Original Article

A Qualitative Study on Emotional Labor Behavior of Oncology Nurses and its Effects

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Abstract

Background: With the ever increasing cancer cases, the quality and patient satisfaction of the healthcare services provided are not merely limited to the healthcare services provided. In this process, it is expected that the oncology nurses should also help promote patient satisfaction by getting their emotional labor.
Aim: This study has been conducted with the aim of identifying the thoughts of oncology nurses on the concept of emotional labor and its use as well as establishing the individual and organizational impacts of the use of emotional labor.
Method: This is a qualitative study based on a phenomenological design where 25 oncology nurses are interviewed and asked 11 open ended, semi structured and in depth questions.
Results: As a result of the study, following main themes were determined based on definitions made by the oncology nurses: emotional labor, emotional conflict, empathy, individual and organizational effects.
Conclusions-Implications: Emotional labor is instrumental in facilitating interpersonal relationships and maintaining care and is a big therapeutic value within the relationship between oncology nurses and patients and patients' relatives. More studies are needed to be conducted at the oncology departments where the use of emotional labor is most intense.

Keywords: Emotional labor, Oncology nursing, Qualitative study

Introduction

Today, growth of healthcare sector has brought along competition in this sector. Quality of the healthcare service, patient satisfaction, and healthcare institutions' reaching their goals are possible with efforts of nurses who are constantly in communication with the people receiving the service. In this process, emotional status of nurses providing healthcare services is also important and they are expected to keep the patient satisfaction level as high as possible by using their emotions (Tracy, 2005; McClure & Murphy, 2007).

According to Hochschild (1983), the first person who brought up the concept of emotional labor comprehensively; it is a form of emotion regulation to be observed by other persons as part of a job and accordingly a facial and bodily display. Ashforth and Humprey (1993) addressed the emotional labor as an observable behavior pattern rather than internal management of feelings. In other words, they are nameless duties that employees should perform while doing their works (Mastracci, Newman, & Guy, 2006).

Hochschild (1983) examined behaviors of employees related to their emotions in two dimensions as surface act and deep act. Surface act refers that personnel fake their emotions within the scope of institutional and occupational rules, differentiate them from emotions they really feel and refer them to the receiver (Hochschild, 1983; Brotheridge & Grandey, 2002; Grandey, 2003; Mikolajczak et al., 2009).

In deep act, the personnel focus on internal emotions, endeavor to perform a role expected from themselves like an actor or actress, and thus

try to transmit their emotions (Brotheridge & Grandey, 2002; Smith & Lorentzon, 2007; Rupp et al., 2008).

Grandey (2000) examined long term results of using the emotional labor in two ways as its individual and organizational effects. Its individual effects are burnout and the decrease in work satisfaction. Indicators of burnout are stated as weariness, depersonalization and decrease of personal success. Its organizational effects were stated as performance and tendency of withdrawal from work (Grandey, 2000; Gungor, 2009).

Previous studies have revealed that emotional labor is closely correlated with performance, work stress, burnout, and job dissatisfaction (Mann & Cowburn, 2005; Bakker & Heuven, 2006; Zapf & Holz, 2006; Judge, Woolf, & Hurst, 2009).

Hochschild (1983) also mentioned nursing profession in terms of using emotional labor and stated that nurses always have to perform emotions such as being positive and reliable against the patient. Gray and Smith (2008) examined the concept of emotional labor by carrying out in-depth interviews with 16 nurses working at intensive care, psychiatry, and pediatric oncology units.

As a result of the study, by focusing on gender factor and considering nursing as “female profession”, the concept of emotional labor was identified with women’s “motherhood role”. Also, the participants stated that the emotional labor is obligatory for nursing profession and an integral part of healthcare service culture (Gray & Smith, 2008).

In the units such as oncology unit where patients during terminal period are provided care, patients suffer from pain and patients frequently die, patients and their families are constantly communicated from the diagnosis to loss of the patient; oncology nurses experience emotional dissonance and perform an intense emotional labor (Dunne, Sullivan, & Kernohan 2005; Mohan et al., 2005; Kendall, 2007).

This study was conducted in a qualitative design in order to determine the opinions of oncology nurses, who perform more emotional labor more than many units and health occupational groups, concerning the concept of emotional labor and its use and specify individual and organizational effects of using emotional labor.

Method

Design and Setting

This is a qualitative study conducted in the phenomenological design. Qualitative studies are an effective study design in determining experiences of healthcare professionals who directly deal with patient care and have face-to-face communication. It is especially effective in comprehensively revealing the cases which we are aware of but do not have deep and detailed knowledge about (Polit & Beck, 2012; Liamputtong, 2013).

Participants

Purposeful sampling method was used for the interviews. Purposeful sampling enables in-depth studies in information-rich cases (Polit & Beck, 2012). The study was conducted with 25 oncology nurses who were working in an oncology center in Istanbul, agreed to participate in the study, and had the oncology experience of at least one year. The participant nurses were informed about the study before the interview and their consents were obtained.

Data Collection

The study was carried out by a researcher and a research assistant. Before initiating the data collection for the study, the interview questions prepared by the researchers were evaluated by three field specialists. Then, the preliminary pilot application of the study was executed with randomly selected 5 oncology nurses and they were asked to respond to open ended questions. Therefore, the data were obtained for the structuring of the questions and interviews. In accordance with interview data obtained, the interview form consisting of 11 questions was put into final form in collaboration with specialists.

The interview starts with preparing questions such as; “Could you please introduce yourself briefly?”, “What factors were effective in your decision of choosing the nursing profession?”, “How many years have you been working in this unit?”. Then, the interview continued with open ended questions such as “What changed in your personality after starting to work as a nurse?”, “How would you describe your communication with the patients and their relatives?”, “What does emotional labor mean for you?”.

Before the interviews, the demographic data of each participant within the scope of the study were collected. The individual, in-depth, and

semi-structured face-to-face interviews continued with 25 oncology nurses until a new data was not obtained. In addition to the interview questions, the interview was directed with additional questions when required. The interviews lasted for averagely 50 minutes (between 45 and 60 minutes), between September and November 2014.

In order to increase the recording quality of the interviews, two digital recording devices were used simultaneously. The records were analysed within 24 hours of each interview and additionally, notes were taken during the interviews. The recordings were repeatedly listened and the notes taken by the researchers during the interview were also recorded. Analyses were verified with oncology nurses participating in the study in order to ensure accuracy and validity of the obtained data.

Ethical Consideration

The data of the study were started to be collected after obtaining institutional approval (no: 37227) and ethics committee approval (no: 8238) from a university hospital in Istanbul. The participants were informed about the study verbally and in written and their written consents were obtained prior to interviews. The participants were informed that they did not have to answer the questions that they did not want to answer, and they could withdraw from the study at anytime.

Limitations of the Study

Limited number of the qualitative studies carried with oncology nurses on "emotional labor" constitutes the limitation of this study.

Data Analaysis

Qualitative content analysis approach was used for the analysis of the obtained data in the study (Jirojwong, Jobson, & Welch, 2014). The responses given by the participants for the open-ended and semi-structured interview questions were analysed in the research. The researchers analysed the given responses, classified similar answers under certain categories, and gathered and interpreted them within the frame of certain concepts and themes. The correlated concepts were unified under a certain theme.

Table 1. Themes and Sub-Themes

Emotional labor	Sincere Behavior-Empathizing	Experiencing Emotional Conflict	Individual Effects	Organizational Effects
A special bound established with the patients	Putting themselves in patients' shoes		Burnout	Wishing to change the unit
Moral support	Empathizing with the patients and their relatives		Increase in using Emotional Labor	
Empathizing			Decrease in Job Satisfaction	

Results

When examining the demographic data of 25 oncology nurses included in the study, it was determined that their average age was 33.40±8.27, and their average of working years in the oncology unit was 7.85±5.46 years, and 60% of the oncology nurses participating in the study had a bachelor's degree, and 90% were women.

At the end of the study, results of the study were gathered under 5 main themes: emotional labor based on description of oncology nurses, oncology nurses' displaying sincere behavior towards the patients and their families-emphasizing, emotional conflict experienced by oncology nurses, organizational and individual results of emotional labor on oncology nurses (Table 1).

Emotional labor based on description of oncology nurses

In their studies conducted by Hochschild (1983) and Gray and Smith (2008) with nurses they stated that most nurses described the concept of emotional labor as "ongoing communication", "feeling that they can be called for duty for 24 hours" and "providing feeling of trust and warmth to the patients". In other words, they described it as "being a part of making the patients feel comfortable, safe and at home".

Moreover, it is also stated that emotional labor makes patient-nurse communication easier (Smith & Lorentzon, 2005). In addition to social and psychological concepts, emotional labor is also regarded as an unseen bound between patients and nurses (Allan & Barber, 2005). Emotional labor is also defined as removal of emotional and sensitive barrier between the patients and nurses. This enables nurses to have easier communication with the patients and relative, and give a more efficient care (Smith & Lorentzon, 2005).

All the oncology nurses participating in the study described emotional labor as "a special bound established with the patient", "giving moral support" and "emphasizing".

> **"***In this department, a special bond is established between the patient and you, this is emotional labor. Because mostly same patients come here and you get used to them so much. An emotional connection is developing and you become like a family. Most of the time we do not see our loved one as much as we see them. Every month they come to receive treatment and you get used to them ... They know a lot of things about me like my children and childhood."* (Interview 8)

> **"***Emotional labor is moral support we have provided to patients and their relatives. The people that need attention, love, compassion at most are in this unit. I'm happy doing it. Maybe you're tired of spending half an hour to make an explanation to a patient. Communicating with the patient, a smile, smiling face, even a simple touch can be good for patients."* (Interview 3)

> *"For example, I was deeply affected when I lost a patient. The patient relative lost her father. I hugged her and cried together with her. I tried to support her in that way. Because she needed the support and touch. Maybe I needed to shed tears with her to show her that I understood her. It makes you sad and you empathize. We think that we could have been the patient or relative of the patient.."* (Interview 10)

Oncology nurses' displaying sincere behavior towards the patients and their family-emphasizing

In addition to analyzing emotional labor as surface and deep act, Ashforth and Humphrey (1993) also formed the concept of "sincere emotions". Accordingly, they stated that the personnel displaying deep and surface acting would get used to this act after a while and start doing it without any effort, in other words that this behavior would become a habit. Nonetheless, it was stated that the employee would not need to act or try to accord her emotions, would be able to experience real emotions, and this would be "sincere behavior". For instance, it was stated that nurses acted neither deep or superficially, instead performed sincere behavior with their real feelings when treating an injured child (Ashforth & Humphrey, 1993; Secer, 2007). All of the oncology nurses participating in the study stated that they "put themselves in patients' shoes" and "emphasize". Oncology nurses expressed their situation with following sentences:

> *"In this unit, I'm trying to understand patients better, maybe I'm empathizing better. Everybody uses the word "empathy", but how much can we emphasize? Can we say "What would I do if I were in that bed I"? We should do this."* (Interview 21)

> *"Imagine you are in the agony that the patient is experiencing. A dangerous, terminal illness. We need to understand the psychology of the patient. What would you do if you are told that you have three days left? Think about that three days would not you be get agitated? Would not you be attacking someone? Would not you think that the medication and treatment is futile? I mean, would not you reject? We could do these all. Thus, in this unit you experience all the feelings so deep."* (Interview 12)

Emotional conflict experienced by oncology nurses

Emotional conflict, being one of dimensions under which Morris and Feldman (1996) examined the emotional labor, is described as individuals' suppressing their emotions as a result of the difference between the emotions he has and the reaction requested by the

organization. For instance, it is stated that nurses had to have more controlled, skilled, and meticulous behavior features in order not to have conflict between the reality and the emotions they have to display when they provide care to patients for a long time (Morris & Feldman, 1996; Oschner & Gross, 2007; Sapolsky, 2007).

"Sometimes, you share many things with the patients or patient relatives. I mean there may be some people to whom you feel so close." (Interview 2)

"Due to having a long term communication with oncology patients, sometimes you can feel them closer than your relatives or friends and establish close relationships. You can share a lot with them. You have to behave professionally when you lose a patient, no matter how sad you are." (Interview 1)

Individual effecfts of using emotional labor on oncology nurses

Individual effects of intensely using emotional labor are stated as burnout and the decrease in job satisfaction. Morris and Feldman (1996) defined burnout as directly proportional with four dimensions of emotional labor: frequency of emotional labor performance, attention paid to rules of conduct, variety of emotions, and emotional conflict. They argued job satisfaction to be inversely related. Consequently, they argued that as emotional labor increased, burnout increased and as emotional conflict increased, job satisfaction decreased (Morris & Feldman, 1996). Grandey (2000) stated the indicators of burnout as emotional weariness, depersonalization and decrease in individual success.

Burnout syndrome is assessed in three dimensions. These are emotional burnout, depersonalization, and personal accomplishment. Emotional burnout is experiencing burnout and spending so much energy at work. Depersonalization is insensate behavior of personnel towards the people he/she provides service to. Personal accomplishment is defined as productivity and competence. The symptoms of burnout are problems such as lack of motivation, lack of confidence, feelings of worthlessness, discomfort, hopelessness, dissatisfaction, irritability, chronic fatigue, sleep disorders, and stomach problems (Brotheridge & Grandey, 2002; Cropanzano, Rupp, & Byrne,, 2003). Participating oncology nurses stated that they "had difficulties in enjoying life", "had fear of losing their relatives", and "had intolerance towards their family members and friends".

"My view of life has changed dramatically... I do not want to make plans for the future, I do not want to get married, I have not gotten married... I do not want to have children neither. Yes, I do not want to have children. I do not really enjoy my life." (Interview 25)

"You see the patient you lose, you see that life is meaningless. These tear your heart out. You think that you can die at any moment. Whenever someone in your family has any kind of pain you are scared that they have cancer. In addition, since you show tolerance all the time, you lose your patience to patients as well as your colleagues and family. I have no tolerance for anything anymore." (Interview 15)

Nurses are stated to be the healthcare professionals experiencing burnout at most due to providing care to the patients in negative cases such as illness, pain and death and being involved in every single problem that patients experience (Sahin et al., 2008). Especially the nurses working in the oncology unit often confront with the factor of facing with death along with factors such as stress, violence etc. (Kelly et al., 2000).

"Death has begun to like a very simple issue. My first 6 months in this unit was terrible. I was crying each time I lost a patient but then you do not even cry, you do not even feel anything. While a patient dies and people cry, you cannot even feel sorry. You feel laughing, you become dull. What do you call this feeling? I do not know if it is burnout syndrome, but depersonalization is present." (Interview 16)

"I have become completely depersonalized at the end of 5 years. I feel I have lost all my feelings. I cannot cry anymore, even if I lose one of my relatives, I cannot feel sorry. I am not scared of my own death. I think death is salvation from this world, a beautiful end." (Interview 14)

Organizational results of using emotional labor in oncology nurses

Negative organizational effects of displaying intense emotional labor are stated as decrease in performance and tendency to withdraw from work. However, it was also stated that expressing real own emotions sincerely, in other words performing deep act is improving performance (Oschner & Gross, 2007; Sapolsky, 2007; Gray, 2009; Gungor, 2009). While some of the

oncology nurses participating in the study did not mention anything about negative organizational effects of performance of emotional labor, some of them stated that they wanted to "change the unit they are working in". As one of the oncology nurses stated:

> *"We often observe death in this unit and it our life energy negatively. I have been demanding to change my unit for four years, yet I received negative response for all the petitions I filled. My unit cannot be changed due to insufficient number of nurses and lack of suitable positions."* (Interview 5)

Discussion

The results of the study indicated that performance of emotional labor between oncology nurses and patients and relatives is an essential value in terms of quality of healthcare. In addition, emotional labor facilities interpersonal relationships and continuation of healthcare. As a result, emotional labor is an essential therapeutic value (Smith, 2005; Zapf & Holz, 2006; Hunter & Smith, 2007).

The oncology nurses participating in the study stated emotional labor as "a special bound established with the patient", "providing moral support" and "empathizing". In the studies related conducted on nurses about emotional labor, emotional labor was expressed as "self sacrifice", "adding a warm smile to the care provided for the patient", "making the patient feel safe and providing a holistic care" (Grandey, Fisk, & Steiner, 2005; Smith & Lorentzon, 2007; Gray, 2009).

All of the oncology nurses participating in the study stated that they "put themselves into patients' shoes", "empathized" with the patients and their families and this situation caused them to experience "emotional conflict" while providing care to patients. As stated by Ashforth and Humphrey (1993); in the cases of long term interaction and intensive emotional sharing, empathy is developed between the patients and nurses and caregivers integrate themselves with the patients. It is stated that this situation caused nurses to experience conflicts between the emotional bounds and their professional identities (Morris & Feldman, 1996; Mann, 2005; Mikolajozak et al., 2009).

When the individual effects of using emotional labor in oncology nurses were assessed, the nurses stated that they "did not enjoy their lives", "had the fear of losing their family members due to cancer", "experiencing intolerance in their social lives" and "became depersonalized about concept of death". It is stated that the people spending intensive emotional labor experience burnout and it shows itself as lack of motivation, lack of confidence, feelings of worthlessness, discomfort, hopelessness, dissatisfaction, irritability etc. (Brotheridge & Grandey, 2002; Cropanzano, Rupp, & Byrne, 2003). In addition, in a study conducted with oncology nurses experiencing burnout, they stated that they developed depersonalization to death, which they often encounter, in order to sustain their mental health (Bolton, 2000).

When the organizational effects of using emotional labor in oncology nurses were analyzed, half of the oncology nurses participating in study stated that they wanted to "change their units". In the studies it is stated that performance of intensive emotional labor shows itself as tendency to withdraw from work (Grandey, 2000; Gungor, 2009).

Conclusion

Emotional labor is strengthening nursing practices in terms of delivering sustainable and desirable care between oncology nurses and patients and patient relatives. Individual and organizational negative effects of using emotional labor should also be evaluated in addition to its positive effects. It can be suggested to evaluate negative individual and organizational effects such as oncology unit, such as burnout, depersonalization, decreased job satisfaction and unit change with certain intervals in nurses who are in close interaction with patients and patient relatives especially in units like oncology where intensively emotional labor is performed, to take necessary precautions and to make regulations.

Acknowledgement

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Relevance to clinical practice

The concept of emotional labor has gained a value increasing with each passing day when its individual and organizational effects are considered; however, number of related studies is insufficient. In this regard, more studies are required to be conducted especially in units such as oncology unit where intense emotional labor is essential.

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