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Research Article

EMOTIONAL EXPERIENCES AND COPING STRATEGIES OF NURSING AND MIDWIFERY PRACTITIONERS IN PAKISTAN

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Abstract:

Background: Emotional regulation forms an integral part of healthcare delivery. In the performance of the core duties of nursing and midwifery, health professionals are expected to enhance occupationally/organizationally required emotions. The purpose of this study is to explore the meaning nurses and midwives give to emotional labor as well as the coping resources employed by these professionals in order to manage the emotional demands of their profession. **Method:** A qualitative study was conducted using a semi-structured interview guide with fifteen (15) purposively selected focal persons from a pool of 45 random nurses and midwives grouped in 15 teams having 3 members each. Interviews were recorded and simultaneously translated and transcribed. Thematic analysis was used to analyze the data. **Results:** Our findings showed that participants conceptualized emotional labor as display of rules. Sadness, abuse and bullying, poor incentivisation, emotional exhaustion and emotional mix bag were reported by the participants as emotional demands and deficits. Nurses and midwives coped with emotional labor through the use of five (5) main resources: psychological capital, routinisation of emotions, religious resources, social support and job security. **Conclusion:** Nursing and midwifery professional duties are accompanied with emotional regulations which tend to have consequential effects on a myriad of work-related issues. Clinical healthcare training needs to intensify and equip professionals with the skills of regulating and managing their emotions since managing emotional demands are central to effective healthcare delivery.

Keywords: Emotional labor, Emotional demands, coping strategies, nurses and midwives, defense

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INTRODUCTION:

Emotional stability and mental equilibrium form the core values of the nursing profession and midwifery equally [1, 2]. The occupational niche of the of nurses and midwives are surrounded by vast emotional spectrum including abuse by verbal and physical abuse by seniors and clients, death of the patients etc leading to emotional turmoil and burnout. [7]

[3–5]. Even though there exist various areas of emotional regulation and management in professional healthcare, Emotional stress has emerged as a new star in the horizon of healthcare management literature [6],[7].Nurses and other midwives are expected to demonstrate good interpersonal skills and values along with empathetic attitude towards patient management goals to combat the dilemma associated with emotional burnout. [7], [5].

[5]. Wide array of emotional experiences are encountered by the healthcare workers including anger, guilt, helplessness [3, 8].

Literature review has enlisted two domains of coping mechanism viz. surface acting and deep acting [9, 10]. Nurses are expected to show minimal level of positive energy in dealing with patients even though they are not happy inside [7]. Surface acting is a term coined to mask real inside feelings purpose to harvest departmental wellbeing [10, 11]. Whereas, deep acting refers to the concept of involving emotional expressions which are consistent with internally felt emotions [9].

Sufficient evidence exists in the favor of surface acting that it leads to internal and emotional discordances while suppressing true responses [12– 15]. This, in turn lead to job dissatisfaction and professional disharmony [16]. Whereas deep acting has contributed inconclusive evidences in the concerned literature mainly due to the type of research approach [17–20]. There is a vast room to untwine the differences the establishment of rationale and concept of the beliefs. [7, 21]. Emotional labor theory proposed by Grandey exists as a cornerstone in the prevailing debate of the facts and figures [13]. The present study is tailored to analyze the perspective and theoretical stance of job demand resources model to gaze results of emotional labor.

Previous studies revealed that surface acting related with job attitudes whereas deep acting was not and opinion pertaining to the organizational support has a least impact on the relationship between surface acting and job attitudes [12-14]. Another study found that clinical learning experiences associated among nursing students are highly influenced by the emotional stress [7]. The current study is used as tool to bridge the gaps in the relationship between emotional workload and professional attitudes.

Grandey's [13] emotional labor theory provides a working framework for the current study. According to Grandey [13] every healthcare employee, engage in either surface acting (masking or faking felt emotions) or deep acting (try to experience the desired emotions). This phenomenon casts an impact to their functional behavior and attitude. According to the job demand-resource model working environment drains the physical, emotional, psychological and other resources of the individual which may have detrimental results on the job outcome and attitude [22, 23, 24].

Research design

This study is an explorative multiple case qualitative study which was drafted to compare the older similar studies [29, 30]. Purposeful sampling was used to enroll 50 nurses working in different departments of University of Child Health Sciences and Children Hospital, Lahore during May 2020 to August 2020 with at least 6 months of work experience. [33]. Only nurses and midwives having professional experience of equal or greater than 5 years were included. Students and rotational nurses were excluded. A semi-structured closed and open ending questionnaires was designed to extract demographic and professional data for example “is your profession emotionally demanding? “how do you handle these emotional demands regarding your profession” and “do you think these emotional liabilities drain your professional attitudes?” Data was collected after formal approval from the Ethical Review Board of University of Child Health Sciences and Children Hospital, Lahore and written consent of all the volunteers. Privacy and Confidentiality was maintained at every level.

A summary of the demographic characteristics of the sample used is presented in Table 1.

Code	Age (Years)	Marital Status	Religion	Designation	Experience (Years)
A	50-54	Married	Islam	Head Nurse	18
B	45-49	Married	Islam	Head Nurse	16
C	40-44	Married	Islam	Head Nurse	15
D	35-39	Married	Christian	Charge Nurse	09
E	30-34	Married	Islam	Charge Nurse	08
F	25-29	Widowed	Islam	Charge Nurse	08
G	30-34	Married	Islam	Midwife	07
H	30-34	Married	Islam	Midwife	07
I	25-29	Divorced	Islam	Charge Nurse	06
J	30-34	Married	Christian	Midwife	06
K	30-34	Single	Islam	Charge Nurse	06
L	25-29	Married	Islam	Midwife	06
M	25-29	Married	Christian	Charge Nurse	05
N	25-29	Single	Christian	Midwife	05
O	25-29	Single	Christian	Midwife	05

Results: The study revealed that a significant relationship exists between surface acting and job attitudes but no significant relationship between deep acting and job attitudes as witnessed by [14] A summary of the themes and sub-themes which emerged from the qualitative data analyzed is also presented in Table 2

Table-2:

Theme	Sub-theme	Focal Person Views
Conceptualizing emotional labor	•Display rules	This happens when a patient or an attendant provokes you through verbal or physical assaults then comes the liability to show the resolve of displaying emotions, you are always looked forward and required to display the positive emotions e.g. happiness, contented and benevolence because it not only has a therapeutic value in the model of holistic medicine but also necessary for one's own professional development.
Emotional demands and deficits	•sadness •Emotional exhaustion •Abuse and bullying •Emotional mix bag •Poor incentivization	There are numerous instances when we feel emotionally disturbed especially when resuscitating and declaring deaths of young kids, attending cases of household poisoning, road traffic accidents and neglected children, violence etc. although major part of the responsibility lies on their parents and the guardians who brought them late or could not pick the danger signs early yet as a part of the community the pain we feel is similar to if we were treating our own kids. It is a highly asking job with a lot of unmet and consistent demands emerging with each new

		<p>case. We are expected to provide quality nursing care along psycho-social support.</p> <p>There is lack of motivation in this profession with negligible positive re-enforcement and appreciation from the patients, attendants and the administration in terms of financial or emotional support.</p>
Coping with emotional labor	Psychological Capital Normalization/Routinization	<p>The mental endurance of each healthcare worker varies depending on the demographic background and the patient needs. The coping mechanisms evolve with each passing day so that the senior colleagues are well versed with handling emotional situations.</p> <p>We are trained in such a way that our senses receive and react to stimuli according to its nature and intensity. Thus we cannot force a decision on someone we like or don't like on the basis of our own preferences. We don't take any matter personal, everything is dealt according to the merit and professionally.</p>
	<ul style="list-style-type: none"> •Religion/ spirituality •Social support 	<p>Nursing is a profession of healing and have strong religious aspects. We find this as an opportunity to play our part via pertaining to the holistic model of medicine and provide religious input.</p> <p>Due to the hectic and monotonous nature of job we are left isolated and tired on reaching our homes. Therefore there is a strong need of social support from the family and friends to revitalize ourselves.</p>
	•Job security	<p>The whole month passes while looking at the calendar and counting the days left on receiving our next salaries and the day offs according to the rosters. The feeling that we will relish our salaries at the end of the month, keep us moving forward to do more hardwork.</p>

Emotional demands and deficits

Irrespective of the way emotional labour is defined as, each health care worker is stormed by the emotional liabilities in the course of their professional career. The emotional needs as identified by these health professionals range from positive (happiness) to negative emotions (sadness, abuse, and emotional burnout). Moreover, no mechanism exists within any organization to look up into this phenomenon for its compensation or solution.

Sadness

Healthcare service operates on the verge of emotional attachments predominantly sadness. This probably true because of the prognosis associated with the negative outcome of the critical patients. Hence, the loss of any patient causes a deep impact on the conscious and sub-conscious of any member of the

health care team. However, all health professionals are not expected to be influenced by the sadness during their professional obligations.

Abuse and bullying

Nursing and midwifery suffers another emotional setup in terms of bullying and abuse whether verbal or physical. This is of particular concern for the staff working in the ICUs, Gynae/Obs ER, Pediatric ICUs and Psychiatric nurses due to the nature of admitted patients being treated. Many incidence of violence has been reported.

Poor incentivization

Employees always look forward to their immediate bosses and the administration to safeguard their rights and acknowledge their input for the cause of the organization. The absence of departmental support

makes employees carry the negative impact of their professional responsibilities in terms of emotional needs and are therefore, prone to develop negative job attitudes. On the contrary, the provision of such support from the organizations serves as a protective shield against the negative odds of emotional asking. In Pakistan such concept is less prevalent and the nurses and the midwives feel less supported by their employers.

Emotional exhaustion

Healthcare delivery is believed to be a stressful job due to nature of situations that need to be managed by the frontline member of the healthcare team. All these stresses accumulate to make an individual emotionally exhausted at any time of his/her professional career.

The job of a nurse or a midwife may appear simple and ordinary in the society for example, cleaning a pregnant woman but the emotional and the psychological impact it creates on the treating staff cannot be sensed by others.

Emotional mix bag

Healthcare delivery service hosts an array of emotions both positive and negative. Although the negative side predominate yet the emergence of joyous respites amid a hectic working day cany not be overlooked. Hence all nurses and midwives must be competent enough to latch onto every opportunity that comes their way to maintain a healthy equilibrium.

Coping with emotional labor

Persistent emotional labor gives birth to negative work attitudes and brain drain. However employees harness coping/defense methodologies or accord to some time-tested universal solutions to deal with the emotional demands of their profession. These included psychological capital, routinisation/normalization, religious resources, social support and job security.

Psychological capital

This encircles an individual's intrapersonal idiosyncratic attributes which enable nurses and midwives to deal with the emotional needs of their profession. Most of these qualities are a by-product of their social upbringing and religious bonding which optimizes their personal resources to confront situations of perceived injustice, to forgive, and to build interpersonal relationships.

Routinization/normalization

Nurses and midwives mostly perceive emotional demands as part and parcel of their profession. The normalization and/or routinization of their emotional requirements enables nurses and midwives to handle

and manage the emotional requirements of their profession. They recognize that a good patient orientation can save them from being drained and that the emotional setbacks are the by-products of certain organizational norms.

Religious resources

Hospitals are the settings next to the Holy worshipping places that inculcates the sense of submission and fear of God. Healthcare workers witness miracles and the battles of death and life in their routine duties therefore they subject to the religious or spiritual practices which enable nurses and midwives to manage the emotional burden of their professional duties.

Social support

Nurses and midwives count on the support they lend from their coworkers, family, friends and relatives to enable them to better handle the emotional demands of their healthcare service. Random chats over a cup of tea/coffee, weekend plans and surprise visits and gifts are some of the tools they use to combat the depression associated with the nature of their jobs.

As mentioned below the management of ties with the seniors and juniors is an important part of any service delivery system and the appraisals from the senior folks fuel the functioning capacity of the organization.

DISCUSSION:

As evidenced by the thematic analysis, the health professionals' perception regarding emotional labor projects a response to adopt to the institutional set of standards. Thus, nurses and midwives belief that while performing their professional obligations, they are expected to uphold certain emotions while masking others. In line with the conceptualization of emotional labor by Hochschild [10, 11] and Theodosius [41], emotional labor denotes the engagement in display rules by either hiding the true felt emotions or going through their natural feel.

Nevertheless, the finding from the present study contradicts the finding by [12] who revealed that the concept of emotional labor in medical practitioners based on faking. Unlike the study by [12], the professional undertaking of healthcare team doesn't promote the concept of faking emotions because it is directly linked with managing human lives and therefore, the theory of Grandey's foresees emotional labor as a response to organizationally or occupationally designed emotions (display rules).

The findings from the current study as evidenced by the literature suggest that nurses and midwives are

engaged in a wide array of emotions ranging from negative to positive. For instance, initial studies by [3, 4, 7] point to the fact that nurses and midwives experience diverse emotional situations such as verbal and physical abuse from clients, seniors and colleagues, brain drain, panic, guilt, anger, frustration from the death of the patient. The sequelae of these emotional outcome has been best narrated in the literature [14].

Due to the prevailing circumstances, the people are enrolling themselves in the healthcare field not because of the love for this job but because of scarce vibrant alternatives. This attitude is making them prone to practice surface acting rather than deep acting, as discussed [14].

The present study has highlighted that routinization and normalization of the emotional experiences of health professionals serves as valuable tool for defense mechanism and safeguard them against the brunt of the hiking emotional demands.

As proved by this study these health professionals heavily rely on some of these coping strategies viz. psychological, religious/spiritual and social to equip them deal with the job related emotional demands of their profession. Thus, their availability largely determines the fate of the individual experiences the emotional consequences.

According to job demand-resources model, healthcare delivery system is influenced by emotional experiences like bullying, abuse, emotional exhaustion and sadness. Therefore healthcare worker adopt varying available resources to respond to their emotional demands and professional duties.

CONCLUSION:

The job nature nurses and midwives warrants them to be equipped with techniques of schooling the emotions applying the principles of emotional intelligence. The outlook of their emotional mix should be in accord to the organizationally structured emotions and universal professional attitudes. The current study has highlighted and endorsed the fact that professional healthcare is accompanied with emotional consequences ranging from abuse, bullying, sadness and emotional burnout. Moreover, this study has re-invented number of coping strategies and defense mechanisms that the nurses and midwives in employ to manage their emotional challenges.

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Competing interests

The authors declare that they do not have any conflict of interest.

REFERENCES:

1. Brink H, Van der Walt C, Van Rensburg G. Fundamentals of research methodology for health care professionals. Lansdowne: Juta and Company Ltd; 2012.
2. McQueen AC. Emotional intelligence in nursing work. *J Adv Nurs*. 2004; 47(1):101–8.
3. Bagdasarov Z, Connelly S. Emotional labor among healthcare professionals: the effects are undeniable. *Narrat Inq Bioeth*. 2013;3(2):125–9.
4. De Castro AB. Emotional vs. Physical Labor: The demand of using emotions as a job duty. *Am J Nurs*. 2004;104(3):120.
5. Kinman G, Leggetter S. Emotional labour and wellbeing: what protects nurses? *Healthcare*. 2016;4(4):89–98.
6. Mróz J, Kaleta K. Relationships between personality, emotional labor, work engagement and job satisfaction in service professions. *Int J Occup Med Environ Health*. 2016;29(5):767–82.
7. Msiska G, Smith P, Fawcett T. Exposing emotional labour experienced by nursing students during their clinical learning experience: a Malawian perspective. *Int J Afr Nurs Sci*. 2014;1:43–50.
8. Hilliard C, O'Neill M. Nurses' emotional experience of caring for children with burns. *J Clin Nurs*. 2010;19(19-20):2907–15.
9. Hennig-Thurau T, Groth M, Paul M, Gremler DD. Are all smiles created equal? How emotional contagion and emotional labor affect service relationships. *J Mark*. 2006;70:58–73.
10. Hochschild AR. *The managed heart: commercialization of human feeling*. Berkeley, CA: University of California Press; 1983.
11. Hochschild AR. *The Managed Heart: Commercialisation of Human Feeling*. 3rd ed. USA: University of California Press; 2012.
12. Agyemang CB. *Emotional labour and psychological health: a study of Ghanaian media practitioners (doctoral dissertation, University of Ghana)*; 2017.
13. Grandey AA. When “the show must go on”: surface acting and deep acting as determinants of

- emotional exhaustion and peer-rated service delivery. *Acad Manag J.* 2003;46:86–96.
14. Lartey JKS, Amponsah-Tawiah K, Osafo J. The moderating effect of perceived organisational support in the relationship between emotional labour and job attitudes: a study among health professionals. *Nursing Open.* 2019;6(3):990-7.
 15. Mann S. A health-care model of emotional labour: an evaluation of the literature and development of a model. *J Health Organ Manag.* 2005;19(4 / 5):304–17.
 16. Wang X, Wang G, Hou WC. Effects of emotional labor and adaptive selling behavior on job performance. *Soc Behav Pers.* 2016;44(5):801–14.
 17. Bhavé DP, Glomb TM. The role of occupational emotional labor requirements on the surface acting–job satisfaction relationship. *J Manag.* 2013;42:722–41 <http://doi.org/8zm>.
 18. Ghalandari K, Jogh MGG, Imani M, Nia LB. The effect of emotional labor strategies on employees job performance and organizational commitment in hospital sector: moderating role of emotional intelligence in Iran. *World Appl Sci J.* 2012;17(3):319–26.
 19. Yang FH, Chang CC. Emotional labour, job satisfaction and organizational commitment amongst clinical nurses: a questionnaire survey. *Int J Nurs Stud.* 2008;45(6):879–87.
 20. Grandey AA, Diefendorff JM, Rupp DE. Bringing emotional labor into focus: a review and integration of three research lenses. In a. A. Grandey, J. M. Diefendorff, & D. E. Rupp (Eds.), *Emotional labor in the 21st century: diverse perspectives on emotion regulation at work* (pp. 3–27). New York, NY: Psychology Press; 2013.
 21. Davel NJ. Emotional labour in the south African postgraduate supervisory process: a student perspective (doctoral dissertation, University of Pretoria); 2014.
 22. Bakker AB. An evidence-based model of work engagement. *Curr Dir Psychol Sci.* 2011;20:265–9.
 23. Bakker AB, Demerouti E. The job demands-resources model: state of the art. *J Manag Psychol.* 2007;22(3):309–28.
 24. Bakker AB, Demerouti E. *Job Demands-Resources Theory.* USA: John Wiley & sons; 2014.
 25. Boateng R. *Research made easy (Classic Edition);* 2014.
 26. Hacking I, Hacking J. *The social construction of what?* Harvard university press; 1999.
 27. Lincoln YS, Guba EG. *The constructivist credo:* Left Coast Press; 2013.
 28. Sale JE, Lohfeld LH, Brazil K. Revisiting the quantitative-qualitative debate: implications for mixed-methods research. *Qual Quant.* 2002;36(1):43–53.
 29. McLEOD JOHN. Qualitative research methods in counselling psychology. *Handbook Of Counselling Psychology* 2003;2: 74–92.
 30. Willig C. *Introducing qualitative research in psychology.* McGraw-hill education (UK); 2013.
 31. Edwall LL, Hellström AL, Öhrn I, Danielson E. The lived experience of the diabetes nurse specialist regular check-ups, as narrated by patients with type 2 diabetes. *J Clin Nurs.* 2008;17(6):772–81.
 32. Baker SE, Edwards R. “How many qualitative interviews is enough?”, Discussion Paper, National Center of Research Methods; 2012. <http://eprints.ncrm.ac.uk/2273/>.
 33. Hossain A, Aktar N. Influence of perceived organizational support, supervisory support, and working environment on employee service quality: an empirical study on non-Govt. *Employees Bangladesh.* 2012;1:2–24.
 34. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol.* 2006;3(2):77–101.
 35. Braun V, Clarke V. What can “thematic analysis” offer health and wellbeing researchers? *Int J Qual Stud Health Well-Being.* 2014;9(1). <https://doi.org/10.3402/qhw.v9.26152>.
 36. Creswell JW, Miller DL. Determining validity in qualitative inquiry. *Theory Pract.* 2000;39(3):124–30.
 37. Steinke I. Quality criteria in qualitative research. In: Flick U, von Kardoff E, Steinke I, editors. *A companion to qualitative research.* Los Angeles, CA: SAGE; 2004. p. 184–90.
 38. Whitemore R, Chase SK, Mandle CL. Validity in qualitative research. *Qual Health Res.* 2001;11:5222–37.
 39. Asamoah-Gyadu JK. *Sighs and signs of the Spirit: Ghanaian perspectives on Pentecostalism and renewal in Africa:* Wipf and Stock Publishers; 2015.
 40. Quayesi-Amakye RDJ. *Prophetic practices in contemporary Pentecostalism in Ghana.* Canadian J Pentecostal-Charismatic Christianity. 2015;6(1):43–69.
 41. Theodosius C. *Emotional labour in health care: the unmanaged heart of nursing.* London: Routledge; 2008.