human relations
THE TAVISTOCK INSTITUTE

Emotions in uniform: How nurses regulate emotion at work via emotional boundaries

human relations
64(11) 1501–1523

DOI: 10.1177/0018726711419539
hum.sagepub.com
SAGE

Renae Maree Hayward
University of South Australia, Australia

Michelle Rae Tuckey
University of South Australia, Australia

Abstract

The management of emotions at work has been conceptualized in terms of its association with emotional inauthenticity and dissonance. In contrast, we integrate the idea of emotion regulation at work with basic strategic and adaptive functions of emotion, offering a new way of understanding how emotions can be harnessed for task achievement and personal development. Through a content analysis of interview data we examined *how* and *why* emotion regulation is carried out by employees, focusing on the in situ experiences of nurses. The manipulation of emotional boundaries, to create an emotional distance or connection with patients and their families, emerged as a nascent strategy to manage anticipated, evolving, and felt emotions. The emotional boundary perspective offers possibilities for knowledge development that are not rooted in assumptions about the authenticity of emotion or the professional self but that instead account for the dynamic, complex, multi-layered, and adaptive characteristics of emotion management.

Keywords

emotional boundaries, emotional labour, emotion management, emotion regulation, emotion work, emotions

Corresponding author:
Renae Maree Hayward, UniSA – School of Psychology, Social Work and Social Policy, University of South Australia, GPO Box 2471 Adelaide, South Australia 5001, Australia.
Email: hayrm001@mymail.unisa.edu.au

'Emotion is an integral part of the workplace' (Miller, 2002: 588). Emotions, during their elicitation, stimulate closely associated behavioural, cognitive, and physiological changes that enable individuals to respond adaptively to environmental demands (Frijda, 1986; Sapolsky, 2007). They have been conceptualized as affective and physiological states, physiological and behavioural responses, temporal in nature, and characterized by their intensity and positive or negative valence (Gross, 1998; Oschner and Gross, 2007). Despite the functional utility of naturally emerging emotions, contextual (i.e. societal, professional, and organizational) norms may dictate the appropriateness or inappropriateness of expressing particular emotions in the workplace, such as anger or frustration towards customers (e.g. Hochschild, 1983; Tracy, 2005). Hence the unwritten task of managing one's emotions – the extrinsic and intrinsic processes involved in monitoring, evaluating, and modifying emotions to accomplish goals (Thompson, 1994: 27–28) – necessitates emotion management as an essential skill for many employees.

A prime example occurs within the nursing context, where managing one's own emotions that arise during interactions with patients and their families typically occurs alongside clinical tasks and decision making (Bolton, 2000). This process is termed 'double-faced emotion management' (Tracy and Tracy, 1998: 407). Managing one's own emotions, and anticipating and influencing the emotions of others, are crucial to successfully meeting the demands of many jobs (Snyder and Ammons, 1993) and enhance the 'smooth functioning' of work-related interactions (Sass, 2000; Stenross and Kleinman, 1989). Hence, emotion management skills are strategic tools that facilitate effective workplace functioning (Tracy, 2005). Underpinning this article is the view that the management of emotion in the work context should be perceived as a strategic approach to work, in terms of its potential to sustain employees in their chosen occupations by facilitating job performance, preventing the drain of valuable emotional resources, and enabling employees to flourish.

In response to calls from researchers across a range of fields (e.g. Bolton, 2005; Gray, 2009; Mann, 2005; Mikolajczak et al., 2009) we aim to develop a comprehensive understanding of *how* and *why* naturally emerging emotions (as they evolve) are regulated at work within a dynamic work context: nursing. The primary contribution of this article is the development and presentation of the concept of emotional boundary management, a strategic approach to performing emotion work that reconnects the process of emotion regulation at work with the basic adaptive function of emotion.

Managing emotions

When an individual attends to an internally or externally psychologically relevant situation, the situation is appraised to imbue it with personal meaning and relevance. In turn, an emotion is initiated along with the cognitive, physiological, and behavioural response patterns typically associated with that emotion (Gross and Thompson, 2007; Lazarus et al., 1984; Oschner and Gross, 2007). However, emotions and their response patterns are not fixed. They can be manipulated to change the type, intensity, duration, and trajectory of emotions likely to be or being experienced.

Hochschild's (1983) qualitative analysis identified deep and surface acting as two distinct, broad processes through which employees regulate emotions during customer

interactions to influence customer cognitions and mood, and align their own behaviour with organizational and professional expectations. Deep acting involves active effort to align inner feelings and observable behaviours with these expectations. This process is generally viewed as more healthy in the long term (compared with surface acting) as internally experienced and externally displayed emotions are congruent (Bolton, 2000). Surface acting entails the manipulation of observable behaviour to be congruent with organizational and professional expectations despite inner feelings (which remain unchanged), and has been associated with feelings of inauthenticity, alienating the professional self from felt emotion, leading to burnout (e.g. Bolton, 2000; Brotheridge and Lee, 2002; Hochschild, 1983; Mann and Cowburn, 2005). Both deep and surface acting imply the existence of *inauthentic* emotion in that internally felt emotion is actively suppressed (surface acting) or changed (deep acting; Miller, 2002). Hochschild's account also depicts two different concepts of the professional self: real and fake (1983; Tracy, 2005). We believe that these dichotomies – authentic versus inauthentic emotion, the real versus the fake self – direct attention away from the personal and professional adaptability of emotions and emotion management within the work context.

More recent extensions include the study of: passive deep acting ('required' emotions are genuinely felt and expressed); active deep acting (effort is required to influence inner feelings and behaviours to match organizational expectations; Kruml and Geddes, 2000); emotional dissonance (i.e. the discomfort felt during the behavioural expression of emotion that is not felt); emotional deviance (where one chooses not to display organizationally desired emotions; Ashforth and Humphrey, 1993; Morris and Feldman, 1996); and the requirement to be sensitive to the emotional state of customers or clients (Zapf et al., 2001). Reviews by Bono and Vey (2005), Mikolajczak et al. (2009), and Zapf (2002) have highlighted the mixed results of this body of research. One factor that has prevented the emergence of a unified set of findings from this body of literature is the range of different conceptual frameworks through which emotion work has been studied. There remains a need to go beyond these diverse operational definitions of emotion work to get to the heart of emotion management: the *how* (i.e. the psychological processes that underpin the regulation of felt emotions as they emerge *during* interactions with customers/clients) and *why* (i.e. the underlying purpose or function of emotion regulation efforts). Our research addresses this gap.

The theorizing and laboratory work of Gross (1998) has shed some light on the psychological processes involved in emotion management, translated into the work context by Grandey (2000). Specifically, Gross has proposed that *antecedent*- and *response*-focused emotion regulation represent two sets of regulatory strategies that are distinguished by the temporal point at which they primarily (but not exclusively) influence how an emotion is generated. Gross's emphasis is less on inauthentic emotion as per Hochschild (1983) and more on how *felt* emotion is generated and modified. According to Gross, antecedent-focused strategies occur before a complete emotion and its associated pattern of cognitive, physiological, and behavioural responding are initiated. The focus is on manipulating the nature, intensity, and/or duration of felt (inner) emotion. Gross (1998) described four families of antecedent-focused strategies: situation selection (avoiding a situation); situation modification (changing the situation in some way); attentional deployment (manipulating one's focus); and cognitive change (changing how

one thinks about the situation). Although diverse, the common underlying thread is that these strategies are designed to shape the character of the felt emotion that is ultimately experienced. In addition to the laboratory work of Gross and colleagues, a number of field studies have identified the manner in which these techniques are used on the job (e.g. Grandey, 2000; Scott and Myers, 2005; Smith and Kleinman, 1989; Sutton, 1991; Tracy, 2004, 2005; Tracy and Tracy, 1998). Antecedent-focused regulation has generally been associated with more positive psychological health and well-being as it takes place before complete emotional response patterns are elicited and holds the key to circumventing response patterns associated with undesired emotions and what some view as the necessity to suppress and fake emotions (see Mikolajczak et al., 2009).

Response-focused regulation strategies are initiated once an emotion has been felt and the associated cognitive, physiological, and behavioural responses have been completely generated. The focus is on modifying the emotional and physiological experience and behavioural response connected to the emotion (Gross and Thompson, 2007). Strategies include expressive suppression, venting and interacting with others, and the use of drugs, alcohol, relaxation, aggression, and exercise to deal with the physiological manifestation of the emotions experienced (Gross, 1998). Suppressing negative emotions while expressing contrasting emotions has so far been assumed to be maladaptive and associated with poor health and well-being outcomes (see Mikolajczak et al., 2009).

Gross (1998) also described a feedback loop from the response-focused emotion stage back to any prior point within the emotion generative process. When applied to the work context, this loop recognizes the malleable nature of emotions and the potential for emotion regulation to influence employees' dynamic experiences of their work – the regulation of emotion experienced in a situation may change the situation itself and/or the perceptions of the situation in some way. In turn, felt emotions and their associated response patterns are further altered, and so on.

Overall, the simplicity and comprehensiveness of Gross's model aids in depicting the temporal progression of emotion elicitation, including when and how the characteristics of emotion may be altered. Hence, a major strength is the presentation of antecedent- and response-focused emotion regulation processes. Further, the feedback loop alludes to the complexity involved in emotion regulation. However, for driving efforts to understand the in situ flexible, enduring, and adaptive nature of emotion regulation within the work context, the model is too simplistic. It does not adequately capture the dynamism of emotion regulation in terms of the different layers or combinations of emotion regulation strategies that may be employed simultaneously, and the adaptive functions (i.e. the self-protective and/or personal developmental roles) of the strategies adopted.

While Gross's model began to move away from the static dichotomies referred to earlier regarding work-related emotion and the professional self, in this article we move away entirely from the perspective that emotions felt in the workplace are always managed (i.e. masked or modified) in ways that lead to inauthentic emotional experiences and displays and dissonance (Gross, 1998; Hochschild, 1983). We also dig much deeper than the characteristics (e.g. frequency, intensity) of emotion and emotion regulation in work-related interactions; these characteristics represent important demands on workers that require emotional effort, but fail to provide insight into *how* and *why* emotion work is performed. Instead, we conceptualize emotion management as a proactive, strategic

approach wherein emotions can be used in an adaptive way to achieve work-related goals and promote employee growth. While we build on earlier emotion management literature that recognizes the need for workers to manage emotions and that has begun to consider the mechanisms involved in doing so, we reconnect this literature to the basic function of emotion. Emotion is useful in that it guides adaptive responses to our environment. We believe that it is important to consider how emotion management is linked to, affects, and embraces this basic function of emotion.

We propose that manipulating emotions at work can be adaptive via two different pathways. First, it may protect workers from experiencing maladaptive emotions and the associated physiological arousal and strain. Individuals may utilise emotion regulation strategies to create a protective emotional barrier preventing the elicitation or further evolution of felt emotion. Second, emotion management may nurture the growth and development of personal resources (e.g. self-esteem, sense of competence, sense of relatedness; Ryan and Deci, 2000), via mechanisms that either neutralize (aversive) or enhance (positive) felt emotion. In stressful situations individuals may invest their resources (e.g. emotional energy and cognitive effort) to protect and strengthen existing resources and to gain new ones (Hobfoll, 1989). In this way, emotion regulation can be considered as an investment for future resource gain; a perspective that is absent in the literature.

In sum, we believe that emotion management can be used reactively, as is evident in the literature, but also proactively. Through this lens, we seek to further our understanding of *how* and *why* work related emotions are managed dynamically in situ, to answer questions such as:

- How do nurses describe managing their emotions during interactions with patients and patients' families?
- How do nurses describe moderating their inner emotions and expressed emotions in light of on-going interactions with patients and patients' families?

These questions were fundamental drivers of our qualitative study in which nurses gave heartfelt accounts of interactions encountered within their daily working lives. The result of this exploration is our conceptualization and discussion of emotional boundary manipulation as a form of emotion regulation in which workers take proactive (and sometimes reactive) control of their emotional space to enhance their adaptability to the work environment. Refocusing on the adaptive function of emotion and how it can be embraced within the work context shifts the conceptualization of emotion management to processes promoting personal and professional growth and development, not only those enabling the achievement of work-related goals.

The present research

This research was undertaken within the nursing context, as the emotionally demanding nature of nursing has been well established in the literature (see McVicar, 2003, for a review). Skott and Eriksson (2005) pointed towards the paucity of descriptive data on the personal experiences of caring, a silent aspect of the nursing role. Through nurses'

accounts of work-related interactions, our research was aimed at determining *what* it is that nurses do in situ to regulate their own emotions in response to the emotional challenges inherent to their profession. Our primary focus was on the regulation of emotional space between nurses and their clients (patients and patients' families). A content analysis of semi-structured cognitive interviews shed insight into how and why emotional boundary management was employed in different work-related situations.

Method

Participants and procedure

Ethics approval was granted from two human research ethics committees. Level one and two enrolled and registered nurses (i.e. those who have regular patient contact) from two Australian metropolitan public hospitals were targeted. Given our intent to capture a wide spectrum of emotion regulation strategies, a letter of invitation was sent to a sample of nurses from various specialties via email (30 nurses, 0 responses) or posted to their home address (60 nurses, 14 responses). The final sample consisted of 12 nurses (nine female and three male), from different fields (emergency, intensive care, organ donation, renal dialysis, general wards, mental health, and imaging), aged from 24 to 52 years, with nursing experience ranging from 14 months to 33 years.

Interviews were conducted in both hospitals in a private room away from where the nurses worked. Nurses were paid a small honorarium for their participation. Interviews were recorded (with permission) and transcribed fully, as soon as possible after each interview, and each transcript was analysed once completed. Hence data collection and analysis occurred concurrently, with the coding and interpretations directing the following interviews. Upon analysing data from the tenth interview no new themes were apparent. After two more interviews no new themes had emerged, hence a point of data saturation had been reached (Schilling, 2006). The remaining two nurses were not interviewed.

Interview

The semi-structured interview schedule drew upon a key principle, context reinstatement, from the cognitive interview format used in eyewitness testimony, which asks interviewees to reconstruct physical and personal aspects of a situation and to talk from that perspective (Centofanti and Reece, 2006; Fisher et al., 1989). This process enhances access to stored memories and information (Cutler et al., 1987; Tulving and Thomson, 1973). Emotion regulation occurs in practice through interacting with others (Shuler and Sypher, 2000) so we asked participants to recall specific work-related interactions and experiences. Each nurse and the interviewer then reflected on the emotions felt during the interaction and how they were managed at the time.

The interview questions addressed two types of situations: (1) routine, typical given the nurse's speciality, wherein emotion regulation strategies tend to become automated (Mann and Cowburn, 2005); and (2) novel, which as a result aroused strong emotions (e.g. interactions that went unexpectedly or were potentially traumatic) where more

controlled processing and thoughtful action (including emotion regulation) are required (Ashforth and Tomiuk, 2000; Gilbert and Burgess, 2008). The questions were:

1) Think back to a routine day on the job. In particular, think about an interaction you have had with a patient and their family. It doesn't have to be any particular or special patient, just the typical sort of patient that you see in your work. Can you describe that situation to me as if you are there now?
2) The second situation I'd like you to bring to mind is an unexpected or traumatic situation and the associated interactions with a patient or their family. Can you describe this situation to me, again as if you are there now?

Follow-up questions probed: what interviewees did, thought, and felt; reactions of others; how the interviewees managed their feelings; whether feelings helped or hindered completion of clinical tasks; how they felt after the situation; and changes in their view of the situation.

The interviews were conducted by the first author and ran on average for 55 minutes. They were highly emotive with one nurse describing her job as a 'melting pot of emotions' (Nurse L). The range of emotional descriptions included feelings of 'panic' (Nurse A) and 'devastation' (Nurse J) through to feeling 'inspired and motivated' (Nurse G).

Analysis

Data analysis was conducted by the first author, who brought with her an understanding of the theoretical assumptions surrounding the generation of emotion outlined earlier and the broad categories of emotion regulation (surface and deep acting; antecedent- and response-focused emotion regulation). The verbatim transcriptions totalling 163 pages were directly entered into NVivo8 and analysis was conducted in line with recommendations from Schilling (2006). Data were screened and statements identified that described some form of emotion regulation. Preliminary notes were then made outlining the different emotion regulation processes reflected in each statement. A second round of screening refined these descriptions by removing unnecessary/redundant information to retain the essence of the emotion regulation processes described (Braun and Clarke, 2006; Fereday and Muir-Cochrane, 2006). A third round temporally coded the descriptions into strategies utilised to regulate 1) anticipated or evolving emotions, and 2) completely generated emotions to ensure that both behavioural and cognitive strategies utilised during different stages of emotion generation were identified.

A fourth round of analysis grouped descriptions into separate strategies by identifying common processes involved in regulating emotions. Definitions were then developed for each strategy and exemplar statements identified. At this stage, so as to better integrate and communicate the findings within the existing theoretical literature, relevant bodies of literature pertaining to strategies used to manage emotions were referred to (as per Fereday and Muir-Cochrane, 2006).

With the exception of emotional boundaries, the definitions were integrated with the existing literature, and augmented with information from our interviews and attached to exemplar statements. These definitions are presented in Table 1. The conceptual

Table 1 Definitions and examples of emotion regulation strategies

Emotion regulation strategy	Defining features	Example statements
Situation modification		
Direct situation modification (Gross and Thompson, 2007)	Active efforts, generally behavioural, to directly modify the experience of the situation in order to alter its emotional impact.	'I'll just completely walk away . . . I'll just take myself out of the situation completely.' (Nurse H)
Expression (Gross, 1998; Hochschild, 1983; Mikolajczak et al., 2009)	Expression of felt emotion (before a complete response pattern has been elicited) as an attempt to manage the other person's behaviour to change the type and/or intensity of the felt or anticipated emotion. In some cases this involved conscious intent to alter the emotional impact of the situation, while in other cases this became an automated response to specific circumstances.	I just walked in and I said 'Don't you dare talk to my nursing staff like that, we're here to look after you, don't you dare do it', and then he turned around and said 'Oh, I'm so sorry' and apologised. (Nurse E)
Attentional deployment		
Refocusing (Gross, 1998; Lazarus and Folkman, 1984)	Directing attention to a particular aspect of the situation in a way that minimizes its emotional impact. For example breaking a situation down into a series of tasks that can be addressed enables the individual to focus attention on a specific aspect of the situation and to concentrate on the demands of the task, diverting attention away from the emotional aspects of the situation.	'. . . just tried to break things up, you've got all this to do, but just one thing at a time, and just ask lots of questions.' (Nurse K)
Rumination (Morrow and Nolen-Hoeksema, 1990)	Cognitively generating an internal version of an experienced situation and replaying and focusing one's thoughts on emotive aspects of the scenario. The intent is to change an element of the internal version of the situation or how one views it to minimize the associated feelings. However, by intensely focusing on specific aspects the associated emotions are often re-experienced.	If it's been a particularly traumatic, or stressful day, that's when you think about it, you don't sleep properly. . . . I was replaying the whole conversation in my head, and thinking should I have said this instead of that. . . . sometime even just thinking about it in your head. . . my face will go hot. (Nurse G)

Table 1 (Continued)

Emotion regulation strategy	Defining features	Example statements
Cognitive change		
Acceptance (Carver et al., 1989; Garnefski and Kraaij, 2007; Mikolajczak et al., 2009)	Attitudes and thoughts of giving in and accepting the situation and the associated felt emotions.	'I think . . . I probably process things and go you know what, we tried really hard today, and not everyone is going to live.' (Nurse F)
Positive reappraisal (Carver et al., 1989; Garneski and Kraaij, 2007; Gross, 1998)	Reframing the situation in a *positive* light, such as searching for positive meaning in the experience of the situation. Its focuses on applying a positive meaning to the situation.	'I deal with the situation as more like a challenge.' (Nurse L)
Perspective taking (Garnefski and Kraaij, 2007)	Adopting a cognitive perspective of the situation that minimizes its emotional impact. This often involves dampening the meaning and/or seriousness of the situation.	'I just put it down to the patient not being well, not mentally stable.' (Nurse D)
Emotional boundaries	The ability to cognitively and behaviourally establish, maintain, and regulate an emotional boundary with the other person one is interacting with. This mechanism enables the individual to control the emotional distance or an emotional connection between themself and the patient and/or their family. This may be an automatic or a controlled process.	So I guess, these are the sort of things that go through your head, you know, you try and have a bit of empathy, how would I feel if I was there, but then you also try and hold back a little bit as well, because I can't be there with everybody, you know, 15 years in [Department], I can't be there with everybody. . . . Because I don't want to think about how it would feel for it to be me, I just need to be that professional nurse . . . so there are times. . . I can't afford to get involved in that emotive side of things. (Nurse P) 'I can at the moment drop that barrier, easy and just talk to people as people deal with their problems.' (Nurse B)
Response modulation		
Expressive suppression (Gross and Levenson, 1993)	Thoughts and actions employed to inhibit the observable expression of felt emotion.	'. . . at that time I suppressed it, I held it back.' (Nurse C)

development of the emotional boundary strategy was initially drawn from characteristics inherent within the interview data and then further enhanced by situating it within the related literature. At this point the two authors discussed and reached agreement upon the characteristics of the nine identified strategies, going back to the raw data where necessary. Finally, an independent researcher coded 18 statements (two statements randomly selected from each coded strategy) against the definitions. After referring to the context surrounding two of the coded statements, 100 percent agreement was reached. The emotional boundary concept will be developed further in this article.

Results and discussion

The adaptive nature of emotion

Reflecting upon the interviews, it was clear that emotions have an important signal function for nurses, often something of which they are not consciously aware. Skott and Eriksson (2005) described nurses' feelings as being fused with their knowledge, helping their understanding of a situation, which was echoed by Gray (2009). Likewise Shuler and Sypher's (2000) research with 911 dispatchers suggested that instincts are important and closely entwined with emotions to the point where highly emotive calls enhanced their ability to think and perform rationally. Additionally, Scott and Myers (2005) noted the importance for fire-fighters of having an awareness of and connection to their emotions to avoid complacency and fearlessness; rather than completely masking or changing emotions (such as aggression) these fire-fighters discussed the importance of managing the emotional intensity. These accounts all highlight the adaptive nature of emotions. In our study emotions were described as preparing nurses for what may be likely to happen, for instance, heightening their sensitivity to the situation or even making them withdraw. The following statement describes a situation in which this young nurse described a feeling of 'impending doom' referring to it as some form of intuition:

> . . . I guess the impending doom like, kind of intuition of it . . . kind of, it makes me want to stand back a bit, but at the same time, it also makes me want to go and spend a bit extra time, you know, to try and calm the situation . . . it does affect the way I treat the patient, just because of the situation . . . (Nurse K)

Engaging in emotion regulation did not negate the important adaptive role of authentic emotions but instead worked towards managing naturally emerging emotions to facilitate the emotional, cognitive, and physical functioning of these nurses in each interaction and in subsequent interactions.

Emotion regulation strategies used by nurses

Nine different emotion regulation strategies were identified (refer to Table 1). The nurses described using a range of antecedent-focused strategies identified in the literature (situation modification, expression, refocusing, rumination, acceptance, positive reappraisal, perspective taking, and emotional boundaries) to manipulate the nature,

intensity, and/or duration of anticipated and evolving emotions. Likewise, the nurses talked about using (response-focused) expressive suppression to influence physiological and behavioural manifestations of completely generated emotions. In this way, we saw evidence of emotion regulation in situ via the range of strategies already canvassed in the literature. Table 1 defines and describes these strategies using the broader emotion regulation mechanisms identified by Gross (1998).

The exception was the use of an emotional boundary, a nascent approach to emotion regulation at work that incorporates the use of multiple antecedent-focused mechanisms. We focus on this new ground. Below we define and further develop this concept and describe how the use of emotional boundaries is supported by the other antecedent-focused strategies identified within the interviews; in doing so we connect the use of emotional boundaries to concepts already established in the literature.

Managing emotional boundaries

Emotional boundaries are used by nurses to regulate anticipated or felt emotion, which is an antecedent-focused approach in itself. However, the use of emotional boundaries is typically not attached to a single interaction (as other antecedent strategies may be) but, rather, establishing and regulating an emotional boundary represents a broader approach to work, part of a nurse's professional persona when relating and interacting with others. It was described as a mechanism that supported the nurses' need for professionalism in their work. The desire, of the nurses we interviewed, to maintain their professionalism sometimes required strengthening or reducing the emotional boundaries between them and their clients. It emerged from the interviews that the discrete antecedent-focused strategies referred to in Table 1 are utilised throughout the working day to help manipulate emotional boundaries, enabling nurses to emotionally distance or connect with others at work. Hence the manipulation of emotional boundaries encompasses multiple cognitive and behavioural mechanisms inherent in the different antecedent-focused strategies (situation modification, attentional deployment, and cognitive change).

Emotional boundaries were depicted as an emotional force field manipulated to influence the nature, intensity, and duration of emotions experienced at work. Arguably the use of an emotional boundary may evade the need, in Hochschild's words, to 'push [the] real self further inside, making it more inaccessible' (1983: 34) and may lessen the disconnection between authentic feelings and behaviour and the corresponding likelihood of alienation, depersonalization, and burnout. In essence we offer the concept of emotional boundaries as an alternative way to view emotion management at work, in terms of the drive (protective or developmental and resource enhancing) to emotionally distance or emotionally engage with customers/clients. It may be a way of maintaining a nurse's authentic self by choosing to engage with or distance one's emotional self from work-related emotions, in effect exercising emotional control in the interaction (cf. Karasek and Theorell, 1990; Tracy, 2000).

Through these interviews we sensed that emotional boundaries evolve to become part of the nurse's professional persona, akin to putting on their uniform:

Interviewer: When you say let your guard [emotional boundary] down, is that automatically there . . .
Interviewee: Yeah, absolutely.
Interviewer: . . . it comes down or stays there, or?
Interviewee: No, I have that in place, in each situation I walk into.
Interviewer: You start with that, and then . . .
Interviewee: Yeah absolutely, yeah . . . And when I say I start with it, I'm certainly not clinical or horrible, but, I don't give them all of me, so I'm, yeah, absolutely and every situation I'll start with that.
Interviewer: And is that guard very much a thought based thing?
Interviewee: Yep, I think it's actually an automatic thing now, I just, that's just what I do.
Interviewer: Do you get that in training or through experience?
Interviewee: No, I think it's an experience thing, I think, the older I get, the more I'm able to do it, I'm, yeah, I'm able, although, I think when I was younger, I was probably less empathic than what I am, yeah, a bit more gung-ho . . . I think time and age . . . absolutely . . . I react much differently. (Nurse F)

The concept of empathy is linked to the manipulation of emotional boundaries. Empathy involves both cognitive (recognizing and communicating an understanding of the other's feelings) and affective (engaging with and experiencing the feelings of the other person) processes (Hojat et al., 2002). We suggest that emotional distancing is associated with the cognitive aspects of empathy where the nurse chooses to engage with the patient at the cognitive level only. Emotionally connecting involves both the cognitive and affective aspects of empathy in which a nurse invests the emotional self in the interaction.

Below we add to the literature by further defining the characteristics of emotional boundaries in the work of nurses. More specifically we distinguish between i) emotional and cognitive distance, ii) emotional distance and emotional connection, and iii) the protective versus the motivational and developmental processes involved in manipulating emotional boundaries within this professional context.

Emotional and cognitive distance We believe the distancing mechanism specifically refers to *emotional* distancing while the nurse may still cognitively engage by talking with patients and their families in relation to clinical matters, making clinical decisions, and performing clinical tasks:

> I was still there and I had to be there for the parents, and so I guess I did try to just, to some extent, make it, bring it back to the clinical focus. (Nurse C)

> . . . sometimes I repress that [emotionally connecting], because I don't want to think about how it would feel to be me, I just need to be that professional nurse, and that's often what families want from me as well, you know, they want someone who knows what they're doing, and is good at what they do, and yet, yeah, so there are times that I suppress that, and think, no, I can't afford to get involved in that emotive side of things. (Nurse F)

Allan and Barber's (2005: 391) qualitative research with advanced fertility nurses described 'a feeling of closeness . . . while at the same time maintaining a distance or safe boundary with which both nurses and patients are comfortable'. We suggest the safe boundary is facilitated through emotionally distancing one's self while remaining connected to the patient at the cognitive level. Other researchers have described the maintenance of a professional boundary (Ablett and Jones, 2007) and the protective nature of working personas that facilitate nurses' disengagement from their work environment. The 'professional face' of nurses has been described as incorporating both caring and distance (Bolton, 2000: 584). The 'professional face' was described in two ways: i) representing emotional neutrality, where emotion was prevented from being elicited, and ii) akin to expressive suppression, where the professional face acted to suppress the expression of the nurse's feelings. To provide a deeper insight into mechanisms underpinning emotional boundaries and, based on our study, we suggest that nurses manipulate their emotional boundaries to create an emotional distance or space *prior* to commencing an interaction, *in anticipation* of an emotion being generated, and at the very *beginning* of feeling certain emotions, with the effect of preventing fuller emotional response patterns taking hold. The effort involved in establishing and regulating emotion will vary depending upon the stage (in the emotion generation process) at which a nurse intervenes to manage his/her emotions.

Emotional distance and emotional connection We take this concept further to suggest that the emotional boundary is not only manipulated to create an emotional *separation* but to also emotionally *connect* with others at work. Hence emotional boundaries regulate the emotional space between nurses and clients, creating a distance or a connection at the emotional level. Conversation with patients and their families, similar to the concept of rapport-talk (Sass, 2000), represents an investment of emotional resources and may be a means of regulating the emotional boundary to establish an emotional connection. Nurses in our study described using personal conversations to manipulate the degree of emotional connection:

> . . . with this lady, we really connected on that day, and you know, I looked after her husband for seven hours and he was very unstable and I think towards the end, it was probably the last one to two hours of the shift, that he started to stabilize, and the liver had started to work, and so things were looking so much better, and her son had arrived, and she was showing me photos of her grandchildren. So we sort of started to talk about, do I have children, does she have grandchildren, do we, what do you and [patients name] do, you know, they're retired and they do this, so I started to find out about him, and that changes your emotional connection to your patient. (Nurse F)

How a nurse looks at a patient and holds a patient's hand (Gray and Smith, 2009) are also mechanisms that facilitate connecting emotionally with patients.

A nurse's approach to engaging and manipulating emotional boundaries, to emotionally distance or connect with others at work, was depicted as a filter through which the interaction takes place where the nurse is physically and cognitively present, yet controls their emotional connection. Achieving neutrality through initially distancing themselves

emotionally may assist nurses in strategically determining whether to remain distant or to engage emotionally with patients. The act of modulating the emotional space between themselves and patients was described as an evolutionary process, which became a crucial part of these nurses' professional identities. This is hinted at in the following statement where the experience of pulling back from the emotionality of the situation is automated, script-like, and embedded in how she approached her role as a nurse:

> I know my triggers, it's almost like an out of body experience, I feel I'm almost witnessing myself, and I know when to, okay, let's just pull back a little bit here, and yeah, it's almost like a script in my mind, that I know, that okay, let's change tact or this is just futile. (Nurse H)

Protective and motivational/developmental processes Manipulating one's emotional boundaries was depicted as a domain specific (emotional) form of 'control' that these nurses used in managing their own and others' emotions during interactions (cf. De Jonge and Dormann, 2006). Bolton (2000) described a degree of autonomy and discretion in how patient relationships are negotiated. This flexibility is consistent with descriptions of manipulating emotional boundaries in our study, where nurses exercised control over the extent to which they emotionally engaged or distanced themselves. Shuler and Sypher (2000) also described the achievement of emotional neutrality as a form of control. We suggest that managing emotional distance and connection are strategic forms of emotional control. In one the control mechanism is aimed at neutrality (distancing); in the other the control mechanism is to allow one to feel and actively engage (connecting). In making these choices, whether consciously or automated, the combined needs of both interaction partners are weighed up in determining how to utilise their emotional boundary. The work stress body of literature clearly indicates that control over how one performs their work, such as having the discretion over which skills to use and when to use them, acts as a protective mechanism against poor health outcomes such as burnout, but also may act as a resource promoting motivation and engagement with one's work (Bakker and Demerouti, 2007; Karasek and Theorell, 1990; Van Den Tooren and De Jonge, 2008; Wharton, 1999) and facilitating the development of further personal resources (Hobfoll, 1989).

Emotionally connecting was described as a process that worked to refuel these nurses' emotional and energetic reservoirs, which motivated and validated them personally and professionally (cf. Hobfoll, 1989). In our study, having the level of expertise and perceived authority to choose when and how to emotionally connect and get to know patients on a personal level was described as enabling these nurses to feel good about themselves, inspired, lucky, excited, and to live life in the present:

> Yeah, absolutely, because you have a few like, they're not nice patients . . . and nothing's right. Whereas you have other patients where, things aren't going right, they've been waiting for hours, but they're still happy and can joke with you and it's not your fault, like, making you feel okay about yourself, whereas, yeah they help you get through and deal with the noxious ones yeah. (Nurse K)

> . . . we sort of started to talk . . . I started to find out about [the patient], and that changes your emotional connection to your patient . . . he stops being that ventilated man, liver transplant in

> front of me, and he now starts being a person who has likes and dislikes . . . it was just really lovely . . . you get that overwhelming pride, I felt, whoa man, I did a really good job today. (Nurse F)

> That [getting to know the patient] makes you just, whether that inspires you, that makes you feel good that you've actually you know, helped . . . But it kind of makes you realize how lucky you actually are sometimes, working in this industry. Like you get a lot of homeless people, you get you know, abused people. Some of the life stories that you hear from them. You just kind of think yourself as lucky. (Nurse D)

> It [emotionally connecting with your patient] just made me realize you know, it's just like, oh my god, yeah, I think it was, she was just so, so frail, and I thought, we're all going to be like that, so it makes me, so it's made me live more in the now. (Nurse B)

Rutter (1985) suggested that immersing oneself in challenging situations may enable the growth of personal resources such as a sense of mastery and self-confidence and promote an individual's resilience to stress. Emotional labour has been linked with job satisfaction (Grunfeld et al., 2005) and 'enhancing work experience[s]' (Shuler and Sypher, 2000: 52). We hypothesize that the developmental and motivational processes associated with emotionally connecting with patients may also facilitate a sense of job satisfaction, professional identity and belonging (Tracy and Trethewey, 2005) and positive perceptions of emotionally charged work experiences, which may positively influence job performance as well as longevity within the profession.

Nurses' emotional boundaries seemed to be managed in response to their own and other's needs, acknowledging that demands from home and work are interlaced. In addition to knowing what they are able and prepared to give on any given day, nurses in the current study described an acute sensitivity to the situation and its likely progression with regard to the emotions that may emerge. Being attuned to their own needs and the emotional and clinical needs of others is weighed up by the nurse who consciously, and in some cases automatically, manipulates this emotional boundary. The nurses recognized that their personal lives may also affect energy levels and their ability to deal with emotionally demanding situations, highlighting that the private and public selves are not discrete domains. Manipulating emotional boundaries was their way of meeting organizational expectations of nurses' behaviour while also accounting for their own emotional and physical state, rather than negating their sense of self:

> *Interviewee*: I think that's just a skill that you learn . . . because we almost indoctrinate that into new staff as well, we sort of like, we can't let the patients know, you might be going through a divorce, your kid might be in having tumour surgery, whatever, but if you're at work, you've got to stay professional and not let those emotions out, and just be on an even keel.
>
> *Interviewer*: When you say even keel, do you think, if you've got stuff like that happening, you possibly don't connect as well, you still do your job.
>
> *Interviewee*: . . . I think it depends on how many times you've had to deal with a huge drama in your life. (Nurse D)

The following statements depict nurses considering different aspects of the work context as well as themselves before deciding upon an emotional approach to adopt. This includes: weighing up their own levels of exhaustion:

> Maybe if I'm having a really bad day, or I'm tired, I don't, I'm maybe not be quite as chirpy, just like 'Yep, hi I'm [nurse's name], come on through' . . . maybe I don't . . . talk about extra stuff, maybe, depending on how busy, yeah. (Nurse K)

their workloads:

> *Interviewer*: . . . are you also gauging how much can I give today?
> *Interviewee*: Oh yeah, very much so.
> *Interviewer*: Okay. So that awareness about where you're sitting with your exhaustion, with, emotional sensitivity, with what's been happening personally . . . you're weighing up a whole pile of things at the same time.
> *Interviewee*: Right . . . enough and it's when, that's why I was so fascinated with your study, I think it's, yeah, why, how do we do what we do and what makes one person better at it than others, and how have I stayed up beat for 15 years, seeing the things I've seen. (Nurse F)

as well as characteristics of the patient:

> Some people have a sense for it, they're quite intuitive when it comes to patients' needs. (Nurse L)

before deciding whether to maintain a distance or to emotionally connect. Establishing an emotional distance has been described by trauma staff as a strategy utilised when a nurse experiences tiredness and diminished emotional capacity and energy to manage emotional interactions (Tutton et al., 2007). Possessing the autonomy and competence to manipulate emotional boundaries when needed may thus act as a protective mechanism preventing any further depletion of a nurse's emotional and energetic reservoirs.

The ability to utilise this strategy seems to be associated with years of experience, both professionally and personally. Nurses from our study who manipulated emotional boundaries described competence in a wide range of emotion regulation strategies that they had developed and used over years in the nursing profession. Hence, experience leading to success and proficiency in utilising discrete antecedent-focused emotion regulation strategies may be a stepping stone towards being able to consciously and eventually automatically manipulate emotional boundaries at work (cf. Gray, 2009). Other research suggests that skills in managing emotions are linked to socialization processes (Miller, 2002).

With experience and exposure to a range of situations and increased competence in employing antecedent-focused emotion regulation strategies, a nurse's professional cognitive networks may develop to incorporate the manipulation of emotional boundaries as part of their professional schemata (mental representations of their role as a nurse based on training and experience). As the ability to successfully manipulate these

boundaries becomes part of their professional identity, they are less effortful to activate and more likely to become an automated way of performing their role as a nurse (Bargh and Williams, 2007; Greenwood, 1993). As these nurses remain in the nursing profession for many years and indicated dedication to their profession, this form of emotion regulation may emerge as a highly adaptive strategy in terms of well-being, vitality, longevity, and work-related performance.

The dynamism of work-related emotion regulation

In any one situation, numerous forms of emotion regulation can be employed to create an emotional distance or connection and to moderate the physiological and behavioural experience of felt emotions. The following statement refers to a single interaction yet highlights the dynamic and complex nature of emotion regulation in an ongoing interaction. It reflects the use of expressive suppression (a response-focused strategy) and the antecedent-focused strategies of situation modification, refocusing, expression, perspective taking, as well as and the emerging approach described here – emotional boundaries – specifically emotional distancing:

> . . . once we'd strapped the guy up, I got a second staff member to come with me, and we went to an office next door, and he, once again, still just wanted to go, and we said 'No, we need to talk about what happened, it was unacceptable' I was completely shaking, but I feel I put on a tough exterior, because I really wanted to know what precipitated this, where did this come from, had I brought this on . . . (Nurse H)

Redirecting her attention (antecedent-focused) to questioning the patient facilitated this nurse's ability to stop her feelings from showing (response-focused) and the presence of another nurse (antecedent-focused) and the tone and content of her expression assisted her in putting on a tough exterior (response-focused). While suppressing her feelings and questioning the patient this nurse tried to influence the nature, intensity, and duration of the negative emotions she experienced by reframing the situation from the patient's perspective (antecedent-focused). Adopting the patient's perspective reflects cognitively engaging with the patient at the level of mentally understanding and acknowledging the patient's experience while at the same time attempting to establish some degree of emotional distance (regulating the emotional boundary).

Although the feedback loop outlined by Gross (1998) acknowledges the potential for emotions, emotion regulation, and the situation itself to influence each other, it is constrained to response-focused emotion regulation. Going back to the above quotation, the loop does not capture the use of antecedent strategies such as refocusing, cognitive reframing, modifying the situation, and expression *to support* response-focused expressive suppression, while at the same time attempting to establish an emotional distance. The management of emotional space through strategies that support emotional distancing processes captures this dynamism, whereby the multiple regulation strategies at play in any one interaction and the potential for interconnections between these multiple layers of emotion regulation are illustrated.

General discussion

This research examined both *how* (the cognitions, behaviours, and timing) and *why* (the implicit functional drivers underpinning emotion regulation efforts) nurses engage in emotion management practices in their work contexts. Our findings augment the literature by presenting the regulation of emotional space as a unique way of managing emotions, and by uncovering the psychological mechanisms underpinning the manipulation of emotional boundaries. This knowledge is important because it outlines how emotion regulation is used by workers to meet their intrinsic and extrinsic work and personal related goals. Workers moderate the connection with and distance from their clients to better perform their work (not just to adhere to contextual norms) and they do so by using multiple emotion regulation strategies simultaneously. Hence, the use of emotional boundaries underpins successful efforts to meet extrinsically-governed work tasks. Moreover, the emotional boundaries approach involves the application of emotion regulation processes that can be applied at different stages within a particular situation or across many situations as a stylistic approach. Despite what may initially be a huge emotional investment, we expect that the regular use of emotional boundaries by workers to assist them to achieve work-related goals will, in the longer term, promote competence, confidence, and pride, and enhance the meaningfulness of work.

Emotion regulation in one's work is not simply a reactive process, but a process that can be strategically and proactively engaged and is linked to employees' intrinsic goals to protect, motivate, and develop their professional identity and personal resources (Hobfoll, 1989; Ryan and Deci, 2000; Tracy, 2005). Thus, our findings are important because they show how and why emotion regulation can contribute to employee growth, learning, and development. Based on our data, we envisage that this growth process occurs because employees adopt a longer-term understanding of the products of their immediate emotional investment. There is an inherent belief that the powerful emotions that they may initially feel (e.g. sense of tragedy or despair) holds the potential to evolve into emotions that nurture their sense of competence and belief in their self-efficacy, particularly when reflecting on the experience. As such we view competence in emotional boundary manipulation as a resource that can facilitate performance, buffer against strain, and promote development and well-being (cf. resources as viewed by Bakker and Demerouti, 2007). Overall then, the process of emotional boundary manipulation is a highly adaptive approach to managing emotions at work that does not threaten one's sense of self in the work context and that allows externally and internally-driven goals to be achieved.

The manipulation of emotional boundaries encompasses both distancing and connecting mechanisms dependent upon whether nurses are driven to create an emotional space to protect emotional resources, or to invest their emotional selves in the developing relationship. These distancing and connecting mechanisms can be viewed as the processes that link emotional demands inherent in client-oriented occupations to both positive and negative outcomes in terms of well-being, development, and performance. Future research should thus examine, both qualitatively and quantitatively, the use of emotional boundaries as a form of emotional control in different customer/client-oriented contexts and its influence on employee well-being, recovery, personal and professional development, and performance. A comprehensive approach to research in this area

should operationalize the management of emotions within work roles as i) distinct from cognitive and physical requirements, ii) in terms of *how* (distancing and/or connecting) and *when* (before, during or after emotion elicitation) emotional boundary manipulation is enacted, and iii) whether emotional boundaries are utilised as a protective or motivational/developmental mechanism. This sort of research will enable researchers to capture the dynamic, complex, and multi-layered nature of emotion regulation specifically in terms of how it enables employees to function within their work environments. Framing future research within the emotional boundaries approach will help develop a more cohesive and consistent set of empirical findings that can underpin evidence-based training, development, and job design interventions that ultimately prevent strain and promote well-being and productivity.

Practical implications

In practical terms, educational and training opportunities, as well as a work climate that identifies and acknowledges emotional boundary manipulation as a legitimate approach to managing emotions is needed. Proficiency in harnessing discrete antecedent-focused emotion regulation strategies represents the foundation that supports the ability to control the emotional distance or connection between workers and their clients and the protective and developmental mechanisms that follow. Additionally, skills in sensing the likely progression of the interaction (cf. Gross, 1998; Zapf, 2002; Zapf et al., 2001), manipulating attention resources, and changing the appraisal of a situation (cf. Mauss et al., 2007; Zapf et al., 2001) are all implicated in the ability to manage emotional boundaries. Hence, creating learning and work environments that facilitate the practice of managing one's emotional space will enhance the confidence and competence that underpin the ability to manipulate emotional boundaries at work.

Limitations

Although the concept of emotional boundaries has important theoretical and practical implications, we must acknowledge some factors that limit the conclusions we can draw from these data. Although a point of data saturation had been reached within this study the results may not represent the full range and combination of emotion regulation strategies available to employees in this and other occupations. Second, our methods provided the opportunity to examine micro-level emotion regulation and the dynamic, multifaceted context in which it occurs; however, this exploration was limited to the retrospective verbal descriptions of typical and novel/emotionally arousing patient interactions. Hence, the themes that emerged were based on our induction of the data drawn from these interaction-specific descriptions and as such the analysis was limited to these contexts.

Conclusion

Emotional boundaries are presented here as a multi-pronged and comprehensive way to conceptualize work-related emotional management that is connected to the adaptive function of emotion. Through this conceptualization we hope to move theoretical

perspectives in directions that focus on the dynamic, complex, and strategic adaptability of emotion management at work, rather than in the static and dichotomic terms that have defined emotion management through a focus on inauthenticity and dissonance (e.g. Hochschild, 1983; see also Tracy and Trethewey, 2005). This new perspective offers possibilities for knowledge development that are not rooted in assumptions about the authenticity of emotion and that do not threaten the authentic self. Instead, it presents a lens through which to investigate how employees regulate emotion for extrinsic and intrinsic goals, and the psychological mechanisms involved in these endeavours, to ultimately enrich current understandings of adaptive emotion management practices in work contexts. By studying and promoting the management of emotions at work through the legitimate manipulation of emotion space, we can improve employee physiological, emotional, and mental recovery after each work day, as well as enhance resilience, performance, and longevity within customer oriented professions.

Acknowledgements

The authors would like to acknowledge the three anonymous reviewers and Professor Karen Ashcraft, Associate Editor, for their thoughtful and extensive feedback. We would like to also thank Dr Carolyn Boyd for feedback on previous versions of this article and Professors Dieter Zapf and Christian Dormann for encouraging us to pursue this concept.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

References

Ablett JR and Jones RSP (2007) Resilience and well-being in palliative care staff: A qualitative study of hospice nurses' experience of work. *Psycho-Oncology* 16(8): 733–740.

Allan H and Barber D (2005) Emotional boundary work in advanced fertility nursing roles. *Nursing Ethics* 12(4): 391–400.

Ashforth BE and Humphrey RH (1993) Emotional labor in service roles: The influence of identity. *Academy of Management Review* 18(1): 88–115.

Ashforth BE and Tomiuk MA (2000) Emotional labour and authenticity: Views from service agents. In: Fineman S (ed.) *Emotion in Organizations*, 2nd edn. London: SAGE, 184–203.

Bakker A and Demerouti E (2007) The job demands-resources model: State of the art. *Journal of Managerial Psychology* 22(3): 309–328.

Bargh JA and Williams LE (2007) The case for non-conscious emotion regulation. In: Gross JJ (ed.) *Handbook of Emotion Regulation*. New York: Guilford Press, 429–445.

Bolton SC (2000) Who cares? Offering emotion work as a gift' in the nursing labour process. *Journal of Advanced Nursing* 32(3): 580–586.

Bolton SC (2005) Women's work, dirty work: The gynaecology nurse and the 'other'. *Gender, Work & Organization* 12(2): 169–186.

Bono JE and Vey MA (2005) Toward understanding emotional management at work: A quantitative review of emotional labor research. In: Hartel CEJ, Zerbe WJ and Ashkanasy NM (eds) *Emotions in Organizational Behavior*. London: Lawrence Erlbaum Associates, 213–233.

Braun V and Clarke V (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology* 3: 77–101.

Brotheridge CM and Lee RT (2002) Testing a conservation of resources model of the dynamics of emotional labor. *Journal of Occupational Health Psychology* 7(1): 57–67.
Carver CS, Scheier MF and Weintraub JK (1989) Assessing coping strategies: A theoretically based approach. *Journal of Personality and Social Psychology* 56(2): 267–283.
Centofanti AT and Reece J (2006) The cognitive interview and its effect on misleading postevent information. *Psychology, Crime & Law* 12(6): 669–683.
Cutler BL, Penrod SD and Martens TK (1987) Improving the reliability of eyewitness identification: Putting context into context. *Journal of Applied Psychology* 72(4): 629–637.
De Jonge J and Dormann C (2006) Stressors, resources, and strains at work: A longitudinal test of the triple-match principle. *Journal of Applied Psychology* 91(6): 1359–1374.
Fereday J and Muir-Cochrane E (2006) Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International Journal of Qualitative Methods* 5(1): 2–11.
Fisher RP, Geiselman RE and Armador M (1989) Field test of the cognitive interview: Enhancing the recollection of the actual victims and witnesses of crimes. *Journal of Applied Psychology* 7(5): 722–727.
Frijda NH (1986) *The Emotions.* Cambridge: Cambridge University Press.
Garnefski N and Kraaij V (2007) The Cognitive Emotion Regulation Questionnaire: Psychometric features and prospective relationships with depression and anxiety in adults. *European Journal of Psychological Assessment* 23(3): 141–149.
Gilbert SJ and Burgess PW (2008) Executive function. *Current Biology* 18(3): R110–R114.
Grandey AA (2000) Emotion regulation in the workplace: A new way to conceptualize emotional labor. *Journal of Occupational Health Psychology* 5(1): 95–110.
Gray B (2009) The emotional labour of nursing: Managing emotions in nursing work. *Nurse Education Today* 29(2): 168–175.
Gray B and Smith P (2009) Emotional labour and the clinical settings of nursing care: The perspectives of nurses in East London. *Nurse Education in Practice* 9(4): 253–261.
Greenwood J (1993) The apparent desensitization of student nurses during their professional socialization: A cognitive perspective. *Journal of Advanced Nursing* 18(9): 1471–1479.
Gross JJ (1998) Antecedent- and response-focussed emotion regulation: Divergent consequences for experience, expression, and physiology. *Journal of Personality and Social Psychology* 74(1): 224–237.
Gross JJ and Levenson RW (1993) Emotional suppression: Psychology, self-report, and expressive behaviour. *Journal of Personality and Social Psychology* 64(6): 970–986.
Gross JJ and Thompson RA (2007) Emotion regulation conceptual foundations. In: Gross JJ (ed.) *Handbook of Emotion Regulation.* New York: Guilford Press, 3–24.
Grunfeld E, Zitzelsberger L, Coristine M, Whelan TJ, Aspelund F and Williams E (2005) Job stress and job satisfaction of cancer care workers. *Psycho-Oncology* 14(1): 61–69.
Hobfoll SE (1989) Conservation of resources: A new attempt at conceptualizing stress. *American Psychologist* 44(3): 513–524.
Hochschild A (1983) *The Managed Heart*. Berkeley: University of California Press.
Hojat M, Gonnella J, Nasca T, Mangione S, Vergare M and Magee M (2002) Physician empathy: Definition, components, measurement, and relationship to gender and speciality. *American Journal of Psychiatry* 159(9): 1563–1569.
Karasek R and Theorell T (1990) *Healthy Work: Stress, Productivity and the Reconstruction of Working Life*. New York: Basic Books.
Kruml SM and Geddes D (2000) Exploring the dimensions of emotional labor: The heart of Hochschild's work. *Management Communication Quarterly* 14(1): 8–49.
Lazarus RS and Folkman S (1984) *Stress, Appraisal, and Coping*. New York: Springer.

McVicar A (2003) Workplace stress in nursing: A literature review. *Journal of Advanced Nursing* 44(6): 633–642.
Mann S (2005) A health-care model of emotional labour: An evaluation of the literature and development of a model. *Journal of Health Organization and Management* 19(4–5): 304–317.
Mann S and Cowburn J (2005) Emotional labour and stress within mental health nursing. *Journal of Psychiatric and Mental Health Nursing* 12(2): 154–162.
Mauss IB, Bunge SA and Gross JJ (2007) Automatic emotion regulation. *Social and Personality Psychology Compass* 1(1): 146–167.
Mikolajczak M, Tran V, Brotheridge CM and Gross JJ (2009) Using an emotion regulation framework to predict the outcomes of emotional labor. In: Ashkanasy NM, Zerbe WJ and Härtel CEJ (eds) *Emotions in Groups, Organizations and Cultures Research on Emotions in Organizations*, vol 5. Bradford: Emerald, 245–273.
Miller K (2002) The experience of emotion in the workplace: Professing in the midst of tragedy. *Management Communication Quarterly* 15(4): 571–600.
Morris JA and Feldman DC (1996) The dimensions, antecedents, and consequences of emotional labor. *Academy of Management Review* 21(4): 986–1010.
Morrow J and Nolen-Hoeksema S (1990) Effects of responses to depression on the remediation of depressive affect. *Journal of Personality and Social Psychology* 58(3): 519–552.
Oschner KN and Gross JJ (2007) The neural architecture of emotion regulation. In: Gross JJ (ed.) *The Handbook of Emotion Regulation.* New York: Guilford Press, 87–109.
Rutter M (1985) Resilience in the face of adversity: Protective factors and resistance to psychiatric disorder. *British Journal of Psychiatry* 147(6): 598–611.
Ryan RM and Deci EL (2000) Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist* 55(1): 58–78.
Sapolsky RM (2007) Stress, stress-related disease, and emotion regulation. In: Gross JJ (ed.) *Handbook of Emotion Regulation.* New York: Guilford Press, 606–615.
Sass JS (2000) Emotional labor as cultural performance: The communication of caregiving in a nonprofit nursing home. *Western Journal of Communication* 64(3): 330–358.
Schilling J (2006) On the pragmatics of qualitative assessment: Designing the process for content analysis. *European Journal of Psychological Assessment* 22(1): 28–37.
Scott C and Myers KK (2005) The socialization of emotion: Learning emotion management at the fire station. *Journal of Applied Communication Research* 33(1): 67–92.
Shuler S and Sypher BD (2000) Seeking emotional labor: When managing the heart enhances the work experience. *Management Communication Quarterly* 14(1): 50–89.
Skott C and Eriksson A (2005) Clinical caring – the diary of a nurse. *Journal of Clinical Nursing* 14(8): 916–921.
Smith AC and Kleinman S (1989) Managing emotion in medical school: Students' contacts with the living and the dead. *Social Psychology Quarterly* 52(1): 56–69.
Snyder EE and Ammons R (1993) Baseball's emotion work: Getting psyched to play. *Qualitative Sociology* 16(2): 111–132.
Stenross B and Kleinman S (1989) The highs and lows of emotional labor: Detectives' encounters with criminals and victims. *Journal of Contemporary Ethnography* 17(4): 435–452.
Sutton RI (1991) Maintaining norms about expressed emotions: The case of bill collectors. *Administrative Science Quarterly* 36(2): 245–268.
Thompson RA (1994) Emotion regulation: A theme in search of a definition. *Monographs of the Society for Research in Child Development* 59(2–3): 25–52.
Tracy SJ (2000) Becoming a character for commerce: Emotion labor, self-subordination, and discursive construction of identity in a total institution. *Management Communication Quarterly* 14(1): 90–128.

Tracy SJ (2004) The construction of correctional officers: Layers of emotionality behind bars. *Qualitative Inquiry* 10(4): 509–533.
Tracy SJ (2005) Locking up emotion: Moving beyond dissonance for understanding emotion labor discomfort. *Communication Monographs* 72(3): 261–283.
Tracy SJ and Tracy K (1998) Emotion labor at 911: A case study and theoretical critique. *Journal of Applied Communication Research* 26(4): 390–411.
Tracy SJ and Trethewey A (2005) Fracturing the real-self↔fake-self dichotomy: Moving toward 'crystallized' organizational discourses and identities. *Communication Theory* 15(2): 168–195.
Tulving E and Thomson DM (1973) Encoding specificity and retrieval processes in episodic memory. *Psychological Review* 80(5): 352–373.
Tutton E, Seers K and Langstaff D (2007) Professional nursing culture on a trauma unit: Experiences of patients and staff. *Journal of Advanced Nursing* 61(2): 145–153.
Van Den Tooren M and De Jonge J (2008) Managing job stress in nursing: What kind of resources do we need? *Journal of Advanced Nursing* 63(1): 75–84.
Wharton AS (1999) The psychosocial consequences of emotional labor. *Annals of the American Academy of Political Social Science* 561(1): 158–176.
Zapf D (2002) Emotion work and psychological well-being: A review of the literature and some conceptual considerations. *Human Resource Management Review* 12(2): 237–268.
Zapf D, Seifert C, Schmutte B, Mertini H and Holz M (2001) Emotion work and job stressors and their effects on burnout. *Psychology & Health* 16(5): 527–554.

Renae Maree Hayward is a PhD Candidate at the University of South Australia, in the Centre for Applied Psychological Research. She lectures and coordinates courses in organizational psychology and professional development for counselling and psychology and has worked as a human resource consultant specializing in work related injury. She works with fire and emergency service workers promoting stress prevention and management. Her research interests lie in the areas of work stress, emotional and traumatic stress, and health and well-being at work. She has conducted research with police officers, fire-fighters, and nurses. Her research has so far been published in *Applied Psychology: An International Review*. [Email: renae.hayward@unisa.edu.au]

Michelle Rae Tuckey is a Senior Lecturer in the School of Psychology, Social Work and Social Policy at the University of South Australia, and a member of the Work & Stress Research Group in the Centre for Applied Psychological Research. Her programme of research aims to improve the psychosocial well-being of workers, concentrating on the issues of workplace bullying, occupational stress, and work engagement. She also works with emergency services agencies to enhance stress prevention and management practices. Michelle has published in leading journals such as *Clinical Psychology: Science and Practice*, *Journal of Occupational and Organizational Psychology*, and *Accident Analysis and Prevention*. She currently serves on the editorial boards of *International Journal of Stress Management* and *Stress and Health*. [Email: michelle.tuckey@unisa.edu.au]