frame of emotional intelligence deals with valuing emotional competence as useful to organizational goals. It tends to categorize emotions in successful and unsuccessful to performance behaviors. Emotional labor research, instead, focuses on emotions originated by the relation with clients/patients, in regard to emotional display rules. It underscores that employees could manage with emotions in different ways. The point of this theory is *how* employees handle with emotions generated in the interactions at work in order to fulfil organizational expectations. Emotional labor studies differentiate neither emotions nor moods; it categorizes different emotional regulation strategies used by employees in relationship with clients/patients. These strategies are divided in functional and dysfunctional in regard to employees well-being. The effects of emotional labor may be different for different employees. Some may be better equipped and skilled to perform emotional labor affectively and without adverse consequences (Ashkanasy & Davs, 2002; Coté, 2005) This doctoral dissertation aims to investigate the role played by nurses' different personal states involved in regulating emotions during interaction with patients and test whether or not it may contribute to positive experiences in nurses work. For this reason considering emotional labor theory as frame of our research seems very useful and pertinent. The theory of emotional labor in nursing will be analysed in details the next chapter.

OVERVIEW OF THE CHAPTERS

These opening pages are written to orient to the field of emotions at work, presenting the arena of studies regarding emotions in the workplace. The remaining chapters present the specific domain of this dissertation: the role of emotional dissonance and empathy in the nursing context. In order to do so, this volume is split in two parts. The first one is dedicated to the theoretical frame of the matter and the second one contains experimental studies, which appear in articles form. The first chapter is dedicated to emotional labor. From its sociological born, due to Hochschild's book to the last studies of the topic, this concept is described and explained. Particular attention is given to the role played by emotional labor in the health care structures and performed by nurses. The second chapter is dedicated to underscore emotional

dissonance, as core of emotional labor, and its correlates in the nursing profession.The third chapter is dedicated to empathy. Empathy is considered an important element for nurses because it enhances the "right" emotional distance from the patients. Empathy and its correlate outcomes are also taken into account. The fourth chapter introduces the concept of quality of work life in the nursing context and presents the indicators (job satisfaction, work engagement and organizational citizenship behaviors) studied in this dissertation. Numerous studies have investigated the link between emotional labor and well-being, both theoretically as well as empirically. Yet findings are inconsistent regarding the size and direction of effect. This makes it difficult to draw reliable conclusions about the nature of such relation and impedes the development of clear suggestion for practices. Emotions are, in fact, an integral part of adaptation in everyday work and employees should be able to recognise and managing with their own and others' emotional states (Hunter & Smith, 2007). On this purpose Hunter and Deery (2005) underline that, in spite of the increasing interest on emotions in the workplace, there is disappointingly little evidence emotional research influences the practice of nurses. Nursing students still feel unable to dealing with emotional demands of practice. This gap suggests the importance of going beyond the negative side of emotional load and focusing on how workers might handle with emotional labor in a positive perspective. In order to fulfill to this aim, the second part of this volume, provides empirical researches about the topic. The introduction presents and explains the three experimental studies performed during this doctoral experience. Theoretical frame, aims, results and discussions for each study are carried out in chapters six, seven and eight. The volume concludes with some reflections on the main themes and implications.

CHAPTER 1

EMOTIONAL LABOR IN THE NURSING CONTEXT

Preamble

Health care work is, by its nature, an area of heightened emotions, and thus is ripe ground for the exploration of emotions in the workplace. In particular, emotional labor studies have contributed to our understanding of the crucial role emotion management plays in health care settings, as nursing, and the impact this has both positively and negatively on patients and employees. It is fundamental to begin by setting out exactly what "emotional labor" means. Sources of emotional labor, within nursing, is particularly needed when working in distress situations, for example, caring for terminally ill patients, experiencing loss and pain. Nurses are expected to express compassion and caring, at the same time that they are encouraged to develop a level of professional detachment (Savett, 2000). Hunter (2005) found that it was managing the dissonance generated by the co-existence of conflicting ideologies of practice that was the key source of emotional labor. The ability of nurses to hold competing emotions is at the heart of a number of recent studies in which the emotional labor of nurses in different clinical settings. McCreight (2005) considers nurses' use of emotions as a valid resource in the construction of professional knowledge. Since the publication of Hochschild's original work (1983), we have witnessed different conceptualization of emotional labor. The changing nature of health care sector implies the feelings aspect of nursing life is increasingly acknowledged. What it is provided in the following pages is trying to portrait an authentic acknowledges of the significance for nurses of handling emotions in patients' interactions. Without this recognition, it is hard to see how the emotional well-being of nurses and their patients can ever be seriously addressed.

1.1. Emotional labor: A Portrait of Current Theoretical Perspectives

Along with the interest emotional labor has generated, numerous theoretical approaches and perspectives have been promoted. Glomb and Tews (2004), while arguing that these approaches represent complementary perspectives; concede *"It could appear that the emotional labor domain is in a theoretical quandary, flooded with a multitude of conceptualizations*" (p.4). The following review of the literature is intended to provide a clear idea of the state of emotional labor theory and to lead to a conceptualisation of emotional labor that is inclusive of how employees express and constrain emotions as a functional aspect of their role. Emotional labor, which is the display or constraint of emotional expression as part of the work role to meet organizational, social or occupational expectations and rules, is an integral aspect of working life for many employees (Mann, 1997). Given the importance of emotional management in many occupations and its negative well-being associations (Hochschild, 1983; Pugliesi, 1999; Williams, 2003), its detailed examination is of importance to employees and employers.

1.1.1. The Hochschild original conceptualization

The concept of emotional labor was introduced by Hochschild (1979, 1983); in her book, published in 1983, she refers to the quality of interactions between employees and clients; "Client" is used to refer to any person who interacts with an employee, for example children, customers, students and patients. Following Hochschild ground breaking dramaturgical perspective of the emotional interchange between flight attendants and passengers, emotional labor research has become a burgeoning research area (Ashkanasy, Härtel, & Daus, 2002). Occupational fields as diverse as hotel staff (Seymour & Sandiford, 2005), doctors (Larsen & Yao, 2005), university employees (Pugliesi, 1999), social workers (Cheung & Tang, 2007) call centre workers, bank employees, and teachers (Zapf & Holz, 2006) have been studied in emotional labor research.

One of the most studied areas for emotional labor researchers has been the health sector, in particular nursing, in which emotional management is a crucial aspect of the role (Mann, 2005). As care givers, nurses are seen as sources of emotional support for patients and family members and this role is sometimes considered as important as their clinical duties (Smith, 1992). In the Hochschild (1983) classification, in fact, a significant element of nursing

workload, is the high emotional labor spent in relationship with patients (Mann, 2005). Hochschild (1983) drew upon the work of Goffman (1959) to point that in all social interactions, people tend to play roles and try to create certain impression on others. This idea also applies to interactions in organizations. Emotional labor requires that one expresses or suppresses feelings that produce an appropriate state of mind, according to organizational *feeling rules* (Ashforth & Humphrey 1993). In helping professions as nursing, in addition to organizational policies of how to behave with patients, there also exist very clear societal norms and expectations how the professionals should behave. For these reasons nurses are required to manage their emotions as a part of their work. It's important to underscore that this is very different from considering emotions as reactions to several conditions of the organizational context (Briner, 1999), rather the focus is on emotions as needed requirements in the workplace. Nurses typically are requested to be polite and quiet and to reassure patients. However, they would also sometimes not smile, do not reassure, for example, when dealing with arrogant patients, when they feel exhausted or when they are sad or angry. Emotion work as a part of the job, however prescribes that the "positive" emotions are required even in such situations. For this reason Morris and Feldman (1996, p.987) defined emotional labor as the "effort, planning and control needed to express organizationally desired emotions during interpersonal interactions". Serious problems associated with aspects of emotional labor including emotional exhaustion (Brotheridge & Grandey, 2002), depression (Mann, 1997) and physical symptoms (Schaubroeck & Jones, 2000), make the detailed study of emotional labor in occupations with a heavy emphasis on interactions with clients, a very important consideration. The major theoretical approaches to emotional labor underline the importance of identifying separate emotional labor components as crucial in determining which aspects of emotional labor provide particular well-being outcomes and under what circumstances (Grandey, 2000).

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

Hochschild , being a sociologist, differentiates emotional labor and emotion work. The first one is "…the exchange value to work which is sold for a wage …" and the second one "…

refers to the private context where they have use value" (1983, p.7). Emotion work has been defined as the management of one's own feelings or as "work done in a conscious effort to maintain the well-being of a relationship" (Ferraro, 1993, p.87). Emotional labor refers to the emotional work done in a paid work setting, while emotion work relates to the unpaid emotional work that a person undertakes in their relationships with family and friends. Examples of emotion work include showing affection, apologizing after an argument, bringing up problems that need to be addressed in an intimate relationship or any kind of interpersonal relationship, and making sure the household runs smoothly (Grandey, 2000). In psychological studies, regulation of the work actions, rather than societal and economics aspects of labor, are considered. In psychology the term labor is used when sociological concepts are involved, but this term is not used to describe individual actions or intrapsychic concept (Zapf, 2002). As Hochschild mentions, the acts are the same and so are most of the psychic processes for emotion work inside and outside of the job although in some respects this differentiation plays a role in the appraisal of what one is doing. Although Zapf advised, to be compatible with other fields of work and organizational psychology, the term emotion work is to prefer (Zapf, 2002), emotion work and emotional labor are often used interchangeably, in multidisciplinary perspective. Authors differ somewhat in their conceptualization of emotion labor. Whereas Hochschild (1983, p. 7) was interested in handling feelings to create a publicly observable facial and bodily display, other authors focused on the expressive behavior because this is what they perceived to be organizationally desired and relevant (Ashforth & Humphrey, 1993; Morris & Feldman, 1996). Hochschild's (1983) investigation was largely focused on flight attendants and the ways in which they complied with organizational expectations of how they should manage and express desirable emotions in their dealings with passengers. For example, flight attendants are expected to display friendliness by smiling, and allay passenger fears of flying by presenting a calm demeanour. These emotional expressions are expected even in the face of demanding or abusive clients. Importantly, Hochschild saw that emotional labor included the requirement to suppress unacceptable or non-prescribed emotions, often while simultaneously expressing the required expression, entailing a complex degree of emotional management. Hochschild (1979, 1983) used a dramaturgical perspective in which "feeling rules" or the organizationally defined constraints of acceptable and unacceptable emotional expression are seen as similar to a script. Hochschild (1983) found that over time, the performance of emotional labor had serious adverse well-being outcomes for employees. As an explanation for such negative well-being consequences, Hochschild introduced the notion of emotive dissonance, similar to

cognitive dissonance, as an uncomfortable internal state, resulting from the tension created from the difference between felt and expressed emotion. Emotive dissonance (often referred to as emotional dissonance) has since been defined as "*the expression of emotions that are not felt*" (Zapf & Holz, 2006, p.1). Hochschild (1983) also argued that emotional expression and feelings are such a personal experience, that the expression of them for a wage on organizational demand must be inherently unpleasant. Hochschild found that the emotional labor of flight attendants was associated with sleep disturbances, sexual problems, and a general deadening of affect. Hochschild's (1983) perspective presents emotional labor very much as an employer driven and directed process in which employees, despite sometimes "rebelling" against the expected expression, are generally at the behest of the organization and have little choice, but to express sanctioned emotions, regardless of what they are feeling. The overriding reason for emotional labor is to increase profit through customer satisfaction and return business. Hochschild's bleak view of emotional labor (1979, 1983) as a means by which employers increase profit at the expense of an employees' well-being, has not gone unchallenged in other theoretical perspectives (Ashforth & Humphrey, 1993; Wouters, 1989). However, there is recognition that Hochschild's (1983) original accounts of emotional labor, and of how employees manage emotion as part of their role, has become the basis for much emotional labor research since. In particular, the importance of the central tenets of surface and deep acting and emotive dissonance have endured and been supported in both qualitative (Boyle, 2005; Mann, 2004) and quantitative studies (Brotheridge & Lee, 2003; Martínez-Iñigo, Totterdell, Alcover, & Holman, 2007; Näring, Briët, & Brouwers, 2006). Therefore, even though subsequent research has built considerably on Hochschild's work, her original conceptualisation can be seen as a robust basis for emotional labor researchers to work from.

Figure 1.1. : Model based on Hochschild"s (1983) emotional labor theory.

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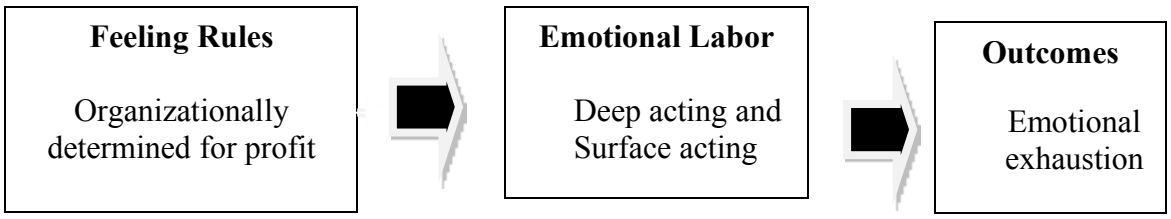


1.1.2. Emotional Labor as Observable Behavior

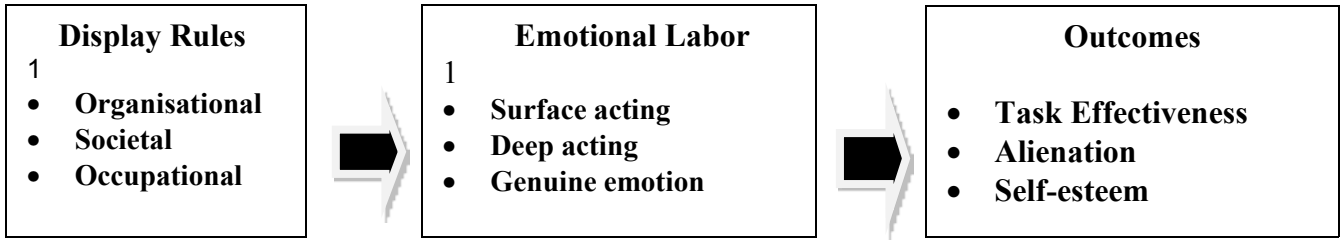
Implicit in Hochschild's (1979, 1983) definition and description of emotional labor is the notion that the management of feeling requires the control of internal processes. Ashforth and Humphrey (1993), in their definition of emotional labor as "*the act of displaying the appropriate emotion*" (p. 90), view observable behavior as a more relevant focus for investigation. They argue that observable behavior is what is seen by clients while internal states are difficult to assess, and conformity may not require altering of felt emotion. It may be helpful to draw parallels to other concepts of work behavior. Hacker (1973), in his book, argued that work psychology has to deal with the psychological processes of work which refer to work actions. These psychological processes refer to goal development, planning, monitoring, and feedback information processing which control the work actions. Accordingly, emotion work should be conceptualized as the psychological process necessary to regulate organizationally desired emotions[1].. The 'acts' of emotion display (Ashforth & Humphrey, 1993) are necessarily regulated by intra-psychological processes. Since most authors agree that Hochschild's deep acting (see below) is a means to attain the goal of organizationally and professionally desired emotions, Hochschild's and Ashforth & Humphrey's definition do not seem to be really contradictory. Rather, it is suggested to comply with Ashforth and Humphrey in their emphasis on the visible behavior which is the main goal of emotion work in most cases, but it is also suggested that processes referring to the inner feelings which support the visible behavior and should be part of the emotion work concept at least for two reasons: first, in several professions (for example nursing) it is part of the social and professional identity to genuinely feel an emotion, and second, the person may feel hypocritical if, he/she is not able to feel what he/she should feel (Briner, 1995). Unlike Hochschild's (1983) bleak assessment of the effects of emotional labor, Ashforth and Humphrey (1993) argue that emotional labor can have positive well-being outcomes. This is most likely the case when the employee identifies with the role and has some latitude for expression. This is thought to lead to a more convincing emotional performance, thus

[1] Emotion regulation means the processes of initiating, maintaining and modulating the occurrence, intensity and duration of internal feeling states and psychological processes related to emotions (Kokkonen & Pulkkinen, 1999). The adaptative aim of emotion regulation is twofold. It helps to prevent stressful levels of both negative and positive emotions (Kopp, 1989) which product maladaptive behaviors and, secondly, plays a fundamental role in emotional openness and self reflection (Labouvie-Vief, 1989). Studies on emotion regulation focus on various means emotions may be regulated. Literature refers to coping strategies, (Campos & Barrett, 1984), Coping responses (Labouvie-Vief & Hobart, 1987) emotion regulation/management skills (Thompson, 1994) and approach/avoidance, inhibitory mechanisms (Thompson, 1990) Emotions are regulated both consciously and unconsciously (Karoly, 1993) and can be divided into problem focused or emotion focused strategies (Cicchetti, 1995) For more information on emotion regulation: Cicchetti, Ackerman, & Izard, 1995; Eisenberg, 1997,1998; Gross & Levenson, 1997; Calkins, 1994, Lazarus, 1990)

facilitating a smooth interaction between the employee and client, leading to the satisfaction of both. In addition, Ashforth and Humphrey suggested that it occurs when spontaneous and genuine emotions (emotion that naturally corresponds with display rules) are performed. To illustrate such natural emotions, Ashforth and Humphrey provide an example of a nurse who is naturally sympathetic towards sick children, which will lead to exactly the type of empathic emotional displays required as part of the role. This means that the nurse has not had to work to elicit a particular emotion to conform to display rules as is the case with deep acting. The example of the nurse used by Ashforth and Humphrey also shows that the use of genuine emotion is also distinguishable from surface acting as the employee would not have to mask or artificially express a particular emotion.

Ashforth and Humphrey (1993) argued that a key consideration of whether or not emotional labor results in positive or negative well-being outcomes rests on the social and personal identity of the employee and how closely this aligns to the role. Using social identity theory (Ashforth & Mael, 1989; Tajfel & Turner, 1985), Ashforth and Humphrey argued that when employees can more readily identify with the service role, compliance with the emotional requirements may be easy and enjoyable. Such identification is likely to lead to less effort and a more natural performance. In this respect Ashforth and Humphrey saw the outcomes of emotional labor as either positive or negative (as shown in figure 1.2) depending on how well the employee is able to align their identity with their role and conform to display rules.

Figure 1.2.: Model based on Ashforth and Humphrey"s (1993) theory of emotional labor.

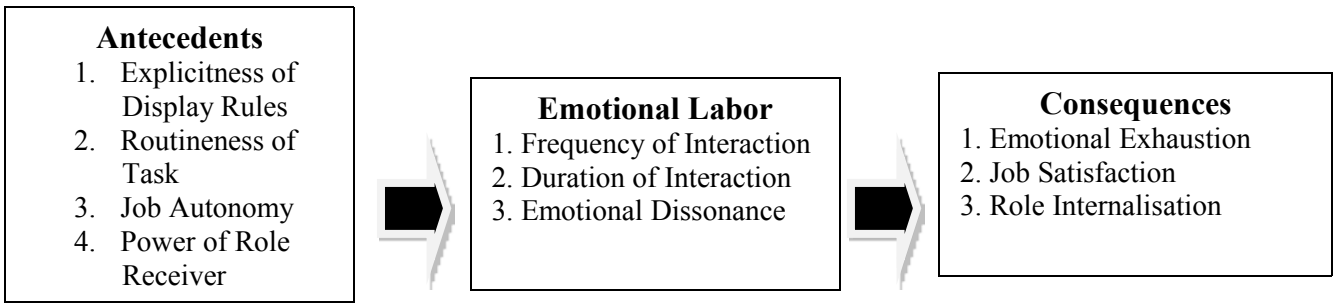


1.1.3. Morris and Feldman's interactionist model

Following Ashforth and Humphrey (1993), Morris and Feldman published their theory of emotional labor in 1996. According to Morris and Feldman (1996), emotional labor was "the effort, planning, and control needed to express organizationally desired emotion during interpersonal transactions" (p. 987). Morris and Feldman argued that emotional labor was multi-faceted and was based on an interactionist model of emotion. According to these researchers, the majority of the previous research done on emotional labor used frequency as the only measure of emotional labor. Frequency in this context merely means a count of how frequently the appropriate emotional displays are exhibited during interactions between the service providers and the clients. While Morris and Feldman acknowledged that frequency is an important indicator and dimension of emotional labor, they did not feel that frequency alone captured the planning, control or skill need to regulate and display emotions. The Morris and Feldman work is viewed as a theory that is focused on the expressive behavior rather than the management of emotions. As such, this theory does not specifically address surface or deep acting, although they did acknowledge the utility of both surface and deep acting as way ways in which people could manage their emotions. Instead, these researchers believed that the main focus should be appropriate expressive behavior because that is what organizations desire. How the employees manage their emotions so that they can produce the desired emotional display was of little consequence in this theory. Therefore, Morris and Feldman posited three additional dimensions of emotional labor: attentiveness to required display rules, variety, and emotional dissonance. This final component, according to Morris and Feldman, reflects the conflict between actual felt emotion and displayed emotion. Adding emotional dissonance as a component of emotional labor was a shift in the literature according to Morris and Feldman because up until that time emotional dissonance had been viewed as a consequence of emotional labor. "…In previous examinations of emotional dissonance researchers typically have considered dissonance as a consequence of emotional labor (Adelmann, 1989): however, emotional dissonance should be considered a dimension of the emotional labor construct…" (Morris & Feldeman, 1996, p.992) Morris and Feldman argued that emotional dissonance should be considered a dimension of emotional labor because it is the mismatch between felt and displayed emotion that requires greater control, effort and skill for people to display the required emotion thus resulting in greater emotional

labor. "… the act of presenting desired emotions during interpersonal transactions becomes much more demanding when requires greater skill to control true feelings. Thus it is much more "labor" for a nurse to display emotional neutrality when long term patients whom he or she likes is dying. When mismatches between genuinely felt and organizationally required emotions exist, greater control skill and attentive action will be needed" (Morris & Feldman, 1996, p.992). This conceptualization of emotional dissonance as a separate component of emotional labor plays an important role in our doctoral dissertation as it will be underscored in the next chapter. The benefit that Morris and Feldman model brought was to provide a model of emotional labor that depicts emotional labor as a multi-dimensional construct and to provide additional ways to measure emotional labor other than simply measuring frequency of displays. In addition, Morris and Feldman detailed anticipated antecedents and consequences of emotional labor as shown in figure 1.3.

Figure 1.3. Antecedents and Consequences of Emotional Labor (Source; Managing emotions in the workplace. By J. A. Morris and D. C. Feldman (1997). *Journal of Managerial Issues, 9,* page 260).



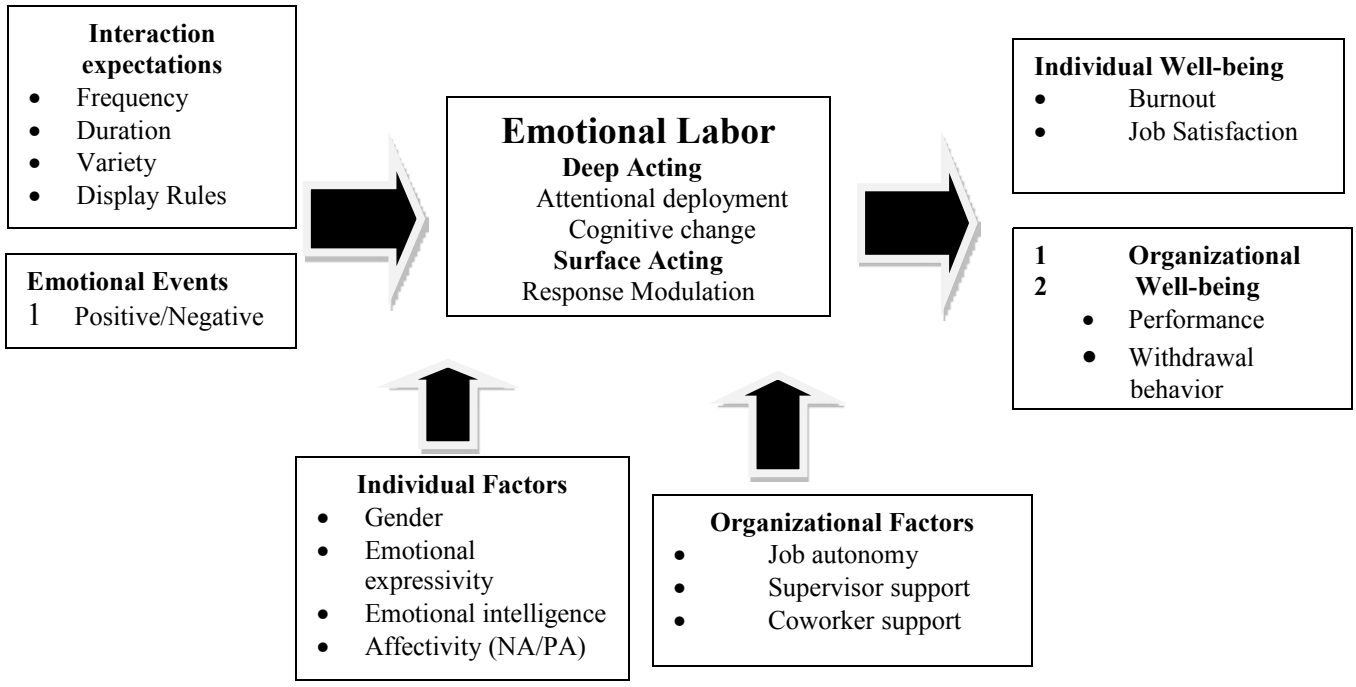
1.1.4. The Grandey's emotional regulation model

Like Hochschild (1983), Grandey (2000) considered both the management of internal processes and outward expression in a definition of emotional labor as "*the process of regulating both feelings and expressions for organizational goals*" (p. 97). Grandey (2000) sought to combine the situational focus of Morris and Feldman (1996) as antecedents of emotional labor, together with the central tenets of surface and deep acting (Ashforth & Humphrey, 1993; Hochschild, 1983) as the emotional labor mechanisms by which the display

rule demands are met (see Figure 1.4). Grandey (2000) appealed to Gross's (1998a; 1998b) theoretical model of antecedent-focused and response-focused emotion regulation.

Gross saw emotional management as being regulated at either one of two points. Antecedent-focused regulation entails anticipating and preparing for the emotionally stimulating event prior to exposure. Conversely, response-focused regulation entails the individual suppressing or modifying their emotional response once the stimulus has been received. Gross (1998) further divided antecedent focused emotion regulation into four categories (situation selection and modification, attentional development and cognitive change). Situation selection and modification involve choosing to approach or avoid certain stimuli; attentive development involves focusing one's attention away from the emotion provoking event by using techniques such as distraction. Cognitive change situation strategies focus on reappraising or reinterpreting situation so as to modify the subjective meaning, thereby altering the emotional impact of the situation on the person. Cognitive change strategy include techniques such as perspective taking. Attentive development and cognitive change are used often on event has occurred but before or full-blown affective reaction (Gross, 1998).

Figure 1.4. The proposed conceptual framework of emotional regulation performed in the workplace setting, NA = negative affect; PA = positive affect. (Source: Emotion regulation in the workplace: A new way to conceptualize emotional labour. By A. A. Grandey (2000), *Journal of Occupational Health Psychology, 5,* page 101).



Grandey (2000) saw Gross's model as being relevant to emotional labor theory, particularly as antecedent-focused regulation is conceptually similar to the notion of deep acting (requiring the modification of feelings before exposure), and response-focused regulation is similar to descriptions of surface acting (requiring the modification of expressions at and after exposure). Importantly, Gross (1998a) found that there was a greater sympathetic nervous system activation associated with response focused regulation as opposed to antecedent focused regulation. Such sympathetic nervous system responses have well-known associations with adverse health consequences (Gross, 1998a), suggesting that surface acting may be a more damaging emotional labor strategy for employees (Grandey, 2000).

Grandey (2000) also saw the emotional labor process as being contingent upon antecedent variables such as the frequency, duration, and variety of interactions. In addition, Grandey argued that the ease of compliance with display rules would be dependent on previous emotional events from work related and personal sources, such as an abusive or critical customer or a sick relative. Grandey suggested that such negative events result in a greater difficulty for a subsequent positive demeanour. As well as antecedent variables, Grandey's (2000) model considers individual and organizational factors as having a direct impact on whether surface or deep acting are utilized as emotional labor strategies. The type of individual factors considered includes gender, emotional expressivity, emotional intelligence, and the affective tendency of the individual. Organizational factors include sources of social support and the level of job autonomy. Overall, the antecedents, whether from personal or organizational sources, have an impact on whether surface or deep acting is used. In situations in which demands are frequent and the preceding emotional events are negative, the employee is likely to be distracted and in a negative emotional state, resulting in a greater propensity for surface acting to be used, particularly when positive emotion is required.

Finally, in line with Gross's (1998a, 1998b) emotional regulation model, Grandey (2000) saw individual outcomes such as burnout and job satisfaction, and organizational outcomes such as performance and withdrawal, closely contingent upon whether surface or deep acting is used as the emotional labour strategy. More stressful individual outcomes for surface acting are expected and Grandey adds to the idea of surface acting generating poorer outcomes by arguing that surface acting is more likely to produce emotional dissonance and to be detected as insincere by clients, resulting in a less effective performance. In a subsequent conceptualization and empirical investigation, Grandey (2003) reorganized the way in which factors were considered. For instance, instead of job satisfaction being an outcome variable,

the level of job satisfaction was viewed as an antecedent and impacted on how much an employee had to act to comply with display rules with those high in job satisfaction being more likely to comply more naturally. In keeping with emotional regulation theory (Gross, 1998a, 1998b), surface acting, but not deep acting, had a strong association with emotional exhaustion (Grandey, 2003).

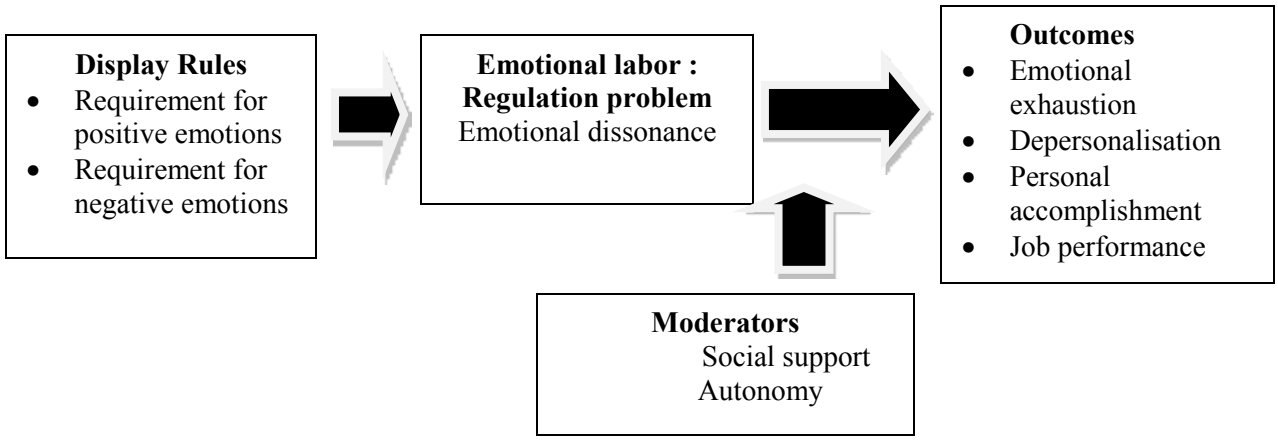
Grandey's (2000, 2003) conceptualization of emotional labor is restricted to methods of actually expressing and constraining emotion, but it also allows for the impact of antecedent variables. The use of Gross (1998a, 1998b) emotional regulation explains the different cognitive mechanisms behind surface and deep acting and why these strategies might have differential consequences. Grandey's perspective can be seen as a reasonably comprehensive conceptualization of how emotional labor is conducted as well as how antecedents, and organizational and individual factors impact on how employees use emotional labor components and their subsequent association with well-being outcomes. Grandey added emotional events as a pre-curser to emotional labor which had not previously been proposed. The possibility that natural emotion can be an emotional labor strategy in the same way as surface and deep acting is missing from Grandey's (2000) model probably because the use of natural emotion as an emotional labor strategy is not as easily explained by Gross's (1998a, 1998b) emotional regulation model. As previously outlined (Ashforth & Humprey, 1993), there is good reason to include natural emotional expression as a means of expressing emotion to meet display rules, and the use of natural emotion can be distinguished from both surface and deep acting. Grandey (2000) also omits Ashforth and Humphrey's (1993) proposed moderators. Given that the inclusion of these factors allow for consideration of the influence of the particular role or profession, this exclusion represents a limitation. However, Grandey's perspective can be seen as a reasonably comprehensive conceptualization of how emotional labor is conducted as well as how antecedents, and organizational and individual factors impact on how employees use emotional labor components and their subsequent association with well-being outcomes.

1.1.5. The Action theory's model

Zapf, Vogt, Seifert, Mertini and Isic (1999) have taken an action theory view of the emotional labor process. The core tenet of action theory is that individuals seek to actively engage in their environment, to have some level of control over their condition and are generally not passive respondents to environmental demands (Frese & Zapf, 1994). Regulation problems

occur when requirements exceed the resources of the individual or if regulation possibilities are limited. For example, emotional dissonance is seen as a regulation problem due to a lack of choice (low control) the individual has in meeting display rules (Zapf et al., 1999). In accordance with action theory, Zapf et al. (1999) conceptualized emotional labor using the following six factors; requirements to display positive emotions, requirements to display negative emotions, variety of emotions, sensitivity requirements (all emotional regulation requirements); interaction control (emotional regulation possibilities); and emotional dissonance (emotional regulation problems). In a further development Zapf (2002) identified the actual emotion work strategies as automatic emotion regulation (similar to natural emotion), deep acting, surface acting, emotional deviance, and sensing emotions. All of these are responses to job requirements to display positive or negative emotions, the level of emotional dissonance and sensitivity requirements. In his inclusion of emotional deviance, Zapf called upon the work of Rafaeli and Sutton (1987) who argued that emotional deviance is the act of displaying emotions which are counter to display rule requirements. Zapf argued that emotional deviance is a response to display rules in which an employee either chooses not to comply or is unable to comply due to emotional exhaustion. Sensing emotions is considered by Zapf as an emotional labor strategy used to guide responses and shape the behavior of the client. Zapf sees the main problem for individuals engaged in emotional labor as emotional dissonance and its relationship with burnout and suggests that autonomy and social support represent control mechanisms that may alleviate regulation problems. Autonomy may not only be achieved by allowing employees greater latitude in expressing emotions as they see fit, but could also be achieved by providing timeouts from situations in which display rules need to be closely observed or where there are largely negative interactions. Emotional dissonance is thought to be moderated by social support and job autonomy. In his earlier studies, Zapf (2002) underscores that emotional dissonance is not always negative for employees, but only under certain conditions. This finding has opened a new arena in studying emotional labor. The detrimental effects of managing emotions can be moderated through personal and organizational resources. Moreover, this perspective seems fundamental in the nursing context. Given reports of a recent nursing shortage (Hogan, Moxham, & Dwyer, 2007), hospitals and other health care organisations have a particular interest in investing in methods of reducing poor individual outcomes in order to attract and retain staff.

Figure 1.5*:* Model based on Zapf's (2002) model of emotional labor



1.1.6. Glomb and Tews's conceptualization

The newest conceptualization of emotional labor was provided by Glomb and Tews in 2004. Glomb and Tews (2004) acknowledged the confusion which abounds in the emotional labor research domain and argued that consensus among researchers has never been reached from either a theoretical or methodological standpoint. Theoretically, Glomb and Tews argued that there are three main themes that guide the emotional labor research. These themes would include internal states, internal processes and external behavioral displays. Morris and Feldman (1996) would represent a theory with an internal state theme, Grandey (2000) would represent a theory with an internal process theme and Ashforth and Humphrey (1993) would represent a behavioral display theme. Glomb and Tews argued that the emotional labor domain could appear to be in a "theoretical quandary, flooded with a multitude of conceptualizations" (p. 4). However these authors also posited that researchers need to recognize the complexity of emotions in the workplace and view emotional labor as a network of related constructs. To illustrate how the different themes may, in fact, be complimentary, Glomb and Tews used the example of display rules motivating an employee to experience emotional dissonance (internal state), requiring the employee to use surface or deep acting (internal process), resulting in an organizational emotional display (behavior display). The

Glomb and Tews conceptualization of emotional labor focuses largely on the behavioral expression and non-expression of felt or unfelt emotions as they respond to display rules. Utilizing the framework provided by Glomb and Tews is helpful in understanding their concept of emotional labor and emotional dissonance's contribution to emotional labor. Possibly the greatest contribution that these researchers made to further the understanding of emotional labor was when they stated, "the theoretical orientation a researcher adopts will depend on the research question" (Glomb & Tews, 2004 p. 4). Their study was designed to examine whether personality characteristics would serve to lessen the incongruence between actual felt emotions versus displayed emotion. From a theoretical standpoint, this incongruence would be defined as emotional dissonance, which Glomb and Tews measured by capturing both suppressed and faked emotions. Further their research was designed to determine if lower emotional dissonance led to increased job satisfaction.

1.1.7. Summary on theoretical perspectives

The concept of emotional labor originated with Hochschild (1983) who defines emotional labor as "the management of feelings to create a publicly observable facial and bodily display; emotional labor is sold for wage and therefore exchange value" (p.7). Since then, researchers have attempted to conceptualized and develop this construct, in order to provide fundamental understanding of how emotions are regulated and managed in response to display rules so that work goals can be achieved. Further empirical development ensued as researchers began using quantitative approaches to explore the dimensions of emotional labor and its impact on employees' well-being and organizational performance (Wharton, 1993, Grandey, 2000, Liu et al. 2004). Debate continues regarding the conceptualization and different theoretical approaches to emotional labor (Brotheridge & Grandey, 2002) and there is disagreement over its operationalization (Bono & Vey, 2005). However a general distinction still exists between conceptualization and defining emotional labor because researchers have used the different theoretical approaches of a job-focused or an employee-focused approach (Brotheridge & Grandey, 2002, Chu et al. 2011). The job focused approach emphasizes the presence of emotional labor in one's job and focus on the nature of emotional display rules and emotional dissonance (Morris & Feldeman, 1996, Zapf, 2002). Conversely the employee-focused approach examines the internal emotion managements processes (such for example deep acting or surface acting) of employees who are expected to perform proper emotional display (Grandey, 2002). More recently researchers argue that emotional labor studies should take

into account individual differences when explaining the variation in emotional labor (Diefendorff et al., 2005, Zapf & Holz, 2006). In other words job's emotional demands do not necessarily have the same effects on all employees. Individual traits and personalities should explain the variation in emotional labor consequences (Chu et al., 2011). There are inconsistencies in understanding the role of individual differences variables in moderating emotional labor's consequences. Moreover, yet to date few studies have tested how organizational resources may lessen the impact of emotional labor on employees (Zapf, 2002).

1.2. Emotional labor in nurse – patient interactions

Emotional labor is a significant component of jobs that need either face to face or voice to voice interactions with clients. This refers to service sector and in particular to the helping professions as nursing. The current research is focused on the investigation of distinct health care groups as means of adding to the understanding of emotional labor. However, some authors have questioned whether mainstream emotional labor theories are applicable to nursing (de Raeve, 2002; Mann, 2005) has suggested that the specific interaction requirements of health care employees require a separate model of emotional labor. However, the previous wide applicability and relevance of emotional labor theories to many occupational situations, including health care, suggest that these arguments are still to be tested. For example, While de Raeve (2002) argues that Hochschild (1979, 1983) emotional labor concepts of deep and surface acting cannot be applicable to nursing, as acting or non-genuine emotional expression would violate the trust required in the nurse-patient relationship, this view is not supported empirically. For example, Bolton (2000b) and Garel, Etienne, Blondel and Dommergues (2007) provide clear evidence of surface acting in their descriptions of how nurses covered feelings of abhorrence and grief when faced with foetal abnormalities and deaths. In terms of deep acting, research has also demonstrated that surgical nurses coped with stressful and distressing events by taking on a work persona in which certain personal characteristics, such as a calm demeanour, ware cultivated more diligently than in the non-work persona (Lewis, 2005; Mackintosh, 2007). Importantly, this was seen as subjectively protective in that nurses spoke of the work persona as shielding them from becoming too emotionally involved with distressing events such as a patient death.

Even though the repudiation of surface and deep acting in nursing can be challenged, many emotional labor studies that have examined nursing have spoken of emotional labor, either

without any reference to, or only an occasional mention of, surface or deep acting, emotional dissonance, display rules, or other terms commonly associated with emotional labor theory (Dent et al., 1991; Henderson, 2001; Lewis, 2005; Li, 2005; Skilbeck & Payne, 2003). Consideration of these emotional labor components and associated factors has been identified as being extremely important in terms of their associations with well-being outcomes (Grandey, 2000). Therefore, their neglect as considerations in situations in an occupation with such a central focus on relationships with patients represents a substantial and important gap in emotional labor research.

A second argument for a specialized model of emotional labor in health care context, is proposed by Mann (2005), based on the notion that the relationships between health care providers and clients (typified by nursing as the caring profession) represent deeper and markedly different interactions than those seen elsewhere. Nurses might consider emotion work as a central part of their work to interact with their patients and deal with both pleasant and unpleasant emotions. Working as a nurse brings out many emotions. The most common are: Anger, Frustration, Helplessness, Hopelessness and Sadness. Anger could be directed at a colleague who did something inappropriate or didn't do something he/she should have. Frustration could be towards a patient who is demanding or doesn't seem to try to help himself get better. Helplessness and hopelessness could rise up when a patient isn't getting any better and nurses feel like he/she should be able to do something else, but he/she can't. Sadness could rise from losing a patient or realizing that there is nothing more one can do. In these events nurses are demanded not only to suppress this kind of emotions, but also are requested to express another one, for example neutrality. A situation high in sensitivity requirements may be demanding not only for negative emotions. Nurses also witness small miracles and see positive outcomes as well. Nurses feel happy when patients improve and go home and satisfied when patients have a good compliance to treatments. In this case nurses are asked to know how to express and communicate this kind of feelings in order to motivate and support their patients. Emotional labor can be finally considered as a central part in nurses competence. Gray (2008) presents a qualitative study where semi-structured interviews are collected in order to explore the role of nurse-patient interaction in emotion work. All nurses in this study focus on emotional labor as the effort to give the patient the feeling of “being safe and warm”. Nurse’s role and aim is identified in making patients feel “safe”, “comfortable” and “at home”.“.. I feel (an interviewed nurse) that emotion work is the way that nurses look after people so they feel comfortable and their relatives feel that they are safe. A part of nursing is *to show you care of them,* even if you’re having a terrible day and are fed

up with everyone else. You have to give patients the extra support they need…*You have to get in contact with your emotions and how patients feel*" (Gray, 2008, p.170). A nurse said in another interview: "It's just sitting with the patient and feeling there is a link. I'll just sit on the corner of their bed and take their hand so they feel a little better… I try to do that each day that I'm on duty with less independent patients…Nurses sometimes don't see *how important is just show you care*…It's not something that everyone can immediately see, so a *lot of feelings and work you do with patients just goes unnoticed.* You cannot put feelings of intimacy in the patients' notes or record…" (Gray, 2008, p.171). It merges nurses feel to be strong required to be in emotional involved with patients; to support them and make them feel at ease. These expectations are shaped by patients, organizations and conventional images of nursing (Byrne, 2003) and that is what authors refer to *feeling rules* (Diefendorff & Richard, 2003, see below). Nurse-patient interaction with emotional implication is seen as almost invisible bond, which is not recognized and valued (Savage, 1995). Many authors underline that this miss-understanding of emotional work importance may contribute to the recent nurses' crisis (Mann, 2005) and claim that investigate the role played by emotions in the nursing context could contribute to recognise them as essential in the nurses' workload. Emotions in person-related works are express in order to influence others' attitudes and behaviors, usually by influencing their moods or emotions (Zapf, 2002). A nurse may talk in a soft and calming way in order to reassure a very anxious patient or can be severe and assertive with a diabetic patient who can't moderate his/ her binge eating. The idea that emotion work tends to influence others is the central part of emotion work of Strauss (1980) and Brucks (1998). Strauss and his colleagues presented their qualitatively studies on nurses in hospitals. They categorized as primary task the treatment of patients (injections, blood transfusions, blood pressure monitoring...). Some of these treatments can cause fear or even panic in patients. Therefore, emotion work has to be done in order to change patients' emotions, attitudes and behaviors to a desired direction. Authors differentiate several forms of emotion work. Low forms of emotion work occur if it's constrained to gesture and remarks. More intensive forms occur if a treatment is hurting or in case of mourning work (Strauss, 1980). Based on this observations emotion labor sometimes is necessary to carry out medical treatments. Locke (1996), observing child nurses, noticed they're often confronted with desperate children and their relatives. In this case they use "comedic performance" to actively change children and their parents' negative feelings. Locked (1996) observed a nurse who has to medicate a little girl's abdomen wound. He starts joking, touches her and says: "Is your breakfast there?". By trying to "find your breakfast", he hides his primary task of medicating

the wound. Emotion work facilitates nurses' medical actions by influencing patients' emotions and feelings in order to obtain more compliance to the treatment. To be able to manage the patients' emotions, the accurate perception of their emotions is an important prerequisite. This is in accord with communication psychology (Riggio, 1986) and the literature on empathy (Hojat, 2006). Based on these work, Zapf et al; (1999) developed a scale of "sensitivity requirements", which is positively correlated with emotion expression requirements because the expression of an emotion during an interaction, usually depends on the emotion of the interaction partner. In the nursing context the "sensitivity requirements" may be represented by empathetic attitudes. In order to perform emotion work and to recognize patients' emotions, nurses are requested to be empathetic. The importance of empathy and is links with health care will be discussed in chapter 3.

1.3. Nurses Emotional Labor and Display Rules

In 1959, Goffman indicates that people respect several rules in every social interactions (Goffman, 1959). More recently Ekman called the appropriate emotional expression is regulated by display rules (Ekman, 1973). These are norms of behavior which indicate the most appropriate emotions to show in a given situation and also how these emotions should be publicly expressed. Emotion control for organizational purposes has been referred to as *display rules* (Ekman & Friesen, 1975; Rafaeli & Sutton, 1989; Wharton, 1993), which remove emotional autonomy from the employee. These display rules refer to the degree to which showing and hiding emotions is seen as an expected part of employees performance (Wharton & Erickson, 1995). Hochschild named these norms "feeling rules" because in her theoretical frame the focus is on the management of inner feelings (Hochschild, 1983). Ashfort and Humprey (1993) introduce display rules in order to refer to the organizational rules about what kind of emotion to express on the job and to underscore the importance of the outer expression. In the organizational studies the expression "display rules" are used at most. Most part of European companies do not have explicit display rules as a part of organizational culture or as a part of job descriptions. They may be hidden in metaphors built up by organizational culture and values (Zapf, 2002). Metaphors, such as "family", "team" usually contain strong implicit messages of how to feel and what emotions are requested (Briner, 1999). Most examples of explicit display rules come from U.S.: Delta Airlines, McDonald's, Disney (van Maanen & Kunda, 1989, Leidner, 1993). Display rules are,

however, incorporated in the mission statements of several companies. In the helping profession, health care structures do not have normally explicit norms of how to behave in interactions with patients, but implicit emotional display rules exist through goals and performance expectations. A recent qualitative research (Brown, 2011) shows that there was a lack of organizationally defined display rules, especially for nursing participants. The general notion to remain calm and not be drawn into volatile interactions with patients seemed to be in widely shared yet fairly vague agreement. In terms of a pre-existing requirement to display or constrain specific emotions, most participants expressed the belief that the constraint of anger was most important. The lack of a clear pre-existing display rules, leads to the conclusion that knowledge about what was appropriate or inappropriate was most determined by social or professional norms (Ashforth & Humphrey, 1993), which would assumedly be largely determined by the social identity of nurses (Smith, 1992). Ekman and Friesen (1975) pointed out that display rules varied as a function of occupational requirements. For example nurses are socialized to express compassion, caring and empathy (Hinds, Quargneti, Hickey, & Magnum, 1994) and at the same time they are encouraged to develop a level of professional detachment (Savett, 2000) In nursing, in addition to organizational policies of how to behave with patients, there also exist very clear societal norms and expectations how the professionals should behave. Be gentle with a patient could improve his/her compliance to treatments, reassuring an anxious patient may reduce the risk of pain prone complications These expectations may be implicity or explicity taught in one's education and become part of one's professional ethos (Rafaeli & Sutton, 1987). At first the *frequency* of such emotional display has been mostly investigated in organizational study, in order to test the original idea of Hochschild (1983), who claims frequent emotional displays would overtax employees and lead them to alienation and exhaustion. Rafaeli and Sutton (1989) introduced the *duration* of interaction related to the scriptedness[2] of interaction. If an interaction is very short, is likely to be strongly scripted. A person controlling tickets in a theatre, for example, may only to be gentle. Morris and Feldman (1996) suggested the effort involved in these short interactions is lower than in interactions of longer periods of time. In longer interactions more intense emotions have to be displayed too an this process is less scripted. A nurse, for example, are requested to be gentle and ready to response to patients' needs. It's very likely that such a behavior is not always considered as adequate. For example to certain patients (drugs addicts, borderline patients...) nurses have to act firmly and to set a limit. Therefore a nurse at first

[2] Scripts are cognitive schemata available in the long term memory that include information to control routine behavior (Schank, Abelson, 1977) Cognitive scripts" is the term used for the themes that flow habitually through thoughts. These cognitive scripts can influence both emotions and behavior (Neisser, 1967).

would probably try to understand the emotional situation of patients and then try to suppress certain feelings and express other ones, in order to show to take care of them. In this case emotion work is more effortful because it cannot be based on scripts (Zapf, 2002). Higher involvement in the interactions may be also effortful because is likely strong personal feelings are more difficult to suppress (Cordes & Dougherty, 1993). That's what Morris and Feldman (1996) call *intensity* of emotional display. They refer to how strongly an emotion has to be expressed. It's argued displaying intense emotions is more effortful, especially in case of a opposite inner feeling. For example is difficult for a nurse inspire a patient with hope to if he/she knows the patient has an incurable disease. A further dimension of Morris and Feldam's (1996) emotional display's classification is the *variety* of emotions required to be expressed. The authors suggest emotion work is higher when a higher variety of emotions has to be displayed. Nursing is the prototypical work where a variety of emotion is requested. In the same situation (injections), to different patients (children, scared patients, impolite patients...) a nurse has to show different emotions and feelings. According to Morris and Feldman (1996) intensity, duration and variety are the three dimensions of the emotional display. The link between organizational control of emotional displays and stress has received mixed support in both qualitative (Leidner, 1999; Tolich, 1993) and quantitative research. In one study, the requirement to hide negative emotions was positively associated with burnout (Best, Downey, & Jones, 1997). Similarly, the perceived requirement to express positive emotions and hide negative emotions was related positively to physical symptoms for employees in one organization (Schaubroeck & Jones, 2000). A study with hospital employees found that the requirement to be friendly was unrelated to feelings about work (Bulan et al., 1997). Wharton (1993) found a positive relation between display rules and job satisfaction; the same result was reported by Grandey (1998). In order to better understand the impact of emotional display rules, the focus has recently shifted from the nature of display rule to the employees' *perceptions* of with such emotion display (Brotheridge & Lee, 1998; Zapf, 1999). The perception of display rules is a complex, multifaceted task. For example Morris and Feldman (1997) found that *explicitness* of display rules was negatively correlated to the frequency of emotional labor. In contrast, Hochschild (1983) reported that explicit display rules heavily impacted workload. These differences are most likely due to the discrepancies in conceptualizations of display rules. The perceived requirement to display particular emotion has been directly linked to well-being outcomes. For example, Schaubroeck and Jones (2000) differentiated between the requirement to express positive and negative emotion, finding that when positive emotions were required, job satisfaction was

higher compared to when negative emotions were required. However, demands to express positive emotion were related to health symptoms (sleep disturbances, time away from work due to illness) if employees had a low job involvement or did not identify with their role. The notion of professional or occupational display rules may have particular resonance within the health sector, particularly amongst health care professionals. In the helping profession, health care structures do not have normally explicit norms of how to behave in interactions with patients, but implicit emotional display rules exist through goals and performance expectations. In nursing, in addition to organizational policies of how to behave with patients, there also exist very clear societal norms and expectations how the professionals should behave. For example, there is evidence of a clear delineation in the emotional expression expectations between nurses and doctors (Griffin, 2003; Timmons & Tanner, 2005), and nursing carries with it the expectation of a certain level of emotional involvement with clients (Smith, 1992). There are several professionally derived, overarching standards for behavior and guidelines for how interactions between nurses and patients should be managed. For example, in Australia, two of these are codes of ethics (Australian Nursing and Midwifery Council, 2008a), and professional conduct (Australian Nursing and Midwifery Council, 2008b). The code of ethics for Australian nurses highlights the vulnerability of patients and the subsequent requirement by nursing staff to recognize and manage the power differential that this vulnerability creates. The code of professional conduct for nurses explicitly forbids close personal relationships between nurses and patients or their family members. Each place the responsibility for ensuring boundaries that are maintained on nurses. While these guidelines do not specifically prescribe the exact manner in which emotions should be displayed or withheld, they do provide general parameters for behavior, which may affect the way in which emotions are expressed. In addition to the above codes, there exists a state government policy with jurisdiction over all health sector employees. The policy and guidelines for the prevention of workplace aggression and violence sets out the rights of health sector employees to be free from aggression and violence in the workplace (Department of Health Western Australia, 2004). This policy applies to all incidences of aggression and violence in all health sector occupations, and therefore covers all employees participating in the current research. Importantly, the policy states that there is a zero tolerance of abusive and violent behavior from clients towards employees, which may have ramifications for how employees respond to abusive behavior from clients and how they manage emotion as a result.

Highly explicit display rules would exacerbate the importance of sanctioned emotional expression and create a larger spread between required and felt emotion. Thus, the more explicit and normative the display rules are, the greater is the possible perceived dissonance. Employees may perceive emotional display as norms, which serve to regulate the type of sanctioned expression in a given situation as well as the degree to which it is expressed (Rubin et al., 2005). Employees may feel to be « on stage » in the sense that these display rules require employees to become actors (Grandey, 2001), acting out organizationally *prescribed emotions*, that may not be congruent with their own personal emotions. Organizational expectations to manage emotions may more deleterious than the performance of emotional labor itself (Ashfort & Humprey, 1993). According to the action theory, prescribed emotional display rules lessen emotion work control and autonomy (Zapf, 1999). Prescribed norms are likely to be shaped top-down and include expectations of organizations and managers (Pescosolido, 2002). However, display rules may be not perceived only as prescribed emotional expressivity, but also as *emotional guidelines* that are culture specific to be unified socially and in a conforming consensus to organizational norms. According to the emotional labor literature, display rules shape employees emotional displays in ways that may facilitate the attainment of organizational goals. However, empirical studies have yet to examine whether employees actually share display rule beliefs and what effect these share rule beliefs might have on emotional labor processes. More recently, Diefendorff and colleagues have developed the idea that display rules are, in part, shared norms derived from unit or group level characteristics and assessed whether display rules exhibit shared properties. For example nurses of the same unit will could adopt similar display rules. For example child nurses may view the expression of sympathy and caring as the only "professional" way to act (Lewis, 2005). Shared emotions may be shaped by bottom-up processes (Kozlowski & Klein, 2000). There is consensus that each individual has his/her own belief about what emotional expressions are most appropriate in a given situation (Dieferdoff & Greguras, 2009), opening the possibility that the personal display rules may influence other members' beliefs and become shared through patterns of social interaction, role modelling and advice giving (Kozlowiski & Klein, 2000). In this sense, shared display rules are proposed to relate to nurses well-being (Diefendorff, Erickson, Dahling, & Grandey, 2011). In particular shared display rules interact with individual level affectivity to predict employee use of emotion regulation strategies and can provide the motivation to express a genuine sense of caring (Goldberg & Grandey, 2007). The social identity model (Dawes, 1980) underscores that only beliefs that are perceived to be shared by a relevant group will

affect action and behavior (Cancian 1975). If people are motivated to conform by their desire to acquire or maintain a given social identity, it follows that they are not committed to any given norm, but to the identity that a norm supports. For example, a person who cares about that particular role will then act in conformity to the group's expectations because he/she she wants the group to validate her identity (Hirschman 1982). Conformity to a norm does not involve internalization of that norm. In sciences such as psychology and sociology, internalization is the process of acceptance of a set of norms established by people or groups which are influential to the individual. The process starts with learning what the norms are and then the individual goes through a process of understanding why they are of value or why they make sense, until finally they accept the norm as their own viewpoint (Meissner, 1981). Internalization concerns individual-level display rules (Diefendorff, 2011) and affects how effectively employees perform emotional labor (Grandey, 2003, Totterdell & Holman, 2003). There is some evidence that nurse may perceive accordance between their feelings about work and display rules. For example a nurse may perceive a patient is very anxious about a forthcoming operation and engages in a reassuring conversation. In this case the nurse's supportive attitude complies and matches with emotional display rules. In this case display rules have been internalized as a part and parcel of the role and can foster satisfying experiences at work (Salmela & Mayer, 2009). An investigation of different aspects of display rules and their role in emotional labor process will be examined in the third study of our empirical research.

1.4. Nurses and Surface Acting

Most emotion researchers claim that emotions have several subsystems (Scherer, 1997): subjective feelings, psysiological reaction patterns and expressive behaviours (facial expressions, gestures, mimic...) In according to these concepts, surface acting is the act of displaying emotions that are not felt (Pugh, 2011). Surface acting is a response – focused form of emotion regulation that is applied when the emotion is already developed. It doesn't concern an adjustment of one's actual feeling, but refers to the handling with the emotional expression. Employees performing surface acting put on a mask. They adjust the emotional response by suppressing, amplifying or faking emotions. In consequence the emotional experience remains discordant (Gross, 1998; Bono & Vey, 2005). Whereas deep acting (see 1.5) involves a modification in felt emotions, regulating emotional displays through surface

acting, means that employees try to manage only the "visible aspects" of emotions. Surface acting may sometimes be a problematic strategy, because often more is expected than "superficial" emotions (Zapf, 2002). According to Thompson classification (1984), surface acting may be considered a maladaptive coping strategy of the emotion regulation process which involves inhibitory mechanisms and it is widely automatic. Employees produce surface acting in interactions with patients/clients and they aim to be in line with the organizational display rules, while the inner feelings remain unchanged. For example parents know that a child nurse works for money, but they wish and expect that nurse really takes care of their child. This implies mechanical conformity with display rules is not enough (Ashfort & Humprey, 1993). In hardly standardized situations it could be easy to fake an emotion, but in less standardized ones, there is the risk that the true feeling may lurk through and may be recognized by other people. For example true and false smiles innervate different muscles (Ekman, 1982) and the false smile does not activate the muscle groups in the eye region and the resulted facial expression is more asymmetric and follows a different time course (Gross & Levenson, 1993). Surface acting is widely considered the more detrimental emotional labor strategy and has been linked to negative outcomes, including lower job satisfaction, higher levels of burn out and stress, intentions to quit (Mann & Cowburn, 2005; Hulsheger & Schewe2011; Gursoy, 2011). These negative outcomes are linked to the detrimental effects of surface acting as stemming from alienation and/or estrangement from true feelings (Morris & Feldman, 1997). Hiding feelings of truth, harms employees well-being because it reminds their lack of control over their own emotion (Erickson & Ritter, 2011) Simpson and Stroh (2004) argued surface acting by displaying unfelt emotions contradicts "a social identity linked to forthright and open communication of emotional states " (p.717). The common assumption is that employees have a meta cognitive awareness of the discrepancy between felt and expressed emotions and are distressed by this discrepancy, this dissonance, which can be considered the first and most significant antecedent of surface acting (Zapf, 2002).

1.5. Nurses and Deep acting

In contrast to surface acting, when people engage deep acting do no experience discrepancy between felt and displayed emotions. When use deep acting, the employees' sense of authenticity is not compromised (Rubin, 2005). Deep acting is an antecedent focused form of emotion regulation that affects the perception and the processing of emotional cues at the

onset of an emotion (Gross, 1998). This strategy elicits behavioral, experiential or physiological response tendencies. Deep acting occurs before an emotion develops and it aims to change the situation or its perception (Grandey, 2000). In this case not only the expressive behavior, but also the inner feelings are regulated. When engaging in deep acting individuals try to align required and true feelings. To reach this goal, they can direct attention toward pleasure thoughts and/or invoke images or memory to invoke a certain emotion (Ashforth & Humprey, 1993). In contrast to surface acting, which drains mental resources and diminishes well-being (Zyphur, 2007), deep acting requires less cognitive resources (Totterdell & Holman, 2003). Building on Gross and colleagues' research on the cognitive costs of suppression and reappraisal (Gross, 1998, Richards & Gross, 2000), deep acting has been described similar to reappraisal and this process diminishes mental resources only at the onset of emotion. It has consequently been argued that the amount of cognitive (attention, concentration...) and motivational (resilience, drive...) resources invested are lower for deep acting than for surface acting (Sideman, Goldberg, & Grandey, 2007). Not only is deep acting less effortful than surface acting, but also less dangerous for employees' well-being. Furthermore deep acting helps create rewarding social interaction with clients/patients. In contrast to surface acting, deep acting, in fact, yields authentic emotional displays which should facilitate social interactions and benefit performance (Zyphur, 2007). Displaying authentic emotions helps employees to convey important social information to clients/patients and to influence their behaviour and attitudes (Van Kleef, 2009). Researchers has shown that deep acting elicits favourable reactions from customers/patients, contributes to establish a strong relationship and favours positive evaluations (Hennig & Thurau, 2006) This mechanism contributes in building up restoring resources (Martinez-Inigo, 2003, Hulsheger, Lang, & Maier, 2010) which play a role a virtuous circle, created and maintained by deep acting. In the nursing context the deep acting's regulation strategy requires a certain level of empathy (Diefendorff, 2005, Cossette, 2008). " when individual possess a high level of empathic concern, they utilize genuine acting to perform emotional labor Even when a simultaneous genuine response is difficult to achieve, individual with high empathic concern use deep acting to generate emotions and responses appropriate to the situation..." (Chu et al., 2011). In fact, in order to induce metaphors or images of the patient, nurses have to use the empathic perspective taking: the capacity of taking into account others' thoughts and feelings. For example a nurse may use a metaphor of thinking of a difficult patient as a child, who is probably scared and for that, not responsible for his/her behaviour (Hochschild, 1983). Empathic nurses are more likely to be emotionally responsive and to adapt their felt and/or

expressed emotions to those of the patients In the helping professions, as nursing, not only play organizational display rules a role in prescribing emotions to express, but there also exist very clear societal norms and expectations how the professionals should behave. Nurses are expected not only to *cure*, but also to take *care* about the patients and to do so empathic involvements are necessary (Boyle, 2005). Only if a nurse recognize patients' emotions and expectations, might answer to them and fulfil his/her task. This mechanism elicits emotions that are actually felt and functions also as a protective factor to emotional exhaustion. For example, a very scared and anxious patient may be reassured by using firmness and professionalism. In this case the empathic response works to temporarily suspend emotional attachment to the patient as human being and to prevent contagion to his/her emotions (Hojat, 2007). Deep acting or the attempt to actually feel the required emotion (Hochschild, 1983) was described as the accordance with the greater level of emotional engagement with patients. This aspect of how nurses elicited the required demeanour prior to their interactions with patients was prominent when these nurses commented on what can be identified as deep acting. In a qualitative research (Brown, 2011) where interviews are collected, a nurse explained how she had to steel herself for a particularly taxing situation prior to each interaction in order to ensure a calm demeanour; "*Yeah, I had parked the car and I have to take a deep breath because it was hard going, because you are not only ministering to the dying girl but you are also ministering to the mother and it is really hard*." The following comment showed how this nurse had to be very careful to ensure she was in the right emotional space to broach issues surrounding death. This highlights the importance of empathy to perform deep acting, as well as the centrality of emotional engagement with patients as being extremely important. Grandey (2000) has explained that deep acting contains an important preparatory element to assure the right emotional distance. The most prominent aspect of the instances of deep acting was that preparation was key to ensuring that the employees involved were in the appropriate emotional space. The ability to be able to get "into the role" of care giver, recognize and differentiate personal feelings and patients' emotions has been found to work as a protective mechanism for nurses (Mackintosh, 2007). If nurses are able to use their judgment to control interactions with patients and use what they feel in a controlled and purposeful manner, it is clear that well-being need not suffer and may even benefit. The findings of the relationships between deep acting well-being has been found to be neutral (Bono & Vey, 2007; Brotheridge & Lee, 2003; Gross, 1998a; Martínez-Iñigo et al., 2007; Näring et al., 2006; Totterdell & Holman, 2003; Zammuner & Galli, 2005) or positive well-being associations (Yang & Chang, 2007; Zhang & Zhu, 2008)

Although there are positive correlations between empathy and deep acting (Zammuner & Galli, 2005), the two constructs must be differentiated. In the nursing context deep acting is a process to regulate emotions which promote patients and nurses well-being and satisfaction (Fleesion, Malanos, & Achille, 2002). Clinical empathy is an emotional states, which can be considered as a useful emotional resource for nurses (Alligood, 2005), because helps in emotional transactions with patients and prevents emotional exhaustion (Hojat, 2007). This phd dissertations focuses on empathy. The concept of clinical empathy and the corresponding theoretical frame will be discussed in the third chapter of this volume.

Conclusion

Nursing is a hard emotion-charged work, where nurses and their patients engage in a complex dance of emotional nuance. In this environment regulation of emotion takes a specific meaning: "full emotional labor involves *working with feelings*, rather than denying them (Finemann, 2008, p.95). This work is an integral part of nursing workload, that may have positive or negative implications. In this doctoral dissertation we refer to job focused approach to emotional labor. In particular we consider emotional dissonance as the problematic core of emotional labor concept (see chapter 2). We aim to verify the role of emotional dissonance on different indices of well-being, the link with emotional display rules and the influence of some individual variables and organizational resources. We aim to show that handling with emotional labor represents a challenge, which, under certain conditions, nurses may successfully win . A "sufficient good" management of emotion may lead to satisfying experiences, including sense of achievement (Wong & Wang, 2009). Meyerson (2008) talks about "honoured" emotions. Honouring emotions may be a legitimate alternative ways of thinking and acting, which may lead to authenticity of emotions. By incorporating the job focused approach (considering emotional dissonance as the core of emotional labor) with individual variables (such for example empathy, see chapter 3) and organizational resources (i.e emotional support, see chapter 8), this doctoral study aims to provide better understanding of emotional labor constructs and aid in the development of emotional labor theory in the nursing context. The central concepts of emotional dissonance and empathy will be discussed in the next chapters.

CHAPTER 2

EMOTIONAL DISSONANCE IN THE NURSING CONTEXT

Preamble

Nursing is among the prototypical type of helping profession to perform emotional dissonance. According to Hochschild's (1983) classification, in fact, a significant element of nursing work load, is the high emotional labor spent in relationship with patients (Mann, 2005). Nurses are required to express or suppress feelings that produce an appropriate state of mind, according to organizational *feeling rules* (Ashforth & Humphrey 1993). In nursing, in addition to organizational policies of how to behave with patients, there also exist very clear societal norms and expectations how the professionals should behave. These expectations may be implicitly or explicitly taught in occupational education and become part of one's professional ethos (Briner, 1999; Rafaeli, 1987). While the expression of these feeling rules is in most cases a spontaneous process of acceptation and effortless cooperation (Zapf, et. al. 2001), some situations call for the stimulation or the suppression of emotions that may be in conflict with truly felt emotions. This gap between felt and expressed emotions has been referred to as emotional dissonance, which may be considered the central core of emotion labor. (Zapf, Seifert, Schmutte, Mertini, & Holz, 2001).

2.1. Introduction and Rationale for the Research

Emotional dissonance occurs when an employee is required to express emotions which are not personally felt in a particular situation (Hochschild, 1983). Most studies of emotion work include the concept of emotional dissonance (Zapf, 1999, Mertini & Holz, 2001, Martinez, 2008). However its status is seen differently and researchers have used different and often ambiguous conceptualisations of the concept (Van Dijk & Kirk, 2006). Early work on emotional labor described emotional dissonance as the discrepancy between felt and expressed emotions in order to satisfy organizational rules (Rafaeli & Sutton, 1987). In this case emotional dissonance involves three aspects: prescribed emotions, expressed emotions

and felt emotions (Zerbe, 2000). Studies have considered different combinations of the three aspects to conceptualize and measure emotional dissonance. Some researchers view emotional dissonance as the discrepancy between required and felt emotions (Zapf & Holz, 2006); other ones consider it as the discrepancy between expressed and felt emotions (Coté, 2005). In the first case emotional dissonance has been referred as "emotion-rule dissonance", in the second one, it has been defined as "fake emotion display" (Holmann, 2008). Although there are still different points of view, the majority of research assesses emotional dissonance as emotion-rule dissonance (Dormann & Kaiser, 2002, Hulsheger & Schewe, 2011). This differentiation has important implications for the role ascribed to emotional dissonance in the emotional labor process. Some theoretical models of emotional labor, which use a job-focused approach, define emotion rule dissonance as a separate component of emotional labor and an antecedent of emotional regulation strategies (Chissick & Todderell, 2002). Other theoretical models, the employees-focused approaches to emotional labor, consider emotional dissonance as a result of maladaptive emotional regulation strategies as for example surface acting (Grandey, 2002) Although there are correlations between emotional dissonance and surface acting, the concepts are to be differentiated. Surface acting describes the effortful process of regulating emotion, whereas emotional dissonance is a "state of being". In this doctoral dissertation, emotional dissonance will be focused in terms of emotion-rule dissonance and consider as a separate component of emotional labor, which may influence and may be influenced by some personal and organizational variables (Zapf, 2002). The job-focused approach will be taken into account. Moreover emotional dissonance may be considered a form of person-role conflict (Abraham, 1999) emerging from the incongruence between emotions that are actually felt and emotions that are required by display rules (Brotheridge & Grandey, 2002) and resulting in an unpleasant state of emotional tension, which is characterized by a double bind. Employees can overrule their own values, adhere to organizational display rules[3] and thereby threaten their sense of inauthenticity, or they can hold their professional duties and running the risk of dissatisfying clients and supervisors (LePine, 2005). Emotional dissonance results also from an implicit job demand. There are qualitative differences in social situations which are not sufficiently described by the parameters for display rules and by formal descriptions of emotion work, such as the frequency and duration of emotion work episodes. Display rules describe the desired state of emotion display, but they do not comprise how often individuals are exposed to situations

[3] Emotional display rules are described in detail in chapter one.

where they have to show the required emotion. The positive or negative interaction may influence what people feel and whether this fits the emotion required (Zapf, 2002). Emotional dissonance may be considered as an emotional regulation problem, which is the core of emotional labor (Zapf et al., 1999). Emotional dissonance may be considered as an external demand rather than a reaction to emotion display. Given a certain requirement for frequency and content, it should then depend on the employee and his or her personality to what extent he or she feels in line with the requirement emotions. In this sense emotional dissonance would be a stress reaction. However there are qualitative differences in social situations that are not sufficient described by the concepts of display rules. This is because the notion of display rules describes the required state of emotional display, but it does not comprise anything about how people feel when they are exposed to situation where they have to show required emotions. Display rules do not reflect other factors, namely how useful they are considered by employees during interactions and whether they share and fit the emotion required by the display rules for a particular situation (Doucet, 1998). For example a nurse in a children's hospital shares the same display rules of a nurse in a senior home (Friendliness, kindness...) and also the frequency and duration of interaction may also similar. However the nurse in the senior people's home may encounter situations where spontaneously feels disgust or anger. Consequently the number of situations where the emotional gap appears may differ considerably, although the display rules and the requirements are the same. The discrepancy between what an average person is likely to feel and what the respective display rule is, varies from situation and situation and from person to person. Emotional dissonance has also discussed with reference to the difference between the use value and exchange value of work (Nerdinger, 1994). Hochschild (1983), who coined the term emotional labor, claimed that "emotional labor is sold for a wage and therefore has exchange value" (p.7). However, in several cases the full service requires an interaction as if there were not an economic but a family like interaction. For example parents expect the child nurse really loves and cares their child, not only because he or she is paid for it. Nerdinger (1994) underscored that the social interactions are not only meant to deliver a service, but they are part of the service product. Thus an employee may face contradictory expectations given by the personal interactions with clients and the economic interests of his/her employer. Moreover the requirements of the organization itself may be ambiguous. For example a nurse may be required to show empathy and care but not to waste time with patients. Such contradictory job requirements are thought to be another source of emotional dissonance, which is not yet adequately tested. This matter of fact contributes to the complexity of emotional dissonance, which is far from being totally

understood. Nursing is the prototypical context where this complexity merges. Nurses are confronted not only with organizational emotional display rules, but also with personal values of professionalism, patients' expectations and ethos prescriptions. All of these requirements may lead to emotional regulation problems, but they may be relevant to the concept of personal enhancement (Freese & Zapf, 1994). This means that they may enable individuals to develop skills and further satisfaction and self esteem (Edwards & van Harrison, 1993). This double-bind may be related to the inconsistencies regarding emotional dissonance. For example, although there is general support the discrepancy produced by emotional dissonance is a source of work strain, there are some inconsistencies in these findings (Pugh et al., 2011). The main purpose of this doctoral dissertation is contributing in critically examining the concept of emotional dissonance in the nursing context. We aim to integrate the studies of emotional dissonance as a personal stay, which may be considered the problematic core of emotional influence and be influenced by different variables at different levels.

2.2. Empirical Studies on Emotional Dissonance

Most of researchers have explored the consequences of emotional dissonance. Morris and Feldman (1997) found a significant positive relationship between emotional dissonance and emotional exhaustion. This finding is extremely interesting in that Morris and Feldman also attempted to make a connection between the frequency and duration components of emotional labor to emotional exhaustion and were unable to do so thus implying two things: one, that it is the emotional dissonance component that affects emotional exhaustion and that emotional dissonance is a distinct component of emotional labor with its own unique consequences.

Abraham (1998) also explored consequences of emotional dissonance and found that both job satisfaction and emotional exhaustion were related to emotional dissonance. Job satisfaction was negatively related to emotional dissonance and emotional exhaustion was positively related to emotional dissonance. In addition, job satisfaction's relationship with emotional dissonance was moderated by social support such that those with high levels of social support were less likely than those with low levels of social support to experience the negative effects of emotional dissonance on satisfaction. Abraham extended these findings in 1999 when she confirmed that job satisfaction

mediates the relationship between emotional dissonance and intention to quit as well as emotional dissonance and organizational commitment. According to Abraham (1999), increased emotional dissonance results in decreased job satisfaction, which then leads to both

increased turnover intention and decreased organizational commitment. While validating the emotional labor scale, Brotheridge and Lee (2003) found that emotional exhaustion and depersonalization were significantly correlated with their surface acting subscale. These researchers felt that these findings suggested that the effort to hide one's true feelings or to pretend to feel those that were expressed is the major contributor to emotional strain. More importantly, these researchers confirmed that surface acting is comprised of both suppressing and faking emotions. Using this rationale, then the Johnson (2004) results are relevant in that she found that surface acting was positively and significantly related to emotional exhaustion, and negatively and significantly related to affective well-being and may be considered a possible consequence of emotional dissonance. Overall, it would appear that past research has clearly shown the negative effects of emotional dissonance on job satisfaction and turnover intentions. The relationship between emotional dissonance and job satisfaction is of particular interest, because job satisfaction, or lack thereof, has been found to be linked to job performance. Past meta-analyses have estimated that the correlation between job satisfaction and job performance is in the .20s (Iaffaldano & Muchinsky, 1985; Petty, McGee, & Cavender, 1984). A meta-analysis was also conducted by Mathieu and Zajac (1990) that confirmed the small but positive relationship (r = .13) between organizational commitment and job performance. Individual components of organizational commitment have even stronger positive relationships with job performance (Hackett, Bycio, & Hausdorf, 1994). In all of these cases, job performance was related to variables that have been shown to be strongly affected by emotional dissonance. Currently, the thrust in the emotional dissonance research area is to determine whether individual differences exist in people's ability to handle emotional labor and emotional dissonance (Brotheridge, 2003; Kring, Smith , & Neale, 1994; Tews & Glomb, 2003; Vey & Bono, 2003). The research community has been very vocal about the need to find individuals who are well suited to the emotional requirements of the job. Sutton (1991) stated: "organizations should focus substantial efforts on attracting and selecting candidates who are disposed to feel and display required emotions" (p. 266). Morris and Feldman (1996) stated: "from a selection perspective, selecting employees on the basis of their general tendency to experience certain emotions may lead to a better fit between an employee's expressive behaviors and work role requirements" (p. 1006). Moreover researches have recently focused on organizational environment impacts emotional dissonance (Grandey, 2000). The frequency, variety, intensity, and duration of emotional expression have been considered as antecedents of the emotional labor process in previous research (Brotheridge & Lee, 2003). Studies investigating these four variables have produced mixed results. Closely

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

2.3. Consequences of Emotional Dissonance

The Hochschild's original sociological conceptualization, focused on the detrimental effects of estrangement, has dominated the literature on emotional dissonance which was included in the large arena of burn out[4] (Abraham, 1999; Bakker & Heuven, 2006) and the impact of such

[4] It could be argued that the stress related phenomena known as employee burnout may have initially been identified largely as a result of exactly the type of work now conceptualized as emotional labour. The first concerted efforts to conceptualize and examine burnout were made during the mid-seventies (Freudenberger, 1974, 1975), when employees in free health clinics in the United States were identified as having a syndrome-like cluster of symptoms thought to be a result of multiple sources of long-term stress. Burnout was most prevalent in occupations where the employee-client relationship was of central importance to the role (Maslach, Schaufeli, & Leiter, 2001; Schaufeli & Buunk, 1996). Burnout was used to describe a cluster of symptoms that had an identifiable etiology, therefore the concept of burnout was established via a ground-up process rather than by theory (Maslach & Goldberg, 1998). There are three components of burnout; (i) exhaustion (the central component), (ii) depersonalisation (a self-protective response to exhaustion, a means of distancing oneself from the source of stress), and (iii) personal accomplishment (sometimes reversed to reflect a negative valence in accordance with the other two components) (Maslach et al., 2001). The relationships between these three components depend on which stressors are prominent in the workplace. However, exhaustion (often described as emotional exhaustion (e.g. Lee & Ashforth, 1990), is usually the precursor, or at least occurs in conjuncture with one or both of the other two components (Maslach et al., 2001).
As the name suggests, emotional exhaustion is typified by subjective feelings of exhaustion and being emotionally overtaxed without opportunity for replenishment of emotional resources (Maslach & Goldberg, 1998). Emotional exhaustion is the most studied and necessary element for the existence of burnout (Maslach, 2003) and is considered as the first stage (van Dierendonck, Schaufeli, & Buunk, 1998).
Depersonalisation is identified as a common, coping mechanism in response to emotional exhaustion and can be thought of as an objectification of clients, akin to emotional withdrawal (Maslach et al., 2001). While this may provide immediate emotional protection for employees, long term and repeated depersonalisation is seen as maladaptive and could result in a cynical dehumanizing approach to clients (Maslach & Goldberg, 1998).
Finally, a sense of reduced personal accomplishment follows, which encompasses reduced confidence, reduced self-efficacy, and low self-evaluation in relation to dealings with clients (Maslach et al., 2001). Reduced personal accomplishment is seen as the result of the long-term existence of emotional exhaustion and depersonalisation. It can be thought of as resignation to a lack of effectiveness in the role.

discrepancy was discovered to negative correlate to nurses' well being (Heuven & Bakker, 2003, Zapf, 2002). Nurses may experience emotional dissonance as a conflict when they are not able to feel what they should feel, may feel false and hypocritical and, in the long run, they may feel alienated from their own emotions (Geddes, 2000). Zapf et al. (1999) identified a significant relationship between emotional dissonance and the burnout dimensions of emotional exhaustion and depersonalisation amongst employees with a substantial level of contact with clients, and Zapf and Holz (2006) found that emotional dissonance was related to emotional exhaustion in a similar sample. In a wide ranging sample including nurses, teachers and social workers, emotional dissonance had a significant relationship with all three burnout dimensions (Cheung & Tang, 2007).

Emotional dissonance was also found to positive correlate to job dissatisfaction and increasing nurses' turn over intention (Murphy, 2005). Studies that have examined the relationship between emotional dissonance and psychosomatic complaints, including affective well-being and physical symptoms of stress, have mostly shown the same pattern of results as for other outcomes. As is clearly the case for much of the emotional labor research, emotional dissonance is often seen as harmful because it leads to surface acting. For instance, surface acting was related to negative affective well-being (measured by subjective mood states), although this relationship was moderated by gender, with females more likely to show negative effects when surface acting than males (Johnson & Spector, 2007). Zapf and colleagues (1999) also found that emotional dissonance was associated with physical complaints such as headaches and insomnia, and Erickson and Wharton (1997) found evidence that inauthentic emotional displays can lead to depression.

Although there are general support and acceptation for the positive link between emotional dissonance and work strain, there're some inconsistencies in these findings (Pugh, Thurau, & Groth, 2011). For example, Wharton discovered that emotional dissonance is positively related to job satisfaction and suggested that emotional dissonance actually might make interactions more predictable and help workers avoid embarrassing interpersonal problems. This should, in turn, help reduce stress and enhance satisfaction (Wharton, 1993). Smith and Kleinman (1989) believed that when medical personnel can maintain a neutral mood by suppressing or faking emotions, he/she can maintain a proper distance to stay away from psychological unhappiness. More recently Duke and colleagues (2009) have verified the negative aspects of emotional labor are lessened by perceived organizational support. Heuven (2006) shows that high levels of emotional dissonance do not affect the level of work

engagement in high efficacious workers. McCreight (2005) claims nurses' managing of emotions is a valid resource in the construction of the professional knowledge and in the adoption of "working persona" (Mackintosh, 2006). These last results suggest that the detrimental effects of emotional dissonance can be reduced on different levels. Consequently, the aim of this doctoral dissertation is to critically question the relationship between emotional dissonance and well- being, by focusing on *how* employees could manage their emotions in the workplace, rather than categorised them negative or positive (Diefendorff et al. 2008). Social support has been identified as the variable most likely to reduce burnout resulting from emotional labor. This is especially true for perceived support from coworkers and supervisors (Brotheridge & Lee, 2002; Halbesleben, 2006; Zellars & Perrewe, 2001) and to a lesser extent, for perceived organizational support (Jawahar, Stone, & Kisamore, 2007), and perceptions of support from the employee family (Baruch-Feldman, Brondolo, Ben-Dayan, & Schwartz, 2002). Martínez-Iñigo and colleagues (2007) also found that employees' satisfaction with clients partially mediated the relationship between surface acting and emotional exhaustion.

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

As the burnout literature suggests, distancing may prove problematic. In an examination of the ways in which nurses manage emotions in a surgical areas, Froggatt (1998) showed that nurses sometimes felt the need to distance themselves from clients as protection from emotional exhaustion. However, there was a perception that this form of self protection created a risk of the development of a callous attitude (Mackintosh, 2007). Studies on emotional dissonance have also focused on the links with job satisfaction. This relationship between is mostly found to be negative in quantitative studies. For example, attempts to control both the emotions of the self and others were associated with low job satisfaction amongst university employees (Pugliesi, 1999), and emotional regulation was also negatively related to job satisfaction in human service employees working in health care (Bono, Foldes, Vinson, & Muros, 2007).

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

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

The general finding that emotional dissonance has a negative impact on an employees' sense of job satisfaction is not universal. Wharton (1993) found that employees in high emotional labor occupations were more satisfied with their jobs as opposed to those in occupations with a low emotional labor content, although classification of emotional labor and non-emotional labor jobs was theoretical rather than empirical. More telling evidence of a positive relationship between emotional dissonance and job satisfaction can be found in qualitative studies which have examined emotional dissonance in a variety of nursing groups. For example, nurses from mixed settings spoke of their satisfaction with their emotional labor work (Henderson, 2001), and despite sometimes being emotionally upsetting (Smith, 1992; Staden, 1998), nurses explained how they derived a great deal of personal satisfaction from their interactions with patients, and this included how they managed their emotion to help patients. In a specialist baby care unit, Lewis (2005) showed that even in the stressful event of a baby death, the emotional engagement with parents was a source of satisfaction. Palliative care nurses have been found to derive a deep satisfaction from the management of emotional dissonance with clients. The emotional engagement with clients is also seen by palliative care nurses as a key aspect of their role. For example, Li (2005) found that palliative care nurses and clients collaborated closely and shared stories of the insensitivity of doctors, which engendered close relationships and was mutually beneficial. Similarly, the connection created between nurses and clients in the process of assisting clients to come to terms with death was found to be extremely satisfying for nurses (Mok & Chiu, 2004).

Overall, subjective perceptions of job satisfaction can be seen to be negatively associated with emotional dissonance in quantitative studies, although there may not always a direct relationship between the two factors. In contrast, qualitative assessments of how nurses in a

variety of settings describe their interactions with clients show that they garner satisfaction from this work, although even amongst the extensively studied palliative care group, the identification of surface and deep acting or any other specific emotional strategy in the research is thin. Therefore, further investigation of how nurses and others in health care manage emotion and handle with emotional dissonance, as well as how these strategies are associated with job satisfaction, are important areas for emotional labor research that are currently lacking. In study 1 (model 2) of our doctoral dissertation (chapter 7) the links between emotional dissonance and job satisfaction will be tested in details.

2.4. Individual Differences and Emotional Dissonance

In the past several decades, much research has been done regarding personality and work. In the emotional dissonance research, individual differences have been seen as moderators of the impact of well-being at work. The personality factors act, to a certain degree, to cause "fit" between the actual felt emotions and the emotions required to be displayed in the workplace.

In her original conceptualization of emotional dissonance, Hochschild (1983) talked about " emotional stamina", as the ability to express desired emotions over an extend period of time and in spite of competing demands. While measures of "emotional stamina" have yet to be developed, other personal characteristics of employees have been tested to may influence the strength of emotional dissonance on well-being. Personality dimensions, as described in the five-factor model (John & Srivastava, 1999; McCrae & Costa, 2003) have been associated with emotional labor strategies and resulting wellbeing. The theoretical underpinnings of the five factor model suggest that individuals high in extraversion, conscientiousness, openness to experience, emotional stability and agreeableness should be associated with more positive emotions and an optimistic and engaging approach to interactions with others compared to those who exhibit lower levels of these traits (McCrae & Costa, 2003). Therefore, personality dimensions have been examined in relation to way in which emotional labor is carried out, as well as the resulting well-being outcomes. The influence of the traits Extroversion/Introversion was firstly tested on emotional dissonance (Barrick & Mount, 1991). A person who scores high on extraversion, for example, would be someone is sociable, gregarious, assertive, talkative and active. This factor was examined by Tews and Glomb

(2003) in their exploration into whether certain personality traits affect the ability to express and/or suppress emotions differently. These researchers found that extraversion was positively related to expressing genuinely felt positive emotion ($r = .46$, $p < .01$) as well as positively related to faking positive emotions ($r = .27$, $p < .10$).

Moderators, such as self-monitoring and self-competence were found to reduce the deleterious impact of emotional dissonance on job satisfaction and emotional exhaustion in the helping professions, as nursing, (Abraham, 1998) Self-monitoring refers to the extent to which people monitor, control and modify their expressive behavior to meet standards of social appropriateness (Snyder, 1974). Research has indicated that high self-monitors pay more attention to situational cues about which emotions are appropriate, and also are more skilled at presenting emotions (Snyder, 1974; Riggio & Friedman, 1982). Therefore, employees who are high self-monitors should be more likely to comply with organizational display norms because they are more willing to monitor expressive behavior. That is, high self-monitors may be more likely to handle with emotional dissonance's effects, because they are proficient at monitoring and controlling their expressive behavior. In addition, this inclination of high self-monitors to comply with organizational display norms may result in less dissatisfaction with the emotional labor part of their jobs due to their ability to regulate their expressive behavior. In fact, they may be more satisfied with the emotional labor component of their job because it rewards them for behavior in which they normally engage. Conversely, low self-monitors may be more prone to emotional exhaustion than other workers who perform emotional labor, because their expressive behavior is guided more by their affective states rather than by desire to comply with social standards, therefore to obey display rules they may have to engage in more effortful deep acting (Wharton, 1993). Consequently, high self-monitors should have to expend less emotional effort to display the organizationally prescribed emotions via surface acting. In fact, recent research has shown that high self-monitors engaged in more surface acting than low self-monitors (Brotheridge & Lee, 2002).

In the nursing context the trait helpfulness may also play a role in the congruence between felt and required emotion for nurses. For example Penner and colleagues (1995) tested the dimension of Other-Oriented Empathy, which measures five related traits: empathic concern, ascription of responsibility, other-oriented moral reasoning, perspective taking and mutual-concerns moral reasoning. This factor attempts to assess cognitions and affect (Penner et al, 1995). People who score high on this factor tend to feel responsibility and concern for other people. This factor appears to assess both behavioral tendencies and affect. People who score high on this factor tend to be altruistic and help others but they do not tend to experience self-

oriented discomfort when another person is in extreme distress. As cognitive dissonance may be reduced trough justification of altruism, Grant and Sonnentag (2010) suggest employees who experience their work as benefiting customers/patients, may more likely to justify emotional dissonance as worthwhile. In this doctoral research we aim to test the role played by the impact of empathy on the link between emotional dissonance and job satisfaction.

2.5. Organizational Resources and Emotional Dissonance

As suggested by Ashforth and Humprey (1993) and Grandey (2000), the environment is a very important factor in understanding emotion management. It's very possible that the situation in which employees work may affect the level and type of emotional dissonance in which they engage. Support from co-workers and supervisors should create a positive working environment (Schneider& Bowen, 1985). An employee's perception that he or she works in a supportive climate has been found to relate to job satisfaction, lowered stress and turn over intention (Cropanzano, Grandey & Mohler, 1999). One may genuinely feel the emotions that are expected in a service environment if the interpersonal relationships are positive and supportive (Eisenberger, Huntington, Hutchison, & Sowa, 1986; Halbesleben, 2006; House, 1981). The subjective perception of social support has generally been identified as important in terms of its association with positive well-being outcomes for individuals and organizations (Halbesleben, 2006); with for example, social support being associated with reduced symptoms of depression either directly or as a buffer against stress (Cohen & Wills, 1985). There have been four main sources of support studied in organizational psychology literature, including perceived organizational support (Rhoades & Eisenberger, 2002), perceived support from supervisors, (Schriesheim, Castro, & Cogliser, 1999), perceived co-worker support (La Rocco & Jones, 1978), and perceived support from family members and friends (Baruch-Feldman et al., 2002). In a meta-analysis of the relationships between these sources of support and the three burnout dimensions, all sources were found to be significantly related to all burnout dimensions, except for a non-significant relationship between family/friends support and depersonalisation (Halbesleben, 2006). Perceived organizational support has also been associated with job satisfaction and reduced intentions to quit (Cropanzano, Howes, Grandey, & Toth, 1997; Eisenberger, Cummings, Armeli, &

Lynch, 1997), and perceived support from co-workers and supervisors has been suggested as a factor in the retention of child welfare employees (De Panfilis & Zlotnik, 2008).

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

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

Other researches examine social and emotional support as organizational characteristics that may act as main effects on the level of emotional labor performed and directly impact on employees' well-being. In call centre operators, support from supervisors was negatively related to emotional exhaustion (Wilk & Moynihan, 2005), and combined supervisor and co-worker support was associated with reduced emotional exhaustion and increased job satisfaction (Lewig & Dollard, 2003). In a sample of prison officers, reduced social support was associated with emotional exhaustion, leading to depressive symptoms and absenteeism (Neveu, 2007). Co-worker support amongst prison officers has subsequently been recognized as an important factor for organizations to nurture and facilitate in order to counter work related stress (Tracey, 2008). As with prison officers, traffic wardens experience a high degree of interpersonal conflict as a normal aspect of their role. Support from family members was associated with reduced burnout for this group, and supervisor support was associated with higher productivity and job satisfaction (Baruch-Feldman et al., 2002).

In studies of nursing, emotional support from co-workers has been identified as important when nurses experienced grief in relation to patients (Staden, 1998), and where co-worker support was lacking, nurses experienced greater stress and the negative effects of emotional dissonance was reduced by support from supervisors (Smith, 1992). In qualitative studies, nurses have described the importance of support from supervisors and co-workers as an important coping mechanism in direct relation to the interaction aspects of their role. For example, supervisors have been described as crucial in setting the emotional tone of the ward, and for providing leadership and direction in emotional expression, whereas co-workers were

seen as more important in providing moment-to-moment emotional support (McCreight, 2005). Both instrumental and emotional support from supervisors was interpreted as an important mechanism to allow nurses to reflect on how they can handle with emotional dissonance and on their relationships with patients (Huynh, Alderson, & Thompson, 2008). Interestingly, most of the qualitative research that has examined the importance of support is devoid of references to the organization more broadly. The evidence supports the notion that emotional support plays an important role in positive well-being outcomes for individuals in organizations. In particular, and with reference to Hobfoll's (1989) in situations in which emotional expenditure is substantial, emotional support may be particularly relied upon. However, currently lacking in the research is a focus on how support is relied upon and provided in health groups with distinctive forms of interactions. In addition, many quantitative measures of support are broad, without distinguishing emotional and instrumental aspects. As can be seen, there are many unknowns and both lab and field research are needed to test the role played by perceived support in the emotional labor process. This doctoral dissertation tales into account emotional support and aims to verify its impact on emotional dissonance, as explained in chapter 8 of this volume.

Conclusion

The purpose of this chapter was twofold: to review and compare previous researches on emotional dissonance and to provide an integrative perspective which includes individual differences and organizational factors. The general aim of this dissertation is to critically examine the nature of emotional dissonance in the nursing context and its links with antecedents, consequents and moderators in order to offer some different theoretical approaches. The definition of emotional dissonance as detrimental and negative for workers has dominated the research for long time. Emotional dissonance was included in the large arena of burn out and work strain. Recently, a new approach to emotional dissonance has been developing. The focus has been shifted from the negative effects of emotional dissonance to how this state of being can be managed. This theoretical approach has fostered studies to test whether emotional dissonance may be influenced at different levels: personal and organizational. The purpose of this doctoral study is to examine the link between emotional dissonance, moderators and positive outcomes, to offer an alternative perspective, which takes into account the suggestions of Pugh, Thurau and Groth (2011). The authors maintain that emotional dissonance has been mostly investigated through the Hochschild's sociological

point of view, but dissonance, both emotion and cognitive, is a psychological state (Festinger, 1957), which is not negative on its own and can be lessened under specific conditions (Harmon-Jones, 1996). This theoretical perspective will be examined in detail in the second part of this volume, dedicated to experimental studies.

CHAPTER 3

CLINICAL EMPATHY IN THE NURSE – PATIENT INTERACTION

Preamble

The notion of "empathy" has a long history marked by ambiguity, discrepancy, and controversy among philosophers and behavioral, social, and medical scholars (Aring, 1958; Preston & deWaal, 2002;Wispe, 1978, 1986). Because of this conceptual ambiguity, empathy has been conceptualized as an "elusive" concept (Basch, 1983); one that is hard to define and measure (Kestenbaum, Farber, & Sroufe, 1989). Eisenberg and Strayer (1987a, p. 3) described empathy as a "slippery concept . . . that has provoked considerable speculation, excitement, and confusion." Also, because of the ambiguity associated with the concept of empathy, Pigman (1995) suggested that empathy has come to mean so much that it means nothing! More than half a century ago, Theodore Reik (1948, p. 357), the prominent psychoanalyst similar comments: "The word empathy sometimes means one thing, sometimes another, until now it does not mean anything at all". Because of the conceptual ambiguity, Wispé (1986) suggested that the outcomes of empathy research may not be valid because empathy means different things to different investigators, who may believe they are studying the same thing but actually are referring to different things! As a result, Lane (1986) suggested that empathy may not even exist in reality after all. Later, Levy (1997) proposed that the term should be eliminated and replaced by a less ambiguous one. Despite the conceptual ambiguity, it is interesting to note that empathy is among the most frequently mentioned humanistic dimensions of patient care (Linn, DiMatteo, Cope, & Robbins, 1987). Many successful clinicians know intuitively what empathy is, without being able to define it. In that respect, empathy may be analogous to love, which many of us have experienced without being able to define it! Thus, while we all have a positive image of the concept of empathy and a preconceived idea about its positive outcomes in interpersonal relationships,

we wonder how to define it operationally. Needless to say, no concept can be subject to scientific scrutiny without an operational definition.

3.1. Origin and History of the term

The concept of empathy was first introduced in 1873 by Robert Vischer, a German art historian and philosopher who used the word *Einf˙uhlung* to address an observer's feelings elicited by works of art (Hunsdahl, 1967; Jackson, 1992). According to Pigman (1995), the word was used to describe the projection of human feelings onto the natural world and inanimate objects. However, the German term was originally used not to describe an interpersonal attribute, but to portray the individual's feelings when appreciating a work of art, specifically when those feelings blurred the difference between the observer's self and the art object (Wispe, 1986). In 1897, the German psychologist-philosopher Theodore Lipps brought the word *Einf˙uhlung* from aesthetics to psychology. In describing personal experiences associated with the concept of *Einf˙uhlung*, Lipps indicated that "...when I observe a circus performer on a hanging wire, I feel I am inside him..." (cited in Carr, Iacoboni, Dubeau, Mazziotta, & Lenzi, 2003, p. 5502). In 1903, Wilhelm Wundt, an experimental psychologist, who established the first laboratory of experimental psychology in 1879 at the University of Leipzig in Germany, used *Einf˙uhlung* for the first time in the context of human relationships (Hunsdahl, 1967). In1905, Sigmund Freud (1960) used *Einf˙uhlung* to describe the psychodynamics of putting oneself in another person's position (cited in Pigman, 1995). The English term "empathy" is a neologism coined by psychologist Edward Bradner Titchener (1909) as an English equivalent or the translation of the meaning of *Einf˙uhlung*. The term empathy derives from the Greek word *empatheia*, which means appreciation of another person's feelings (Astin, 1967; Wispe, 1986). Although Titchener (1915) used the term empathy to convey "understanding" of other human beings, Southard (1918) was the first to describe the significance of empathy in the relationship between a clinician and a patient for facilitating diagnostic outcomes. Thereafter, American social and behavioral scientists have often used the concept of empathy in relation to the psychotherapeutic or counselling relationship and in the discussion of prosocial behavior and altruism (Batson & Coke, 1981; Carkhuff, 1969; Davis, 1994; Eisenberg & Strayer, 1987; Feshbach, 1989; Feudtner, Christakis, & Christakis, 1994; Hoffman, 1981; Ickes, 1997; Stotland, Mathews, Sherman, Hansson, & Richardson, 1978). Empathy also has been discussed frequently in the psychoanalytic literature (Jackson, 1992) and in social

psychology, counselling, and clinical psychiatry and psychology (Berger, 1987; Davis, 1994; Eisenberg; Strayer, 1987c; Ickes, 1997).

3.2. Introduction and Conceptualization of Empathy

A review of the literature (Hojat, 2007) show that there are several disagreements among researchers about the definition of empathy. Presenting a long list of definitions and descriptions of empathy would take far beyond the intended scope of this work. A few definitions and descriptions were deliberately chosen because they seem to be most relevant to the theme and the aim of this dissertation and also can provide a framework for the conceptualization and definition of empathy in the context of nurse / patient interactions. Carl Rogers (1959, p. 210), the founder of client-centred therapy, suggested the following often-cited definition of empathy as an ability "... to perceive the internal frame of reference of another with accuracy as if one were the other person but without ever losing the *'as if '* condition". In addition, Rogers (1975) described the experience of empathy as entering into the private perceptual world of another person and becoming thoroughly at home in it. Similarly, in one of the first psychoanalytic studies of empathy, Theodore Schroeder (1925, p. 159) suggested that "empathic insight implies seeing *as if* from within the person who is being observed". George Herbert Mead (1934, p. 27) suggested the following definition of empathy more than seven decades ago: "The capacity to take the role of another person and adopt alternative perspectives." About half a century ago, Charles Aring (1958) described empathy as the *act* or *capacity* of appreciating another person's feelings *without* joining those feelings. Robert Hogan (1969, p. 308) defined empathy as "the intellectual or imaginative apprehension of another's condition or state of mind *without* actually experiencing that person's feelings". Clark (1980, p. 187) defined empathy as "the unique capacity of the human being to feel the experience, needs, aspirations, frustrations, sorrows, joys, anxieties, hurt, or hunger of others *as if* they were his or her own" . These definitions by Hogan and Clark are in line with Rogers's (1959) "as if" condition in describing empathy and with Aring's (1958) "without joining" feature of empathy described earlier. Wispe (1986, p. 318) described empathy as "the attempt by one self-aware self to comprehend non judgmentally the positive and negative experiences of another self." Baron-Cohen and Wheelwright (2004) described empathy as the "glue" of the social world that draws people to help one another and stops them from hurting others. William Ickes (1997, p. 183) defined empathy as "a state of our mind upon which we reflect." Bellet and Maloney (1991, p.183) claimed that empathy is

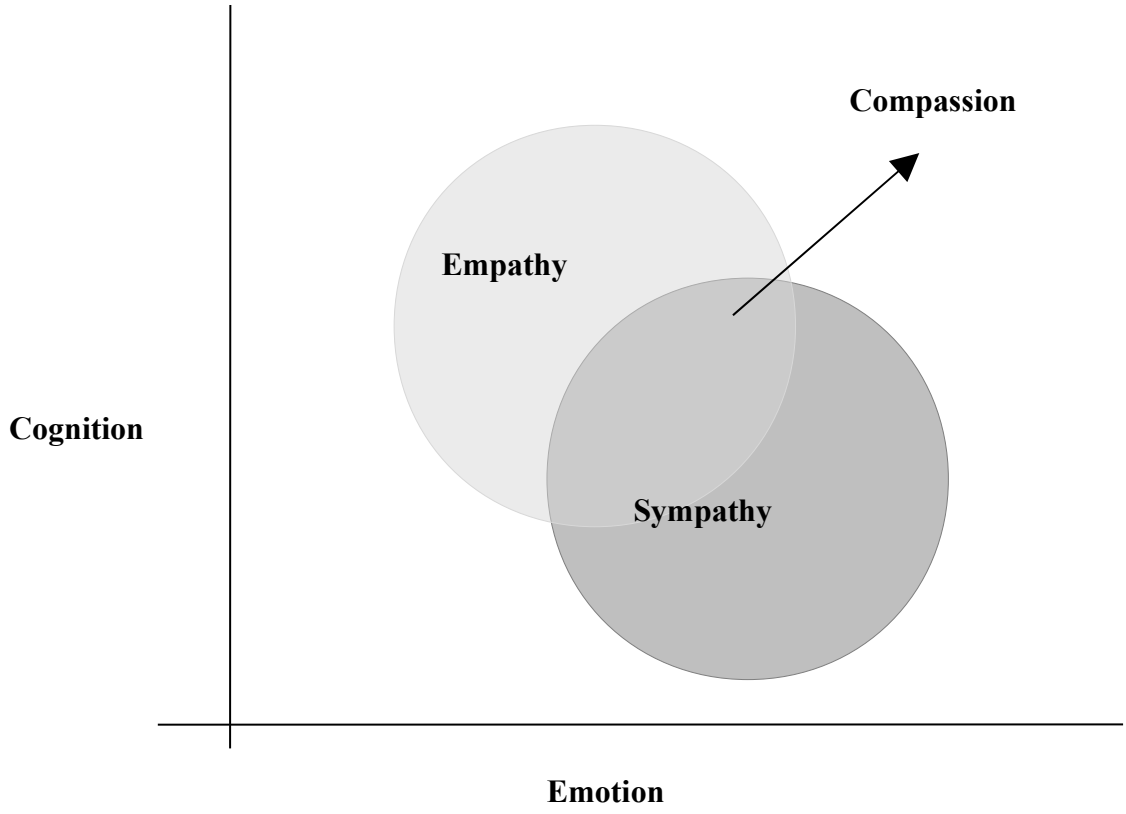
"the capacity to understand what the other person is experiencing from within the other person's frame of reference and the capacity to place oneself in another's shoes." Hamilton (1984, p. 217) portraits empathy as a "vehicle for understanding one another in a meaningful way." Levasseur and Vance (1993, p. 83) described empathy as follows: "Empathy is not a psychological or emotional experience, nor a psychic leap into the mind of another person, but an openness to, and respect for, the personhood of another." , adding that "... is a mode of caring, which is not for those who are flourishing or happy... Empathy is for those who need help or are suffering or struggling in some way" (p.82). Similarly, Shamasundar (1999) suggested that the intensity of empathic resonance is deeper for negative states, such as sadness, anger, and hostility. These descriptions portray the importance of empathy in situations where others are suffering or are sad. Thus, the importance of empathic relationships in patient encounters is apparent. Recently, empathy has been described as the neural matching mechanism constituted of a mirror neuron system[5] in the brain that enables us to place ourselves in the "mental shoes" of others (Gallese, 2001, 2003). These definitions described empathy as a cognitive or an emotional attribute or a combination of both. Cognition is mental activities involved in acquiring and processing information for better understanding, and emotion is sharing of the affect manifested in subjectively experienced feelings (Colman, 2001). Two types of empathy, cognitive empathy and emotional empathy, match these descriptions. Rosalind Dymond (1949) viewed empathy as a cognitive ability to assume the role of another person. Kohut (1971, p. 300) described empathy as "a mode of *cognition* that is specifically attuned to the perception of a complex psychological configuration". MacKay, Hughes, and Carver (1990, p. 155) described empathy as "the ability to understand someone's situation without making it one's own." Cognitive activities, such as perspective taking and role taking, are among the features some authors have presented in their definition of empathy. For example, Dymond (1949, p. 127) describes empathy as "the imaginative transposing of oneself into the thinking, feeling, and acting of another, and so structuring the world as he does." Several authors have , differently, describes empathy as an emotional response by generating identical feelings and sharing emotions between people. For example, Batson and Coke (1981, p. 169) defined empathy as "an emotional response elicited by and congruent with the perceived welfare of someone else." , Rushton (1981, p. 260) shows empathy as "experiencing the emotional state of another." Eisenberg (1989) described it as "an emotional response that stems from the apprehension of another's emotional state or

[5] Mirror neurons are brain cells that are activated when we observe another person who is performing a goal-directed action as if we are performing that act (Carr et al., 2003; Gallese, 2001; Iacoboni et al., 1999). These new studies suggest the possibility that, in the future, empathy may be defined in neuroanatomical terms and be measured by physiological indicators.

condition and is congruent with the other's emotional state or condition" (p. 108). Kalisch (1973, p. 1548) defined it as "the ability to enter into the life of another person, to accurately perceive his current feelings and their meaning"; and Hoffman (1981, p. 41) defined it as "a vicarious affective response to someone else's situation rather than one's own.". A number of researchers, however, believe that empathy involves both cognition and emotion (Baron-Cohen & Wheelwright, 2004; Davis, 1994). For example, Bennett (2001, p. 7) defined empathy as "a mode of relating in which one person comes to know the mental content of another, both *affectively* and *cognitively*, at a particular moment in time and as a product of the relationship that exists between them." Davis (1994) believes that cognitive and affective facets of empathy interact in his organizational model of empathy. He defined empathy as "a set of constructs having to do with the responses of one individual to the experiences of another. These constructs specifically include the process taking place within the observer and the affective and non-affective outcomes which results from those processes" (Davis, 1994, p. 12). Hodges and Wegner (1997, p. 313) suggested that "empathy can have either an emotional component, or a cognitive component, or both".
Hojat (2007, p.10) starts defining empathy differentiating it from sympathy "Both empathy and sympathy are important components of interpersonal relationships. The two distinct concepts of empathy and sympathy are often mistakenly tossed into the same terminological basket in empathy research; this mistake has created conceptual confusion and debates for years. However, evidence suggests that the two constructs of empathy and sympathy reflect different human qualities that have different measurable influences on clinicians' professional behavior, utilization of resources and clinical outcomes ". According to Decety and Jackson (2004, p. 85) "an essential aspect of empathy is to recognize the other person as like self while maintaining a clear separation between self and other." This theoretical conceptualisation claims the central feature of empathy is the *cognitive* information processing that distinguishes it from the predominantly *emotional* mental processing involved in sympathy (Brock & Salinsky, 1993; Streit-Forest, 1982; Wolf, 1980). Figure 3.1. (taken from Hojat, 2007, p.11) is a graphic presentation showing the relative contribution of cognition and emotion in empathy and sympathy and the overlap between them. Figure 1 shows empathy is in the area of higher cognition than emotion. Conversely, sympathy is in the area of higher emotion than cognition. Compassion, Hojat proposes, resides in the area of the overlap

between empathy and sympathy, where both of these attributes are expressed in a moderate amount.

Figure 3.1 : Graphical representation of Hojat's theoretical concept of empathy (2006, p.11)



Empathy is an *intellectual* attribute, whereas sympathy is an *emotional* state of mind (Gruen, Mendelsohn, 1986). Empathy refers to one person's attempt to comprehend non judgmentally another person's experiences (Wispe, 1986). Self-awareness is augmented in empathy, but it is reduced in sympathy. So, whereas the aim of empathy is to *know* another person's concerns better, the aim of sympathy is to *feel* another person's emotions better. The empathic relationship implies a *convergence* of understanding between two people, and the sympathetic relationship implies a *parallelism* in the feelings between the two (The underlying behavioral motivation in empathy is likely to be altruistic, but is more likely to be egoistic in sympathy).

The ultimate goal of altruistically motivated helping behavior is to reduce another person's distress without any expectation of reward, whereas the primary goal in egoistically motivated helping behavior is to reduce one's own level of stress, to avoid adverse feelings, or to receive rewards (Coke, Batson, & McDavis, 1978). "A genuine attempt to understand the experiences of another person or *empathic understanding*, increases the likelihood of altruistic helping behavior. However, feeling the emotions of others, or sympathetic sharing of emotions, leads to physiological arousal, thus increasing the likelihood of egoistic behavior to reduce emotional arousal and avoid aversive experiences" (Hojat, 2007, p.11). In clinical settings, as nursing, empathy involves an effort to *understand* the patient's experiences without joining them, whereas sympathy involves an effortless feeling of *sharing* or joining the patient's pain and suffering (Aring, 1958). Understanding the *kind* and *quality* of the patient's experiences is the area of empathy, whereas feeling the *degree* and *quantity* of the patient's concerns the terrain of sympathy. A patient will feel felt if the clinician understands the kind and quality, not the degree and quantity, of the patient's experiences (Greenson, 1960). Whereas empathy is an internal cognitive process that should be communicated, sympathy seems to be more transparent (Disraeli , 2005). The difference between empathy and sympathy is more than a semantic quarrel, because each involves different mental activities during information processing (Gruen & Mendelsohn, 1986). The cognitive response of empathy is more likely to be non spontaneous because it is influenced by the regulatory process of appraisal. An affective reaction (in sympathy) is more likely to be spontaneous because it is influenced by the psychological regulatory process of arousal (Siegel, 1999). Also, empathy as a cognitive response is characterized by an inhibitory energy-conserving state in the parasympathetic branch of the neurological regulatory process. However, sympathy as an emotional reaction is characterized by an excitatory energy-consuming state related to the sympathetic neurological regulatory process (Siegel, 1999). Despite the differences between empathy and sympathy, they cannot be completely independent from one another. Hojat and colleagues (2006) found that the overlap between the two concepts is approximately 20% (coefficient of determination: r 2 = 0.452 = 20%). The distinction between sympathy and empathy has important implications for the clinician–patient relationship because joining the patient's emotions (a key feature of sympathy), can impede clinical outcomes. A clinician should feel the patient's feelings only to a limited extent to improve his or her understanding of the patient without impeding professional judgment (Starcevic & Piontek, 1997). When experiencing empathy, individuals are able to disentangle themselves from others, whereas individuals experiencing sympathy have difficulty maintaining a sense of whose feelings

belong to whom (Decety & Jackson, 2006). From the perspective of this dissertation, which deals with the health care organization and the nursing profession, the distinction between empathy and sympathy is of critical significance. Chu et al. (2011) consider empathy a genuine acting to perform emotional labor and a prerequisite to generate emotions and responses appropriate to the situation. We assume that empathy is a functional emotional competence in regulating emotions during interactions with patients.

3.3. Clinical Empathy in patient care

The constitution of the World Health Organisation (1948, p. 1) defines health as "a state of complete physical, mental, and social well-being, and not merely an absence of disease or infirmity." These words are consistent with the biopsychosocial paradigm of illness in medicine (Engel, 1977, 1990; Hojat, Samuel, & Thompson, 1995). In this paradigm, the targeted treatment of an affected organ is replaced by curing the whole patient, who is perceived as a system of being, always in relation to the biological, psychological, and social elements interacting closely with one another. In addition to the importance of pathophysiological determinants of infirmity, in the biopsychosocial paradigm, psychological, social, and interpersonal factors, such as health-promoting effects of human connections, including empathic physician–patient engagement, are taken into consideration as well (Engel, 1977, 1990). This paradigm of health and illness attests that curing occurs when the science of medicine (the biomedical and pathophysiological aspects of disease) and the art of medicine (the psychological, social, and interpersonal aspects of illness) merge into one unified holistic approach to patient care. Empathy is a key element in this holistic approach. Empathy in patient care has been characterized as arising "out of a natural desire to care about others" (Baron-Cohen, 2003, p. 2). Gianakos (1996, p. 135) referred to empathy in patient care as "the ability of physicians to imagine that they are the patient who has come to them for help." Greenson (1967, p. 367) described empathy in patient care as follows: "I have to let a part of me become the patient, and I have to go through her experience *as if* I were the patient." (The "as if" condition reminds us Rogers's definition of empathy described in the previous paragraph.). To Larson and Yao (2005, p. 1105) empathy is the royal road to treatment and "a symbol of the health care profession." Engaging in empathic relationships makes physicians more effective healers and makes their careers more satisfying. Freud (1958a) suggested that empathy is not only a factor in enhancing the physician–patient relationship; it also provides a condition for correct interpretation of the patient's problems.

Therefore, empathy is valuable both in making accurate diagnoses and in achieving more desirable treatment outcomes. Both the patient and the physician benefit from empathic engagement. Considering the various descriptions and features of empathy that were described in the previous paragraph, and taking into account the specific nature of empathy in patient care, the following definition of the Jefferson Medical Center (Hojat et al., 2002b, 2002d, 2003b) is of critical significance: "Empathy is a predominantly *cognitive* (rather than an emotional) attribute that involves an *understanding* (rather than feeling) of experiences, concerns and perspectives of the patient, combined with a capacity to *communicate* this understanding". The three key terms in this definition are printed in italics to underscore their significance in the construct of empathy in the context of patient care. Hojat developed this definition after a comprehensive review of the literature (Hojat et al., 2001b; Hojat et al., 2003b) and a careful consideration of three factors that contribute to positive patient outcomes. The three key ingredients in the definition of empathy *cognition*, *understanding*, and *communication* need some elaboration.

3.3.1. Empathy and Cognition

Empathy as a predominantly cognitive (rather than an emotional) attribute is based on a belief that in patient-care situations, empathy emerges as a result of mental activities which involve cognitive information processing as reasoning and appraisal, which are the basis of clinical judgment. Although cognitive mental processing (a key feature of empathy) can lead to positive patient outcomes, overwhelming emotion (a key feature of sympathy) can obstacle the optimal outcomes by obscuring objectivity in clinical judgments. Cognition and emotion, although seemingly related, have different qualities independent of their joint appearance (Lazarus, 1982). The distinction between cognition and emotion (and correspondingly, between empathy and sympathy) may not seem as important in situations where patient care is not a primary consideration. In the context of patient care, however, such a distinction must be made because of the different implications regarding patient outcomes. Nurses should feel their patients' feelings only to the extent necessary to improve their understanding, without impeding their professional judgment (Starcevic & Piontek, 1997). It is not essential in the care context one feel the patient's feelings to an overwhelming degree. Emotional over-involvement is a feature of sympathy, not empathy (Olinick, 1984). The notions of "detached concern," "compassionate detachment" and "affective distance" have been used to describe the limits of emotional engagement in the physician–patient relationship (Blumgart, 1964;

Halpern, 2001; Jensen, 1994). Ayra (1993) suggested that physicians' dissociation from patients' emotions can help them to retain their mental balance. Farber and associates (1997) reported that although medicine is a profession characterized by caring and empathy, it also has been characterized throughout history as aspiring to "objective detachment". This is possible when emotional involvement in physician–patient encounters is restrained. Despite this restraint, however, complete emotional detachment has its own perils in the context of patient care (Friedman, 1990). The controversy about detached concern in physician–patient encounters arises from confusion about the nature and meaning of empathy and sympathy. Maintaining an affective distance to avoid emotional over involvement (a feature of sympathy) makes the physician's clinical judgment more objective, but cognitive overindulgence (a feature of empathy) can always lead to a more accurate judgment. Objectivity when making clinical decisions can be better achieved by avoiding emotional over-involvement, which clouds medical judgment (Koenig, 2002). It is difficult to be highly emotional and objective at the same time (Wispe, 1986) because excessive emotion in patient care can interfere with the principle of objectivity when making diagnostic decisions and choosing treatments (Blumgart, 1964; Gladstein, 1977; Spiro, 1992). Borgenicht (1984) suggested that in performing certain procedures, physicians must maintain a certain degree of emotional distance from the patient because overwhelming emotional involvement may prevent them from making objective decisions at times of crisis. Too much affect impedes effective communication between physician and patient, whereas an abundance of understanding facilitates it. Brody (1997) suggested that the real danger to the physician's effectiveness lies in sympathetic over-engagement with the patient. Leif and Fox (1963) introduced the concept of "detached concern" in the medical education literature to prevent emotional over-engagement between physicians and patients. In contrast, no one has ever expressed concern about excess in understanding. An "affective distance" between physician and patient is desirable not only to avoid an intense emotional involvement, which can jeopardize the principle of clinical neutrality, but also to maintain the physician's personal durability (Jensen, 1994). Because excessive emotions can obscure the physician's judgment concerning the patient's predicament, Freud (1958) proposed that to achieve better therapeutic outcomes, clinicians must put aside all of their human sympathies! For practical reasons, a distinction between cognition and emotion is important because of its implications with regard to developing educational programs to enhance empathy, and assessing patient outcomes. The amenability to change will vary for cognitive and emotional behaviors.

3.3.2. Empathy and Understanding others feelings

Understanding others' feelings and behaviors is central to human survival (Keysers & Perrett, 2004). Understanding is also a key ingredient of empathic engagement in the physician–patient relationship (Levinson, 1994). Patients' perception of being understood, according to Suchman, Markakis, Beckman, and Frankel (1997), is intrinsically therapeutic because it helps to restore a sense of connectedness and support. Empathy in patient care is built on the central notion of connection and understanding (Hudson, 1993; Sutherland, 1993). Because being understood is a basic human need, the physician's understanding of the patient's physical, mental, and social needs is, in itself, relevant to the fulfilment of a basic human need: "...when an empathic relationship is established, a basic human need is fulfilled..." (Hojat et al., 2003b, p.27). According to Schneiderman (2002, p. 627), "the better we understand them [the patients], the closer we come to discovering the true state of affairs, and the more likely we will be able to diagnose and treat correctly." Understanding of the patient's perspective was considered as an essential element of physician–patient communication by a group of medical education experts in the Kalamazoo, Michigan, conference held in 1999 (Makoul, 2001). A specific feature of understanding in the physician–patient relationship is the ability to stand in a patient's shoes without leaving one's own personal space and to view the world from the patient's perspective without losing sight of one's own personal role and professional responsibilities. With this background in mind, our research decided to consider "understanding" (rather than "feeling") as a keyword in the definition of empathy in the context of patient care, as shown in the second empirical part of this dissertation. Accuracy of understanding is another topic of discussion in empathy research. In general, the accuracy of understanding depends on the strength of the empathic relationship and the feedback mechanisms. Because the accuracy of understanding is an issue that may be a subject of debate, physicians should occasionally verify the degree to which their understanding is accurate.

3.3.3. Communication of Understanding

According to Carkhuff (1969) and Chessick (1992), the central curative aspect of clinician–patient relationships rests not only on the clinician's ability to understand the patient but also on his or her ability to communicate this understanding back to the patient. Reynolds (2000) and Diseker and Michielutte (1981) included communication of understanding as a feature of

empathy in physician–patient relationships. For example, Carkhuff (1969, p. 315) indicated that "[empathy is] the ability to recognize, sense, and understand the feelings that another person has associated with his (her) behavioral and verbal expressions and to accurately communicate this understanding to him or her." Reynolds (2000, p. 13) defined empathy as "an accurate perception of the client's world and an ability to communicate this understanding to the client". Communication of understanding also is a key feature in LaMonica's description of empathy: "... Empathy involves accurate perception of the client's world by the helper, communicating of this understanding to the client, and the client's perception of the helper's understanding" (LaMonica, 1981, p.398). Truax and Carkhuff (1967, p. 40) described empathy as involving the ability to sense the client's "private world" and to communicate this understanding in "a language attuned to the client's current feelings." A physician who has an empathic understanding of the patient but does not communicate such an understanding would not be perceived as an empathic physician (Bylund & Makoul, 2005). An important aspect of communication in patient care is the notion of "reciprocity" or "mutuality" (Makoul, 1998; Miller, 2002; Raudonis, 1993). Although the idea that empathy involves mutual understanding is not widely discussed in empathy research (Bennett, 2001), it must be regarded as an essential ingredient of empathic engagement in patient care. Mutual understanding generates a dynamic feedback loop that is helpful not only in strengthening empathic engagement but also in making a more accurate diagnosis and thus providing better treatment. It is important to note that mutual understanding and reciprocal feedback during verbal and nonverbal exchanges indicate that both physician and patient must play an active role to enhance empathic engagement. Without such features, empathic engagement cannot fully develop. Care givers should let their patients know that their health problems and their psychosocial concerns are fully understood. Mutuality generates a belief in the patient that not only enhances the empathic relationship but also has a mysterious beneficial effect on clinical outcomes (Hudson, 1993). Although the mechanism of the positive effect of mutuality in understanding is not well understood, one could speculate that the beneficial outcomes are attributable to greater satisfaction with the health care provider, to better compliance with treatment, or to such psychological factors as reduced anxiety, enhanced optimism, and perceptions of social support, which are activated in mutually understood interpersonal relationships. Both the patient and the physician benefit from empathic engagement.

3.4. Clinical Empathy and its correlates in the nursing context

In recent times, evidence has steadily accumulated in support of the utility of empathy in clinical nursing (Mercer & Reynolds, 2002). The importance of empathy in the nursing context is related to a core set of common aims or purposes (Branch et al., 2001). These include: clinical empathy and patients' outcomes , empathy and clinical competence and clinical empathy and emotional labor/well-being of nurses.

3.4.1. Clinical Empathy and Patients Outcomes

The interaction between intrapersonal and interpersonal dynamics brings about cognitive processes that can lead to an orientation or a behavior. When the orientation is empathic, the likelihood of a positive patient outcome will increase. In this case, the system has achieved its scope and can be considered functional. Training humane clinicians has long been a concern of education in the health professions. Because of the general societal changes that are taking place, particularly in the industrialized world, and directly or indirectly are reducing the power of important social support systems and because of the changes that are evolving in the health care system and leading toward detached care, research on elements that contribute to the understanding and enhancement of empathy in patient care is now more important and timely than ever before (Hojat, 2007). Research on empathy in patient care deserves serious attention, not only because of its importance in training humane clinicians, but also because of its implications for the selection and education of clinicians. Empirical research on empathy in patient care is still in its infancy; therefore, much more research is needed to enhance our understanding of the antecedents, development, measurement, and outcomes of empathy in patient care. Research has shown that empathy is linked to a number of demographic and psychosocial variables, indicators of clinical competence, and career interest. Evidence also suggests that empathic engagement in patient care is associated with physicians' diagnostic accuracy and patients' adherence to treatment, increased satisfaction with their health care providers, and a reduced tendency to file malpractice claims (Yarnold, Greenberg, & Nightingale, 1991, MacPherson, Mercer, Scullion, & Thomas, 2003, Kim et al., 2004). There is general support that nurses' empathic attitude is important for good quality care and patients' satisfaction and compliance (Olson, 1997, Watt, Wattson, 2000), More than two decades later, Olson and Hanchett (1997) adopted Orlando's model as a suitable method of studying empathy and patient outcomes and hypothesized that if nurses understood their patients' needs accurately and shared that understanding with patients, who in turn confirmed

its accuracy, patient outcomes would improve. Accordingly, Olson and Hanchett initiated a study involving 70 staff nurses and 70 patients to test the hypothesis that nurses' empathy would reduce patients' distress and overlap with the patients' perceptions of the nurses' empathy, as measured by the Empathic Understanding subscale of Barrett-Lennard's Relationship Inventory. At the end of the study, the authors reported a moderate but statistically significant relationship between the nurses' self-reported empathy and the patients' perceptions of the nurses' empathy and the hypothesis was confirmed.

3.4.2. Empathy and Clinical Competence

Empathy also was found to predict ratings of clinical competence among medical students and physicians. Furthermore, the findings on sex differences in empathy scores call for more empirical research to discern whether the differences are more likely to be related to "intrinsic" sex characteristics or to "extrinsic" sex-role socialization. Such research is needed because determining the proportion of the variance in empathy scores that is accounted for by intrinsic or extrinsic factors in the analyses of sex differences is an important issue. The answer would potentially have different implications in relation to the selection and education of health professionals (Gonnella & Hojat, 2001; Gonnella et al., 1993a, 1993b). Several studies underscore that the measures of personal qualities could predict ratings of clinical performance in the third year of medical school more accurately than grade-point averages or MCAT scores (Hojat et al., 1993, 1996; Hojat, Vogel, Zeleznik, & Borenstein, 1988). In other words, incremental validity can be improved significantly by including indicators of interpersonal skills and measures of personal qualities in multiple regression models (Hojat et al., 1988, 1993; Zeleznik et al., 1988). Professionalism in health care context is defined as an array of personal qualities beyond the requisite medical knowledge and procedural skills that health care professionals must possess to deliver high-quality health care to their patients that leads to positive clinical outcomes (Veloski & Hojat, 2006). Medical educators currently are encouraged to make every effort to foster professionalism in medicine by offering programs at the undergraduate, graduate, and continuing education levels. Although no consensus exists regarding the number and nature of personal qualities required for professionalism in nursing, compassionate care and empathy have frequently been mentioned as its key components (Arnold, 2002; Barondess, 2003; Linn et al., 1987). Despite the consensus regarding the healing potential of empathic encounters in patient care, insufficient attention has been given to enhancement of the capacity for empathy in the design of nursing education curriculum. As

a result, the concept of empathy in patient care, according to Novack (1987), seems to be fading away in modern nursing education, with the exception of a few lonely souls who attempt to treat empathy with respect, as if it were an endangered species on the verge of extinction. The current system of medical education does not seem to be seriously concerned about nurses' losing their healing touch, treating it instead "as if it were a relic of an unscientific past" (Novack, 1987, p. 346). The lack of attention to empathy in patient care is partially the result of overreliance on computer-based diagnostic and therapeutic technology. A recent review about empathy in nursing (Pedersen, 2009), underscores that, despite the growing interest on empathy in the last two decades, there are still some inconsistencies and missing information in the findings. The majority of study has been focused on evaluation on empathy. LaMonica, Carew, Winder, Haase, and Blanchard (1976) developed an empathy training program for hospital nursing staff based on Carkhuff's human relationship model (1969). During the brief program, nurses learned to interpret patients' nonverbal behaviors and expressions of anger, engaged in empathic role playing, and practiced responding empathically. Despite a significant increase in the nurses' empathy scores, the authors reported that the majority of participants needed more training. As a result of extensive work in nursing education and research in the 1960s and 1970s, Orlando (1961, 1972) developed a model of therapeutic encounters proposing that when nurses interacted with patients, they should validate their perceptions to ensure that they had an accurate understanding of the patients' experiences.

3.4.3. Clinical Empathy, Emotional Labor and Nurses Well-being

Ku and Kirk (2008) show there are still inconsistencies in considering clinical empathy as an element in nurses' emotional labor. For example Lin Chu (2002) considered empathy as an antecedent of emotional labor and did not find strong relationships among them. More recently Chu et al. (2011), referring to hotel workers, have found that emotional contagion (the ability to feel compassion to others) put forth more effort to induce a positive mood to meet customer expectations and employees' empathic concern mat not be a strong indicator of how employees enact emotional labor. On the contrary McAlpin (2009) and Zimmermann (2011) found that empathy is a part of emotional labor which makes physicians to be more effective healers and enjoy more professional satisfaction. The links between empathy and nurses' well-being have also shown mixed results. For example, there are controversial results about the correlations between empathy and burn out (Astrom, 1990) and stress. Beddoe and

Murphy (2004) exposed nursing students to an 8-week "mindfulness-based stress reduction" program to explore the program's effects on stress and empathy. At the end of the 8 weeks, the authors reported favorable changes in the students' scores on the Personal Distress and Fantasy subscales of the IRI. Vice-versa some quantitative studies indicate possible associations between empathy and nurses' fatigue, hunger, burnout and depression (Thomas, 2007, Shanafelt, 2005, Youssef, 1996). There are few empirical studies about the links between empathy and positive outcomes in the nursing profession such as job satisfaction, job involvement, organizational citizenship behaviors and work engagement. Parker and Axtell (2011) propose that perspective taking of empathy will enhance interpersonal facilitation, or those cooperative and helping acts that support the work context. This proposition is consistent with Brief and Motowidlo's (1986) suggestion that empathy is a key predictor of prosocial behaviors such as helping others and with Bateson's (1991) statement which consider perspective taking is also a key concept in research investigating interpersonal processes such as altruism. Hochschild (1983) noted that when nurses are able to handle inner feeling and manage with patients' emotions, it may produce satisfaction. This finding shows that when managed emotions coincide with inner feelings, job satisfaction is enhanced and empathy is clearly involved in this process. Pedersen (2009) suggests that these controversial results are found because empirical research on empathy is dominated by relatively quantitative methods and the possible conditions of working conditions on empathy have not been adequately explored. Given the conceptual complexity and variability in definitions on empathy, it's fundamental to focus on how empathy is studied and what is meant by empathy. The literature analysis shows that it's important to evaluate and develop studies that can capture the multifaceted dimensions of empathy. In this doctoral dissertation we firstly aim to explore the nature of empathy and to test its major components. Secondly we will to test the role played by empathy in nurse/patient interactions and, in particular, we want to verify if the personal state of empathy may contribute in handling emotional dissonance by promoting well-being experiences in nursing work.

Conclusion

In this chapter we consider the descriptions and the role of empathy in patient care. We focus on clinical empathy as an emotional resource in the nurse – patient interactions (Liu et al. 2008) and we assume its role is crucial in managing emotions during this interactions. The Hojat's conceptualization of empathy, focused on the cognitive filter ingenerated by

"perspective taking", seems relevant for the aims of this research, which explore the role played by emotions in nurses' interactions with patients. We hypothesize this "detached involvement" in handling emotions with patients, may produce positive experiences in the nursing work. We aim to contribute to an acquisition of scientific knowledge about the links between empathy, emotional dissonance and some indicators of quality of working life (see Chapter 4). In exploring this missing information in literature, we aim to demonstrate the empathic attitude could help to highlight the invisible emotional workload of nursing.

CHAPTER 4

Quality of Work Life : Job satisfaction, Work Engagement and Organizational Citizenship Behaviors in the nursing context.

Preamble

Psychology has for sometime maintained an interest in the promotion of psychological well-being in the workplace. Peter Warr's seminal work (Warr, 1996) in the 90s has enabled the conceptual understanding of issues around employees' well-being. Subsequent research in this area has led to an understanding of the detrimental effect of work-related stress on employee health (Bond, 2004; Loretto et al, 2005). The World Health Organization's 2005 Health Action Plan for Europe (St John, 2005) has called for an improvement of employees health and has made specific recommendations for the provision of well-being care services in the workplace. These developments have important scientific and employment implications for psychology. Quality of Work Life (QWL) is defined as the effectiveness of work environment that transmit to the meaningful organizational and personal needs in shaping the values of the employees that support and promote better health and well-being. Understanding the nature of work in the contemporary environment seems to play a fundamental role in promoting better health and well-being at work. As the work culture changes drastically in the recent years, the traditional concept of work to fulfils humans' basic needs are also facing out. The basic needs are continued to diversify and change according to the evolution of the work system and standards of living of a workforce. This chapter reviews the meaning of QWL based on models and past research and analyses constructs of job satisfaction, work engagement and organizational citizenship behaviors as indicators of QWL in the nursing context.

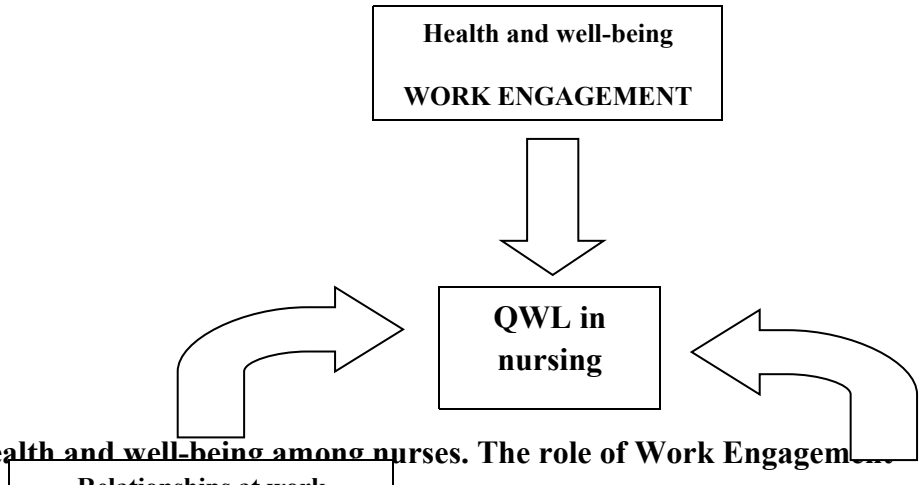
4.1. Introduction: Meaning of Quality of Work Life (QWL)

The concept of QWL was firstly discussed by Suttle (1977). The author defined it as the degree to which work are able to satisfy important personal basic needs through their experience in the organization. Because of the important changes work culture, this definition is no longer relevant. Generally jobs in the contemporary work environment offer sufficient rewards, benefits, recognition and control to employees over their actions. Although to some extent contemporary workforce are compensated appropriately, their personal spending practices, lifestyles, leisure activities, individual value systems, health and so forth can affect their levels of need. the argument posted in the Maslow's hierarchy of needs in which each individual has different level of needs because in reality what is important to some employees may not be important to others although they are being treated equally in the same organization. This definition, focusing on personal needs has neglected the fact that the construct of QWL is subjective and continuously evolves due to a growing needs of each and every employees. Hackman and Oldhams (1980) further highlight the constructs of QWL in relation to the interaction between work environment and personal needs. The work environment that is able to fulfill employees' personal needs is considered to provide a positive interaction effect, which will lead to an excellent QWL. They emphasized the personal needs are satisfied when rewards from the organization, such as compensation, promotion, recognition and development meet their expectations. Parallel to this definition, Lawler (1982) defines QWL in terms of job characteristics and work conditions. He highlights that the core dimension of the entire QWL in the organization is to improve employees' well-being and productivity. The most common interaction that relates to improvement of employees' well-being and productivity is the design of the job. Job design that is able to provide higher employee satisfaction is expected to be more productive. However, he accepted the fact that QWL is complex, because it comprises physical and mental well being of employees. Later definition by Beukema (1987) describes QWL as the degree to which employees are able to shape their jobs actively, in accordance with their options, interests and needs. It is the degree of power an organization gives to its employees to design their work. This means that the individual employee has the full freedom to design his job functions to meet his personal needs and interests. This definition emphasizes the individual's choice of interest in carrying out the task. However, this definition differs from the former which stresses on the organization that designs the job to meet employees' interest. It is difficult for the organization to fulfill the personal needs and values of each employee. However if the organization provides the appropriate authority to design work activities to the individual employees, then it is highly possible that the work activities can match their

employees' needs that contribute to the organizational performance. In the same vein Heskett, Sasser and Schlesinger (1997) define QWL as the feelings that employees have towards their jobs, colleagues and organizations that ignite a chain leading to the organizations' growth and profitability. A good feeling towards their job means the employees feel happy doing work which will lead to a productive work environment. This definition provides an insight that the satisfying work environment is considered to provide better QWL. Proceeding to previous definitions, Lau, Wong, Chan and Law (2001) operationalised QWL as the favorable working environment that supports and promotes satisfaction by providing employees with rewards, job security and career growth opportunities. Indirectly the definition indicates that an individual who is not satisfied with reward may be satisfied with the job security and to some extent would enjoy the career opportunity provided by the organization for their personal as well as professionals growth. The recent definition by Serey (2006) on QWL is quite conclusive and best meet the contemporary work environment. The definition is related to meaningful and satisfying work. It includes (i) an opportunity to exercise one's talents and capacities, to face challenges and situations that require independent initiative and self-direction; (ii) an activity thought to be worthwhile by the individuals involved; (iii) an activity in which one understands the role the individual plays in the achievement of some overall goals; and (iv) a sense of taking pride in what one is doing and in doing it well. This issue of meaningful and satisfying work is often merged with discussions of job satisfaction, and believed to be more favorable to QWL. This review on the definitions of QWL indicates that QWL is a multi-dimensional construct, made up of a number of interrelated factors that need careful consideration to conceptualize and measure. It is associated with job satisfaction, work engagement, motivation, productivity, health, safety and well-being, job security, competence development and balance between work and non work life as is conceptualized by European Foundation for the Improvement of Living Conditions (2002). To summarize, QWL is viewed as a wide-ranging concept, which includes adequate and fair remuneration, safe and healthy working conditions and social integration in the work organization that enables an individual to develop and use all his or her capacities. Most of the definitions aim at achieving the effective work environment that meets with the organizational and personal needs and values that promote health, well being, job security, job satisfaction, competency development and balance between work and non-work life. The definitions also emphasize the good feeling perceived from the interaction between the individuals and the work environment. A recent study (McGillis et al., 2006) has examined the dimensions of QWL in the nursing context. We took into account this study and selected health and well-being, job satisfaction and

professional relationships as indicators of QWL for nurses. In choosing the indicators of nurses' quality of work life, we also focus on the outcomes which are considered more pertinent with emotional labor research, which is the domain of this doctoral dissertation. With regard to nurses well being, we focus on work engagement, which can be also conceptualized as a well-being's outcome and can be defined as a persistent, pervasive and positive affective-motivational state of fulfilment in employees (Schaufeli, Salanova, Gonzalez-Roma´, & Bakker, 2002). Recent papers in the nursing literature have called for more research on this construct to be conducted with nurses because nurse engagement is still inadequately understood (Freeney & Tiernan, 2009) and its links with emotional labor are still to be verified. Then, we focus on job satisfaction, which has been described as an individual attitude to how well personal expectations at work correspond to outcomes (McKenna, 2000). Job satisfaction is considered as key outcome, given that enhances quality of work life and is one of the most examined outcomes in the emotional labor literature (Abraham, 1998; Brotheridge & Lee, 1988; Grandey, 2003; Bono & Vey, 2005). Organizational citizenship behaviors (OCB) may be also considered as indicators of QWL. In particular recent studies have reinforced the belief that the foundation of nurses' quality of working life within the context of professional practice is strengthened by connectedness (Goldberg, 1988). Connectedness is the feeling of being fully engaged and a part of the whole organization or workplace setting. When Organ (1977) first started discussing the idea of citizenship, introduced that sense of fulfilment and motivation may be only weakly related to in-role job performance, but should be significantly related to employees' willingness to engage in extra-role behaviours, which are outside the scope of an employee's formally prescribed job duties. OCB serve to improve organizational effectiveness in different way, but OCB may also contribute to nurses' QWL, because they create a solidarity gain spiral and they contribute to foster good relationships between among colleagues and between employees and their organization (Pohl & Paille, 2011). The following paragraphs discuss each of the constructs of QWL from the nursing's perspectives.

Figure 4.1 : Indicators of QWL in nursing.



4.2. Health and well-being among nurses. The role of Work Engagement

Health a[illegible] physical and psychol[illegible]n any working environment. An unstrained work environment ensures good health and psychological conditions which enable the employees to perform job and non-work related functions without inhibitions. Thus, it leads to an unstressful work environment providing comfortable work life. There are many definitions of stress as it is deemed as a subjective phenomenon of QWL. Chan (2006) defines stress as a response to the perceived relationship between the demands on individuals and the ability to adjust to their work environment. In the nursing context stress and burnout are major factors that nurses have to deal with often while in their work environment. Nursing as a career is considered to be inherently stressful (Decker, 1997). Nurses are confronted with suffering, death and grief on a daily basis, while, at the same time, performing certain tasks that could only be described as mundane (McGrath et al., 2003). Historically, nurses have long been associated with the experience of burnout, with approximately 7–10% of European nurses suffering from severe or clinical burnout (Schaufeli & Buunk, 2003; Kristensen et al., 2005) with as many as 25% suffering from some degree of burnout (Landau, 1992). Indeed, the prevalence of burnout among both doctors and nurses is on the increase (Escriba`-Agouir et al., 2006). Unfortunately, due to a variety of historical, financial, organizational, and professional factors, the literature demonstrates that nurses are reporting poorer than expected health and wellness, and increased risks to their personal safety (Zboril & Benson, 2002). Consequently, high rates of nurse absenteeism,

injury and disability, poor nurse health, and poor patient/client outcomes have all been consistently reported in the literature (Canadian Institute for Health Information, 2006). Carayon, Smith and Haims (2001) revealed that stress and burn out arise in the process of interaction between a person and the work environment that threatens the individual's physical, psychological and physiological homeostasis. Physical illness and psychological disorders increase when pressure at work increases. The prevention strategies should focus on the relationship between the individual job context, working conditions and the changes in the workplace. The prevention strategies must be healthy and humanistic nature in order to enable nurses to work comfortably. An unstressful workplace is not merely from the financial reimbursement or other benefits that matter. It is a feeling of fulfillment and gratification that the employees experience from working, thus it eventually provides a good health and well being. More recently in the burnout literature, there has been a shift in focus, in line with the alternative movement of ''positive psychology'', which gives more attention to human strengths and optimal functioning rather than to their deficits (Maslach et al., 2001). Thus, rather than focusing on burnout, the idea is for psychologists to find ways of increasing the positive consequences for people as a result of investing extensive time and energy into their work. The value of engagement would seem to lie in its foundation in positive psychology. Too often, psychologists are focused on problems and deficits with individuals. There is a risk of some type of self-fulfilling prophecy with this focus, where if practitioners expect there to be problems, they will indeed find them. Engagement gives practitioners and nurse leaders the opportunity to focus on positive aspects of the workplace and to concentrate on developing interventions that foster nurses' well-being (Freeney & Tiernan, 2009). Engagement is couched as the opposite to burnout and while there have been numerous studies that have supported the relationship between organizational antecedents and employee engagement, nurse engagement is still inadequately understood. Recent papers in the nursing literature have called for more research on this construct to be conducted with nurses so that nurse leaders can be better informed about the impact of engagement on outcomes for the organization. Work engagement has been described in many different ways; we take into the account the definition of Schaufeli and colleagues (2003), who consider engagement as a personal state of fulfillment with the job. This last theoretical frame seems very pertinent to the scopes of our dissertation, which deals with well-being as component of QWL. Work engagement is described as a persistent, positive, affective-motivational state of fulfillment in employees that is characterized by vigor, dedication and absorption (Schaufeli & Bakker, 2003). Vigour refers to high levels of energy and mental resilience while working, the

willingness to invest effort in work. Dedication refers to a strong involvement, accompanied by feelings of enthusiasm and significance and by a sense of pride and inspiration. Finally, absorption refers to a state in which individuals are fully concentrated on and engrossed in their activities. Although originally three dimensions of work engagement were distinguished, recent empirical research suggests that vigour and dedication constitute the core dimensions (Llorens, Garcia, Salanova, & Cifre, 2003; Schaufeli & Bakker, 2004; Storm & Rothmann, 2003), which are the direct opposites of the dimensions of burnout (exhaustion and dedication, respectively). Engaged employees find their work to be meaningful and in line with their values. According to Maslach and Leiter (1997), employees achieve their best when they believe in what they are doing. Leiter and Maslach (1999) argue that this area of organizational life is at the centre of employees' relationships with their work and that personal values ''encompass the ideals and motivations that originally attracted them to the organization'' (p. 482). Leiter and Harvie (1997) investigated value congruence between employees and their organization. They found that meaningfulness of work was one of only a very small number of variables to be related to all three dimensions of burnout, depleted energy, reduced involvement and undermined professional efficacy. The building of engagement from the outset, rather than investing efforts in dealing with burnout once it has developed, has numerous benefits, not least being that prevention is better than cure. Firstly, by having a policy of building engagement, levels of burnout will decrease, in turn, reducing absenteeism (Firth & Britton, 1989) and, thus, reducing costs for the health services. Secondly, current studies link engagement to superior performance (Salanova et al., 2005), thus improving efficiency and quality care within the health service. Thirdly, engagement produces not only benefits for the organization but also engenders a sense of well-being for the employee (Demerouti et al., 2001). This third point of view has been considered at most in this doctoral research, which takes into account Simpson 's research (2008). The author and his colleagues highlighted the need for health organizations to be provided with a greater understanding of the concept of engagement, its antecedents and consequences through future research. Simpson (2008) concludes that further exploration of nurses' work environments is particularly important in order to build a ''conceptually consistent definition and measurement'' (p. 11) of engagement. Nurses' engagement appears to centre on issues of energy, intrinsic reward and having a connection with others at work. The main barriers to nurse engagement appear to be work and responsibility overload, lack of autonomy, not being treated equally to other staffing groups and finally, the fact that hospitals being run as businesses conflicts with their natural propensity to put patients first. For this reason it seems

fundamental to explore the link between engagement and emotional interactions with patients in the nursing context. Freeney and Tiernan (2009) in their qualitative research on engagement underscore that nurses talk about how hospitals are being run as businesses to the detriment of the patient. This relates to managers forgetting how things are done on the ward. The following quotes, taken from focus groups recollected in this study, illustrates that sometimes management forget that they are running a hospital by flouting the basic procedures or by ignoring the needs on the ward. The first piece of conversation relates to the use of alcohol gel to prevent the spread of MRSA:"… *a lot of the management in this hospital forgets this is the hospital, they could be managing a tax office up there. And somebody told me about a particular specialized unit in the hospital here, where people go in on a daily basis here for treatment . . . and the ward clerk there said [to the hospital managers] 'excuse me did you use the gel?', so they looked a bit perturbed and a bit put out and then they did use the new alcohol gel on the way in, because she said it. . . .When they were coming back out she said again to them 'don't forget to use the gel'. They were totally thrown. . . They forget the humane side of the hospital, to them it is a business* …"… In this piece a nurse, agreed that the greatest challenge with which nurses are faced is bed shortages. ''. . . *But the biggest pressure I'd say we all probably have is bed supply*….''. How this relates to mismatched values is that because of the bed shortages, nurse managers are under pressure to become more and more ''efficient'' by pushing patients to recover more quickly than ever before. ''. . . *patients are being pushed to recover more quickly and it's become a real conveyor belt* ….'' (Freney & Tiernam, 2009, p.6). This goes against their natural inclination to care for others and, thus, is a great source of stress, as their values are in conflict with the obligations placed on them by the organization. From a nurse's point of view, personal achievement and focus are patient centered but management point of view it is not at all patient centered. In terms of Schaufeli and Bakker's concept of engagement (2003), the findings seem to fit only partially, with issues of vigor and dedication emerging. However, the third component of absorption may not work as well with nurses. Absorption is a state of immersion in work where employees can even have difficulty detaching themselves from work at the end of the day. Some nurses in these focus groups talked about leaving certain areas of nursing because they couldn't detach themselves at the end of the day (Freney & Tiernam, 2009) and they have difficult in switch off or withdrawal, a loss of caring beyond a certain acceptable level (Mackintosh, 2005)

This apparent inconsistency moves us to better investigate the links between emotional connections with patients and nurses' engagement. Previous studies underscore involvement

with patients play a key role in fostering nurses' engagement, but may also be detrimental for it. We aim to investigate in which case emotional labor with patients may (not)contribute to work engagement in nurses' profession. We take into account the work of Mackintosh (2005) who claims that the development of a successful relationship with patients builds the work related persona as separate from the individuals own persona and that enabled nurses to continue to work successfully in what otherwise might be considered a high stress situation. In the first empirical study of this dissertation we consider the cognitive factor of empathy (perspective taking) as determinant in fostering work engagement. Perspective taking produces a cognitive filter which protects nurses from an excess of identification with their patients and produces a gain spiral in their interactions (Hojat, 2007). The specific nature of this kind of emotional involvement appeared to have a twofold purpose; to promote the facilitation of patient care towards the aim of helping patients recover, but also to protect the nurses themselves from some of the distressing situations they encountered, promoting well-being experiences (Corley, 2002).

4.3. Job Satisfaction in the nursing profession

Job satisfaction is a topic of wide interest to both people who work in organizations and people who study them. It is a most frequently studied variable in organizational behavior research, and also a central variable in both research and theory of organizational phenomena ranging from job design to supervision (Spector, 1997). The traditional model of job satisfaction focuses on all the feelings that an individual has about his/her job. However, what makes a job satisfying or dissatisfying does not depend only on the nature of the job, but also on the expectations that individuals have of what their job should provide. Job satisfaction has been defined in different ways, but a review of the matter (Lu, 2005) underscores that there is a common element in all these definition. Thus job satisfaction is the *affective orientation* that an employee has towards his or her work (Price, 2001). It can be considered as a global feeling about the job or as a related constellation of attitudes about various aspects or facets of the job. It is also widely expressed that job satisfaction appears to stem from the interaction between the employee, the job itself and the organizational context within which the job is carried out. The global approach is used when the overall attitude is of interest while the facet approach is used to explore which parts of the job produce satisfaction or dissatisfaction.

Based on the review of the most popular job satisfaction instruments, Spector (1997) summarized the following facets of job satisfaction: appreciation, communication, co-workers, fringe benefits, job conditions, nature of the work itself, the nature of the organization itself, an organization's policies and procedures, pay, personal growth, promotion. Given that job satisfaction has been found to be related to performance within the work setting (Landeweerd & Boumans, 1988), it is not surprising that the concept of job satisfaction has attracted much attention. Researchers have attempted to identify the various components of job satisfaction, measure the relative importance of each component of job satisfaction and examine what effect these components have on workers' productivity (Burnard et al., 1999). A range of findings derived from quantitative studies as well as qualitative studies has been reported in the literature on sources of job satisfaction among nurses. Different measurements regarding nurses' job satisfaction show various sources of satisfaction. These different studies underscore that job satisfaction is a complex phenomenon and the identification of these factors and exploration of their effects on job satisfaction has the potential to refine the theoretical models of nurses' job satisfaction and aid the development of management interventions (Blegen, 1993). In summary, the scope of job satisfaction allows the utilization of the ability of employees, proud of working in an organization and a sense of belonging that leads to job satisfaction are among the items adopted in any studies on QWL.

The specific link between nurses' job satisfaction and emotional labor with their patients is still ambiguous. A recent review shows that previous theoretical work on emotional labor suggested a negative relationship between emotional labor and job satisfaction. (Yang & Chang, 2008). However, two empirical tests of this relationship (Adelmann, 1989, Wharton, 1993) contradicted the above view. Moorman's (1993) study found that when only one dimension is used to measure the relationship between emotional labor and job satisfaction, the correlation coefficients range from 0.16 to 0.44, suggesting that measuring emotional labor with only one dimension is inappropriate. Lin (2000) studied emotional labor and found that it should be measured using different dimensions such as emotional display rules, surface acting, deep acting, variety of emotions required, frequency and duration of interactions. However, few studies have investigated the relationship between these dimensions and job satisfaction. Morris and Feldman (1997) provided direct empirical evidence that previous research has overemphasized the negative aspects of emotional labor. Sampling employees from multiple job categories in debt collection agencies, military recruiting battalion headquartered and nursing, Morris and Feldman found that emotional dissonance is associated

with higher emotional exhaustion and lower job satisfaction. Wharton's (1993) examination of the emotional dissonance offered results that often directly contradict earlier studies. Sampling employees from multiple job categories in a large bank and a teaching hospital, Wharton discovered that emotional dissonance is positively related to job satisfaction, a finding inconsistent with Hochschild' s (1983). Ashforth and Humphrey (1993) suggested that emotional dissonance actually might make interactions more predictable and help workers avoid embarrassing interpersonal problems. This should, in turn, helps reducing stress and enhancing satisfaction. Smith and Kleinman (1989) believed that when medical personnel can maintain a neutral mood, he/she can maintain a proper distance to stay away from psychological unhappiness. However, empirical findings of an integrated approach adopted by this study revealed that the relationship between emotional dissonance and job satisfaction is uncertain. Theodosius's (2006) concern was that emotional labor in nursing was considered to be marginalized due to organizational constraints and the low status attached to emotion work within and outside of nursing (James, 1992; Smith, 1992). She also reveals that working with emotions is integral to the way in which nurses construct their personal identity which goes beyond external factors to the very reasons why they choose to do nursing in the first place such as 'unconscious love' (Theodosius, 2006, p. 899).

For this reason it seems fundamental considering emotions as essential elements in fulfilling nurses' expectations. In a Japanese study, for example, Gregg and Magilvy (2004) found that nurses consider the relation with patient a key element in the perception of being a "good nurse". These researchers found that their respondents:" strongly value *considering a patient's feelings*. During practice they described *being connected to the patient* and said that they were having *a relationship as a human being*. They practice *being with a patient, touching a patient and advocating for their patients"* (Gregg & Maglvy, 2004, p. 15). Nurses are daily called to manage emotions and handle with emotional involvement and this effort plays an important role in contributing to their satisfaction (Smith, 2010). Emotional labor has been explored in detail elsewhere and explained as involving the regulation and management of feeling (Hochschild 1983, Smith 1992). For example, a nurse actually feels disgust towards the patient but represses the feeling which is considered unacceptable by organizational and professional ethic's feeling rules. In doing so, the idea that the nurse does not feel disgust is interpreted by her effort to provide care and kindness and the emotion is identified as empathy. The feeling of disgust is never actually unconscious, but the ideational presentation of the nurse as caring has repressed it (Theodosius, 2006). Thus, conscious and unconscious emotion which directly impact on both internal and external behavior patterns can bypass

cognitive processes which mediate the sharing of emotion in nurse/patient interaction (Theodosius, 2006). Hochschild (1983) noted that when nurses are able to handle inner feeling and manage with patients' emotions, it may produce satisfaction. This finding shows that when emotional labor coincides with inner feelings, job satisfaction is enhanced. This doctoral research embraces these suggestions and aims to test whether and how management of emotion in patients' interactions may (not) contribute to nurses' job satisfaction. We believe this orientation has some important implications. This perspective suggests that nurses considered these aspects as highly important and positive attributes which enabled them to promote the preservation of the self and enhanced their ability to continue working as a nurse. We aim to underscore that emotions continue to be an important feature of both learning and nursing, despite a culture which does not recognize their importance in understanding the organizational support required to manage complex feelings. A program to address these issues must by necessity be ambitious and multifaceted and embrace education, research and practice. The practice of nursing is simultaneously scientific and humanistic in nature. Nurses utilize knowledge in an effort to provide scientifically sound and humanistic care. To ensure the well-being an important prerequisite is restoring the relationship between nurse and patient. In regard to that, Perry (2010) found that nurses who have provided high quality care and have made strong connections with patients feel very satisfied with their professional work life. Connection with patients involves managing emotions, such as fear, anger, pain, sorrow, sadness and being able to handle with this emotional workload. Several studies underscore that positive self esteem mediates the level of mental energy and predicts positive professional fulfillment and decreased work exhaustion. We aim to test the role played by handling with emotions in patients' interactions in (not) promoting nurses' job satisfaction. We assume that handling emotions in patients interactions, may play a fundamental role in fulfilling nurses' needs, motivations and aspirations.

4.4. Organizational Citizenship Behaviors in the nursing context

Organizational citizenship behaviors (OCB) has attracted the attention of both academics and practitioners since long time. The concept of organizational citizenship behavior was first

introduced in 1983 by Bateman and Organ, and since the introduction of this concept more than 650 articles have been published on OCB and related concepts (Podsakoff, Whiting, Podsakoff, & Blume, 2009).

OCB is described by Organ as "individual behavior that is discretionary, not directly or explicitly recognized by the formal reward system and that in the aggregate promotes the effective functioning of the organization" (1988, p. 4). When Organ (1977) first started discussing the idea of citizenship, introduced that satisfaction may be only weakly related to in-role job performance, satisfaction should be significantly related to employees' willingness to engage in extra-role behaviors (i.e., behaviors outside the scope of an employee's formally prescribed job duties). Later, Organ specified that OCB is "performance that supports the social and psychological environment in which task performance takes place" (Organ, 1997, p. 95). OCB is not required by the demands of task or job (Norris-Watts, 2004). It may be described as a lubricant of the social machinery of the organization, reducing friction and increasing efficiency (Organ, 1988). OCB is considered to be beneficial and supportive for the organization and the individual (Bolino, Turnley, & Bloodgood, 2002). More recently, (Ma, Yu, & Hao, 2010; Lambert, 2000) QWL has found to benefit from organizational citizenship behaviors directly, through obligations incurred as a result of social exchange, and indirectly, through enhanced perceptions of organizational support.

OCB has almost always been depicted in three positive assumptions. The first is that OCBs stem from positive or non-self-serving motives (such as job satisfaction, organizational commitment, or conscientiousness); the second one is related to the fact that OCB facilitates the effective functioning of organizations and the third is that citizenship in organizations ultimately benefits employees by making organizations a more attractive place to work (Organ, 1988; Podsakoff, MacKenzie, Paine, & Bachrach, 2000). OCB may be described as positive experiences not only for organizations but also for employees. Firstly, workers who engage in OCB tend to receive better performance ratings by their managers (Podsakoff et al., 2009). This could be because employees who engage in OCB are simply liked more and perceived more favorably and this has become known as the 'halo effect' (Zhang, 2011) or it may be due to more work-related reasons such as the manager's belief that OCB plays a significant role in the organization's overall success, or perception of OCB as a form of employee commitment due to its voluntary nature (Organ et al., 2006). Regardless of the reason, the second effect is that a better performance rating is linked to gaining rewards (Podsakoff et al., 2009) – such as pay increments, bonuses, promotions or work-related benefits. Thirdly, because these employees have better performance ratings and receive greater

rewards, when the company is downsizing e.g. during an economic recession, these employees will have a lower chance of being made redundant (Organ et al, 2006). OCB create also social capital, where better communication and stronger networks facilitate accurate information transfer and improve efficiency. Employees who perform OCB are more likely to benefit of good interactions among colleagues and cooperation climate (Zhang et al., 2012). The construct of OCB, from its conception, has been considered multidimensional and there is no clear consensus in the literature on the number of dimensions of OCB (Pohl & Paille, 2011). A variety of forms are proposed. Organ identifies five dimensions of OCB: altruism, courtesy, conscientiousness, sportsmanship and civic virtue. Van Dyne, Graham and Dienesch (1994) propose an alternative model of OCB based on political philosophy. This model also includes five dimensions: obedience, loyalty, advocacy participation, social participation and functional participation (Van Dyne, Graham, & Dienesch, 1994; Van Dyne, & Lepine, 1998). The third concept of OCB proposed by Williams and Anderson (1991) includes behavior focused on helping particular individuals within the organization (altruism, social participation,...) and behavior beneficial to the organization (civic virtue, obedience). Williams and Anderson (1991) differentiates OCB focused on interpersonal relations (OCBI) and OCB focused on the organization as a whole (OCBO). OCBO includes citizenship behaviors that are beneficial to the organization, while OCBI behaviors are aimed at benefiting other individuals. They divided up the dimensions of OCB into two different types of OCB based on whom the behaviors were directed at. Organizational citizenship behavior – individuals (OCBI) include behaviors that are aimed at other individuals in the workplace while organizational citizenship behavior-organizational (OCBO) include behaviors directed at the organization as a whole. Altruism and courtesy are actions aimed at other employees and thus fall under the umbrella of OCBIs. Conscientiousness, civic virtue, and sportsmanship are behaviors intended for the benefit of the organization and can subsequently be considered OCBOs. In the health care organizations, altruism and civic virtue seem to play the most significant role (Parker & Axtell, 2001). This increased interest is reflected in the growth of organizational concepts that emphasize interpersonal and volitional behaviors at work, such as OCBs (Organ, 1988). As Motowidlo and Van Scotter stated, these types of concepts "… highlight behaviors that involve cooperation and helping others in the organization" (1994, p.475). For example, altruism involves an array of volitional behaviors that support the social and motivational context in which work is carried out (Borman & Motowidlo, 1993). The most important dimension of altruism has been shown to be interpersonal facilitation, which includes cooperative, considerate, and helpful acts that assist other workers' performance and

facilitate good working relationships (Van Scotter & Motowidlo, 1996). Rule (1978) claims altruism is a key characteristic in nurses' professionalism. Civic virtue is traditionally considered the cultivation of habits of personal behaviors that are claimed to be important for the success of the community. The identification of the character traits that constitute civic virtue have been a major concern of political philosophy. The term *civility* refers to behavior between persons and groups that conforms to a social mode (that is, in accordance with the civil society), as itself being a foundational principle of society (Bogorad, 2006). In the working context civic virtue is characterized by behaviors that indicate the employee's deep concerns and active interest in the life of the organization (Law, Wong, & Chen, 2005). Civic virtue can take many forms from individual volunteerism to organizational involvement to electoral participation. It can include efforts to directly address an issue, work with others in a community to solve a problem or interact with the institutions (Ketter, 2002). This dimension also encompasses positive involvement in the concerns of the organization (Organ et al., 2006). It is well established within the field of organizational psychology that OCBI enhances interpersonal relations, by increasing helping behaviors and decreasing aggression (Pohl & Paille, 2011). More broadly, the development of volitional behaviors has been shown to be associated with reduced prejudice (Gardiner, 1972) and resolving conflicts cooperatively (Eiseman, 1978). There is increasing interest in fostering effective interpersonal relationships within modern health organizations, where pressures for coordination, performance and integration are high (Parker & Axtell, 2011). Altruism and civic virtue seem to be very pertinent to the scopes of this doctoral research. Not only they are well established to contribute to nurses' well-being, by fostering satisfying relations and by promoting solidarity, but also seem to be very connected to emotional states. Parker and Axtell (2011) propose that perspective taking of empathy will enhance interpersonal facilitation, or those cooperative and helping acts that support the work context. This proposition is consistent with Brief and Motowidlo's (1986) suggestion that empathy is a key predictor of prosocial behaviors such as helping others and with Bateson's (1991) statement which consider perspective taking is also a key concept in research investigating social processes such as altruism. Specifically, we aim to verify in our empirical research (chapter 6) if the empathic perspective taking will be associated with cooperative and helping behaviors towards suppliers.

Conclusion

In this chapter we focus on experiences of QWL in the nursing context. A clear and unique definition of QWL at work is still far from being widely accepted. QWL at work may be described as a multi-dimensional experience which embraces very different elements. However, it's well established that focusing on QWL it means to give attention to resources and strengths rather at work. This perspective, derived from positive psychology, seems fundamental in the nursing context. In choosing the positive outcomes to test in our research we take into account this concept. Job satisfaction, work engagement and organizational citizenship behaviors cannot include the entire QWL's multi facet and complexity. They focus on some important aspects of positive experiences for nurses and they seem very pertinent with the emotional work in interactions with patients. Literature has been largely focused on how emotional labor leads to nurses' burn out, absenteeism and turn over for a long time and this orientation risks to forget nurses' resources and opportunities. It is well known nursing work is hard and complex for many different reasons. But a new paradigm is emerging and focusing on the strong motivations which lead a nurse to his/her profession. In both perspectives a fundamental role is played by the emotions that a nurse handles with the patient and it could be seen an ambivalent matter. The management of patients' emotions could be stressful but also challenging, frustrating but also motivating. In depends on *how* nurses can handle with emotional involvement. In regard of that we aim to test the role played by emotional dissonance and empathy. As seen in previous chapters they can be considered two different personal states, which are stimulated during interactions with patients and may contribute to QWL in different ways. The first purpose of this doctoral research is to verify the role played by emotional dissonance and empathy in (not) promoting job satisfaction, work engagement and organizational citizenship behaviors. Hypotheses, methods and empirical studies will be presented in following chapters of this volume.

CHAPTER 5

PRESENTATION OF THE EMPIRICAL STUDIES

Introduction

In the recent years we have been witnesses to a rise of organized studies of emotions in the workplace, as shown in the first part of this volume. Workplace was thought as cold and rational; yet it is no more emotionless than any other aspect of social life (Fisher & Ashkanasy, 2000). Weiss and Cropanzano (1996) advised workplace experiences comprise many work events that can be pleasing or stressful and frustrating. Doubtless, emotions are beginning an inherent part of the workplace and this assumption plays an important role in the nursing contest. This phd dissertation would like to contribute to recognize emotions as an inherent part of everyday nurses work life, giving them the attention they deserve. Nurses are expected to express caring (Hinds, Quargnenti, Hickey, & Magnum, 1994) and at the same time they are encouraged to develop professional detachment (Savett, 2000). A review (Zapf, 2002) has shown emotion labor has both positive consequences (such as job satisfaction or feeling of personal accomplishment) and negative implications (such as emotional exhaustion, depersonalization, or psychosomatic complaints). This ambivalent character of emotions in the workplace suggests that fostering researches on different emotional labor components, could enhance understanding of how employees manage emotions in the workplace (Diefendorff, 2008). Two studies have been planned in order to investigate the perspective below. The first study presents two models; the first one aims to analyse the structure of empathy and in particular aims to test the two major components of empathy: perspective taking and compassion. The general hypothesis is that empathy (especially its cognitive factor) may contribute to quality of working life in the nursing context. The second model of study one focuses on emotional dissonance and aims to verify its correlations to job satisfaction. To verify our hypothesis, Italian nurses are asked to answer to a questionnaire. The second study has been performed in a Belgian context and it introduces some concepts

such as perception of display rules and emotional support both from supervisor and colleagues.

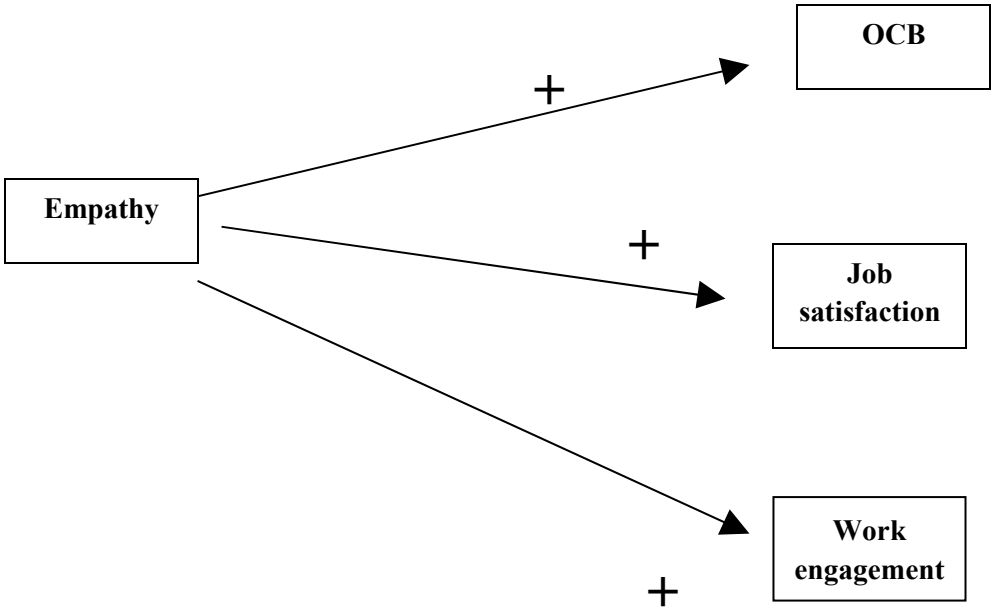
5.1. Aims of Study 1 (Model 1)

The first study aims to verify the nature of empathy and test its links to some positive experiences at work. As seen in chapter 3, the literature analysis shows that it's important to evaluate and develop studies that can capture the multifaceted dimensions of empathy. In order to do so, we take into account the theoretical perspective of Hojat and colleagues (2002), who claim that empathy has two components and the major of them is the cognitive core of perspective taking. We firstly aim to verify this structure and then test its links to positive outcomes in the nursing work. As Ashkanasy and Daus (2002) claim emotional resources as empathy may equip and skill employees to perform emotional labor effectively and without personal consequences. In the emotional labor literature, empathy is widely accepted to be a functional emotional strategy to attempt to bring one's felt affect in line with expressed one (Chu et al. 2011). Nurses have to use the empathic concern of taking into account others' thoughts and feelings (Zammuner & Galli, 2005).

In the first study we expected that empathy has positive correlations with work engagement, job satisfaction and organizational citizenship behaviours. This theoretical model is explained in figure 5.1. Results and implications of this first research are shown and explained in details in the sixth chapter of this section.

These very first results confirm our hypotheses on empathy and have inspired the second empirical research.

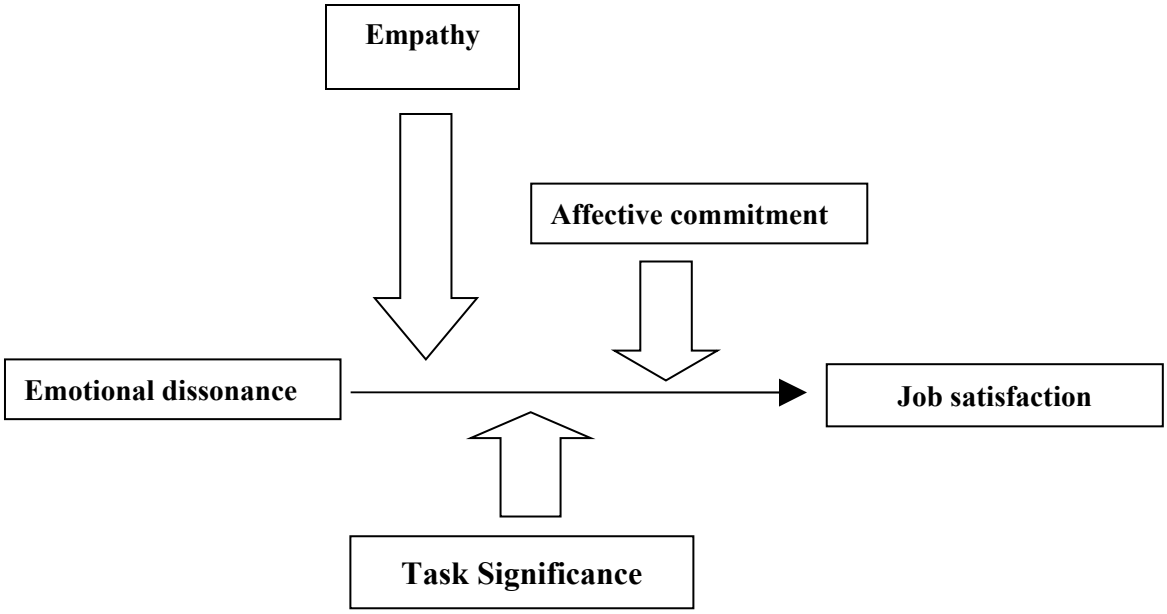
Figure 5.1.: Theoretical model of Study 1 (Model 1)



5.2. Aims of Study 1 (Model 2)

The second model of study 1 aims to critically examine the role played by emotional dissonance on nurses' job satisfaction. In particular we want to test if the detrimental effects of emotional dissonance can be moderated by some personal and or organizational resources. By using the effort justification model as theoretical frame and considering the previous findings of Empathy, we consider it as a personal emotional resource which can lessens the negative effects of emotional dissonance on job satisfaction. We also aim to verify the moderated effects of Affective Commitment and Task Significance. Affective Commitment concerns the level of the nurse/organization inter-play. Task significance is considered an important job characteristic. The Effort-Justification model and the three moderator variables will be described in detail in the seventh chapter of this volume. The theoretical model of study 1, model 2, is presenting in figure 5.2.

Figure 5.2.: Theoretical model of study 1 (model 2).



The results of this second research seem important in order to better understand the role played by emotions in the nurse/patient interaction. These findings underscore that the detrimental effects of emotional dissonance can be moderated on different levels. These evidences confirm some previous researches which have underlined that emotional dissonance is not always detrimental, but only in regard with certain conditions (Wharton, 1983). These findings have stimulated some considerations, which inspired the second study of this doctoral research, which is performed on a Belgian nursing context.

5.3. Aims of Study 2

The second study has three general aims. The first is to (not) confirm previous findings on empathy and emotional dissonance. In the second and in the third part, we introduce some

variables which can be considered very pertinent in managing emotions during interactions with patients and are relevant for effective emotional functioning with patients.

The second aim of our study is to test the roles played by organizational display rules. Traditionally studies have described these rules as organizational norms, customers and patients expectations, managers' prescriptions, ethical requirements. Researchers has not yet clarified how employees interact with these display rules (Zapf, 2002). We focus on how nurses perceive these norms and we aim to test their different influence. We assume that the perception of these rules moves along a similar continuum of Work Motivation, inspired from the Self Determination Theory (Decy & Ryan, 2000). We use a slightly modified version of the *display rules* concept (Ekmann & Friesen, 1975). We assume nurses may perceive these rules as prescribed requirements, as organizationally shared norms and finally they may perceive these rules as internalized standards of emotional behaviors. We hypothesize that, when internalized and shared, these norms may facilitate the attainment of organizational objectives and expectations about nurses' caring of patients. In particular organizational shared rules are positively relate to job satisfaction and internalized display rules have positive correlations to perspective taking (cognitive empathy). On the contrary when display rules are perceived as strongly prescribed, emotional dissonance arises.

In the third part of this study, we introduce the emotional support from supervisor and co-workers. Emotional support refers to how leader and colleagues recognise, emotional workload and help nurses in handling with emotions during interaction with patients. Previous studies suggest emotional support plays a fundamental role in helping nurses to handle emotional workload (Brown, 2010). In particular we aim to test the moderator role of emotional support in the relation between prescribed display rules and emotional dissonance.

The theoretical models of study 2 are reported in figures 5.3, 5.4 and 5.5.

Figure 5.3.: Theoretical Model of Study 2 (Part 1)

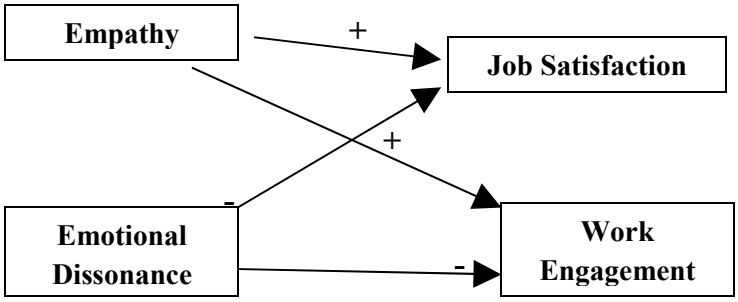


Figure 5.4.: Theoretical Model of Study 2 (Part 2)

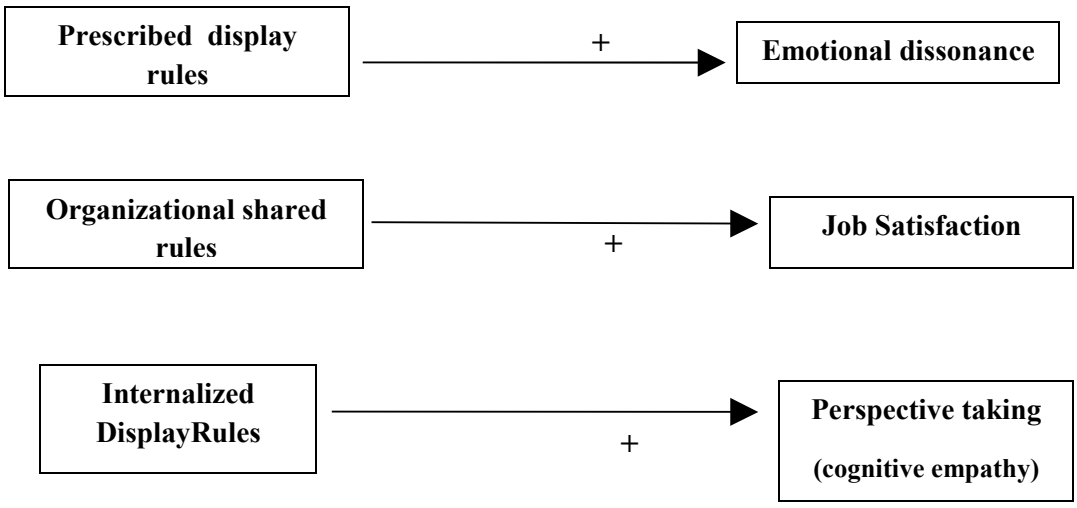
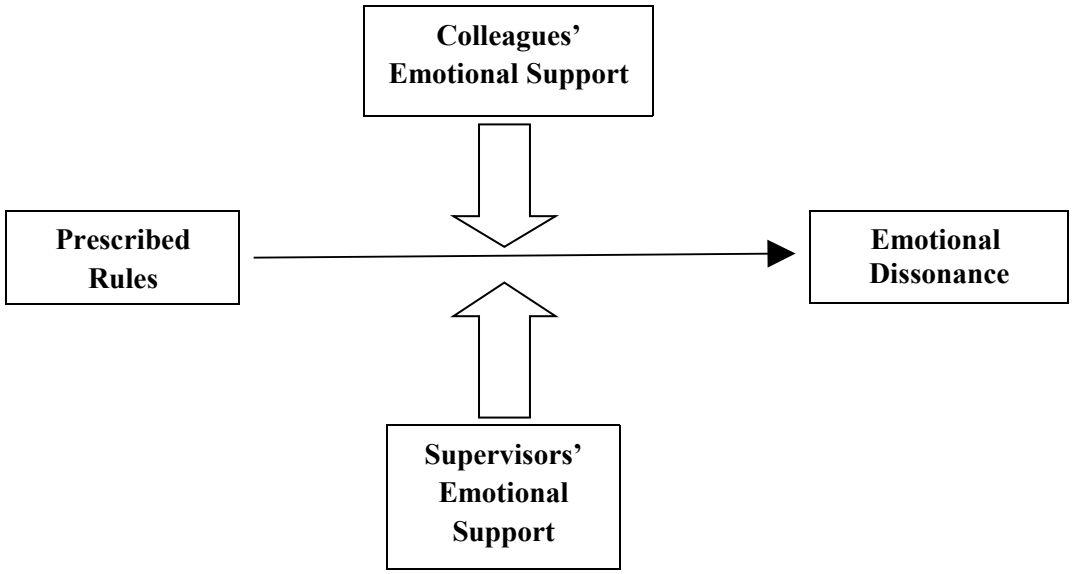


Figure 5.5.: Theoretical Model of Study 2 (Part 3)



CHAPTER 6

The nurse-patient emotional interaction as crucial element in job satisfaction, work engagement and organizational citizenship behaviors: the role of empathy (Study 1; model 1).

Abstract:

Empathy, a complex and multidimensional concept, has been defined in many ways within the context of nursing. Considering the role of empathy in patient care and a review of relevant literature (Yu, Kirk, 2008), this study aims to verify if empathy is predominantly cognitive attribute that involves an understanding of experiences, concerns and perspectives of patients (Hojat 2002). By distributing the Italian version of JPSE to 222 Italian nurses we confirmed empathy is composed by two factor: perspective taking and compassion. Our study shows perspective taking positive enhances job satisfaction, work engagement and OCB. Compassion does not. These findings confirm cognition and affect have different impact on nurses' work conditions. Further studies is required to inform education or for application in clinical settings.

Keywords: perspective taking, compassionate care, nursing, emotions, quality of work life

Introduction

In the recent few years the role of emotions in the workplace has been evaluated as essential in (not) promoting positive experiences at work (Finemann, 2003). Health care work is, by its nature, an area of heightened emotions, and thus is ripe ground for the exploration of emotions in the workplace In particular; emotions' management plays a key role in the helping professions and seems fundamental in the nursing context. (Kent 2007).According to Hochschild(1983) classification a significant element of nursing work load, is the high emotional involvement in relationship with patients (Mann, 2005). Nurses are confronted with suffering, death and grief on a daily basis, while, at the same time, performing certain tasks (McGrath et al., 2003). Handling with emotion, within nursing, is particularly needed when working in distress situations, for example, caring for terminally ill patients, experiencing loss and pain. Nurses are expected to express compassion and caring, at the same time that they are encouraged to develop a level of professional detachment (Savett, 2000).The ability of

nurses to hold competing emotions is at the heart of a number of recent studies. McCreight (2005) considers nurses' use of emotions as a valid resource in the construction of professional knowledge. The changing nature of health care sector implies the feelings aspect of nursing life is increasingly acknowledged.This paper aims to follow this perspective and in particular wants to test the role of empathy as emotional resource in nurse-patient interactions and verify its role in promoting positive experiences at work.

6.1. Literature review

6.1.1. Empathy

A recent review about empathy in nursing (Pedersen, 2009), underscores that, despite the growing interest on empathy in the last two decades, there are still some inconsistencies and missing information in the findings. The notion of "empathy" has a long history marked by ambiguity, discrepancy, and controversy among philosophers and behavioral, social, and medical scholars (Aring, 1958; Preston & deWaal, 2002; Wispe, 1978, 1986). Because of this conceptual ambiguity, empathy has been conceptualized as an "elusive" concept (Basch, 1983); one that is hard to define and measure (Kestenbaum, Farber, & Sroufe, 1989). Eisenberg and Strayer (1987a, p. 3) described empathy as a "slippery concept . . . that has provoked considerable speculation, excitement, and confusion." Empathy also has been discussed frequently in the psychoanalytic literature (Jackson, 1992) and in social psychology, counselling, and clinical psychiatry and psychology (Berger, 1987; Davis, 1994; Eisenberg & Strayer, 1987c; Ickes, 1997). Also, because of the ambiguity associated with the concept of empathy, Pigman (1995) suggested that empathy has come to mean so much that it means nothing! Despite the conceptual ambiguity, it is interesting to note that empathy is among the most frequently mentioned humanistic dimensions of patient care (Linn, DiMatteo, Cope, & Robbins, 1987). Carl Rogers (1959, p. 210), the founder of client-centred therapy, suggested the following often-cited definition of empathy as an ability "... to perceive the internal frame of reference of another with accuracy as if one were the other person but without ever losing the *'as if '*condition". In addition, William Ickes (1997, p. 183) defined empathy as "a state of our mind upon which we reflect". Bellet and Maloney (1991, p.183) claimed that empathy is "the capacity to understand what the other person is experiencing from within the other person's frame of reference and the capacity to place oneself in another's shoes." Bennett (2001, p. 7) defined empathy as "a mode of relating in which one

person comes to know the mental content of another, both *affectively* and *cognitively*, at a particular moment in time and as a product of the relationship that exists between them. Empathy has been at most described as a cognitive or an emotional attribute or a combination of both. Cognition is mental activities involved in acquiring and processing information for better understanding, and emotion is sharing of the affect manifested in subjectively experienced feelings. These two components of empathy are integrated by Hoyat (2002) who described empathy as a concept involving cognitive as well as affective or emotional attribute. The cognitive attribute of empathy involves the ability to understand another person's inner experiences and feelings and a capability to view the outside world from the other person's perspective. The affective attribute involves the capacity to enter into or join the experiences and feelings of another person. The affective relationships that elicit emotional response are conceptually more relevant to sympathy than to empathy. Hojat (2002) has distinguished empathy from sympathy. Empathy is in the area of higher cognition than emotion. Conversely, sympathy is in the area of higher emotion than cognition. Compassion, resides in the area of the overlap between empathy and sympathy, where both of these attributes are expressed in a moderate amount.. The distinction between sympathy and empathy has important implications for the clinician–patient relationship because joining the patient's emotions (a key feature of sympathy), can impede clinical outcomes. A clinician should feel the patient's feelings only to a limited extent to improve his or her understanding of the patient without impeding professional judgment (Starcevic & Piontek, 1997). When experiencing empathy, individuals are able to disentangle themselves from others, whereas individuals experiencing sympathy have difficulty maintaining a sense of whose feelings belong to whom (Decety & Jackson, 2006). Both cognitive empathy and compassionate care involve sharing, but empathetic nurses share their understanding, while compassionate ones share their emotions with the patients. Cognitive and emotional features do not, however, function independently and their interaction makes empathy a multidimensional concept (Hojat, 2002).

6.1.2. Job satisfaction, work engagement and organizational citizenship behaviors as elements of quality work life in nursing.

Quality of Working Life (QWL) is defined as the effectiveness of work environment that transmit to the meaningful organizational and personal needs in shaping the values of the employees that support and promote better health and well-being. As the work culture

changes drastically in the recent years, the traditional concept of work to fulfil humans' basic needs are also facing out. The basic needs are continued to diversify and change according to the evolution of the work system and standards of living of a workforce.

The review on the definitions of QWL (Serey, 2006) indicates that QWL is a multi-dimensional construct, made up of a number of interrelated factors that need careful consideration to conceptualize and measure. It is associated with job satisfaction, work engagement, motivation, productivity, health, safety and well-being, job security, competence development and balance between work and non work life as is conceptualized by European Foundation for the Improvement of Living Conditions (2002).A recent study (McGillis et al., 2006) has examined the dimensions of QWL in the nursing context. We took into account this study and selected health and well-being, job satisfaction and professional relationships as indicators of QWL for nurses. In regard to nurses well-being, we focus on work engagement, which can be defined as a persistent, pervasive and positive affective-motivational state of fulfilment in employees (Schaufeli, Salanova, Gonzalez-Roma´,& Bakker,2002).Recent papers in the nursing literature have called for more research on this construct to be conducted with nurses because nurse engagement is still inadequately understood (Freeney & Tiernan, 2009). Then, we focus on job satisfaction, whichhas been described as an individual attitude to how well personal expectations at work correspond to outcomes (McKenna, 2000).Job satisfaction is considered as key outcome, given that enhances quality of work life (Bono&Vey, 2005). Organizational citizenship behaviors (OCB) may be also considered as indicators of QWL. In particular recent studies have reinforced the belief that the foundation of nurses' quality of working life within the context of professional practice is strengthened by connectedness (Goldberg, 1988). Connectedness is the feeling of being fully engaged and a part of the whole organization or workplace setting. When Organ (1977) first started discussing the idea of citizenship, introduced that sense of fulfilment and motivation may be only weakly related to in-role job performance, but should be significantly related to employees' willingness to engage in extra-role behaviours, which are outside the scope of an employee's formally prescribed job duties. OCB serve to improve organizational effectiveness in different way, but OCB may also contribute to nurses' QWL, because they create a solidarity gain spiral and they contribute to foster good relationships between among colleagues and between employees and their organization (Pohl & Paille, 2011).

6.1.3.Empathy and Job Satisfaction

Whilst substantial literature exists regarding job satisfaction among employees in general and within nursing specifically, there appears to be no agreed precise definition (Cavanagh, 1992, Zangaro & Soeken, 2007). It has been described as an individual attitude to how well personal expectations at work correspond to outcomes (McKenna, 2000). Therefore, an individual's appraisal of the degree to which the job fulfils one's own job values can cause a positive emotional state of satisfaction or a contrasting negative feeling of dissatisfaction. The global approach to measurement is used when the interest is in overall attitude to the job. However, facet approaches can determine which particular aspects of the job are producing satisfaction or dissatisfaction. Facets of job satisfaction can involve any aspect of the job and those frequently assessed include pay, co-workers, supervisors, organisational factors and work environment (Smith et al., 1969; Stamps & Piedemonte, 1986). Job satisfaction among nurses has been identified as a key factor in nurses' turnover with the empirical literature suggesting that it is related to a number of organizational, professional and personal variables (Lu, 2005, Portoghese, Galletta, Penna, Battistelli & Saiani, 2011).There is general support that nurses' empathic attitude is important for good quality care and patients' satisfaction and compliance (Olson, 1997, Watt &Wattson, 2000), More than two decades later, Olson and Hanchett (1997) adopted Orlando's model as a suitable method of studying empathy and patient outcomes and hypothesized that if nurses understood their patients' needs accurately and shared that understanding with patients, who in turn confirmed its accuracy, patient outcomes would improve. Theodosius's (2006) considers managing emotions in interactions with patients as essential elements in fulfilling nurses' expectations. In this vein, Gregg and Magilvy (2004) found that nurses consider the relation with patient a key element in the perception of being a "good nurse". These researchers found that their respondents:" strongly value *considering a patient's feelings*. During practice they described *being connected to the patient* and said that they were having *a relationship as a human being*. They practice *being with a patient, touching a patient and advocating for their patients"* (Gregg & Maglvy, 2004, p. 15).. Empathy is an emotional resource which improves patient quality relation. We hypotheses that empathy is positively correlated with job satisfaction

Hypothesis 1a: Empathy is positively correlated to job satisfaction

6.1.4. Empathy and Work Engagement.

Work engagement can be also conceptualized as a positive outcome of QWL and can be defined as a persistent, pervasive and positive affective-motivational state of fulfilment in employees (Schaufeli, Salanova, Gonzalez-Roma´,& Bakker, 2002). It is composed of three dimensions: vigour, dedication, and absorption. Vigour refers to high levels of energy and mental resilience while working, the willingness to invest effort in work. Dedication refers to a strong involvement, accompanied by feelings of enthusiasm and significance and by a sense of pride and inspiration. Finally, absorption refers to a state in which individuals are fully concentrated on and engrossed in their activities. Although originally three dimensions of work engagement were distinguished, recent empirical research suggests that vigour and dedication constitute the core dimensions (Llorens, Garcı´a, Salanova,& Cifre, 2003; Schaufeli & Bakker, 2004; Storm & Rothmann, 2003), which are the direct opposites of the dimensions of burnout (exhaustion and dedication, respectively). Engaged employees find their work to be meaningful and in line with their values. According to Maslach and Leiter (1997), employees achieve their best when they believe in what they are doing. Recent papers in the nursing literature have called for more research on this construct to be conducted with nurses because nurse engagement is still inadequately understood (Freeney & Tiernan, 2009) and interventions aimed at fostering engagement are called for and through future research in the area of engagement, it is believed that nurses will gain more positive experiences from their work and subsequently a greater sense of well-being (Landau, 1992). Nurses' engagement appears to centre on issues of energy, intrinsic reward and having a connection with others (Simpson, 2008). Freeney and Tiernan (2009) in their qualitative research on engagement underscore that from a nurse's point of view, personal achievement and focus are patient centered. In terms of Schaufeli and Bakker's concept of engagement (2003), the findings seem to fit only partially, with issues of vigor and dedication emerging. However, the third component of absorption may not work as well with nurses. Absorption is a state of immersion in work where employees can even have difficulty detaching themselves from work at the end of the day. Some nurses in these focus groups talked about leaving certain areas of nursing because they couldn't detach themselves at the end of the day (Freney & Tiernam, 2009) and they have difficult in switch off or withdrawal, a loss of caring beyond a certain acceptable level (Mackintosh, 2005)

This apparent inconsistency moves us to better investigate the links between emotional connections with patients and nurses' engagement. Previous studies underscore involvement with patients play a key role in fostering nurses' engagement, but may also be detrimental for it. Mackintosh (2005) claims that the development of a successful relationship with patients builds the work related persona as separate from the individuals own persona and that enabled nurses to continue to work successfully in what otherwise might be considered a high stress situation. We hypotheses that empathy which allow to maintain a good distance with the patient is positively linked to work engagement

Hypothesis 1b: Empathy is positively correlated to work engagement.

6.1.5. Empathy and Organizational Citizenship Behaviors (OCB)

OCB is considered to be beneficial and supportive for the organization and the individual (Bolino, Turnley, & Bloodgood, 2002) OCB has almost always been depicted in three positive assumptions. The first is that OCBs stem from positive or non-self-serving motives (such as job satisfaction, organizational commitment, or conscientiousness); the second one is related to the fact that facilitates the effective functioning of organizations and the third is that citizenship in organizations ultimately benefits employees by making organizations a more attractive place to work (Organ, 1988; Podsakoff, MacKenzie, Paine, & Bachrach, 2000). The construct of OCB, from its conception, has been considered multidimensional. Organizational citizenship behavior – individuals (OCBI) include behaviors that are aimed at other individuals in the workplace while organizational citizenship behavior-organizational (OCBO) include behaviors directed at the organization as a whole. Altruism and courtesy are actions aimed at other employees and thus fall under the umbrella of OCBIs. civic virtue, and sportsmanship are behaviors intended for the benefit of the organization and can subsequently be considered OCBOs. In the nursing contest altruism and civic virtue seem to play the most significant role (Parker & Axtell, 2001; Pohl & Paillé, 2011). Altruism in the workplace consists essentially of helping behaviors. The most important dimension of altruism has been shown to be interpersonal facilitation, which includes cooperative, considerate, and helpful acts that assist other workers' performance and facilitate good working relationships (Van Scotter & Motowidlo, 1996). Rule (1978) claims altruism is a key characteristic in nurses'

professionalism. Civic virtue is characterized by behaviors that indicate the employee's deep concerns and active interest in the life of the organization (Law, Wong,& Chen, 2005). This dimension also encompasses positive involvement in the concerns of the organization (Organ et al., 2006). Civic virtue can take many forms from individual to organizational involvement to electoral participation. It can include efforts to directly address an issue, work with others to solve a problem or interact with the institutions (Ketter, 2002). This dimension also encompasses positive involvement in the concerns of the organization (Organ et al., 2006). It is well established within the field of organizational psychology that OCBI enhances interpersonal relations, by increasing helping behaviors and decreasing aggression (Pohl & Paille, 2011). More broadly, the development of volitional behaviors has been shown to be associated with reduced prejudice (Gardiner, 1972) and resolving conflicts cooperatively (Eiseman, 1978). There is increasing interest in fostering effective interpersonal relationships within modern health organizations, where pressures for coordination, performance and integration are high (Parker &Axtell, 2011). Not only they are well established to contribute to nurses' well-being, by fostering satisfying relations and by promoting solidarity, but also seem to be very connected to emotional states. Parker and Axtell (2011) propose that perspective taking of empathy will enhance interpersonal facilitation, or those cooperative and helping acts that support the work context. This proposition is consistent with Brief and Motowidlo's (1986) suggestion that empathy is a key predictor of prosocial behaviors such as helping others and with Bateson's (1991) statement which consider perspective taking is also a key concept in research investigating social processes such as altruism.

Hypothesis 1c: Empathy is positively correlated organizational citizenship behaviors

6.2.Method

6.2.1. Participants and procedures

To test our hypothesis a questionnaire has been distributed to nurses in the different hospitals in a north region of Italy. Of the 300 copies distributed, 222 were answered, for an overall response rate of 74 %. The survey was anonymous but participants were asked to provide information on their gender, age, level of professional rank and service. The sample was

78.6% women and 21.4% men. Mean of age is 38.44 years and mean of professional tenure is 16.2 years.

6.2.2. Measures

Empathy: the Jefferson Scale of Physician Empathy translated and validated into Italian by Di Lillo et al. was used (Di Lillo M. et al., 2009).The HP (health professional) version of the scale was used and slightly modified in order to best fit to nursing sample. It contains 12 items each answered on a 5 point Likert scale. To reduce acquiescence response style some items are negatively worded and reversed scored. A higher score denotes a higher level of empathy. Sample item included: "My patients' feel better when I understand their feelings.-".

Work engagement: was measured using the Italian validated version of UWES-9 (Utrecht Work Engagement Scale) (Balducci, Schaufeli, & Fracaroli 2010). UWES-9 contains 9 items and presents a three-factor structure of the vigour, dedication, and absorption subscales. Each item is answered on a 5 point scale. Sample item included: "I'm full of energy while I'm working".

Job satisfaction: the adapted Italian version of the Index of Work Satisfaction (Stamps, 1998, Cortese, 2007). It's a self report scale with 22 items which investigate different element of nurses' job satisfaction: for contents and for relationship with colleagues and supervisor. Each item is answered on a 5 point scale. Sample item included: "I'm satisfied for the sense of fulfilment generated in my job".

Organizational citizen behaviors: the Italian short version of Podsakoff, Mac Kensie, Morman& Fetter (1990) was used. Altruism and Civic Virtue subscales are examined. Each of them contains 5 items, answered on a 5 point Likert scale. Sample item included: "I help new colleagues, also if it's not prescribed".

6.2.3. Data analysis

The SPSS software program version 17 was used to carry out correlational studies and regression analysis. Confirmatory analyses were performed using EQS software program.

6.2.4. Ethical considerations

The study was approved by the ethical committee of the University of Brussels, in accordance with the Code of Ethics of the World Medical Association (Declaration of Helsinki).

6.3. Results

A confirmatory analysis was performed to verify the factorial structure of empathy (table 6.1). Results are reported in table 1. Confirmatory factorial analysis was performed using EQS. Results show the two factors solution has good fit index. RMSEA (RootMean Square Error of Approximation) is 0.108, CFI (Comparative fit index) is 0.829, GFI (Good Fit Index) is 0.874 and AGFI (Ajusted Good Fit Index) is 0.821. This factorial structure confirms the two components of empathy proposed by Hojat (2007). The main component (factor 1) is "perspective taking" and can be defined the core cognitive of empathy. Our results confirm several observations which underline that empathy has a stronger cognitive feature than an affective one. Factor 2 is defined "compassionate care" and represents the emotional dimension of empathy. Our results confirm previous studies on empathy (Hojat, 2006). Perspective taking and compassionate care correlations are reported in table 6.2. Regression analyses are conducted in order to address our hypotheses. Table 3 shows regressions' analysis results among predictors (empathy's factors: perspective taking and compassion) and the outcomes considered in this study. As we can see in table 6.3, perspective taking is positively is linked to all indicators of QLW. There no correlations between compassionate care and indicators of QLW.

Table 6.1. : Empathy's confirmatory factor analysis

Items	1	2
My patients feel better when I understand their feelings	.734	
I try to understand what is going on in my patients' minds by paying attention to their non verbal cues and body language.	.721	
My understanding of how my patients and their families feel does not influence medical or surgical treatment	.703	
I try to imagine myself in my patients' shoes when providing care to them	.685	
I consider asking patients about what is happening in their lives as an important factor in understanding their complaints	.679	
I try to think like my patient in order to render better care	.671	
Empathy is a therapeutic skill without which my success as a nurse would be limited	.564	
Affections to my patients have significant place in caring		.724
Emotional ties with my patients have significant influence on their healing outcomes		.709
Attentiveness to my patients' personal experience is irrelevant to treatment effectiveness		.685
I try not to pay attention to my patients emotions in interviewing and history taking		.650
How my patients feel is a relevant factor in medical treatment		.463

Table 6.2.: Means, Standard Deviations and Correlation (Cronbach's alphas are shown in italics)

	Means	SD	PT	COMP	JS	OCBi	OCBo	WE
PT	5.43	.98	*.87*					
COMP	5.22	.97	.409**	*.74*				
JS	3.55	.60	.204**	.021	*.72*			
OCBi	3.94	.60	.377**	.188**	.309**	*.86*		
OCBo	3.53	.62	.327**	.215**	.192**	.633**	*.78*	
WE	4.01	.60	.385**	.648**	.175**	.325**	.334**	*.93*

Note: *N*=222 *p<.05(two tailed) ** p< .01 (two tailed).ED=Emotional Dissonance, PT=Perspective Taking; COMP=Compassionate Care, EMP=Empathy, JS=Job Satisfaction, OCBi=Organizational Citizen Behaviors,Alrtuism, OCBo= Organizational Citizen Behavior, Civic Virtue WE=work Engagement

Table 6.3.: Linear Regression analysis

Predictors	**JS**			**WE**			**OCBi**			**OCBo**		
	T	Beta	Sig	T	Beta	Sig	T	Beta	Sig	T	Beta	Sig.
PT	.204	.368	.002	4.94	.385	.000	6.00	.377	.000	5.09	.327	.000
COMP	-1.03	-.075	.303	3.35	.023	.738	.557	.041	.558	1.39	.098	.163
Adj R^2		.148			.150			.114			.112	

PT=Perspective Taking; COMP=Compassionate Care, WE=work Engagement JS=Job Satisfaction, OCBi=Organizational Citizen Behaviors, Altruism, OCBo= Organizational Citizen Behaviors, Civic Virtue.

6.4. Discussion and implications

Our results confirm the two dimensional model of empathy. As shown in table 6.3, the cognitive core of empathy perspective taking, is a predictor of work engagement, organizational citizenship behaviors and job satisfaction. The results confirm a "detached attachment" in the relation with patients is a useful competence for nursing profession. (Alligood, 2005).When nurses respond with empathetic perspective taking, their feelings are not aroused, nor do they parallel those of patients. Nurses "feel for" patients, but not "feel with" them (Kruml & Geddes, 2000).This kind of emotional sharing has some relevant implication. When nurses successfully manage emotions in interaction with patients they are more satisfied with their work.

Our results support previous observations. Individuals in high emotion work and having emotional resources are more satisfied with their jobs than workers in professions in which

emotional interactions are not a central part of work (Hochschild, 1983; Wharton,1993). Goldberg (1988) found that connectedness is the feeling of being fully engaged and a part of the whole organization or workplace setting. To ensure the well-being an important prerequisite is restoring the relationship between nurse and patient. In regard to that Perry (2010) underscored that nurses who have provided high quality care and have made strong connections with patients feel very satisfied with their professional work life.

Perspective taking predicts work engagement. This result is consistent with Mackintosh's study (2005). The author claims that the development of a successful relationship with patients builds the work related persona as separate from the individuals own persona and that enabled nurses to engage to work successfully. Accordingly with previous studies, the cognitive factor of empathy is a predictor of altruism and civic virtue. As Parker and Axtell, Kiffin-Petersen (2001) claim perspective taking fosters the quality of interpersonal relationships and leads to helping behaviors. Individual who perform perspective taking may have more positive attribution to others' behaviors.

Compassion, the emotional element of empathy (which implies identification with patients and no cognitive filter in interactions with them) may not be a strong indicator of positive experiences of nursing profession. This result confirms previous observations which claim the two components of empathy should be distinguished in patient care situation (Nightingale, Yarnold & Greenberg, 1991). In previous researches compassion shows a significant overlap with sympathy (Hojat, 2001, 2007). Both cognitive empathy and compassionate care involve sharing, but empathetic nurses share their understanding, while sympathetic share their emotions with the patients. Compassionate care, if excessive, could interfere with objectivity in diagnosis and treatment (Aring, 1958) and could burst of emotions that might interfere with personal durability (Jensen, 1994). Without a cognitive filter, individuals are not able to disentangle themselves from other's feelings and have difficulty maintaining a sense of whose feelings belong to whom. (Decety & Jackson, 2006). The cognitive domain of empathy involves the ability to understand another person's inner experience and to view the outside world from the other's person's perspective (Hojat, 2001). Individuals perform perspective taking, to generate emotions and responses appropriate to the situation (Chu et al. 2011). The affective component involves the capacity to enter into and join the feelings of another person (Aring, 1958). Therefore compassion leads individuals to put forth more effort to preserve their personal space (Duan & Hill, 1996). The composite nature of empathy becomes clear in Carl Rogers definition: "the ability to sense the patient's private world as if it were your own, but without losing the "as if" quality" (Rogers, 1961, p.284). The conceptualization of

empathy as a capability to combine affective and cognitive elements confutes the social representations of nurse as "good Samaritan", devoted to their patients. Motivation for empathetic health care relations is not a question of missionary intents, but a result of emotional exchange and lead to develop an internal working model as well as to the regulation of emotions, both of which function as guides to interpersonal relationships (Lipps, 1926, Eisenberg, 1989). According to this characterization, empathy can be conceptualized as an emotional resource which can be "acquired, measured, updated, topped up and handed on" (Young & Salomon, 2005, p.449). This quotation corresponds to the "general competence model" (Greenspan & Gransfield, 1992), which is made up of instrumental and social competence (Neumann, 2009). Future researches have to extend the studies on empathy, in order to better understand how organizational policies could better foster, value and enhance empathetic attitudes among employees. In the health care contests this seems moreover important because interactions with patients play a significant role in the emotional workload (Mann, 2005). Empathetic nurses should be selected, trained and valued especially in those units where interactions with patients are prolonged and difficult (psychiatry, oncology, geriatrics, pediatrics…). Future researches should investigate the antecedents of empathy, both personal and organizational. For example there is a theoretical agreement among authors, which claims there is a prerequisite for the affective understanding of empathy: self-awareness. Only trough self-awareness it's possible to observe the others' expression of emotional state and to make a mental distinction between oneself and the "other self" (Bischof & Koehler, 2000). Experimental researches should replicate this statement in order to better understand personal features as determinants of clinical empathy. In addition future research should include empathy in the emotional labor theory and test how empathetic individuals enact emotional labor. Future studies have to better test the interplay of individual level and organizational values in fostering empathetic concerns. It seems important to test how supervisor and organisation may support nurses in handling with the emotional workload with patients. It was found supervisor and organisation support plays an important role in taking into account nurses' work-related needs and supporting them to perform better in their own work. A high or low level of support varies also the strength of the relationship between care adequacy in the nurses' own unit and job satisfaction (Galletta, Portoghese, Penna, Battistelli, & Saiani, 2011).

6.5. Limitations

This study has several limitations, which might be addressed through further research. First, the use of self-reporting measures without the integration of objective ones, could raise doubts about the validity of the obtained data (Goffin & Gellatly, 2001). Future researches should consider the assessment in others points of view (supervisors, patients, etc. …) to avoid potential problems related to common method bias. Second, a sample of nurses from the north Italy was used. Therefore, it is impossible to compare the measures of this study with data from other regions of Italy. In order to obtain greater support for the model, it might be necessary to replicate the study with nurses from different geographic areas of Italy (e.g. nurses in central and southern areas).Furthermore, the impossibility of comparing measures analyzed with data obtained in different organizational environments and with different types of employees also reduces the external validity of the research. To obtain greater support for the model, it might be necessary to enlarge the study with different populations of workers. Another limitation is the lack of experimental and longitudinal design. because of the design chosen for this study, the difficulty of inferring causality entails a significant limitation that needs to be acknowledged (Bobko & Stone-Roméro, 1988). Duplication of this study using a longitudinal design should serve to mitigate this limitation. Future studies necessarily should consider such a method, and test long-term effects on the relationships examined in the present study and the outcomes.

CHAPTER 7

Does Emotional Dissonance always exploit Nurses' Job Satisfaction?

Managing the detrimental effects of emotional dissonance through empathy, affective commitment and task significance (Study 1 Model 2)

Abstract

Emotional dissonance resulting from nurse/patient interactions is usually considered to lead to negative outcomes, such as job dissatisfaction (Yang & Chang, 2008). Although there does exist some general support and acceptance of the positive link between emotional dissonance and work stress, there are some inconsistencies in these findings (Pugh, Thurau, & Groth, 2011). We will argue here, that the relationship between nurses' emotional dissonance and job satisfaction is moderated on three different levels: personal, individual/organization's interplay and work characteristics. Using the Effort-Justification Model as a theoretical framework, Empathy, Organizational affective commitment and Work Significance are taken into account. A questionnaire was distributed to 222 nurses, working in two multidisciplinary hospitals in a North region of Italy. Results provide support for the moderating role of organizational affective commitment and task significance. Theoretical and practical implications of these findings are discussed.

Keywords: emotional dissonance, job satisfaction, moderation effects, clinical empathy, work significance, affective commitment..

7.1. Introduction

"Emotions are part of everything...without feelings, no action will occur, whether legitimate, illegitimate or for that matter merely satisfactory...all organization are emotional arenas where feelings shape events and events shape feelings" (Fineman, 2003 p.195).Emotions are, in fact, an integral part of adaptation to everyday work and employees should be able to recognize and manage their own emotional states, as well as those of others (Hunter & Smith, 2007). In this manner, Hunter and Deery (2005) underline that, in spite of the increasing

interest on emotions in the workplace, there is disappointingly little evidence that emotional research influences the practice of nurses. Nursing students still feel unable to deal with emotional demands required by their practice. Nursing is among the prototypical type of profession where emotional interplay and labor is involved. According to Hochschild's (1983) classification, a significant element of nursing workload is the high emotional labor spent in relationship with patients (Mann, 2005). Emotional labor requires that one expresses or suppresses feelings that produce an appropriate state of mind, according to organizational *feeling rules* (Ashforth & Humphrey 1993). In nursing, in addition to organizational policies of how to behave with patients, there also exist very clear societal norms and expectations how professionals should behave. These expectations may be implicitly or explicitly taught in occupational education and become part of one's professional ethos (Briner, 1999; Rafaeli, 1987). While the expression of these feeling rules is in most cases a spontaneous process of acceptation and effortless cooperation (Zapf & Holz, 2006), some situations call for the stimulation or the suppression of emotions that may enter in conflict with genuinely experienced emotions. This gap between experienced and required emotions has been referred to as emotional dissonance, which may be considered the central core of emotion labor (Zapf, Seifert, Schmutte, Mertini, & Holz, 2001). Nurses may experience emotional dissonance as problematic when they are not able to feel what they should feel in according to display rules, may feel false and hypocritical and, in the long run, they may feel alienated from their own emotions (Geddes, 2000). Hochschild's original sociological conceptualization, focused on the detrimental effects of emotional dissonance, has dominated the literature on emotional labor. Emotional dissonance was included in the large arena of burn out (Abraham, 1999, Bakker, & Heuven, 2006) and the impact of such discrepancy was discovered to negative correlate to nurses' well-being (Heuven & Bakker, 2003, Zapf, 2002). Emotional dissonance was also found to positive correlate to job dissatisfaction and increasing nurses' turn over intention (Murphy, 2005). Although there is a wide level of general support and acceptance for the positive link between emotional dissonance and work strain, there remain some inconsistencies in these findings (Pugh, Thurau, & Groth, 2011). The aim of our study is to verify whether or not the negative and detrimental effects of emotional dissonance on job satisfaction can be handled with some personal and/or organizational resources. We argue that the relationship between emotional dissonance and job satisfaction can be influenced by empathy, affective organizational commitment and task significance, by considering them through the Effort –Justification Paradigm (Lee, 2010).

7.2. Emotional labor: A Portrait of Current Theoretical Perspectives

Health care work is, by its nature, an area of heightened emotions, and thus is ripe ground for the exploration of emotions in the workplace. In particular, emotional labor studies have contributed to our understanding of the crucial role emotion management plays in health care settings, such as nursing, and the impact this has both positively and negatively on patients and employees. Along with the interest emotional labor has generated, numerous theoretical approaches and perspectives have been highlighted. Glomb and Tews (2004), while arguing that these approaches represent complementary perspectives, concede *"It could appear that the emotional labor domain is in a theoretical quandary, flooded with a multitude of conceptualizations*" (p.4). The concept of emotional labor originated with Hochschild (1983) who defines emotional labor as "the management of feelings to create a publicly observable facial and bodily display; emotional labor is sold for wage and therefore exchange value" (p.7). Since then, researchers have attempted to conceptualize and develop this construct, in order to provide a more fundamental understanding of how emotions are regulated and managed in response to display rules in order for work goals to be achieved. Further empirical development ensued as researchers began using quantitative approaches to explore the dimensions of emotional labor and its impact on employees' well-being and organizational performance (Wharton, 1993, Grandey, 2000). Much debate continues to surround the conceptualization and different theoretical approaches to emotional labor (Brotheridge & Grandey, 2002) and there is disagreement over its operationalization (Bone & Vey, 2005). A general distinction still exists between conceptualization and defining emotional labor, because researchers have mainly used two different theoretical approaches: job-focused and employee-focused approach (Brotheridge & Grandey, 2002). The job focused approach emphasizes the presence of emotional labor in one's job and focus on the nature of emotional display rules and considers emotional dissonance as a component of emotional labor (Morris & Feldman, 1996). Emotion work's strategies are responses to job requirements to display appropriate emotions, to the level of emotional dissonance and sensitivity requirements (Zapf, 2002). Conversely the employee-focused approach examines the internal emotion management processes (such for example deep acting or surface acting) of employees who are expected to perform proper emotional display (Grandey, 2002). According to this perspective, emotional dissonance represents the gap between felt emotions and expressed emotions. Emotional dissonance is linked to surface acting. This study takes

into account the job-focused approach and considers the emotional dissonance as the core of emotional labor. In particular we consider emotional dissonance as the main problem for individuals engaged in emotional labor. Several studies (Pugh et al. 2011) have underscored that emotional dissonance is not always negative for employee satisfaction, but only under certain conditions.

7.3. Emotional labor and job satisfaction among nurses

Job satisfaction is one of the most examined outcomes in the emotional labor literature and has been strictly linked to emotional dissonance (Abraham, 1998, Brotheridge & Lee, 1988, Grandey, 2003, Bono & Vey, 2005, Gursoy, Boylu, & Avci, 2011). Traditionally, job satisfaction has focused on all feelings that an individual has about his/her work (Lu, While, & Barriball, 2005) and has been defined as an evaluative judgment (Weiss, 2002). Job satisfaction has been defined in different ways, but there is a common element in all these definition: the *affective orientation* that an employee has towards his or her work (Lu& al., 2005). Job satisfaction can be considered as an overall feeling about the job or as a related constellation of attitudes about various aspects or facets of the job. The global approach is used when the overall attitude is of interest while the facet approach is used to explore which parts of the job produce satisfaction or dissatisfaction. Based on the review of the most popular job satisfaction instruments, Spector (1997)summarized the following facets of job satisfaction: appreciation, communication, co-workers, fringe benefits, job conditions, nature of the work itself, the nature of the organization itself, an organization's policies and procedures, pay, personal growth, promotion. Different measurements regarding nurses' job satisfaction show various sources of satisfaction are present, such as one's relationship with patients for example (Adam & Bond, 2000, Aiken, 2001). Managing emotions and handling emotional involvement play an important role in (not) contributing to the nurses' satisfaction (Smith & Allan 2010). The specific link between nurses' job satisfaction and emotional dissonance with their patients is still ambiguous. A recent review shows that previous theoretical work on emotional labor suggested a negative relationship between emotional dissonance and job satisfaction. (Yang & Chang, 2008). However, two empirical tests of this relationship (Adelmann, 1989, Wharton, 1993) contradicted the above view. Wharton's (1993)examination of the emotional dissonance offered results that often directly contradict earlier studies. Sampling employees from multiple job categories in a large bank and a teaching hospital, Wharton discovered that emotional dissonance is positively related to job

satisfaction, a finding inconsistent with Hochschild' s (1983). Ashforth and Humphrey (1993) suggested that emotional dissonance actually might make interactions more predictable and help workers avoid embarrassing interpersonal problems. This should, in turn, helps reducing stress and enhancing satisfaction. Smith and Kleinman (1989) believed that when medical personnel can maintain a neutral mood, they are able to retain a suitable distance from psychological unhappiness. More recently Duke et al. (2009) have verified the negative aspects of emotional labor are lessened by perceived organizational support.

7.4. Effort-justification model as theoretical frame to explain the moderation effect between emotional dissonance and job satisfaction.

Effort Justification is an idea and paradigm stemming from Festinger's theory of Cognitive Dissonance. Effort justification is people's tendency to attribute a greater value to an outcome they had to put effort into acquiring or achieving. This paradigm states that dissonance is aroused "...whenever a person engages in an unpleasant activity with intentions to gain a desirable result. From the understanding or cognition that the activity is unpleasant, it follows that one would not begin the activity; because the cognition that the activity is unpleasant is dissonant with engaging in the activity. So, one may attempt to reduce this form of dissonance by motivating the desirability of the outcome, which would be adding consonant cognitions" (Harman-Jones & Mills, 1999, p.7). Cognitive dissonance theory explains changes in people's attitudes or beliefs as the result of an attempt to reduce a dissonance (discrepancy) between contradicting ideas or cognitions. In the case of effort justification, by adjusting, motivating and increasing one's attitude or subjective value of the goal, the cognitive dissonance is resolved. People reduce dissonance by perceiving the chosen alternative as more attractive thereby justifying their decision. Both cognitive dissonance and emotional dissonance are states of *induced hypocrisy,* which is considered as a new dissonance paradigm (Fointiat, 2008). In the emotional dissonance there is a gap between genuinely felt and organizationally required emotions and an individual has to put effort and greater control skill and attentive action will be needed (Morris & Feldman, 1996). We assume, in according to the effort Justification Model, that an employee can better bear to be dissonant if he/she can justify the effort of expressing emotions in according to display rules. In the working context, an employee may justify his/her effort on three different levels: personal, individual/organizational interplay, individual/work interplay.

7.4.1. Clinical Empathy as a personal level moderator

Empathy may be considered as the attribute more essential in understanding another person for promoting the health of that person (Kalisch, 1973). In nursing the concept of empathy, despite its well-known importance, suffered from a lack of consensus in conceptualization. The cognitive core of empathy is *perspective taking* "a predominantly cognitive attribute that involves an understanding of experience, concern and perspectives of another person…" (Hojat, 2007, p. 80)"…Emotional empathy (compassion) is analogous to sympathy and consists of "feeling the inner experience of the patient through a psychological mechanism of identification" (Hojat, 2007, p. 81). Both components involve a degree of sharing, but nurses share their understanding through taking perspective, and their emotions through compassionate care (Nightingale et. al. 1991). The two concepts do not, however, function independently, and both contribute to create "compassion detachment", which allows nurses to feel sympathy for the patient at reasonable enough distance to maintain emotional balance (Hojat, 2002). Hence, an effective distance would be desirable to avoid bursts of emotions that might interfere with clinical neutrality and personal durability (Jensen, 1994). When experiencing empathy, nurses are able to disentangle themselves from patients' emotions, preserving their own personal space without losing sight of their role and professional responsibilities and preserving them from emotional exhaustion (Hojat, 2007). More over mutual understanding generates dynamic feedback in which both nurse and patient play an active and satisfying role (Peplau, 1997). For that reason, empathy may be defined as an emotional resource which leads to altruistic and pro-social behaviors (De Waal, 2011). As cognitive dissonance may be reduced trough justification of altruism, Grant and Sonnentag (2010) suggest employees who value their emotional work as benefiting customers/patients, may more likely to justify emotional dissonance. Based on these findings, we can put forth the hypothesis that empathy moderates the relation between emotional dissonance and satisfaction

HY.1 Empathy moderates the relationship between emotional dissonance and job satisfaction

7.4.2. Organizational affective commitment as an individual/organizational interplay level moderator.

Organizational affective commitment is defined as the employee's positive emotional attachment to or identification with their organization (Meyer & Allen, 1991, Williams 2004). An employee, who is affectively committed, strongly identifies with the goals of the organization and desires to remain a part of the organization. This employee commits to the organization because he/she "wants to". Specifically, individuals who strongly identify with their organizations and/or their jobs may more fully subscribe to the belief that they must often behave in an emotionally 'inauthentic' fashion to serve the purposes of their roles. Thus they will experience little cognitive dissonance following such 'inauthentic' acts. Varied research indicates that, provided that they are fully identified with a higher organizational purpose, people have little trouble behaving in ways they would normally find unnatural or even abhorrent (Schaubroeck & Jones, 2000). Fointiat (2008) underscored that individuals could benefit from the collective elaboration of induced hypocrisy that is the commitment factor. The organizational affective commitment may lessen the negative consequences of emotional dissonance by providing justification of identification and appurtenance (Herrbach, 2006). In line with these results, we hypothesizethe moderating role of organizational affective commitment in the relationship between emotional dissonance and job satisfaction.

HY 2. Organizational affective commitment moderates the relationship between emotional dissonance and job satisfaction.

7.4.3. Task significance as individual/work interplay level moderator

Task significance reflects the degree to which a job influences the lives or work of others, whether inside or outside the organization (Hackman & Oldham, 1975). It is well-known that people with jobs that have a significant effect on the well-being of others experience greater meaningfulness in the work (Hackman & Oldham, 1980, Morgeson & Humprey, 2006). Task significance is thought to enhance intrinsic motivation (Hackman & Oldham, 1976; Grant,

2008). When intrinsically motivated, employees feel naturally drawn, or pulled, toward completing their work. The decision to expend effort is based on personal enjoyment and is thus fully volitional, self-determined and autonomous (Kehr, 2004). When intrinsically motivated, employees are present- focused and they are concerned with the experience of performing the work itself (Quinn, 2005). We hypothesize task significance could lessen the negative effects of emotional dissonance on job satisfaction by giving meaning to the dissonance spread. Individuals with high task significance are more likely to justify the effort of performing emotional dissonance because they are internal motivated to do it.

Based on the previous discussion, the following hypothesis is tested:

HY 3. Task significance moderates the relationship between emotional dissonance and job satisfaction.

7.5. Method

7.5.1. Participants and procedures

A paper questionnaire has been distributed to nurses who work in two hospitals in a Northern region of Italy. These two hospitals were selected due to their comparability in capacity, in organizational practices and additionally their similarity in location and surroundings. Of the 300 copies distributed, 222 were answered, equating to an overall response rate of 74 %. Questionnaires were distributed to nurses through the nurse supervisor of each unit. Participants voluntarily completed the questionnaire during working hours. The survey was anonymous, but participants were asked to provide information on their gender, age, level of professional rank and service. The sample was 78.40% women and 21.60% men. The age mean is 38.44 years and that of professional tenure is 16.2 years.

7.5.2. Measures

Empathy: the Jefferson Scale of Physician Empathy translated and validated into Italian by Di Lillo was used (Di Lillo M. & al. 2009). It contains 12 items each answered on a seven point Likert scale. To reduce acquiescence among responses style, some items are negatively worded and reversed scored. A higher score denotes a higher level of empathy (e.g.: My

understanding of my patients' feelings gives them a sense of validation that is therapeutic in its own right).

Emotional dissonance: the sub scale of Emotional Dissonance (ED) of the Frankfurt Emotional Work Scale was used (Zapf & Holz, 2006). The ED subscale was translated into Italian and then back-translated by bilingual researchers (Brislin, 1980). To ensure the accuracy of the translation a pre-test has been done to nursing students at the University of Verona. The original version contained five items each answered on a five point Likert type scale (e.g.: How do you often have in your job to suppress an emotion to appear more neutral outside?).

Task significance: we use the Italian version of WDQ (Work Design Questionnaire), developed and validated by Morgeson and Humprey (2006).The subscale used was translated and adapted to best fit the nursing sample (e.g.: My job is important and significant on its own).

Organizational affective commitment: we use the Italian version of the subscale of Organizational Commitment Scale (Allen & Meyer, 1990). This version has 10 items each answered on a five point Likert type scale (e.g.: I feel emotionally attached to my colleagues).

Job satisfaction: the adapted Italian version of the Index of Work Satisfaction (Stamps, 1998, Cortese, 2007) has been used. It is a self-report scale with 22 items that investigate different elements of nurses' job satisfaction, such as content and relationships with colleagues and supervisors. Each item is answered on a five-point scale (e.g.: I'm satisfied for the sense of fulfillment generated in my job).

7.5.3. Ethical considerations

The study was approved by the ethical committee of the University of Brussels, in accordance with the Code of Ethics of the World Medical Association (Declaration of Helsinki). The participants were informed that their anonymity was assured. Informed consent to participate was assumed when the nurses returned a completed questionnaire.

7.6. Results

Table 1 presents correlations and descriptive results. Emotional dissonance is negatively correlated to job satisfaction. The link is weak, nevertheless, and this result confirms previous observations of the inconsistencies between emotional dissonance and job satisfaction. Table 7.2 shows hierarchical regression analyses with centered variables (Aiken & West 1991, Jose 2008). Age and tenure were entered as control variables (block 1), having been shown to be related to emotional labor in prior research (Simpson & Stroh, 2004). The independent variables were centered on their respective means to reduce the multi-collinearity between main effects and the interaction term and to increase the interpretability of the beta-weights for interaction terms (Cohen & Cohen, 1983).

Table 7.1.: Means, Standard Deviations and Correlations (Cronbach's alphas are shown in italics).

Variables	M	SD	1	2	3	4	5	6	7
1. Age	38,47	8,13							
2. Tenure	15,85	8,85	.91**						
3. Emotional disson	2,99	0,86	-.10	-.10	*.80*				
4. Empathy	5,34	0,83	-.06	-.06	-.08	*.84*			
5. Affective commit	3,43	0,80	-.34	-.01	-.05	.26**	*.82*		
6. Task significance	3,21	0,86	-.90	-.06	.07	.16*	.37**	*.75*	
7. Job satisfaction	3,55	0,60	.02	-.02	-.16*	.16*	.53**	.40**	*.90*

Note: *N*=222 *p<.05(two tailed) ** p< .01 (two tailed).

Apparently, such a linear transformation has no effect on the multiple *R* coefficients or the beta-weights for the main effects. Empathy, affective commitment and task significance were introduced in block 2. Interaction terms (emotional dissonance X empathy, emotional dissonance X affective commitment and emotional dissonance X task significance) were entered in block 3. As shown in Table 2, the addiction of the interaction terms results are significant for emotional dissonance X affective commitment and emotional dissonance X work significance. The result below indicates no moderated effect inducted by empathy: hypothesis 1 has to be completed rejected.

Table 7.2.: Hierarchical Regression Summary

Predictors	Job satisfaction		
	R^2	*B*	sig
Block 1: control variables	.00		
Age		.11	.51
Tenure		-.12	.47
Block 2: independent variables	.05		
Emotional dissonance		-.16	.01
Empathy		.19	.00
Affective Commitment		.53	.00
Task Significance		.52	.00
Block 3: interactions	.03		
Emotional dissonance X Empathy		.09	.17
Emotional dissonance X Affective Commitment		.38	.04
Emotional dissonance X Task Significance		.38	.02

To test hypotheses 2 and 3, we plotted the interactions with the procedures outlined by Aiken and West (1991), using the values of plus and minus one standard deviation on the moderator variable. Figure 1 shows that the form of the interaction was in the expected direction. A decrease in job satisfaction was associated with high emotional dissonance and this relationship was attenuated by high affective commitment. Hypothesis 2 can be accepted. Relative to the second regression analysis, figure 2 confirms that the negative relationship between emotional dissonance and job satisfaction was lessened by high task significance. Hypothesis 3 can be supported.

Figure 7.1. Two-way interaction effect of emotional dissonance and affective commitment on job satisfaction

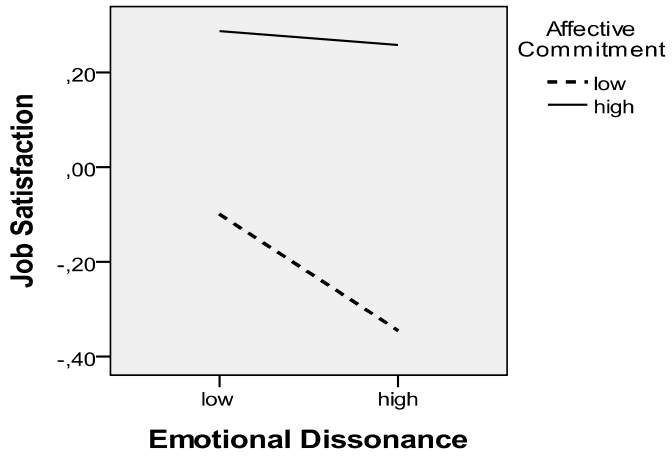
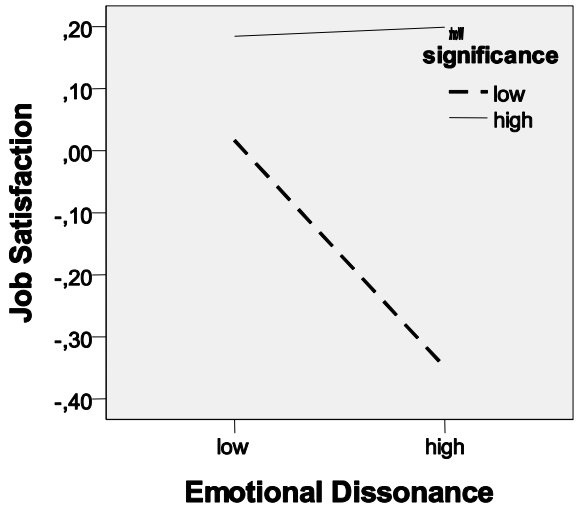


Figure 7.2. Two-way interaction effect of emotional dissonance and perceived task significance on job satisfaction



7.7. Discussion

The purpose of this study was to critically examine the link between emotional dissonance and job satisfaction in nursing and to offer a different theoretical approach. Our results confirm that the negative effects of emotional dissonance on job satisfaction can be lessened

by a moderating factor. It is interesting to note that empathy has no role in reducing the alienation caused by emotional dissonance. This result partially disproves the suggestion that pro-social impact may moderate the negative effects of emotional dissonance by justifying it as benefiting for others. These results have to be discussed again in order to determinate if it is a methodological question (nature of the instruments or the culture features, population) or theoretical. In this case, a question should be answered: "Do empathetic nurses experience emotional dissonance in a different way?" We wonder if dissonance and empathy are not linked by job satisfaction, but instead by another indicator. Job satisfaction refers to a sense of fulfillment for something outside the individual, while empathy points to something that happens inside. Future research should be undertaken to investigate whether empathy and emotional dissonance are linked in the face of some personal state of fulfillment such as helping competence or self-liking (Pugh et al. 2011). Results indicate that organizational affective commitment moderates the negative effects of emotional dissonance on job satisfaction. To explain this result we take into account the recent perspective which claims that organizational affective commitment reflects the individual attachment to the organization (Richards & Schats 2011). Attachment theory posits that human beings are born with the innate drive to maintain proximity with supportive figures to protect against psychological or physical threats and distress (Bowlby, 1969, Mikulincer & Shaver, 2005). In the same way, when affective commitment is experienced in the workplace, affiliate needs are met (Richard & Schats, 2011) This fulfillment provides a sense of appurtenance, belonging and an identification with the goals and the values of the organization. We suggest that the sense of belonging can justify the efforts to perform emotional dissonance. This result underscores the importance of supervisors in fostering affective commitment in the nursing service. Not only does affective commitment reduce turn over intentions among nurses (Galletta, Portoghese, Penna, Saiani, & Battistelli 2011), but it also moderates the negative effects of emotional dissonance. The task significance is also a moderator of detrimental effects of emotional dissonance on job satisfaction. We suggest that this effect is due to the motivational element of such a task characteristic. Morgeson and Humprey (2006*)* indicate that work significance is connected to meaningfulness. This psychological perception may mitigate the induced hypocrisy of emotional dissonance. If a nurse can feel his/her practice is more meaningful, he/she may integrate the negative aspects of emotional dissonance, considering them an intrinsic part of this work. As Aronson (1969, p.5) remarks of cognitive dissonance "... Dissonance arises in situations that create an inconsistency between the self-concept and the behavior...". Similarly, he proposes that the negative effects of dissonance

come from attitudes that threaten one's moral sense and integrity. We adopt this perspective to explain how one can better cope with the effort of managing emotions in interaction with patients, if one can perceive a meaning in doing it. We assume that task significance mitigates the mechanical and inducted adherence of emotional dissonance by presenting an intrinsic motivation, a scope in doing it that is coherent to the role and personal and professional ethos. These evidences have some relevant practical implications which might be underscored. Organizational affective commitment was verified to help nurses in moderating the detrimental effects of emotional dissonance on job satisfaction. This result shows the importance of developing organizational management practices that are necessary to implement nurses' commitment and strategies that facilitate the satisfaction of nurses' needs by promoting both high-quality nurse–supervisor and nurse–organization relationships, activating significant experiences of belonging. Task significance was also found to moderate the negative effects of emotional dissonance on job satisfaction. This result calls for the need of supervisor's feedback on the meaningfulness of nurses' work. Managers may draw on these findings to tailor selection and socialization practices toward intrinsic motivations. From a socialization standpoint, managers may design work contexts to cultivate intrinsic motivations and fulfill affiliate needs. Similarly, empowerment interventions are thought to increase intrinsic motivation, because they provide employees with expanded opportunities to contribute and have an impact (Thomas & Velthouse, 1990).

7.8. Study limitations and future perspectives

This study has several limitations, which might be addressed through further research. First, the use of self-reporting measures without the integration of objective ones could raise doubts about the validity of the obtained data (Goffin & Gellatly, 2001). Future researchshould consider the assessment in others points of view (supervisors, patients, etc. …) to avoid potential problems related to common method bias. Secondly, a sample of nurses from the north of Italy was used. Therefore, it is impossible to compare the measures of this study with data from other regions of Italy. In order to obtain greater support for the model, it might be necessary to replicate the study with nurses from different geographic areas of Italy (e.g. nurses in central and southern areas). Furthermore, the impossibility of comparing measures analyzed with data obtained indifferent organizational environments and with different types

of employees also reduces the external validity of the research. To obtain greater support for the model, it might be necessary to enlarge the study with different populations of workers. Another limitation is the lack of experimental and longitudinal design. Future studies necessarily should consider such a method, and test long-term effects on the relationships examined in the present study and the outcomes. Finally, we only focused on job satisfaction as an outcome variable of positive experience in nursing. It has been frequently examined in prior emotional labor studies (Grandey, 2003, Judge, 2009) and it is relevant for the purposes of this study, but further analyses are needed to examine other key employee and organizational outcomes. Moreover, we focused on empathy as a personal resource in shaping emotional dissonance effects. We can only speculate why it is not a significant moderator. Future research should attempt to replicate our findings to better investigate and or replicate this missing information. Other individual differences that were not addressed in this paper may play a significant role in influencing the detrimental effects of emotional dissonance. Future studies have also to examine the role of coherence (Robert, 2007), because employees who experience emotional dissonance as an integral part of their role may be more likely to justify it as worthwhile. In addition, future research should better test the interplay of individual and organizational values in predicting the effects of emotional dissonance on employee outcomes. For example a study of the nature of the organizational display rules may further the understanding of the outcomes of surface acting (Diefendorff, 2005). Moreover, it seems important to test how supervisor and organization may support nurses in handling emotional workload. It was indeed observed that supervisor and organizational support play an important role in taking into account nurses' work-related needs and helping them to perform better in their own work. A high or low level of support alters the strength of the relationship between care adequacy in the nurses' own unit and job satisfaction (Galletta, et al., 2011). Previous researches also show that organizational support enhances the managing of negative emotions such as anger (Lam & Chen, 2012). Finally, a supervisor's helpful guidance has positive consequences on work satisfaction in spite of stressful emotional demands (Little, 2011).

CHAPTER 8

Empathy, Emotional Dissonance, Perception of Display Rules and Emotional Support as different elements in nurses emotional labor. An explorative study. (Study 2)

Introduction

The concept of emotional labor originated with Hochschild (1983), who defines it as "the management of feelings to create a publicly observable facial and bodily display; emotional labor is sold for wage and therefore exchange value" (p.7). Since then, researchers have attempted to conceptualized and develop this construct, in order to provide fundamental understanding of how emotions are regulated and managed in response to display rules so that work goals can be achieved. Further empirical development ensued as researchers began using quantitative approaches to explore the different dimensions of emotional labor and its impact on employees' well-being and organizational performance (Wharton, 1993, Grandey, 2000, Liu et al. 2004). Debate continues regarding the conceptualization and different theoretical approaches to emotional labor (Brotheridge & Grandey, 2002) and there is disagreement over its operationalization (Bone, Vey, 2005).More recently researchers argue that emotional labor studies should take into account different components when explaining the variation in emotional labor (Diefendorff et al., 2005, Zapf & Holz, 2006). Emotional labor is a fundamental of jobs that need either face to face or voice to voice interactions with clients. This refers to service sector and in particular to the helping professions as nursing. Nurses are expected to express compassion and caring, at the same time that they are encouraged to develop a level of professional detachment (Savett, 2000). Clinical empathy and emotional dissonance are two different personal states involved in nurses emotional labor in interactions with patients (Chu, 2011, Zapf, 2002). When experiencing empathy, nurses genuinely express care for their patients and at the same time they are able to perform a professional "right distance" through perspective taking (Hojat, 2006). Emotional dissonance, on the contrary, is experienced when felt emotions are in contrast with emotional display rules. Emotional dissonance may be considered as the problematic core of emotional labor. The first aim of this study is to test the links between clinical empathy and emotional

dissonance on job satisfaction and work engagement. Secondly we focus on display rules, by considering them as antecedents in the emotional labor model (Zapf, 2002) and in particular we aim to test the roles played by nurses' different perception of display rules. Finally we aim to test the role of emotional support, which is widely considered an important resource, which lessens emotional workload (McCreight, 2005).

8.1. Literature review

8.1.1. Emotional Dissonance and Positive Work Outcomes

Emotional dissonance occurs when an employee is required to express emotions which are not personally felt in a particular situation (Hochschild, 1983). Most studies of emotion work include the concept of emotional dissonance (Zapf, 1999, Mertini & Holz, 2001, Martinez, 2008). However its status is seen differently and researchers have used different and, often ambiguous, conceptualisations of the concept (Van Dijk & Kirk-Brown, 2008). Early work on emotional labor described emotional dissonance as the discrepancy between felt and expressed emotions in order to satisfy organizational rules (Rafaeli & Sutton, 1987). In this case emotional dissonance involves three aspects: prescribed emotions, expressed emotions and felt emotions (Zerbe, 2000). Studies have considered different combinations of the three aspects to conceptualize and measure emotional dissonance. Some researchers view emotional dissonance as the discrepancy between required and felt emotions (Zapf & Holz, 2006); other ones consider it as the discrepancy between expressed and felt emotions (Coté, 2005). In the first case emotional dissonance has been referred as "emotion-rule dissonance", in the second one, it has been defined as "fake emotion display" (Holmann, 2008). Although there are still different points of view, the majority of research assesses emotional dissonance as emotion-rule dissonance (Dormann & Kaiser, 2002, Hulsheger & Schewe, 2011). This differentiation has important implications for the role ascribed to emotional dissonance in the emotional labor process. In this study, emotional dissonance will be focused in terms of emotion-rule dissonance and consider as a separate component of emotional labor, which may influence and may be influenced by some personal and organizational variables (Zapf, 2002).Emotional dissonance may be considered as an emotional regulation problem, which is the core of emotional labor (Zapf et al., 1999). In fact, although there are general support and acceptation for the positive link between emotional dissonance and work strain, there're some

inconsistencies in these findings (Pugh, Thurau, & Groth, 2011). In the first step of our study we aim to critically examine the link between emotional dissonance and positive outcomes such as job satisfaction and work engagement in a Belgium context.

8.1.2. Clinical Empathy and Positive Work Outcomes

Clinical empathy may be considered as the attribute more essential in understanding another person for promoting the health of that person (Kalisch, 1973). The cognitive core of empathy is *perspective taking* "a predominantly cognitive attribute that involves an understanding of experience, concern and perspectives of another person…" (Hojat, 2007, p. 809. The emotional empathy (compassion) is analogous to sympathy and consists of "feeling the inner experience of the patient through a psychological mechanism of identification" (Hojat, 2007, p. 81).Thus, cognitive empathy and emotional empathy should be treated differently in patient care (Hojat, 2007, Wispé 1986). Both components involve sharing, but nurses share their understanding through perspective taking and their emotions through compassionate care (Nightingale et. al. 1991). When experiencing empathy, nurses are able to disentangle themselves from patients emotions, preserving their own personal space without losing sight of their role and professional responsibilities and preserving them from emotional exhaustion (Hojat, 2007). More over mutual understanding generates dynamic feed-back in which both nurse and patient play an active and satisfying role (Peplau, 1997).Sympathetic concern, if excessive, could interfere with objectivity in diagnosis and treatment (Aring, 1958) and could burst of emotions that might interfere with personal durability (Jensen, 1994). Without a cognitive filter, individuals are not able to disentangle themselves from other's feelings and have difficulty maintaining a sense of whose feelings belong to whom (Decety & Jackson, 2006). Previous studies underscore involvement with patients play a key role in fostering nurses engagement, but may also be detrimental for it. Mackintosh (2005) claims that the development of a successful relationship with patients builds the work related persona as separate from the individuals own persona and that enabled nurses to continue to work successfully in what otherwise might be considered a high stress situation. We aim to test the role of empathy in promoting work engagement and job satisfaction in a Belgian context.

8.1.3. Perception of Display Rules

In 1959, Goffman indicates that people respect several rules in every social interaction (Goffman, 1959). More recently Ekman called the appropriate emotional expression is regulated by display rules (Ekman, 1973). These are norms of behavior which indicate the most appropriate emotions to show in a given situation and also how these emotions should be publicly expressed. Emotion control for organizational purposes has been referred to as *display rules* (Ekman & Friesen, 1975; Rafaeli & Sutton, 1989; Wharton, 1993). These display rules refer to the degree to which showing and hiding emotions is seen as an expected part of employee performance (Wharton & Erickson, 1995). Most part of European companies do not have explicit display rules as a part of organizational culture or as a part of job descriptions. They may be hidden in metaphors built up by organizational culture and values (Zapf, 2002). Metaphors, such as "family", "team" usually contain strong implicit messages of how to feel and what emotions are requested (Briner, 1999). Display rules are, however, incorporated in the mission statements of several companies. The link between organizational control of emotional displays and work strain has received mixed support in both qualitative and quantitative research (Leidner, 1999; Tolich, 1993). Researchers' focus has recently shifted from the nature of display rules to how employees *perceive* emotion display norms (Brotheridge & Lee, 1998; Zapf, 1999). The perception of display rules is a complex and multifaceted task. For example Morris and Feldman (1997) found that *explicitness* of display rules was negatively correlated to the frequency of emotional labor. In contrast, Hochschild (1983) reported that explicit display rules heavily impacted workload. These differences are most likely due to the discrepancies in conceptualizations of display rules. For example, Schaubroeck and Jones (2000) differentiated between the requirement to express positive and negative emotion, finding that when positive emotions were required, job satisfaction was higher compared to when negative emotions were required. However, demands to express positive emotion were related to health symptoms (e.g. sleep disturbances, time away from work due to illness) if employees had a low job involvement or did not identify with their role. The notion of professional or occupational display rules may have particular resonance within the health sector, particularly amongst health care professionals. In the helping profession, health care structures do not have normally explicit norms of how to behave in interactions with patients, but implicit emotional display rules exist through goals and performance expectations. In nursing, in addition to organizational

policies of how to behave with patients, there also exist very clear societal norms and expectations how the professionals should behave. Be gentle with a patient could improve his/her compliance to treatments, reassuring an anxious patient may reduce the risk of pain complications. These expectations may be implicitly or explicitly taught in one's education and become part of one's professional ethos (Rafaeli & Sutton, 1987). For example, there is evidence of a clear delineation in the emotional expression expectations between nurses and doctors (Griffin, 2003; Timmons & Tanner, 2005), and nursing carries with it the expectation of a certain level of emotional involvement with clients (Smith, 1992). Highly explicit display rules would exacerbate the importance of sanctioned emotional expression and create a larger spread between required and felt emotion. Thus, the more explicit and normative the display rules are, the greater is the possible perceived dissonance. Employees may perceive emotional display as norms, which serve to regulate the type of sanctioned expression in a given situation as well as the degree to which it is expressed (Rubin et al., 2005). Employees may feel to be « on stage » in the sense that these display rules require employees to become actors (Grandey, 2001), acting out organizationally *prescribed emotions*, that may not be congruent with their own personal emotions. Organizational expectations to manage emotions may more deleterious than the performance of emotional labor itself (Ashfort & Humprey, 1993). According to the action theory, prescribed emotional display rules lessen emotional autonomy (Zapf, 1999). Prescribed norms are likely to be shaped top-down and include expectations of organizations and managers (Pescosolido, 2002). However, display rules may be not perceived only as prescribed emotional expressivity, but also as organizational *emotional guidelines* that are culture specific to be unified socially and in a conforming consensus to organizational norms. According to the emotional labor literature, display rules shape employees emotional displays in ways that may facilitate the attainment of organizational goals. However, empirical studies have yet to examine whether employees actually share display rule beliefs and what effect these share rule beliefs might have on emotional labor processes. Recently, Diefendorff and colleagues (2011) have developed the idea that display rules are, in part, shared norms derived from unit or group level characteristics and assessed whether display rules exhibit shared properties. For example nurses of the same unit will could adopt similar display rules. For example child nurses may view the expression of sympathy and caring as the only "professional" way to act (Lewis, 2005). Shared emotions may be shaped by bottom-up processes (Kozlowski & Klein, 2000). There is consensus that each individual has his/her own belief about what emotional expressions are most appropriate in a given situation (Diefendorff & Greguras, 2009), opening the possibility that the personal

display rules may influence other members' beliefs and become shared through patterns of social interaction, role modelling and advice giving (Kozlowiski & Klein, 2000). In this sense, shared display rules are proposed to positive relate to nurses well-being (Diefendorff, Erickson, Dahling, & Grandey, 2011). In particular shared display rules interact with individual level affectivity to predict employee use of emotion regulation strategies and can provide the motivation to express a genuine sense of caring (Goldberg & Grandey, 2007). Sharing a norm does not involve internalization of that norm. Internalization is the process of acceptance of a set of norms established by people or groups which are influential to the individual. The process starts with learning what the norms are and then the individual goes through a process of understanding why they are of value or why they make sense, until finally they accept the norm as their own viewpoint (Meissner, 1981). Internalization concerns individual-level display rules (Diefendorff et al., 2011) and affects how effectively employees perform emotional labor (Grandey, 2003, Totterdell & Holman, 2003). There is some evidence that nurse may perceive accordance between their feelings about work and display rules. For example a nurse may notice that a patient is very anxious about a forthcoming operation and he/she engages in a reassuring conversation. In this case, the nurse's supportive attitude matches with emotional display rules. When display rules are internalized as a part and parcel of the role, they can foster satisfying experiences at work (Salmela & Mayer, 2009). In the second step of our study we aim to test the role played by prescribed display rules, shared display rules and internalized display rules as different antecedents to emotional dissonance, perspective taking and job satisfaction.

8.1.4. Emotional Support as Moderator

Emotional support is perhaps seen as the most important moderator of emotional distress and outcomes such as burnout (Eisenberger, Huntington, Hutchison, & Sowa, 1986; Halbesleben, 2006; House, 1981). In a meta-analysis of the relationships between these sources of support and the three burnout dimensions, all sources were found to be significantly related to all burnout dimensions (Halbesleben, 2006). In studies of nursing, emotional support was studied as an organizational resource, which can have both a direct impact on emotional labor's variables and can also moderate emotional distress and outcomes. For example emotional support from co-workers has been identified as important when nurses experienced grief in relation to patients (Staden, 1998), and where co-worker support was lacking, nurses

experienced greater stress but the negative effects of emotional labor was moderated by support from supervisors (Smith, 1992). In qualitative studies, nurses have described the importance of support from supervisors and co-workers as an important coping mechanism in relation to the interaction aspects of their role. For example, supervisors' emotional support has been described as crucial in setting the emotional tone of the ward and for providing leadership and direction in emotional expression, whereas co-workers were seen as more important in providing moment-to-moment emotional support (McCreight, 2005). In line with the importance of support in relation to specific incidences, emotional support from co-workers and supervisor was interpreted as an important mechanism to allow nurses to reflect on how they carried out emotional labor and on their relationships with patients (Huynh, Alderson, & Thompson, 2008). In particular, Hobfoll (1989) underscored that in situations in which emotional expenditure is substantial, emotional support may be particularly relied upon. In this study we focus on the moderator role of emotional support and we aim to verify if emotional support moderates the relation between prescribed display rules and emotional dissonance.

8.2. Aims and Hypotheses

This study has three general aims. The first one focuses on the roles played by empathy (both cognitive and emotional empathy) and emotional dissonance in (not) fostering job satisfaction and work engagement in a Belgian context. The second aim wants to test the different impacts of nurses perception of feeling rules on emotional dissonance and empathy. The third aim regards emotional support and moderator of the link between prescribed rules and emotional dissonance.

Step 1

HY1a: Cognitive empathy (perspective taking) positively correlates to job satisfaction and work engagement

HY1b: Emotional empathy (compassion) positively correlates to job satisfaction and work engagement

HY1c: Emotional dissonance negatively correlates to job satisfaction and emotional dissonance

Step 2

HY2a: Perceived organizational prescribed display rules positively correlate to emotional dissonance

HY2b: Perceived organizational shared display rules positively correlate to job satisfaction
HY2c: Internalized organizational display rules positively correlate to cognitive empathy.

Step 3

HY3a: Supervisor's emotional support moderates the link between organizational prescribed rules and emotional dissonance.
HY3b: Colleagues' emotional support moderates the link between organizational prescribed rules and emotional dissonance.

8.3. Method

8.3.1. Participants and procedure

To test our hypothesis, questionnaire has been loaded on line on the web sites of two nursing associations in Belgium. A French version and a Dutch version of the same questionnaire were available. To ensure the accuracy of the translation, the questionnaire was back-translated by bilingual researchers (Brislin, 1980). The survey was anonymous, but participants were asked to provide information on their gender, age, level of professional rank and service. The sample is 88; 74.8% is women. The mean of age is 42.60 and the mean of tenure is 12.90.

8.3.2. Measures

Display rules: display rules were measured with a modified version of the scale of the FEWS (Frankfurt Emotional Work Scale, Zapf & Holz, 2006). Nurses were presented with the sentence " To be effective at work, nurses are required to handle emotions in interactions with patients in a very precise way. How do you perceive these rules?" Three subscales were identified: prescribed rules (PR), organizational shared rules (SR) and internalized rules (IR).14 items are contained, each answered on a five point Likert scale (sample items: (PR) These rules are prescribed in order to be accepted in my work unit, (SR) These rules are integral parts of the organizational culture of my work unit, (IR) I found these rules are very useful and pertinent").

Emotional support: emotional support is measured with a modified version of the scale of perceived organizational support (Eisenberg, 1986). Both colleagues' emotional support and supervisor's emotional support are considered in this scale. In contains 10 items each answered on a five point Likert scale. (sample items: My supervisor gives me pieces of advice if I have problems in handling emotions in interactions with patients, My colleagues help me if I have some problems in managing emotions during interactions with patients).

Empathy: a short French version of the Jefferson Scale of Physician Empathy was used. It contains 12 items each answered on a five point Likert scale. (sample item: My understanding of my patients feelings gives them a sense of validation that is therapeutic in its own right).

Emotional dissonance: the French version of the sub scale of Emotional Dissonance (ED) of the Frankfurt Emotional Work Scale was used (Zapf & Holz, 2006). It contains five items each answered on a five point Likert type scale (sample item: How do you often have in your job to suppress an emotion to appear more neutral outside?).

Job satisfaction: we use the adapted French version of the Index of Work Satisfaction (Stamps, 1998). It is a self-report scale with 22 items that investigate different elements of nurses' job satisfaction, such as content and relationships with colleagues and supervisors. Each item is answered on a five point scale (sample item: I'm satisfied for the sense of fulfilment generated in my job).

Work engagement: was measured using the French version of UWES-9 (Utrecht Work Engagement Scale). UWES-9 contains 9 items and presents a three-factor structure of the vigour, dedication, and absorption subscales. Sample item included: "I'm full of energy while I'm working".

8.3.3. Ethical considerations

The study was approved by the ethical committee of the University of Brussels, in accordance with the Code of Ethics of the World Medical Association (Declaration of Helsinki). The participants were informed that their anonymity was assured. Informed consent to participate was assumed when the nurses returned a completed questionnaire.

8.4. Results

We first run into correlational analyses; results are reported in table 8.1.Linear regression analyses are conducted in order to address our hypotheses of step 1 and 2. Table 8.2 shows regressions analysis results among predictors (cognitive empathy, emotional empathy and emotional dissonance) and job satisfaction and work engagement. Results are only significant in the relation between perspective taking (cognitive empathy) and job satisfaction. HY1a can be partially accepted. HY1b, HY1c have to be refused.

Table 8.1.: Means, Standard Deviations and Correlations (Cronbach's alphas are shown in italics).

	M	Sd	1	2	3	4	5	6	7	8	9	10
Age	42.60	10.35										
Ten	12.90	9.41										
1.ED	2.50	0.86	*.78*									
2.PT	4.12	0.87	-.02	*.87*								
3.CO	3.21	0.86	.05	*.39*	*.71*							
4. JS	3.90	0.53	-.07	.30**	.17	*.72*						
5. WE	3.8	0.51	-.06	.16	-.02	.29**	*. 93*					
6. PR	3.01	.65	.23*	-.06	.08	.10	.06	*. 70*				
7. SR	2.66	.76	.04	-.01	.-06	.28**	.08	.55**	*. 82*			
8. IR	3.4	.76	.03	-.01	.-01	.29**	.24*	.45**	.64**	*.84*		
9. SES	2.92	.75	-.21*	.24*	.11	.53**	.08	.05	.44**	.43**	*.93*	
10. CES	3.01	.65	.05	.18	.10	.48**	.17	.06	.25*	.16	.39**	*.86*

Note: *N*=88 **p*<.05(two tailed) ** *p*< .01 (two tailed). ED = Emotional Dissonance PT= Perspective Taking CO=Compassion JS= Job Satisfaction WE=Work Engagement PR= Prescribed Rules SR= Shared Rules IR = Internalized Rules SES= Supervisor's Emotional Support CES=Colleagues' Emotional Support.

Table 8.2. Results of Linear Regression (Step 1)

Predictors	JS			WE		
	T	Beta	Sig	T	Beta	Sig
PT	4.9	.30	.00	1.4	.17	.17
COMP	-1.03	-.075	.30	-.75	-.94	.45
ED	-.57	-.06	.56	-.65	-.07	.51
Adj R^2		.06			-.01	

Note: PT = Perspective Taking, COMP = Compassion, ED = Emotional Dissonance, JS = Job SatisfactionWE = Work Engagement

Table 8.3 shows linear regression's analysis among predictors (prescribed display rules, shared display rules, internalized display rules) and emotional dissonance, job satisfaction and cognitive empathy. Results show HY2a and HY2b can be accepted. HY2c has to be rejected. We finally conduct hierarchical regression analysis to test moderation effects to address hypotheses of step 3.

Table 8.3. Results of Linear Regression (Step 2)

Predictors	ED			JS			PT		
	T	Beta	Sig	T	Beta	Sig	T	Beta	Sig
PR	3.7	.23	.03						
SR	-1.03	-.075	.303	2.7	.28	.01			
IR							.13	.01	.89
Adj R^2		.04			.07			-.01	

Note: PT = Perspective Taking, COMP = Compassion, ED = Emotional Dissonance, JS = Job Satisfaction, PR = Prescribed Rules, SR = Shared Rules, IR = Internalized Rules.

Table 8.4 shows hierarchical regression analyses with centered variables (Aiken & West 1991, Jose 2008). Age and tenure were entered as control variables (block 1), having been shown to be related to emotional labor in prior research (Simpson & Stroh, 2004). The independent variables were centered on their respective means to reduce the multi-collinearity between main effects and the interaction term and to increase the interpretability of the beta-weights for interaction terms (Cohen & Cohen, 1983).Apparently, such a linear transformation has no effect on the multiple *R* coefficients or the beta-weights for the main effects. Supervisors' emotional support and colleagues' emotional support were introduced in

block 2. Interaction terms (prescribed rules X supervisor's emotional support and prescribed rules X colleagues' emotional support) were entered in block 3. As shown in Table 2, the addiction of the interaction terms results are significant forprescribed rules X supervisor's emotional support. The result below indicates no moderated effect inducted by colleagues' emotional support. HY3b 1 has to be completed rejected. To test hypotheses HY3a we plotted the interactions with the procedures outlined by Aiken and West (1991), using the values of plus and minus one standard deviation on the moderator variable. Figure 1 shows that the form of the interaction was in the expected direction. An increase in emotional dissonance is associated with high prescribed display rules and this relationship is lessened by high supervisor's emotional support.

Table 8.4. Hierarchical Regression Summary (Step 3)

Predictors	Emotional Dissonance		
	R^2	*B*	sig
Block 1: control variables	-.02		
Age		.06	.71
Tenure		.03	.87
Block 2: independent variables	.07		
Prescribed Display Rules		.27	.04
Supervisor's Emotional Support		-.24	.05
Colleagues' Emotional Support		.53	.00
Block 3: interactions	.03		
Prescribed Display Rules X Supervisor Emotional Support		.27	.04
Prescribed Display Rules X Colleagues Emotional Support		-.04	.74

Figure 8.1. Two-way interaction effect of emotional dissonance and supervisor emotional support on perception of prescribed display rules

8.5. Discussion and Implication for Future Research

The results of Table 8.2confirm the importance of considering cognitive empathy (perspective taking) and emotional empathy (compassion) as separate elements. This result confirms previous observations which claim that the two components of empathy should be distinguished in patient care situation (Nightingale, Yarnold & Greenberg, 1991). Both cognitive empathy and compassionate care involve sharing, but empathetic nurses share their understanding, while sympathetic share their emotions with the patients. Without a cognitive filter, individuals are not able to disentangle themselves from other's feelings and have difficulty maintaining a

sense of whose feelings belong to whom. (Decety & Jackson, 2006).Cognitive and emotional features do not, however, function independently and their interaction makes empathy a multidimensional concept (Hojat, 2002). The cognitive domain of empathy involves the ability to understand another person's inner experience and to view the outside world from the other person perspective (Hojat, 2001). Individuals perform perspective taking to generate emotions and emotional responses appropriate to the situation (Chu et al. 2011). As Parker and Axtell, Kiffin-Petersen (2001) claim perspective taking fosters the quality of interpersonal relationships. In regard to that Perry (2010) underscored nurses who have provided high quality care and have made strong connections with patients feel very satisfied with their professional work life. Empathy shows positive links only to job satisfaction as an outcome variable of positive experience in nursing, which has been frequently examined in prior emotional labor studies (Grandey, 2003, Judge, 2009), but not to work engagement. Further analyses are needed to better examine the links between empathy and other key employee and organizational outcomes. Results generally confirm that the negative effect of emotional dissonance have been probably overestimated (Morris & Feldman, 1996). In particular our study confirms that associations between emotional dissonance and work strain are much less prominent amongst nurses than other professions. Qualitative research shows that nurses are both engaged with the emotional aspect of their role, and derive a great deal of satisfaction from this work (Li, 2005). Unlike Hochschild's (1983) position, and in accordance with the views of Ashforth and Humphrey (1995), Wouters (1989), and Zapf and Holz (2006), our results show that emotional dissonance, considered the core of emotional labor, is not necessarily associated with poor well-being outcomes.

Result expressed in table 8.3 show the effects of display rules depend on *how* nurses perceive them. We assume that the perception of these rules moves along a similar continuum of work motivation, inspired from the Self Determination Theory (Decy & Ryan, 2000). Employees may perceive these rules as prescribed requirements, as organizationally shared norms and finally they may perceive these rules internalized standards of emotional behaviors. Employees may perceive emotional display as prescribed norms, which serve to regulate the type of sanctioned expression in a given situation as well as the degree to which it is expressed (Rubin et al., 2005). The perception of high prescribed display rules would exacerbate the importance of sanctioned emotional expression and create a larger spread between required and felt emotion. Our results underscore that the more normative the display rules are, the greater is the possible perceived emotional dissonance. This finding confirms previous results (Zapf, 1999). Display rules may be not perceived only as prescribed

emotional expressivity, but also as emotional guidelines, as shared display rules that are culture specific to be unified in a conforming consensus to organizational norms. Our result show organizationally shared rules are positively associated to job satisfaction. The role of these shared scripts could be explained by the level of organizational involvement with assisting nurses to deal effectively with difficult situations. In particular organizational shared display rules interact with individual level affectivity to predict employee use of emotion regulation strategies and can provide the motivation to express a genuine sense of caring (Goldberg & Grandey, 2007), which widely considered an important element in fostering nurses' job satisfaction (Grandey, 1998). As described by Ashforth and Humphrey (1993), identity with the role carries with it expectations for the ways in which employees conduct themselves. In relation to nurses in particular, a strong identity with the role may lead to conformity with professionally or socially derived accounts of how nurses should manage emotion. In line with this view, the general shared rules, such as the requirement to remain calm and refrain from displaying overt anger or frustration, could simply be seen as what may be considered a way to be professionally appropriate.

Internalized display rules do not relate to cognitive empathy. This result could be explained by considering clinical empathy as a component of *management of natural emotion*, which may be considered as an additional and different emotional labor component. Previous studies clearly identify the management of natural emotion as a distinct and prominent emotional labor component (Brown, 2010). Previous research that has alluded to the use of natural emotion as emotional labor has tended to consider this in terms of emotional consonance or the natural correspondence between what is felt and what is required. In this case empathetic nurses do not internalize display rules, but identify with the aims of organizational display rules .Nurses, high in clinical empathy, show they care for patients, not because caring is prescribed and expected, but because they "feel for" patients (Kruml & Geddes, 2000). Future studies have to better explore the links between management of natural emotions and clinical empathy in the nursing context. In particular, future researches have to better understand the role played by clinical empathy in the emotional labor model. Furthermore future studies have to better understand the influence of personal and organizational features on display rules perception.

Results of Step 3 confirm previous findings on emotional support as an important resource for nurses emotional workload. Results expressed in table 8.4 show supervisor's emotional support lessen the impact of prescribed rules on emotional dissonance. Emotional support from co-workers does not moderate this link. This finding confirms previous results, which

have underscore that some sources of support may be perceived by employees as more important than others, how some sources of support become more crucial when others are unavailable, and how the importance of support varies according to the level of emotional engagement in the role and the subsequent emotional expenditure by employees (Brown, 2010). Previous researches indicate that when supervisors are emotional supportive of subordinates, this treatment leads to favorable outcomes for the employee and the organization such as reduced work stress and enhanced performance (Rhoades & Eisenberger, 2002; Viswesvaran, Sanchez, & Fisher, 1999). Supervisor's emotional support should produce a felt obligation to help supervisors reach the prescribed goals (Eisenberger et al.,2002; Stinglhamber & Vandenberghe, 2003) and supervisor 's emotional support was interpreted as an important mechanism to allow nurses to reflect on how they carried out emotional labor and on their relationships with patients (Huynh, Alderson, & Thompson, 2008).In this sense the supervisor's emotional support may mitigate the induced hypocrisy of emotional dissonance generated by prescribed rules. If a nurse feels to be emotional supported he/she may integrate the prescription of display rules and their impact on emotional dissonance, by considering them an intrinsic part of this work.

8.6. Limitations

This study has several limitations that might be addressed in further research. Firstly, the use of self-report measures could raise doubts about the validity of the obtained data (Goffin & Gellatly, 2001).

Secondly, the impossibility to compare measures analyzed with data obtained indifferent organizational environments and with different types of employees reduces the external validity of the research. To obtain greater support for the model, it might be necessary to replicate the study with different populations of workers.

Finally, another limitation is the lack of experimental and longitudinal design. One should be aware that it is impossible to draw inferences of causality (Mathieu & Taylor, 2006). Emotions are dynamic processes by nature that need longitudinal-types studies to expand the knowledge on these processes and to investigate their evolution across time. Future studies necessarily should consider such a method, and test long-term effects on the relationships examined in the present study.

CHAPTER 9
General Discussion and Conclusions

9.1. Major findings

The findings from this research have a number of important implications for how emotions in nurse-patient interactions should be conceptualized and how the relationships between them and other factors are considered. The most important findings from the current research are summarized below, followed with detailed description of findings, together empirical and theoretical implications.

9.1.1. Emotional dissonance

Unlike Hochschild (1983) position, and in accordance with the views of Ashforth and Humphrey (1995), Wouters (1989), and Zapf and Holz (2006), the combined findings from Study 1 (Model 2) and Study 2 show that emotional dissonance, considered the core of emotional labor, is not necessarily associated with poor well-being outcomes. Our research generally confirms the negative effect of emotional dissonance have been probably overestimated (Morris & Feldman, 1996). In particular our studies confirm that associations between emotional dissonance and work strain are much less prominent amongst nurses than other professions. Qualitative research shows that nurses are both engaged with the emotional aspect of their role, and derive a great deal of satisfaction from this work (Li, 2005), and this is even the case where nurses have used emotional dissonance to constrain negative emotion (Bolton, 2000b). Previous research focused on low status, process driven roles, such as call centre operators (Grandey et al., 2004) or customer service employees (Johnson & Spector, 2007), may show less positive well-being outcomes due to tight constraints on how emotions can be managed (low emotional autonomy) or because of the need for deferential treatment towards customers in profit driven industries. It is also possible that nurses' identity may result in an alignment between personal expectations of a high level of emotional engagement with clients and the actual requirements of the role (Ashforth & Humphrey, 1993). The identification of how perceptions of role responsibilities and requirements are associated with emotional dissonance and well-being and how these differ according to context is crucial to

understanding why nurses may have less problematic outcomes from their emotional labor. Moreover, we have tested two samples of nurses form different cultures Italian and Belgian. We found some differences in the perception of emotional dissonance. In the Italian context emotional dissonance impacts job satisfaction, whereas in the Belgian context does not. Culture influences the emotional adjustment of individuals and their perception of subjective well-being in a variety of ways. For example a trans-cultural study (Paez & Vergara, 1995) comparing different countries focused on the Masculinity-Femininity dimension which is of greater importance in the explanation of the emotional experience variable. The feminine nations (Italy, Chile and Spain) had both greater emotional intensity and greater emotional expressiveness than the masculine nations studied (Belgium, USA and Mexico).We can only speculate if these different cultures give different importance to authentic emotional display (Pugh et al., 2011). Future studies have to better understand the moderated influence of culture on emotions and especially on emotional labor.

Moreover, not only do our studies confirm emotional dissonance is not always detrimental for nurses' well-being, but also underscore that its negative effects can be moderated in different levels: organizational and personal. These results are in line with previous observations (Pugh et al, 2011). In particular Study 1 (model 2) underscores that affective commitment to the work unit and task significance lessen the negative effects of emotional dissonance on job satisfaction. We focus on the sense of belonging, connected to affective commitment, which may move emotional dissonance from a personal state to a shared attitude. The task significance is also a moderator of detrimental effects of emotional dissonance on job satisfaction. We hypothesize that this effect is due to the motivational element of such a task characteristic. Morgeson and Humprey (2006*)* indicate that task significance is connected to meaningfulness. We assume that task significance mitigates the mechanical and inducted adherence of emotional dissonance by presenting an intrinsic motivation, a scope in doing it, that is coherent to the role and personal and professional ethos. If a nurse can feel his/her practice is more meaningful, he/she may integrate the negative aspects of emotional dissonance, considering them an intrinsic part of this work. A nurse can better cope with the effort of managing emotions in interaction with patients if one can perceive a meaning and a sense of belonging in doing it.These results show the importance of developing organizational management practices that are necessary to help nurses in managing emotional dissonance. By implementing nurses' commitment and by promoting both high-quality nurse–supervisor and nurse–organization relationships, significant experiences of belonging are activated. Task significance was also found to

moderate the negative effects of emotional dissonance on job satisfaction. This result calls for the need of supervisor's feedback on the meaningfulness of nurses' work. Supervisors may draw on these findings to tailor selection and socialization practices toward intrinsic motivations. From a socialization standpoint, supervisors may design work contexts to cultivate intrinsic motivations and fulfill affiliative needs. Similarly, empowerment interventions are thought to increase intrinsic motivation, because they provide nurses with expanded opportunities to contribute and have an impact (Thomas & Velthouse, 1990).

9.1.2. Empathy as management of natural emotion.

Finding of Study 1 (model 1 and 2) and Study 2 show that the clinical empathy has positive links to elements of quality of working life. Our results confirm previous observation, which consider empathy a useful emotional resource for nurses (Alligood, 2005). The predominant cognitive feature distinguishes empathy from sympathy (Wispé, 1986) and serves as a buffer against psychological and health problems among nurses (Hojat, 2009). When experience empathy nurses are able to disentangle themselves from others feeling, producing a detached attachment (Hojat, 2007). Empathy enhances a sense of private feelings protection (Huismann, 2006). Using a metaphor, empathy solves the Schopenhauer's dilemma of the two porcupines, producing "the right distance" (Luepnitz, 2002).Our result underscore that empathy does not relate to any aspects of emotional labor, nor emotional dissonance neither display rules. In order to explain these results, we consider empathy as a component of *management of natural emotion*, which may be considered as an additional and different emotional labor component. For example they show care and reassure the patients not because they have to do so, but they feel to do so. Previous studies clearly identify the management of natural emotion as a distinct and prominent emotional labor component, which can be seen as an emotional and physical protection for employees, and as a mean of ensuring that the care of patients is not compromised (Brown, 2010). Some previous conceptualizations of emotional labor have considered naturally felt and natural expression of emotion as a component. However, this aspect of emotional labor is relatively poorly developed as a separate facet of emotional labor and descriptions of how the use of natural emotion forms part of the overall emotional labor construct vary (Diefendorff et al., 2005; Zapf, 2002; Ashforth & Humphrey, 1993; Brotheridge & Lee, 2003, & Morris & Feldman, 1996). For example, the possibility that natural emotion can be an emotional labor strategy in the same

way as surface and deep acting is missing from Grandey's (2000) model probably because the use of natural emotion as an emotional labor strategy is not as easily explained by Gross's (1998a, 1998b) emotional regulation model. As previously outlined, there is good reason to include natural emotional expression as a means of expressing emotion to meet display rules and the use of natural emotion can be distinguished from both surface and deep acting. Surface acting involves affective displays, faking and expressing emotions without feeling them, in order to obtain a mechanical conformity with display rules prescribed by organization (Ashforth & Humphrey, 1993). In this case an emotional distance exists between the inner feelings and the outer expression which persists during the interaction in the workplace. Deep acting strategies, instead, involve influencing personal feeling, in order to assume the role prescribed. In this case, not only the expressive behaviour, but also the inner feelings are regulated. Thoughts, images and memories are actively invoked to induce a certain emotion. A nurse may use the metaphor of thinking of a difficult patient as a child who is vulnerable and not responsible for his behaviour (Briner, 1995). "…Cognitive change strategies focus on reappraising or reinterpreting situations so as to modify their subjective meaning, thereby altering the emotional impact of the situation on the person. Cognitive change strategies include techniques such as perspective taking…" (Diedendorff, Richard & Yang, 2008, p. 499). In this case the cognitive factor of empathy is considered a prerequisite of deep acting and included in the emotional labor's model. However there is no agreement among researchers about this link. Previous research that has alluded to the use of natural emotion as emotional labor has tended to consider this in terms of emotional consonance or the natural correspondence between what is felt and what is required. The problem with considering this as a component of emotional labor is that this suggests the lack of a need for any sort of emotional regulation. For example, both Ashforth and Humphrey (1993) and Zammuner and Galli (2005) argue that employees may experience emotions that match what is required and which therefore do not need to be regulated. Ashforth and Humphrey's (1993) example of a nurse who automatically feels empathetic at the sight of a sick child highlights some problems with the notion that emotional regulation would necessarily be absent in situations such as these. Clearly, even in this example, the nurse must not let his or her emotion extend to the point of becoming an impediment on the ability to function in all aspects of the role. A nurse should feel the patient's feelings only to a limited extent to improve his or her understanding of the patient without impeding professional judgment (Starcevic & Piontek, 1997).Future studies have to better examine the role played by empathy in the emotional labor model and especially have to test the link between empathy and

emotional regulation strategy such as surface acting and deep acting. The current research adds to the previous understanding of how the use of the natural emotion may be used to facilitate purposeful interactions and to control the emotions of both employees and clients as an emotional labor strategy in several ways. Descriptions of the management of natural emotion also show a sense of connectedness. When experiencing empathy, nurses perform a "detached attachment" in the relation with patients (Alligood, 2005). When nurses respond with empathetic perspective taking, their feelings are not aroused, nor do they parallel those of patients. Nurses "feel for" patients, but not "feel with" them (Kruml & Eddes, 2000). The management of natural emotions has some relevant implication. When nurses successfully manage emotions in interaction with patients they are more intrinsically satisfied with their work. Our results support previous observations. Individuals in high emotion work are more satisfied with their jobs than workers in professions in which emotional interactions are not a central part of work (Hochschild, 1983; Wharton,1993). Goldberg (1988) found that connectedness is the feeling of being fully engaged and a part of the whole organization or workplace setting. To ensure the well-being an important prerequisite is restoring the relationship between nurse and patient. In regard to that Perry (2010) underscored that nurses who have provided high quality care and have made strong connections with patients feel very satisfied with their professional work life. Diefendorff et al., (2005) showed the use of natural emotion to be not only a distinct factor from surface and deep acting, but also the most prominent emotional labor strategy used by undergraduate students who were also employed in sales, service, healthcare, childcare, and clerical roles, and Näring and van Droffelaar (2007) found emotional consonance to be associated with better outcomes than other emotional labor components amongst nurses. In addition, there are no studies concerning how natural emotion may be managed to comply with expectations. The role and use of natural emotion as a prominent emotional labor element needs to be further established. There is evidence from the current research that the management of natural emotion as an emotional labor tool may fortify organizational and personal well-being outcomes. For example when describing the empathetic use of managed grief, the palliative care nurses indicated that this strategy was associated with a close connection with clients and a means of providing timely and genuine support (Brown, 2010). The clear and prominent evidence of the management of natural emotion as a distinct emotional labor strategy is an important contribution to emotional labor theory. The management of natural emotion was shown to be an important emotional labor strategy to provide emotional support for patients and to provide psychological and physical protection for nurses and co-workers.

9.1.3. Display rules: prescription, sharing and internalization

Nurses are expected to express compassion and caring, at the same time that they are encouraged to develop a level of professional detachment (Savett, 2000). In order to better understand the impact of emotional display rules, the focus has recently shifted from the nature of display rules to the employees' *perceptions* of such emotional display norms (Brotheridge & Lee, 1998; Zapf, 1999). Study 2 takes this perspective into account and focuses on how nurses perceive the emotional requirements. We assume that the perception of these rules moves along a similar continuum of work motivation, inspired from the Self Determination Theory (Decy & Ryan, 2000). We assume employees may perceive these rules as prescribed requirements, as organizationally shared norms and finally they may perceive these rules as internalized standards of emotional behaviors. Our study confirms previous researches, which underscore that the perception of high prescription in emotional display rules is positively correlate to emotional dissonance and does not promote job satisfaction. Our results are in line with the core tenet of Action Theory (Frese & Zapf, 1994). This theoretical perspective underscore that individuals seek to actively engage in their environment, to have some level of control over their condition and are generally not passive respondents to environmental demands (Frese & Zapf, 1994). Emotions' regulation problems (such as emotional dissonance) occur when requirements exceed the resources of the individual or if regulation possibilities are limited. For example, emotional dissonance is seen as a regulation problem due to a lack of choice (low control) the individual has in meeting display rules (Zapf et al., 1999). According to the action theory, prescribed emotional display rules lessen emotion work control and autonomy (Zapf et al., 1999). Prescribed norms are likely to be shaped top-down and include expectations of organizations and managers (Pescosolido, 2002). However, display rules may be not perceived only as prescribed emotional expressivity, but also as *emotional guidelines* that are culture specific to be unified socially and in a conforming consensus to organizational norms. Our findings confirm organizationally shared display rules are not related to emotional dissonance and positively correlate to job satisfaction. In particular organizationally shared display rules correlate to job satisfaction. The perception of shared display rules can provide the motivation to express a genuine sense of caring (Goldberg & Grandey, 2007). Conformity to a norm does not involve internalization of that norm, which is the process of acceptance of a set of norms established

by people or groups which are influential to the individual. The process starts with learning what the norms are and then the individual goes through a process of understanding why they are of value or why they make sense, until finally they accept the norm as their own viewpoint (Meissner, 1981). Internalization concerns individual-level display rules (Diefendorff, 2011) and affects how effectively employees perform emotional labor (Grandey, 2003, Totterdell & Holman, 2003). There is some evidence that nurses may perceive accordance between their feelings about work and display rules. For example a nurse may perceive that a patient is very scared about a forthcoming blood transfusion and engages in a reassuring conversation. In this case display rules have been internalized as a part of the role and can foster satisfying experiences at work (Salmela & Mayer, 2009). In our research, internalization of display rules does not correlate to empathy. We can only speculate about this result. Empathetic nurse probably do not internalize emotional display rules, but identify their helping behaviors with them " Modern profession of nursing was born out of a passion for the personal and relational skill of healing and nurses are naturally committed to emotional needs for patients… Not just a sense of practical job well done, but a serious conviction that what is due to people in situations where they are helpless and even dying is time – respect and patience…Sickness is not only matters of bodily incapacity, it is also about our picture of ourselves. We are damaged in respect of what we think and imagine we are. Healing and caring are therefore about sustaining and restoring that vulnerable sense of who we are…it is about the service to human dignity" (Williams, 2006, p.8, commemoration of Florence Nightingale).

9.1.4 Emotional support from supervisor and colleagues

Emotional support is widely considered an important factor in improving well-being outcomes, in particular nurses describe more positive well-being outcomes when emotional resources are replenished by the emotional support derived from supervisors and co-workers (Huynh et al., 2008). Emotional support was found to provide protection and moderate the negative relationships between emotional labor and well-being (Lewig & Dollard, 2003). However, the source of support and its relative importance in assisting employees to cope with emotional labor depending on the emotional requirements of the role is less well understood, and requires further research.

Study 2 underscored that emotional support from supervisor has shown both positive relations with perception of organizationally shared display rules, internalization of display rules, perspective taking and job satisfaction. Moreover supervisors' emotional support moderates the link between prescribed display rules and emotional dissonance. In order to explain these results we focus on a new study from the University of Haifa, soon to be published in the *European Journal of Work and Organizational Psychology* (Biron, 2012). The results show that support from a supervisor when an employee is experiencing stress can make a real difference. Supervisor may offer emotional support through a variety of mechanisms. These include connecting the follower's sense of identity and self to the mission and the collective identity of the organization; being a role model for followers that inspires them; challenging followers to take greater ownership for their work, understanding the strengths and weaknesses of followers and being of real help. In our study we focus on supervisor's emotional support during emotional interactions with patients. Our results underscore that nurses perceive emotional support from supervisor as a crucial element in handling emotions with patients. When experiencing emotional support, workers feel more inclined to reciprocate the supportive treatment by keeping their emotional effort high. Supervisor's emotional support should produce a felt obligation to help supervisors reach the prescribed goals (Eisenberger et al., 2002; Stinglhamber & Vandenberghe, 2003) and supervisor's emotional support was interpreted as an important mechanism to allow nurses to reflect on how they carried out emotional labor and on their relationships with patients (Huynh, Alderson, & Thompson, 2008).In this sense the supervisor's emotional support may mitigate the induced hypocrisy of emotional dissonance generated by prescribed rules.If a nurse feels to be emotional supported he/she may integrate the prescription of display rules and their impact on emotional dissonance, by considering them an intrinsic part of this work. Our results underscore that emotional support from co-workers also plays an important role in the nursing workload. Colleagues emotional support has positive correlations with job satisfaction and with the perception of shared display rules. Nevertheless emotional support from co-workers does not mitigate the impact of prescribed display rules on emotional dissonance. This finding confirms previous results, which have underscored that some sources of emotional support may be perceived by employees as more important than others, how some sources of support become more crucial in some circumstances, and how the importance of support varies according to the level of emotional engagement in the role and the subsequent emotional expenditure by employees (Brown, 2010). For example, supervisors have been described as crucial in setting the emotional tone of the ward, and for providing

leadership and direction in emotional expression. Emotional support from supervisors was interpreted as an important mechanism that allow nurses to reflect on how they can handle with emotional dissonance and on their relationships with patients (Huynh, Alderson, & Thompson, 2008), whereas co-workers were seen as more important in providing moment-to-moment emotional support (McCreight, 2005). Previous evidence suggests that the content of employees' interactions with their supervisors differ substantially from their interaction with co-workers due to differences in hierarchy, power bases, trust, physical proximity, amongst others (Ducharme & Martin, 2000). In this sense, a recent study highlighted the need for distinguishing between the sources of social support (i.e. supervisors and co-workers) in order to adequately analyze its influence on employees' well-being (Chiaburu & Harrison, 2008). The support provided by co-workers differs from that provided by supervisors in many aspects. First, hierarchy places a different meaning to the relationship between supervisors and employees, because hierarchy is attributed to authority ranking as opposed to equality matching (Fiske, 1992). Furthermore, the types of power attributed to supervisors and co-workers are also different and consequently shape the perceptions of support provided by both. Supervisors have more formal power (i.e. strength) On the other hand, experienced co-workers are more frequently perceived as sources of reference and expert power (i.e. knowledge) (Tucker, Chmiel, Turner, Hershcovis, & Stride, 2008).

9.2. Organizational and Practical Implications

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

The most important finding from this research was that the management of natural emotion through empathy was an important and separate emotional labor component. These findings add to what is already known about how best to prepare employees for the emotional interactions in their roles. By allowing employees to assess the requirements of individual interactions and to then manage their natural emotion accordingly, employers are in effect, allowing some emotional autonomy. Previous researchers have commented on the importance of emotional autonomy in organizations for employees to avoid negative well-being outcomes (Brotheridge & Lee, 2002; Wharton, 1993). The current research provides further evidence of

the importance of empathy to express and constrain emotion based on subjective assessments of the situation and of the patient, rather than being subject to strict emotional expression requirements, which are often a precursor to emotional dissonance (Zammuner & Galli, 2005).

In Study 1 (model 1), empathy has been described as an emotional resource for interactions through cognitive and emotional change and preparation. Nurses would benefit from being taught about emotional labor strategies and the best methods of expressing and constraining appropriate emotion to protect their own well-being and the well-being of patients, co-workers, and to achieve optimal organizational outcomes.

The importance of emotional support as an aid to emotional interactions with patient was another extremely important finding from the current research. Furthermore, the specific ways in which emotional support was provided and accessed according to the situation suggest specific ways that organizations can help nurses in handling emotions during interactions with patients. One way in which organizations can act is to assist co-workers to support one another. There were substantial organizational efforts to provide an environment in which emotional support was valued, including group and individual debriefing sessions and additional help from supervisors in difficult cases. Such measures and a concerted focus on the importance of support include planning for contact between nurses in emotionally upsetting cases, ensuring time for contact and generating scripts for the nurses to use in difficult discussions with patients. Jenaro and colleagues (2007) have suggested that nurses be educated as to the importance of various forms of support and how they can assist one another when emotional resources are spent in the course of emotional labor. The importance of this message was highlighted in this research. The current research provides added information that should be considered when educating nurses about the importance of emotional support. Nurses should be guided as to how to provide the most beneficial form of support in particular situations. For example, providing a physical presence and being able to recognize when co-workers require help is important as well as making plans to listen to the thoughts and feelings of co-workers after an emotionally difficult interaction with patients. To be able to provide such nuanced information to nurses, employers must first make assessments of the type of emotional support that is required in specific situations.

Our research suggests that even though nurses may consider their co-workers to important source of support, the actions of supervisor have a substantial impact on outcomes. Our results show the importance of developing organizational management practices which can promote high-quality nurse–supervisor relationships, activating significant experiences of

belonging that are necessary to implement nurses commitment and strategies that facilitate the satisfaction of nurses needs. Supervisors may draw on these findings to socialization practices toward intrinsic motivations. From a socialization standpoint, supervisors may design work contexts to cultivate intrinsic motivations and fulfill affiliative needs. This result underscores the importance of supervisors in fostering affective commitment in the nursing service. Laschinger et al. (2001) established that staff nurses experienced high levels of empowerment when managers used leadership behaviors that fostered employee perceptions of autonomy, confidence, and meaningfulness of their work. This result calls for the need of supervisor's feedback on the meaningfulness of nurses' work.

While it is ultimately the responsibility of an employer to ensure the health, safety and well-being of its employees, an important prerequisite to a healthy work environment is active engagement by all members of an organization. To become a leader in the provision of a healthy work environment, recognition of the joint responsibility for the changes needed to achieve this goal is required. With the special skills, education and quality of their employees, health care organizations are perhaps uniquely situated to exploit this shared governance model to achieve success in the health and safety arena. If nurses will accept a share of the responsibility for the current state of affairs (poor nurse health, emotional disconnectedness, organizational disarray, professional powerlessness), then they will also hold and accept the responsibility to reclaim a sense of professional wholeness within the practice of nursing. Re-establishing this sense of a holistic nursing practice through a shared responsibility model for nurse health in the workplace will no doubt facilitate the changes needed to help them achieve the necessary.

9.3. Future perspectives

Increased attention has been paid to the role that culture and ethnicity may play in emotions at work(Perez, Hoon-Kim, Lee, & Minnick, 2011). For example in our empirical studies we examined two different cultures : the Italian and the Belgian one. In our case it would be interesting to introduce culture as moderator to examining effects related to emotional management with patients. Future studies have to consider if and how cultural norms surrounding the expression and suppression of emotions represent contrasting perspectives. Future studies have to test the link between empathy and management of natural emotions. In our studies we only speculate on the nature of empathy and on its role in managing emotions

in interactions with patients. Future researches have to better understand the role of empathy in the emotional labor model. Increased examination has to be develop to display rules. Our study confirms a recent perspective, which claims that it is important to shift the focus from what these display rules are, to how nurses interact with them. The mechanism on how nurses perceive display rules are yet to be clarify. Future studies have to test whether the perception of emotional display rules can be influenced by some personal/organizational variables. Our studies confirm there are some inconsistencies in the emotional dissonance results. Future researches have to better develop the concept of emotional dissonance and to clarify its role in the emotional labor theory. Future studies have also to examine the role of coherence (Robert, 2007), because employees who experience emotional dissonance as an integral part of their role may be more likely to justify it as worthwhile. In addition, future research should better test the interplay of individual and organizational values in predicting the effects of emotional dissonance on employee outcomes. Causal relationships between variables are assumed but not tested in this research. Longitudinal studies are required to analyze and establish causal relationships between emotional dissonance, display rules, empathy, emotional support, and outcomes.

9.4. Limitations

This doctoral dissertation makes important contributions to the study of emotional labor; however some limitations must be recognized. There were some limitations that were applicable to both studies. First, the research methodology was cross-sectional; therefore causal relationships from this research are alluded to and assumed but not tried. The lack of experimental and longitudinal design makes impossible to draw inferences of causality (Mathieu & Taylor, 2006). In particular, emotions are dynamic processes by nature that need longitudinal-type studies to expand the knowledge on these processes and to investigate their evolution across time. Future studies necessarily should consider such a method, and test long-term effects on the relationships examined in the present study. The use of self-reporting measures without the integration of objective ones, could raise doubts about the validity of the obtained data (spurious covariance) and potential problems related to common method bias (Goffin & Gellatly, 2001). Two samples of nurses from Italy and Belgium were used. Therefore, it is impossible to compare the measures of this study with data from other nations. In order to obtain greater support for the model, it might be necessary to replicate the study with nurses from different geographic areas. Furthermore, the impossibility of comparing

measures analyzed with data obtained indifferent organizational environments and with different types of employees also reduces the external validity of the research. Future studies have to enlarge the study with different organizational contexts. Multiple level analyses should be considered.

Finally, we only focused on indicators of quality of working life as outcomes variable of positive experience in nursing. They have been frequently examined in prior emotional labor studies (Grandey, 2003, Judge, 2009) and they are relevant for the purposes of this study, but further analyses are needed to examine the roles played by management of emotions on other key employees and organizational outcomes.

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QUESTIONNAIRE STUDY 1

UNIVERSITÀ DEGLI STUDI DI VERONA

Dipartimento di Medicina e Sanità Pubblica, Unità di Ricerca Infermieristica

Dipartimento di Psicologia e Antropologia culturale

La presente rilevazione viene effettuata nell'ambito di una ricerca scientifica che ha l'obiettivo di aumentare le conoscenze ad *atteggiamenti e motivazioni verso il lavoro* da parte degli infermieri.

Non esistono risposte corrette o risposte sbagliate, soltanto RISPOSTE PERSONALI.

Le chiediamo di rispondere con MOLTA FRANCHEZZA a tutte le domande che le verranno poste, leggendo attentamente le istruzioni indicate di volta in volta. La Sua sincerità è per noi molto preziosa.

E' importante che lei risponda con ATTENZIONE, ma che NON SI SOFFERMI TROPPO A LUNGO SULLE DOMANDE, procedendo speditamente.

A conclusione del questionario CONTROLLI DI AVER RISPOSTO A TUTTE LE DOMANDE: la completezza del questionario è condizione indispensabile per la validità del nostro lavoro.

IL QUESTIONARIO E' ANONIMO PER LA TUTELA DELLA PRIVACY

La informiamo che le risposte da Lei gentilmente forniteci saranno utilizzate solo nell'ambito del progetto di ricerca, i risultati dell'indagine saranno pubblicati solo in modo aggregato e trattati a soli scopi scientifici. (Ai sensi della legge 675/96 sulla "Tutela delle persone e degli altri soggetti rispetto al trattamento dei dati personali")

In questo questionario il genere maschile è utilizzato in forma generica, con il solo obiettivo di non appesantire il testo.

LA RINGRAZIAMO PER LA SUA PREZIOSA COLLABORAZIONE

SCHEDA ANAGRAFICA

Età |_____| Sesso □M □F Stato civile |_____|

Ha figli? SI NO Se SI, quanti? |_____|

Cittadinanza: Italiana Altra cittadinanza (indichi quale) _____	**In caso di altra cittadinanza da quanti anni risiede in Italia?** □ Da meno di 5 anni □ Da più di 6 anni (indichi da quanti anni)_____
Titolo di studio - formazione post-base □ Laurea Specialistica in Scienze Infermieristiche □ Master	□ Sto frequentando Master o Laurea Specialistica □ Ho intenzione di frequentare in futuro Master o corsi di laurea specialistica in scienze infermieristiche
Tipo di contratto di lavoro □ Contratto a tempo indeterminato (a tempo pieno (part time □ Contratto a tempo determinato □ Contratto con incarico libero professionale Altro_____	**Attualmente lavora nel reparto di :** _____

1. Di seguito troverà una serie di affermazioni sui diversi ASPETTI DEL SUO LAVORO per i quali Le chiediamo di *esprimere quanto La soddisfano* utilizzando la scala indicata.

1 Per niente vero

2 = Poco vero

3 = Sufficientemente vero

4 = Molto vero

5 = Completamente vero

1	La crescita personale che deriva dallo svolgere il mio lavoro	1	2	3	4	5
2	Le informazioni che ricevo sulla qualità del mio lavoro	1	2	3	4	5
3	Il livello di autonomia nel mio lavoro	1	2	3	4	5
4	Le persone con le quali lavoro	1	2	3	4	5
5	Il rispetto e la stima che ricevo dal mio coordinatore	1	2	3	4	5
6	La sensazione di realizzazione che mi proviene dal mio lavoro	1	2	3	4	5
7	Il risultato del mio lavoro	1	2	3	4	5
8	Il dialogo con i colleghi	1	2	3	4	5
9	I consigli da parte dei colleghi	1	2	3	4	5
10	La considerazione dimostrata dai coordinatori	1	2	3	4	5
11	Il ruolo assegnatomi	1	2	3	4	5
12	Il sostegno e le indicazioni che ricevo dal mio coordinatore	1	2	3	4	5
13	Le responsabilità legate al mio ruolo	1	2	3	4	5
14	L'opportunità di consultarmi con i colleghi	1	2	3	4	5
15	La partecipazione alla determinazione dei metodi e delle procedure nel lavoro	1	2	3	4	5
16	Il dialogo con i miei coordinatori	1	2	3	4	5
17	La qualità del mio lavoro	1	2	3	4	5
18	Lo sviluppo professionale raggiunto grazie a questo lavoro	1	2	3	4	5
19	La considerazione dimostrata dai colleghi nei confronti del mio lavoro	1	2	3	4	5
20	I contenuti del mio lavoro	1	2	3	4	5
21	Le occasioni di apprendimento e di formazione	1	2	3	4	5
22	La definizione di compiti e delle responsabilità	1	2	3	4	5

1 = Mai

2 = Raramente

3 = Qualche volta

4 = Spesso

2. Utilizzando la seguente scala, indichi in quale misura ciascuna affermazione sotto riportata corrisponde alla SUA PERCEZIONE:

1 = Per niente vero

2 = Poco vero

3 = Sufficientemente vero

4 = Molto vero

5 = Completamente vero

1	Aiuto chi ha molto lavoro da svolgere	1	2	3	4	5
2	Mi tengo aggiornato sui cambiamenti che avvengono in ospedale	1	2	3	4	5
3	Non mi interesso delle conseguenze che le mie azioni hanno sui miei colleghi	1	2	3	4	5
4	Partecipo a riunioni che non sono obbligatorie, ma che considero importanti	1	2	3	4	5
5	Sono sempre pronto a "dare una mano" a quelli che mi stanno attorno	1	2	3	4	5
6	Partecipo ad attività che non sono richieste ma che sono importanti per l'immagine dell'ospedale	1	2	3	4	5
7	Leggo le comunicazioni organizzative per stare al passo con le novità	1	2	3	4	5
8	Aiuto chi è stato assente dal lavoro quando rientra	1	2	3	4	5
9	Mi viene spontaneo aiutare chi ha problemi di lavoro	1	2	3	4	5
10	Aiuto i nuovi infermieri a orientarsi anche se non è richiesto dall'ospedale	1	2	3	4	5

1 = Per niente vero

2 = Poco vero

3 = Sufficientemente vero

4 = Molto vero

3. Le affermazioni che seguono riguardano le SENSAZIONI che percepisce mentre lavora. Risponda a ciascuna affermazione, utilizzando la seguente scala per indicarne la frequenza:

0 = MAI

1 = QUASI MAI (1 volta all'anno)

2 = RARAMENTE 51 volta al mese)

3 = QUALCHE VOLTA (qualche volta al mese)

4 = SPESSO (1 volta alla settimana)

5 = MOLTO SPESSO (qualche volta alla settimana)

1	Nel mio lavoro mi sento pieno di energia	0	1	2	3	4	5
2	Nel mio lavoro mi sento forte e vigoroso	0	1	2	3	4	5
3	Sono entusiasta del mio lavoro	0	1	2	3	4	5
4	Il mio lavoro mi ispira	0	1	2	3	4	5
5	La mattina, quando mi alzo, ho voglia di andare al lavoro	0	1	2	3	4	5
6	Sono felice quando lavoro intensamente	0	1	2	3	4	5
7	Sono orgoglioso del lavoro che faccio	0	1	2	3	4	5
8	Sono immerso nel mio lavoro	0	1	2	3	4	5
9	Mi lascio prendere completamente quando lavoro	0	1	2	3	4	5

4. Le affermazioni che seguono riguardano le EMOZIONI e degli STATI D'ANIMO che si originano nella RELAZIONE CON I SUOI PAZIENTI. Leggendo ognuna delle affermazioni indichi il suo grado di accordo o disaccordo, tenendo conto che la scala sottostante va da un massimo di disaccordo 1 ad un massimo di accordo 5:

5. Di seguito troverà una serie di affermazioni rel
che Lei ha con il personale del Suo REPARTO. Le c
le affermazioni attribuendo un valore seguendo la s

1 = Minimo accordo
2
3
4
5 = Massimo disaccordo

1	La comprensione dello stato emotivo dei pazienti e dei influenza gli standard dell'assistenza infermieristica					
2	I miei pazienti si sentono meglio quando capisco il loro					
3	Per me è difficile vedere le cose dal punto di vista dei pazienti	1	2	3	4	5
4	Cerco di non prestare attenzione alle emozioni dei pazienti durante la raccolta dell'anamnesi	1	2	3	4	5
5	L'attenzione alle esperienze personali dei pazienti non influenza il quadro clinico	1	2	3	4	5
6	Cerco di mettermi nei panni dei miei pazienti quando mi prendo cura di loro	1	2	3	4	5
7	I pazienti apprezzano la mia comprensione del loro stato emotivo, comprensione che ha in sé un valore terapeutico	1	2	3	4	5
8	Le malattie dei pazienti possono essere curate attraverso un'adeguata assistenza infermieristica, in cui i legami affettivi non hanno alcuna influenza significativa	1	2	3	4	5
9	Chiedere ai pazienti cosa sta accadendo nella loro vita privata non è d'aiuto nella comprensione dei loro problemi di salute	1	2	3	4	5
10	Cerco di capire cosa pensano e sentono i pazienti, prestando attenzione ai loro messaggi non-verbali e al linguaggio del corpo	1	2	3	4	5
11	Credo che i sentimenti non giochino alcun ruolo nell'assistenza infermieristica	1	2	3	4	5
12	Credo che l'empatia sia un importante fattore terapeutico dell'assistenza infermieristica	1	2	3	4	5

1 = Per niente vero
2 = Poco v
3 = Suffici
4 = Molto
5 = Completame

1 = Mai
2 = Raramente
3 = Qualche volta
4 = Spesso

7. Le affermazioni che seguono riguardano le EMOZIONI e degli STATI D'ANIMO che si originano nella RELAZIONE CON I SUOI PAZIENTI. Leggendo ognuna delle affermazioni indichi il suo grado di accordo o disaccordo, tenendo conto che la scala sottostante va da un massimo di disaccordo 1 ad un massimo di accordo 5:

1	Provo un senso di appartenenza al mio reparto	1	2	3	4	5
2	Non mi sento emotivamente attaccato a questo reparto	1	2	3	4	5
3	Non sento di "far parte della famiglia" nel mio reparto	1	2	3	4	5
4	Il mio reparto rappresenta molto per me	1	2	3	4	5
5	Sono fiero di appartenere a questo reparto	1	2	3	4	5
6	Sento davvero come se i problemi del mio reparto fossero i miei	1	2	3	4	5

6. Le affermazioni che seguono riguardano le CARATTERISTICHE DEL SUO SPECIFICO LAVORO; risponda a ciascuna affermazione utilizzando la seguente scala:

1 = Per niente vero

2 = Poco vero

3 = Sufficientemente vero

4 = Molto vero

5 = Completamente vero

1 = Minimo accordo

2

3

4

5 = Massimo disaccordo

1	Ha un forte impatto sulla gente esterna all'ospedale	1	2	3	4	5
2	In sé è veramente significativo e importante	1	2	3	4	5
3	Le cose fatte sul mio lavoro hanno un impatto significativo sulla gente esterna all'ospedale	1	2	3	4	5

1	Quante volte nel tuo lavoro hai dovuto reprimere un'emozione per apparire esternamente più neutrale ?	1	2	3	4	5
2	Per A. e' molto importante nascondere i sentimenti personali che possono essere suscitati dai pazienti Per B. nascondere questi sentimenti ai pazienti e' meno rilevante. Quale modalita' e' più simile alla tua ? 1. Esattamente come quella di A. 2. Simile a quella di A. 3. tra A. e B. 4. simile a quella di B. 5. esattamente come quella di B.	1	2	3	4	5
3	Quante volte nel tuo lavoro hai manifestato emozioni che non si accordavano con i reali sentimenti che provavi verso i pazienti ?	1	2	3	4	5
4	Quante volte nel tuo lavoro ti capita di manifestare emozioni positive (ad esempio gentilezza) o negative (ad esempio severità), nonostante tu ti senta interiormente indifferente?	1	2	3	4	5
5	Quante volte nel tuo lavoro devi manifestare emozioni che non si accordano con i tuoi reali sentimenti?	1	2	3	4	5

QUESTIONNAIRE STUDY 2 (French Version)

ULB UNIVERSITÉ LIBRE DE BRUXELLES, UNIVERSITÉ D'EUROPE

Bonjour,

Dans le cadre de mon travail de doctorat, je m'intéresse à la problématique de la relation infirmier-patient, et à l'impact de cette relation sur le bien-être des infirmiers.

L'objectif de cette recherche est de récolter des informations sur cette relation afin de l'améliorer. Pour que cette investigation soit valide, il m'est indispensable d'avoir un nombre des participants

suffisamment important et représentatif des infirmier(e)s. C'est dans ce contexte que je me permets de solliciter votre collaboration.

Le temps de passation est de courte durée, comptez 10 à 15 minutes. Il s'agit d'un questionnaire fermé qui vous demande, de donner votre avis les propositions énoncées. A la fin du questionnaire, une fiche signalétique est proposée, ces renseignements me permettront de définir la population tout en préservant l'anonymat de chacun.

Je vous remercie de bien vouloir me consacrer de votre temps et de contribuer ainsi à la réalisation de ce travail.

Si vous souhaitez obtenir des informations supplémentaires, vous pouvez me contacter à l'adresse mail suivante : lds107@hotmail.com

Letizia Dal Santo

LABORATOIRE DE PSYCHOLOGIE DU TRAVAIL ET PSYCHOLOGIE ECONOMIQUE

Chacun des énoncés suivants traitent de la relation avec votre patient. Veuillez indiquer, **l'importance de votre accord ou de votre désaccord avec chaque énoncé,** en cochant une des cases à droite.

	Fortement en désaccord	**Désaccord**	**Neutre**	**Accord**	**Fortement en accord**
1. La compréhension de la façon dont mes patients se sentent n'influence pas mes soins	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
2. Mes patients se sentent mieux quand je comprends leurs sentiments	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
3. J'essaie de ne pas porter attention aux émotions de mes patients lors de leur évaluation clinique ou lorsque je les questionne sur leur santé physique	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
4. L'attention que je porte aux expériences personnelles de mes patients n'influence pas les résultats de leur traitement	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
5. J'essaie de m'imaginer dans la peau de mes patients quand je leur donne un soin.	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
6. Les liens émotionnels que j'entretiens avec mes patients n'ont pas d'influence significative sur les résultats médicaux ou chirurgicaux	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
7. Interroger les patients sur ce qui se passe dans leur vie personnelle m'aide pour la compréhension de leurs symptômes	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
8. J'essaie de comprendre ce qui traverse l'esprit de mes patients en prêtant attention aux signes non verbaux et au langage corporel.	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
9. Je crois que l'émotion n'a pas de place dans le traitement d'une maladie.	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
10 L'empathie est une aptitude thérapeutique, sans laquelle le succès d'un traitement est limité.	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5

11. Une composante importante dans la relation avec mes patients est la compréhension de leur état émotionnel.	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
12. J'essaie de penser comme mes patients afin de leur donner de meilleurs soins.	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5

Chacun des énoncés suivants traite de la gestion des émotions pendant l'interaction avec votre patient. On vous demande d'indiquer, **la fréquence avec laquelle vous devez gérer vos émotions,** en utilisant une échelle en 5 points.

	très rarement / jamais	**rarement (env. 1 x par semaine**	**parfois (env. 1 x par jour)**	**souvent (plusieurs x par jour)**	**très souvent (plusieurs x par heure)**
1. Dans votre poste, à quelle fréquence arrive-t-il que vous deviez **réprimer vos émotions** de telle manière à avoir l'air "neutre" ?	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
2. Dans votre poste, à quelle fréquence arrive-t-il que vous deviez montrer des émotions **qui ne correspondent pas à ce que vous ressentez momentanément à l'égard de vos patients** ?	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
3. Dans votre poste, à quelle fréquence arrive-t-il que vous deviez montrer des émotions positives (p. ex. de l'amabilité) ou des émotions négatives (p. ex. de la colère) **alors que vous vous sentez** 4. **intérieurement indifférent** ?	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
5. Dans votre activité professionnelle, à quelle fréquence arrive-t-il que vous deviez montrer des émotions **qui ne correspondent pas à vos véritables émotions** ?	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5

Dans le travail de A, il est **très important** de **ne pas dévoiler** aux patients **les émotions que la situation éveille en lui/elle**. Dans le travail de B, on **peut dévoiler** aux patients les émotions que la situation éveille en lui/elle.

Laquelle de ces deux situations ressemble le plus à la vôtre ?

la situation exacte de A	( ) 1
une situation semblable à A	( ) 2
une situation entre A et B	( ) 3
une situation semblable à B	( ) 4
la situation exacte de B	( ) 5

Dans de nombreux hôpitaux où l'on est en contact avec les patients**, il est nécessaire de gérer de manière précise ses propres émotions et les émotions des autres afin d'exécuter ses tâches avec succès.**

La manière dont ceci est régulé est cependant différente d'un hôpital à l'autre. Comment les choses se déroulent-elles sur votre lieu de travail ?

	Fortement en désaccord	**Désaccord**	**Neutre**	**Accord**	**Fortement en accord**
1. Les règles à ce propos m'ont été transmises par mon supérieur.	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
2. Les règles à ce propos m'ont été transmises dans des cours de formation continue organisés par l'hôpital.	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
3. Les règles à ce propos font partie intégrante de la culture d'entreprise de mon service ("on se comporte comme ça").	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
4. L'application de telles règles est indispensable pour être efficace dans mon métier	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
5. L'application de telles règles est indispensable pour avoir de bonnes relations avec mes patients	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
6. L'application de telles règles est indispensable pour être accepté au sein de mon équipe	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5

7. Le non-respect de telles règles entraîne des sanctions de la part de mon supérieur	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
8. De telles règles sont définies par mon service	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
9. De telles règles sont définies par mon supérieur	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
10. De telles règles découlent de l'image de ma profession.	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
11. Les règles à ce propos découlent des attentes des familles des patients à l'égard de ma profession.	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
12. Les règles à ce propos en vigueur dans mon service me paraissent pertinentes	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
13. Je partage les règles à ce propos, en vigueur dans mon service	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
14. Les règles à ce propos en vigueur dans mon service sont utiles pour mieux gérer ma relation avec le patient	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5

Les énoncés qui suivent, concernent la **satisfaction perçue dans votre travail**. Indiquez votre accord ou désaccord en utilisant l'échelle en 5 points (un chiffre plus élevé indique un accord plus élevé).

Je suis satisfait par…..

	Fortement en désaccord	**Désaccord**	**Neutre**	**Accord**	**Fortement en accord**
1) L'opportunité de développement personnel que mon travail me permet	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
2) Les informations que je reçois sur la qualité de mon travail	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5

3)	Le niveau d'autonomie dans mon travail	( )1	( )2	( )3	( )4	( )5
4)	Les gens avec lesquels je travaille	( )1	( )2	( )3	( )4	( )5
5)	Le respect et l'estime que je reçois de mon chef	( )1	( )2	( )3	( )4	( )5
6)	La sensation de réalisation que mon travail me procure	( )1	( )2	( )3	( )4	( )5
7)	Les résultats que j'atteins dans mon travail	( )1	( )2	( )3	( )4	( )5
8)	Le dialogue avec les collègues	( )1	( )2	( )3	( )4	( )5
9)	Les conseils des collègues	( )1	( )2	( )3	( )4	( )5
10)	La considération que mon chef me témoigne	( )1	( )2	( )3	( )4	( )5
11)	Le soutien que je reçois de mon chef	( )1	( )2	( )3	( )4	( )5
12)	Les responsabilités liées à mon travail	( )1	( )2	( )3	( )4	( )5
13)	La possibilité de consulter mes collègues	( )1	( )2	( )3	( )4	( )5
14)	La possibilité de décider des méthodes et des procédures dans mon travail	( )1	( )2	( )3	( )4	( )5
15)	Le dialogue avec mon chef	( )1	( )2	( )3	( )4	( )5
16)	La qualité de mon travail	( )1	( )2	( )3	( )4	( )5
17)	Le développement professionnel atteint grâce à mon travail	( )1	( )2	( )3	( )4	( )5

18) La considération que mes collègues me témoignent	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
19) Le contenu de mon travail	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
20) Les opportunités d'apprentissage et de formation	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
21) La définition des tâches et des responsabilités	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5

Ci-dessous un ensemble de **sentiments que vous pouvez éprouver à l'égard de votre travail**. Dans quelle manière éprouvez-vous chacun de ces sentiments? Si vous n'avez jamais éprouvé ce sentiment, entourez le chiffre 1 , Si vous éprouvez très souvent ce sentiment entourez le chiffre 5. Les cases intermédiaires permettent de nuancer votre jugement.

	jamais	**rarement (env. 1 x par mois)**	**Quelquefois par mois**	**Souvent**	**très souvent**
1. Je déborde d'énergie pour mon travail	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
2. Je me sens fort(e) et vigoureux(se) pour faire ce métier	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
3. Je suis passionné(e) par mon travail	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
4. Faire ce métier est stimulant	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
5. Lorsque je me lève le matin, j'ai envie d'aller travailler	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
6. Je suis content(e) lorsque je suis captivé(e) par mon activité	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5

7. Je suis fier(e) du travail que je fais	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
8. Je suis complètement absorbé(e) par mon travail	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
9. Je suis littéralement plongé(e) dans mon travail	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5

Les affirmations qui suivent concernent le soutien que vous recevez de vos collègues et de votre chef en matière de gestion de vos émotions au travail (par exemple: je ressens une tristesse très forte face à un patient avec une maladie incurable et je ne l'exprime pas). Répondez à chacune des affirmations en utilisant l'échelle suivante. Vous cochez 1, si vous êtes « pas du tout d'accord ». Vous cochez 5, si vous êtes « tout à fait d'accord ». Les cases intermédiaires permettent de nuancer votre jugement.

1) Mes collègues valorisent ma compétence dans la gestion de mes émotions avec mes patients	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
2) Mon chef m'aide à mieux gérer mes émotions avec mes patients	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
3) Mon chef tient compte de ma charge émotionnelle	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
4) Mon chef valorise la façon dont je gère mes émotions avec mes patients	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
5) Mes collègues tiennent compte de ma charge émotionnelle	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
6) Mes collègues m'aident à mieux gérer mes émotions avec mes patients	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
7) Mon chef me donne de bons conseils quand j'ai des difficultés à gérer mes émotions avec mes patients	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
8) Mes collègues me donnent de bons conseils quand					

j'ai des difficultés à gérer mes émotions avec mes patients	( )1	( )2	( )3	( )4	( )5
9) Quand j'ai un problème de gestion de mes émotions avec mes patients, mon chef m'apporte son aide.	( )1	( )2	( )3	( )4	( )5
10) Quand j'ai un problème de gestion de mes émotions avec mes patients, mes collègues m'apportent leur aide	( )1	( )2	( )3	( )4	( )5

Les questions finales portent sur **le temps que vous consacrez au contact avec vos patients** dans votre activité professionnelle**.**

Sur l'ensemble d'une journée de travail, combien de temps en moyenne êtes-vous **en contact avec vos patients (en face-à-face ou au téléphone)** ?

moins de 2 heures par jour	( ) 1
entre 2 et 4 heures par jour	( ) 2
entre 4 et 6 heures par jour	( ) 3
entre 6 et 8 heures par jour	( ) 4
plus de 8 heures par jour	( ) 5

En règle générale, combien de temps **en moyenne** dure **un contact** avec un patient (p. ex. une discussion avec un patient, ou écouter un patient) ?

moins de 5 minutes	( ) 1
entre 5 et 15 minutes	( ) 2
entre 15 et 30 minutes	( ) 3
entre 30 et 60 minutes	( ) 4
entre 1 et 2 heures	( ) 5
plus de 2 heures	( ) 6

Pour finir nous vous demandons quelques renseignements

Age : ……..

Ancienneté dans le service : ……

Ancienneté dans la profession : ……

QUESTIONNAIRE STUDY 2 (Dutch Version)

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Beste,

Binnen het kader van mijn doctoraatscriptie interesseer ik mij in de relatie verpleegkundige-patiënt en de impact van deze relatie op het welzijn van de verpleegkundige. Mijn doctoraatscriptie maakt ook deel uit van een Europees onderzoek rond de relaties tussen de verpleegkundige en de patiënt alsook de impact van de leidinggevende hierop.
Voor dit onderzoek heb ik hier rond informatie nodig met de uiteindelijke bedoeling dat deze de relatie verpleegkundige - patiënt dan ook ten goede komt. Hiervoor heb ik een voldoende aantal deelnemers nodig. Vandaar dat ik Uw medewerking vraag langs het invullen van deze vragenlijst. In principe neemt dit niet meer dan 10 à 15 minuten in beslag neemt. Het betreft een gesloten vragenlijst die peilt naar Uw mening ten aanzien van bepaalde voorop gestelde uitspraken. Op het einde wordt er ook naar bepaalde gegevens gevraagd betreffende de persoon die de vragenlijst heeft ingevuld. Het spreekt voor zich dat deze gegevens volstrekt anoniem worden behandeld.
Ik dank U nu reeds voor Uw tijd en medewerking. De resultaten van het onderzoek zullen U na afloop worden medegedeeld.

Letizia Dal Santo

LABORATOIRE DE PSYCHOLOGIE DU TRAVAIL ET PSYCHOLOGIE ECONOMIQUE


LAPTÉ

Elk van de volgende uitspraken betreffen de relatie met je patiënt. Gelieve duidelijk te maken in welke mate je het eens of oneens bent door het aankruisen van één van de vakjes naast elke uitspraak.

	Uitermate oneens	Oneens	Noch eens, noch oneens	Eens	Uitermate eens
1. Het begrijpen van de gevoelens van mijn patiënten hebben geen invloed op de zorg die ik hen toedien	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
2. Mijn patiënten voelen zich beter wanneer ik hun gevoelens begrijp.	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
3. Bij een klinische evaluatie of wanneer ik mijn patiënten bevraag over hun fysische toestand probeer ik geen aandacht te besteden aan hun emoties.	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
4. De aandacht die ik besteed aan de persoonlijke ervaringen van mijn patiënten beïnvloedt geenszins het resultaat van de behandeling.	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
5. Ik probeer in de huid van mijn patiënt te kruipen wanneer ik zorg toedien.	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
6. Mijn patiënten waarderen dat ik hun gevoelens begrijp.	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
7. De emotionele band met mijn patiënten beïnvloedt geenszins de resultaten op medisch en heelkundig vlak.	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
8. Ik begrijp beter de symptomen van mijn patiënten wanneer ik hen bevraag over hun persoonlijk leven.	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
9. Ik tracht te begrijpen wat er bij mijn patiënten omgaat langs niet verbale tekens en hun lichaamstaal.	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
10. Volgens mij hebben gevoelens geen plaats in de behandeling van een ziekte.	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
11 Zonder empathie als therapeutische vaardigheid is het succes van een behandeling eerder beperkt.	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
12. Begrip voor hun emotionele toestand speelt een belangrijke rol in de relatie met mijn patiënten.	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5

Elk van de volgende uitspraken heeft betrekking op de wijze waarop ik met mijn gevoelens omga in de interactie met je patiënten. Duidt op een schaal van 1 tot 5 de frequentie aan waarmee je genoodzaakt bent dit te doen.

	Heel zelden / nooit	Zelden (ong. 1 x/week)	Soms (ong. 1 x per dag)	Dikwils (merdere malen per dag)	Heel dikwijls (meerdere keren per dag)
1. 1.Hoeveel maal heb je bij het uitoefenen van je werk de indruk je gevoelens te moeten onderdrukken ten einde neutraal over te komen ?	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
2. Hoeveel maal heb je bij je werk de indruk gevoelens te moeten uiten **die op dat ogenblik met de gevoelens ten aanzien van je patiënt niet overeen stemmen.** ?	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
3. Hoe dikwijls heb je de indruk dat je op je werk positieve gevoelens (bv. Vriendelijkheid) of negatieve gevoelens (bv. Woede) moet uiten daar waar je inwendig andere gevoelens ervaart ?	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
4. Hoe dikwijls komt het in je professionele activiteit voor dat je gevoelens moet uiten die niet overeen stemmen met de ware gevoelens die je ervaart ?	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5

5. Bij het werk van A is het belangrijk om zijn / haar gevoelens bij een bepaalde situatie niet te tonen. Bij het werk van B daarentegen mag men wel zijn / haar emoties laten blijken. Welke van beide situaties gelijkt het meest op de jouwe?

Exact de zelfde situatie als A (1)
Een situatie gelijkend op A (2)

Een situatie tussen A en B (3)

Een situatie gelijkend op B (4)
Exact de zelfde situatie als B (5)

In heel wat ziekenhuizen hecht men veel belang aan de **wijze waarop men met zijn eigen gevoelens en deze van anderen omgaat** en dit om zijn taak zo goed mogelijk te kunnen uitvoeren. De manier waarop gevoelens gereguleerd worden is uitermate verschillend van de ene instelling tot de andere. Hoe pakt men dit aan op je werkplek?

	Uitermate oneens	**Oneens**	**Noch eens, noch oneens**	**Eens**	**Uitermate eens**
1. Ik werd door mijn overste hieromtrent ingelicht.	( )1	( )2	( )3	( )4	( )5
2. Ik werd hieromtrent in de vormingssessies van de permanente vorming ingelicht.	( )1	( )2	( )3	( )4	( )5
3. De regels dienaangaande maken deel uit van de algemene bedrijfscultuur van de dienst ("men gedraagt zich op deze of gene wijze!").	( )1	( )2	( )3	( )4	( )5
4. Het toepassen van deze reglementering is onontbeerlijk voor het efficiënt functioneren in mijn beroep.	( )1	( )2	( )3	( )4	( )5
5. Het naleven van deze regels is onontbeerlijk voor een goede relatie met mijn patiënten.	( )1	( )2	( )3	( )4	( )5
6. Het naleven van deze regels is onontbeerlijk om binnen mijn team aanvaard te worden.	( )1	( )2	( )3	( )4	( )5
7. Het niet naleven van deze regels wordt door mijn overste gesanctioneerd.	( )1	( )2	( )3	( )4	( )5
8. Deze regels worden door mijn dienst bepaald.	( )1	( )2	( )3	( )4	( )5
9. Deze regels worden door mijn overste bepaald	( )1	( )2	( )3	( )4	( )5
10. Deze regels zijn het gevolg van de verwachtingen die de patiënten hebben ten aanzien van mijn beroep.	( )1	( )2	( )3	( )4	( )5
11. Het zijn de verwachtingen van de familie ten aanzien van mijn beroep die de regels hieromtrent bepalen.	( )1	( )2	( )3	( )4	( )5
12. De regels op mijn dienst hieromtrent gebruikelijk zijn lijken mij pertinent.	( )1	( )2	( )3	( )4	( )5
13. Ik ben het eens met de regels die op mijn dienst gebruikelijk zijn.	( )1	( )2	( )3	( )4	( )5
14. De regels die hier omtrent gebruikelijk zijn op mijn dienst zijn nuttig in de omgang met de patiënt.	( )1	( )2	( )3	( )4	( )5

In de volgende uitspraken komt je **arbeidsvoldoening** aan bod. Gelieve het vakje aan te kruisen om te kennen te geven in welke mate je akkoord of niet akkoord gaat met de betreffende uitspraak (een hoger cijfer betekent dat je het meer eens bent)

Ik ben tevreden met…..

	Uitermate oneens	Oneens	Noch eens, noch oneens	Eens	Uitermate eens
1) De persoonlijke ontwikkelingsmogelijkheden die mijn werk mij biedt.	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
2) De informatie die ik krijg over de kwaliteit van mijn werk	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
3) Het niveau van autonomie in mijn werk.	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
4) De mensen met wie ik werk	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
5) Het respect en de waardering die ik van mijn overste krijg.	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
6) Het gevoel iets te kunnen realiseren.	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
7) De resultaten die ik verkrijg in mijn werk	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
8) De dialoog met mijn collega's	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
9) De adviezen van collega's	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
10) De achting die mijn overste mij betuigt.	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
11) De steun die ik van mijn overste mag ondervinden.	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
12) De verantwoordelijkheden die met mijn werk verbonden zijn.	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
13) De mogelijkheden om bij mijn collega's raad te vragen	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
14) De mogelijkheid om zelf te beslissen over gebruikte methodes en procedures	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
15) De dialoog met mijn overste					

Hieronder vind je gevoelens die je kan ervaren ten aanzien van je werk. In welke mate ervaar je elk van deze gevoelens ? Indien je dit gevoel nooit hebt ervaren, kruis dan 1 aan. Indien je dit gevoel heel dikwijls ervaart, kruis dan 5 aan. De tussen liggende vakjes dienen om je oordeel te nuanceren.

	Nooit	**Zelden (ong. 1 x / maand)**	**Enkele malen per maand**	**Dikwijls**	**Heel dikwijls**
1) Ik loop over van enthousiasme voor mijn werk.	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
2) Ik voel mij sterk en energiek om mijn beroep uit te oefenen.	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
3) Ik ben door mijn werk gepassioneerd.	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
4) Dit beroep betekent een stimulans.	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
5) ‘s Morgens bij het opstaan heb ik zin om te gaan werken	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
6) Ik ben heel tevreden wanneer ik door mijn werk volledig wordt opgeslorpt.	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
7) Ik ben fier over mijn werk.	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
8) Ik word volledig door mijn werk opgeslorpt.	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
9) Ik ben letterlijk in mijn werk verzonken.	( ) 1	( ) 2	( ) 3	( ) 4	( ) 5

Hieronder vind je beweringen betreffende de steun die je van jouw collega's en je overste krijgt bij het beheer van je gevoelens op het werk (voorbeeld : je voelt je heel triest ten aanzien van een patiënt met een ongeneeslijke ziekte maar je brengt dit gevoel niet tot uiting). Beantwoordt elk van deze beweringen door de volgende schaal te gebruiken. Je duit een 5 aan indien je het volstrekt eens bent en 1 wanneer je het volstrekt oneens bent. De tussenliggende vakjes bieden je de mogelijkheid om je antwoord te nuanceren.					
1) Mijn collega's valoriseren de wijze waarop ik met mijn gevoelens omspring.	( )1	( )2	( )3	( )4	( )5
2) Mijn overste helpt mij om mijn gevoelens in de omgang met mijn patiënten beter te beheren.	( )1	( )2	( )3	( )4	( )5
3) Mijn overste houdt rekening met mijn emotionele last.	( )1	( )2	( )3	( )4	( )5
4) Mijn overste valoriseert de wijze waarop ik met mijn gevoelens omspring.	( )1	( )2	( )3	( )4	( )5
5) Mijn collega's houden rekening met mijn emotionele last.	( )1	( )2	( )3	( )4	( )5
6) Mijn collega's helpen mij om mijn gevoelens in de omgang met mijn patiënten beter te beheren.	( )1	( )2	( )3	( )4	( )5
7) Mijn overste geeft mij goede raad wanneer ik moeilijkheden ondervind in de omgang met mijn gevoelens ten aanzien van mijn patiënten	( )1	( )2	( )3	( )4	( )5
8) Mijn collega's geven mij goede raad wanneer ik moeilijkheden ondervind in de omgang met mijn gevoelens ten aanzien van mijn patiënten	( )1	( )2	( )3	( )4	( )5
9) Mijn overste helpt mij wanneer ik een probleem heb in de omgang met mijn gevoelens ten aanzien van mijn patiënten.	( )1	( )2	( )3	( )4	( )5
10) Mijn collega's helpen mij wanneer ik een probleem heb in de omgang mijn gevoelens ten aanzien van mijn patiënten.	( )1	( )2	( )3	( )4	( )5

Tot slot een paar vragen betreffende **de tijd die je in het contact met je patiënten investeert.**

Hoeveel tijd besteed je gemiddeld over een ganse werkdag aan het contact met je patiënten (face to face of telefonisch)?

Minder dan 2 uur per dag	( ) 1
tussen 2 en 4 uur per dag	( ) 2
tussen 4 en 6 uur per dag	( ) 3
tussen 6 en 8 uur per dag	( ) 4
meer dan 8 uur per dag	( ) 5

Hoelang duurt over het algemeen een gemiddeld contact met een patiënt (bv. Een dicussie met een patiënt, of het luisteren naar een patiënt)?

minder dan 5 minuten	( ) 1
tussen 5 en 15 minuten	( ) 2
tussen 15 en 30 minuten	( ) 3
tussen 30 en 60 minuten	( ) 4
tussen 1 en 2 uur	( ) 5
meer dan 2 uur.	( ) 6

Tot slot vragen we je enkele inlichtingen

Leeftijd : ……..

Anciënniteit in de dienst : …….

Anciënniteit in het beroep : …….

Geslacht : ☐ Vrouw ☐ Man

Dienst : …….

We bedanken je van harte voor je bereidwillige medewerking !!!