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WORK-FAMILY CONFLICT AND EMOTIONAL LABOUR: THE MODERATOR ROLE OF COGNITIVE JOB DEMANDS

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Abstract

Purpose – The purpose of this study is to examine the relationship between the work-family conflict (WFC) nurses feel and the need to hide their emotions in the workplace when interacting with co-workers, through surface acting (SA). We will also explore the moderator role of cognitive job demands (CJD) in this relationship and its consequences to nurse's well-being.

Methodology – The research is a two-wave study of 60 nurses from a Portuguese hospital.

Findings – Data supported the relationship between WFC and SA, and demonstrated the importance of CJD as a moderator of this relationship. WFC is associated with higher levels of SA one week later, only when nurses reported higher levels of CJD.

Research limitations – Although this is a two-wave study causality is not assured since all data was collected through a self-report questionnaire. Hence this study may suffer common-method bias. Nevertheless, since we tested a moderation effect, common-method bias is less of a concern.

Practical implications – Managers should implement measures with the purpose of creating a family-friendly environment, and giving more cognitive job resources to nurses. Flexible work arrangements, a climate of authenticity and emotional training are some of the measures that could improve nurses' well-being.

Originality/value – WFC has been rarely examined as an antecedent of emotional labour (EL). In addition, EL has been studied in the relationships between nurses and patients, and not so frequently in the relationships between nurses and their colleagues.

Keywords - Work-family conflict; emotional labour; well-being; nurses.

JEL Classification – Well-being (I310); Personnel Economics (M5).

Resumo

Objetivo – Este estudo examina a relação entre o conflito trabalho-família (CTF) que os enfermeiros sentem e a necessidade de esconderem as suas emoções quando interagem com os colegas, através de "surface acting". Iremos também explorar o papel moderador das exigências cognitivas do trabalho (ECT) nesta relação.

Metodologia – A investigação foi feita em dois momentos distintos, com 60 enfermeiros de um hospital Português.

Resultados – Foi demonstrado que o CTF sentido está associado a um nível mais elevado de "surface acting" na interação com os colegas uma semana depois, apenas quando os enfermeiros consideram que o seu trabalho nessa semana foi cognitivamente exigente.

Limitações – Apesar do estudo ter sido realizado em dois momentos distintos não podemos assegurar causalidade porque os dados foram recolhidos através de questionários auto relatados. Assim este estudo poderá sofrer de variância do método-comum. Não obstante, visto que testámos um efeito moderador, a variância do método-comum é menos relevante.

Implicações práticas – A criação de um ambiente laboral que valoriza a família, de mais recursos cognitivos para os enfermeiros, a implementação de trabalho flexível, de um clima de autenticidade e de formação emocional são algumas das medidas que podem melhorar o bem-estar dos enfermeiros.

Valor acrescentado – O CTF raramente foi estudado como um antecedente do trabalho emocional. Adicionalmente, o trabalho emocional tem sido observado mais frequentemente nas relações entre enfermeiros e pacientes e não entre enfermeiros e os seus colegas.

Palavras-chave – Conflito trabalho-família; trabalho emocional; bem-estar; enfermeiros.

Classificação JEL – Bem-estar (I310); Economia de pessoas (M5).

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1. Illustrations Index

2. Abbreviations

WFC - Work-family conflict.

CTF – Conflito trabalho-família.

CJD – Cognitive job demands.

ECT – Exigências cognitivas do trabalho.

EL – Emotional labour.

SA – Surface acting.

COR – Conservation of resources.

ANOVA - One-way analysis of variance.

e.g., - for example.

etc., - and so forth.

et al., - and colleagues.

i.e., - that is.

3. Work-family Conflict and Emotional Labour: The Moderator Role of Cognitive Job Demands

In the last 30 years there has been a change on the core of occidental economies to service-oriented ones, with the main goal of reducing costs and improving service quality (Hülsheger & Schewe, 2011; Morris & Feldman, 1996). To do so companies had to improve clients' and customers' perceptions of their interactions with employees. These factors led to the growth on the attention given to how individuals express emotions while hiding others, in different work settings, and instigated the integration of management of emotions in the organizational rules (Ashforth & Humphrey, 1993; Côté, 2005; Hochschild, 1983; Hülsheger & Schewe, 2011; Morris & Feldman, 1997). As organizations have more and more jobs that require management of emotions, it thus becomes imperative to comprehend what are the situations at work that lead people to express emotions they do not feel or hide the ones they do feel.

This phenomenon of regulating the displayed emotions and manage feelings in order to meet the expectations of the organizations, has been called emotional labour (Hochschild, 1983). The majority of times, service-based jobs, frontline jobs or what is called "people work" jobs (e.g. healthcare, customer service, police, bill collectors etc.; Brotheridge & Grandey, 2002) require facial and/or voice contact with other individuals. They demand that employees control their reactions in the context of interactions with customers, clients and colleagues, and they provide opportunities for employers to control the emotional interactions of their employees – characteristics of jobs requiring emotional labour, as pointed out by Hochschild (1983, p. 147).

Being so, when a specific job requires contact with other individuals, organizations seem to invest on regulated display of emotions or feeling rules because they believe that, in doing so, helps avoiding conflicts between employees (Bolton, 2000; James, 1989; Phillips, 1996), helps guiding employees and customers interactions to achieve high performance goals and affects the behaviour of clients in a positive way (Brotheridge & Grandey, 2002; Hülsheger & Schewe, 2011; Morris & Feldman, 1997; Rafaeli & Sutton, 1987). As a consequence, emotional labour has become part of employees' daily responsibilities.

However, the transaction of giving and receiving emotions is not always an even one. The gestures and words that are transmitted may be carried out without a true intention, neglecting the existing rules for that specific situation, or even in complete ignorance of those same rules (Bolton, 2000). This mismatch between what an individual is feeling and expressing leads to different reactions and may have negative effects on employees' well-

being and health (Hochschild, 1983; Hülsheger & Schewe, 2011; Mauno, Ruokolainen, Kinnunen, & de Bloom, 2016; Panagopoulou, Kersbergen, & Maes, 2002), such as drug and alcohol abuse, emotional dissonance, role overload, loss of feelings, strain, anxiety, depression, absenteeism (Hochschild, 1983; Wharton & Erickson, 1993), emotional exhaustion, stress, depersonalization and decrease in job satisfaction and personal accomplishment (Ashforth & Humphrey, 1993; Bakker & Heuven, 2006; Brotheridge & Grandey, 2002; Demerouti, Nachreiner, Bakker, & Schaufeli, 2001; Morris & Feldman, 1997; Pugliesi, 1999; Zapf & Holz, 2006). Furthermore it was also noted that job performance may decrease when employees engage in emotional labour by using surface acting (Totterdell & Holman, 2003) and that emotional labour causes turnover, burnout, cynicism and decrease in self-esteem and sense of authenticity (Bartram, Casimir, Djurkovic, Leggat, & Stanton, 2012; Brotheridge & Grandey, 2002; Chau, Dahling, Levy, & Diefendorff, 2009; Lee & Ashforth, 1996; Mann, 2004). Besides the negative psychological consequences to well-being, over the last years, some psychologists also found a relationship between the management of emotions and physical illness, such as high cholesterol levels, headaches, stomach-ache and backache, hypertension, chest pains, sexual dysfunction, (Frone, Russell, & Barnes, 1996; Grandey, 2000; Hochschild, 1983; Hülsheger & Schewe, 2011; Kinnunen & Mauno, 1998; Wharton & Erickson, 1993) heart diseases, cancer (Gross, 1998) and memory loss (Richards & Gross, 1999).

From the several professions where emotions have to be regulated on a daily basis, the nursing sector is one of the sectors where that happens more intensely, due to the significant emotional demands placed on nurses (Bolton, 2000; Gray & Smith, 2009; Huynh, Alderson, & Thompson, 2008; Mann, 2005; Pisaniello, Winefield, & Delfabbro, 2012; Yang & Chang, 2008; Zapf, 2002). Also as a consequence of the economic problems several countries faced, organizations were pressured to restructure their workforce in order to reduce costs. Hospitals' managers followed this trend and their health care systems were changed to profit oriented systems, operating in a competitive and free-market economy and focused on commercial principles (Frone, Yardley, & Markel, 1997; Simon, Kümmerling, & Hasselhorn, 2004; Yildirim & Aycan, 2008). Consequently, nurses' cognitive, psychological and emotional demands increased, since they focused more on patient-centred care, and struggle to deliver positive interactions to patients and colleagues (Golfenshtein & Drach-Zahavy, 2015; Gray & Smith, 2009; Mann & Cowburn, 2005; Phillips, 1996; Tschanh, Rochat, & Zapf, 2005). Moreover, hospitals' managers also started giving more importance to how nurses controlled their emotions in the workplace, since the better the encounter a patient has

with a nurse, the higher their satisfaction level. With this, managers also expect an increase in service quality, productivity, performance and profits (Hennig-Thurau, Groth, Paul, & Gremler, 2006; Mitchell & Smith, 2003; Seery & Corrigall, 2007).

This way, the emotional aspect of the nursing profession became more complex. Nurses are required to provide treatments and information, and to help their colleagues whilst constantly regulating their emotions according with the social interactions they are involved in (Tschanh et al., 2005; van der Heijden, Demerouti, & Bakker, 2008). They are expected to show genuine care, compassion, affection and empathy for a patient, while maintaining calm detachment and hiding negative feelings, most of the times due to the worsening of a patients' health state (Bechtoldt, Rohrmann, de Pater, & Beersma, 2011; Bolton, 2000; Pisaniello et al., 2012; Zapf, Seifert, Schmutte, Mertini, & Holz, 2001). Accordingly, nurses' job requirements became highly based on work interactions with other individuals in environments where patients have physical and emotional pain, family members are suffering and colleagues are going through the same challenges as them (Hayward & Tuckey, 2011; Kirpal, 2004; Schaubroeck & Jones, 2000; Tschanh et al., 2005). Therefore, when nurses realize that their real feelings are not consistent with the emotions they should express, they engage in emotional labour, assuring a greater emotional control (Hochschild, 1983; Smith & Lorentzon, 2005).

Over the years, studies focused on the nursing sector showed that emotional labour carried out by nurses can be described as difficult, demanding, sorrowful and exhausting, affecting the well-being of nurses (James, 1989; Karimi, Leggat, Donohue, Farrell, & Couper, 2014). They suggest that nurses are more likely to experience burnout, emotional exhaustion and intention to leave the hospital, when engaging in emotional labour (Bartram et al., 2012; Brotheridge & Grandey, 2002; Morris & Feldman, 1996; Zapf, Vogt, Seifert, Mertini, & Isic, 1999). Furthermore, well-being in the workplace is a crucial factor to determine the long-term performance of an organization. Nurses who have higher levels of emotional well-being are more capable of dealing with their job demands more efficiently. On the other hand, nurses who have lower levels of emotional well-being will have their sense of competence diminished, since when they become stressed and exhausted, their performance decreases (Chou, Hecker, & Martin, 2012; Rose & Glass, 2010). Therefore, studying the interactions and factors that enhance the exhibition of emotional labour is useful to know, since it will allow us to understand where and how we should intervene with the purpose of diminishing its use. In fact, by understanding the factors that can enhance, or instead diminish, the emotional labour of nurses we may be helping managers to create

strategies that will inhibit or eliminate the possible extended harmful effects of emotional labour on the well-being of nurses.

The vast majority of studies, focused on the performance of emotional labour in the relationships between employees and clients, or in the case of nurses, between nurses and patients (Delgado, Upton, Ranse, Furness, & Foster, 2017; Tschanh et al., 2005). However, employees may also hide their true emotions when interacting with colleagues and supervisors (Bolton, 2000; Grandey, Foo, Groth, & Goodwin, 2012; Pugliesi, 1999; Schaubroeck & Jones, 2000; Tschanh et al., 2005). Therefore, as a way of complementing the research already done on emotional labour in the nursing profession, we will focus our study on emotional labour performed in the interactions between nurses and their co-workers.

As the concern on the consequences of emotional labour rises, so too the concern on work-family conflict. WFC is a form of inter-role conflict that occurs when the demands of the work and family domains are in some way incompatible (Greenhaus & Beutell, 1985). Companies and governments in occidental economies are not only diagnosing this phenomenon but are also testing measures to reduce its negative effects. One of the most recent examples of this, is the establishment in France, in January 1st 2017, of a law that gives the employees "the right to disconnect". This law obliges companies with more than 50 employees to establish hours when their employees should not send or receive emails. This is a measure that not only prevents burnout, but also protects the employees' private time and reduces WFC (Morris, 2017).

Nonetheless, this concern on WFC is not only due to the intensification on the awareness of its consequences to the labour market, but also because there has been an escalation of the phenomenon in itself. Family income, participation of women in the job market, the number of dual-earner couples with children and worked hours, single-parent households and families facing elder care demands, increased (Amstad, Meier, Fasel, Elfering, & Semmer, 2011; Janssen, Peeters, De Jonge, Houkes, & Tummers, 2004; Kinnunen, Geurts, & Mauno, 2004; Livingston & Judge, 2008). As a consequence, individuals are faced with greater, different and competing responsibilities from the work and family domains that they cannot avoid. This in turn may lead to work-family conflict (Byron, 2005; Greenhaus & Beutell, 1985; Rice, Frone, & McFarlin, 1992; Shockley & Singla, 2011).

Work-family conflict in the nursing profession is particularly important to study, due to the increase shortage of nurses (Hammer, Bauer, & Grandey, 2003; Simon et al., 2004) and because nursing is a highly demanding occupation. Besides the work demands, nurses may also face a considerable amount of family demands, since the workforce in this

sector is predominantly female, and women still have a tendency to have more family responsibilities than men (Unruh, Raffenaud, & Fottler, 2016). Therefore, nursing is highly associated with work-family conflict and health problems, due to the amount of job and family demands nurses face on daily basis (van der Heijden et al., 2008).

We propose that the more WFC individuals feel, the harder they have to try to hide their true emotions in the workplace, engaging more frequently in emotional labour. However, we expect that this detrimental effect of the WFC felt would be enhanced when, besides WFC, the individual also feels that his/hers work has been highly demanding from the cognitive point of view, in that same week. Therefore, our study aims to test the moderator role of cognitive job demands on the impact of WFC to nurses' emotional labour. In order to understand these relationships we will use the conservation of recourses (COR) theory (Hobfoll, 1989) as the theoretical framework that will ground our hypothesis.

Our study contributes to the literature in five ways. First, previous studies on emotional labour in the nursing profession have been centered on the interactions between nurses and patients (Delgado et al., 2017; Tschanh et al., 2005). However, in this study we focus on the experience of emotional labour in the interaction with co-workers. This is important since although nurses interact frequently with their patients, the interactions with their colleagues are usually more long-lasting. Moreover, we believe the nurses' need to hide their emotions is closely associated with their need to show that they are competent in the workplace (Haber, Pollack, & Humphrey, 2014; Jamieson, 2004). If they do not demonstrate to their colleagues that they are affected by the daily challenges of life and work they will appear more composed and more capable to take on with any challenges they may have in the workplace.

Second, to the best of our knowledge, this is one of the first studies that analyses emotional labour as an outcome of WFC. In fact, the majority of the literature that has studied these two variables altogether, has framed work-family conflict as an outcome of emotional labour experienced at work (Sanz-Vergel, Rodríguez-Muñoz, Bakker, & Demerouti, 2012; Wagner, Barnes, & Scott, 2014; Yanchus, Eby, Lance, & Drollinger, 2010). Our study frames emotional labour as a self-regulatory mechanism that nurses may use as a way to deal with the feeling that work is colliding with their family life. This is important because, nurses who do not feel at ease to share their family and work burdens with their colleagues may have the need to hide their true emotions in the workplace, with the purpose of seaming more composed and competent in the workplace.

Third, instead of centering all attention on dispositional predictors of emotional labour, or job characteristics – which are the more frequently studied predictors of emotional labour in the literature (Bartram et al., 2012; Cheng, Bartram, Karimi, & Leggat, 2013; Erickson & Grove, 2008) – in our study we analyse the impact of the interface of work and family in the emotional labour of nurses. This is interesting because the nursing profession is one of the professions most affected by work-family conflict and emotional labour (James, 1989; Karimi et al., 2014; van der Heijden et al., 2008). These two phenomena when combined may have seriously harmful consequences to nurses' well-being. Moreover, the majority of literature studied the impact of emotional labour on sales agents, call centre workers or hotel assistants (e.g. (Brotheridge & Lee, 2002; Gosserand & Diefendorff, 2005; Groth, Hennig-Thurau, & Walsh, 2009; Totterdell & Holman, 2003) employees that do use emotional labour but in a more mechanical and routinized manner. The participants of our study, nurses, belong to the category of workers in high emotion labour jobs (Humphrey, Pollack, & Hawver, 2008), using emotional labour more intensely, which will allow us to gather more interesting and accurate information. We believe this to be another strength of our study. Finally, to the best of our knowledge, this is one of the first studies that analyses the role of cognitive job demands as a moderator between WFC and emotional labour. Hence, the purpose of this study is to understand in which extent the work-family conflict nurses feel is related to their need to hide their emotions in the workplace on the following week. And in what way this relationship may be influenced by the cognitive job demands nurses report.

In this study we will first review the literature on work-family conflict, emotional labour and cognitive job demands. Secondly, we will describe the method used to gather the data of this study and the results achieved. We will also discuss the results obtained and finish by stating the contributions of this study to the organizational context, its limitations and the main overall conclusions that were reached.

4. Literature Review

The purpose of this study is to understand in which extent the work-family conflict nurses feel is related to the need to hide their emotions in the workplace. Furthermore we will test the impact of cognitive job demand on this relationship.

We will first give an overview of the research done on work-family conflict explaining its negative outcomes. Next we will focus on emotional labour, explaining the three different perspectives surrounding this construct and its consequences. Following, we

will examine the relationship between WFC and emotional labour in the specific case of our study's population – nurses. Finally, we will focus on the moderator role of cognitive job demands, and its relationship with WFC and emotional labour.

4.1 Work-Family Conflict and the Conservation of Resources Theory

Greenhaus and Beutell (1985) defined work-family conflict as:

> (…) a form of interrole conflict in which the role pressures from the work and family domains are mutually incompatible in some respect. That is, participation in the work (family) role is made more difficult by virtue of participation in the family (work) role. (p. 77).

According to the role theory (Kahn, Wolfe, Quinn, Snoek, & Rosenthal, 1964)**,** inter-role conflict occurs when pressures arising from one specific role hinders the compliance to the pressures rising from another role possibly affecting the performance on both roles. These pressures may arise due to the values individuals hold regarding one's own performance on a specific role or even due to the expectations other people may have regarding that same performance on the role. More specifically, when it comes to work and family roles, each of them have completely different demands that require individuals to have energy, time, and to be committed if they want to perform each role adequately. When the demands of both roles multiply, individuals may be faced with inter-role conflict and/or overload (Duxbury, Higgins, & Lee, 1994; Greenhaus & Beutell, 1985).

In this study, we are only going to focus on the work to family conflict instead of family-work conflict since previous researches show that the family domain is more permeable than the work domain, in the sense that individuals are less reluctant of letting work demands interfere with the family domain (Eagle, Miles, & Icenogle, 1997; Frone, Russell, & Cooper, 1992a). Moreover, WFC is, in average, reported to be more frequent than the family-work conflict either by men and women (Frone, Russell, & Cooper, 1992b). Work-family enrichment was not considered to this study since this variable is more related with positive consequences to individuals well-being and to deep acting rather than negative affect and surface acting (Greenhaus & Powell, 2006; Yanchus et al., 2010). Therefore, in the present study, we focused on WFC and its consequences to emotional labour.

Greenhaus and Beutell (1985) suggest that the conflict between work and family roles can have three different dimensions: time-based, strain-based or behaviour based conflict. Time-based conflict occurs when the time individuals devote on accomplishing the

requirements of one role does not allow the fulfilment of the requirements of another role. Strain-based conflict occurs when the participation on one role and the strain (e.g., fatigue, dissatisfaction, tension, unease and anxiety) resulting from that same participation does not allow the fulfilment of the requirements of another role (e.g., being very tired due to a difficult day at work does not allow an individual to be entirely available to accomplish the family responsibilities). Behaviour-based conflict occurs when the specific behaviours a person has to enact in one role are incompatible with the expectations of the other role (e.g., being detached from ones' emotions at work may be part of ones' job requirements, but at home if this detachment continues it may lead to family conflicts).

The constant competition of demands between different roles will result in frustration for the employee, which in turn will result in the interruption of the goal-focused activities, a decrease in performance and productivity, and ultimately in the organization overall success (Grandey & Cropanzano, 1999; MacEwen & Barling, 1994; van Steenbergen & Ellemers, 2009).

Grandey & Cropanzano (1999) adapted the conservations of resources theory (Hobfoll, 1989, 2002) to understand the impact of WFC on employees' attitudes and behaviours. The COR theory proposes that people try to acquire and maintain their resources, when they feel that there is a threat of loss or an actual loss, of their resources. By doing so they will feel stressed. Resources can be objects, personal characteristics, life conditions, or energies that are valued by the individual (Hobfoll, 1989). Moreover this theory proposes that WFC "leads to stress because resources are lost in the process of juggling both work and family.", which ultimately may cause depression, tension, anxiety, dissatisfaction and an overall negative "state of being" (Grandey & Cropanzano, 1999: 352). Work-family conflict is in fact associated with higher levels of emotional exhaustion, burnout (Beutell & Wittig-Berman, 1999; Boles, Johnston, & Hair, 1997; Burke & Greenglass, 2001; Kinnunen & Mauno, 1998; Lee & Ashforth, 1996; Posig & Kickul, 2004), sleep complaints, alcohol abuse, and fatigue (Frone et al., 1996, 1997; van Hooff, Geurts, Kompier, & Taris, 2006). Furthermore, one of the most alarming consequences of WFC is high levels of depression (Allen, Herst, Bruck, & Sutton, 2000; Eby, Maher, & Butts, 2010; Frone et al., 1996, 1997; Rice et al., 1992). Therefore, we suggest that WFC will be associated with a need for the individual to self-regulate his/her emotions.

4.2 Emotional Labour

The need for employees to regulate their emotional displays at work is at stake in a great part of jobs, being highly evident in service oriented jobs, such as nursing. To be able to assure "service with a smile" people need sometimes to hide, suppress or fake the emotions they are feeling, "creating a publicly observable facial and bodily display" (Hochschild, 1983: 32) in the name of customer service. Being this what Hochschild (1983) defines as emotional labour.

Emotional labour was first introduced in literature by Arlie Hochschild in 1983 with the publication of the study – The managed heart: The commercialization of human feelings. In this study Hochschild proposes that this behavioural phenomenon is both managed by the individual and the organization, being either, intrinsically and extrinsically controlled. Extrinsic control is achieved when organizations define specific rules regarding emotion display that tend to be socially shared in the organizational context. In other words, they define the type, intensity and extent to which an individual should express, or not, a certain feeling (Hochschild, 1983; Rafaeli & Sutton, 1987).

One of the reasons why over the last years researchers have been giving more focus to the emotional labour is the establishment of service-oriented economies. Because of this, for several work roles, mainly in the service industry, the feeling rules employees should express when interacting with others, such as, clients, customers, patients, passengers or guests became a specific job requirement (Hochschild, 1983; Zapf, 2002). These rules may be informal or may be stated in training programmes. Moreover, it is made clear to the employees, through the interactions with colleagues that, for instance, feeling distress, anger or aversion in the work environment is unprofessional (Bolton, 2000). These "emotional rules" define what an employee should feel in a given scenario, or at least what he is supposed to feel, and consequently how he should act, ignoring the real emotions the employee is feeling. In organizations, these feeling rules can either be expansive or restrictive (Holman, Martínez-Iñigo, & Totterdell, 2008a), they usually advise employees to be expansive regarding a positive emotion and restrictive regarding a negative one (Brotheridge & Grandey, 2002; Holman et al., 2008a; Zapf & Holz, 2006).

But are these rules defined in every organization, for every job positon and in the same way? According to Humphrey et al., (2008), service jobs are the ones where emotional labour occurs more intensely. They proposed that these jobs can be divided in three different categories: customer service jobs; caring professionals; and social control jobs. In fact, employees who work in "emotional labour jobs" often participate in interactions highly emotionally demanding. For example, employees in customer service jobs are encouraged to

transmit good humour and smile when contacting with clients, whereas nurses are encouraged to be calm, empathetic and supportive to their patients and colleagues and not to reveal their worries with a patient's condition in order not to add up to the patient's own worries (Humphrey et al., 2008; Kirpal, 2004; Pugliesi, 1999). In doing this, employees are not only protecting themselves, when interacting with others, but also performing in a specific way to achieve the goals of the organization (Ashforth & Humphrey, 1993; Hochschild, 1983).

In the literature, we noticed the existence of three different perspectives regarding emotional labour introduced by Hochschild, in 1983, Ashforth and Humphrey, in 1993, and Morris and Feldman, in 1996. Although all of these perspectives have in common the consideration that emotions are managed at the workplace in order to follow organizational rules on the correct emotions that should be expressed when interacting with others, there are several divergences on the clear conceptualization of emotional labour.

Hochschild (1983) used a dramaturgical view on the relationship between employees and customers, by applying a metaphor where they are both actors in the workplace stage, where employees, using standardized costumes (uniforms), perform for a client (audience), in order to achieve positive feedback for the organization. Following this view, the employees' (actors') manuscript is the organizational display rules. Although the majority of employees do not want to see themselves as actors, they inevitably still engage in management of emotions (Ashforth & Tomiuk, 2000). Concerning the consequences of engaging on emotional labour, Hochschild (1983) highlights the improvement of customer service as the best positive outcome. Regarding negative consequences, the need to express the right emotion at the right moment is considered, by Hochschild (1983), as highly demanding in terms of emotional control. Furthermore, she suggests that when employees have the perception that the organization is controlling the expression of their emotions, they may feel that the barrier between the individual and the organization is surpassed, which can lead to burnout, job stress and health problems.

According to Hochschild (1983), before engaging on emotional labour individuals have to decide between two regulation methods – surface acting or deep acting – and two directions of emotion regulation – emotion amplification or emotion suppression. Surface acting consists in faking, altering or regulating the emotional expression. Contrastingly deep acting is a more conscious method of modifying the emotions felt within themselves, resulting in a more genuine demonstration of emotions (Brotheridge & Lee, 2002; Grandey, 2000; Hochschild, 1983; Hülsheger & Schewe, 2011). Emotion amplification consists on

enhancing public display of feelings, whilst emotion suppression involves eliminating or reducing them (Hochschild, 1983). Although in theory an individual could eliminate or hide a public display of emotion, in practical terms that is generally impossible, and this is one of the factors that leads individuals to change what they are feeling instead of hiding it (Côté, 2005; Grandey, 2000).

The second perspective of emotional labour was introduced by Ashforth and Humphrey (1993: 90). They defined emotional labour as "the act of displaying appropriate emotion (i.e., conforming with a display rule)", hence the main goal of engaging in emotional labour by expressing what are considered appropriate emotions in the workplace is to make impression management, an instrument of control used by employees to influence others in the organization in their favour (Zapf, 2002). When comparing Ashforth and Humphrey's (1993) perspective with Hochschild's (1983), it may be concluded that the former is more focused on the act of expressing an emotion rather than the control of an individual's feelings before engaging in a specific behaviour. In fact, this perspective does not give much importance to the emotional regulation methods of surface and deep acting as source of ill-being in the workplace, since when employees engage in emotional labour it may not signify that they are doing a conscious effort. It is suggested that when an employee engages often in emotional labour it may become so effortless and part of his daily routine that it does not lead to job stress or other sources of ill-being. In fact, they suggest that the display rules employees have to follow, may actually help them avoid awkward interpersonal situations (Humphrey, Ashforth, & Diefendorff, 2015).

Moreover, they noticed that there is a clear positive relation between the observable emotions employees express and their performance in the workplace, but only if the other party involved in the interaction (customer, client, patient or colleague) perceives the emotion the employee is demonstrating and reacts positively to it (Grandey, 2000). Following this line of reasoning, if for an employee expressing the right emotion at the right time is easy and effortless, if that leads to a good reaction in the person with whom he is interacting, leading, in turn, to a good performance and a reward from the organization, then the employee will feel valued and rewarded. However, if the employee has to make a considerable effort to express the right emotion, the person with whom he is interacting with will see that his expression is not sincere and this may hinder the employee effectiveness when conducting a task (Grandey, 2000). Furthermore Ashforth and Humphrey (1993) noted that the Hochschild (1983) perspective did not account for another type of emotional labour – spontaneous and genuine emotional labour – that occurs when an employee expresses some emotion without

making a cognitive effort to do so (Brotheridge & Lee, 2003; Humphrey et al., 2015). They proposed that in many cases an individual spontaneous emotion follows accordingly with the organization display rules, for instance, when a nurse automatically feels sympathy and concern when seeing an injured person (Ashforth & Humphrey, 1993; Brotheridge & Lee, 2003; Humphrey et al., 2015; Morris & Feldman, 1996).

A third perspective on emotional labour is presented in 1996 by Morris and Feldman. According to them, emotional labour is "the effort, planning, and control needed to express organizational desired emotion during interpersonal transactions" (Morris & Feldman, 1996: 987). When it comes to the uniqueness of this third perspective, it follows under the suggestion that emotional labour depends on four different factors: (a) frequency of interactions, (b) attentiveness (intensity of emotions and duration of interaction), (c) variety and (d) emotional dissonance (Grandey, 2000). According to this we may only consider that an individual is engaging in emotional labour when the frequency of interactions she/he is having is high, when the emotions expressed or repressed are intense and diverse, and when there is a dissonance between the emotions the individual is expressing and what he is truly feeling.

Taking into account these three perspectives, we will refer to emotional labour in the present study as nurses' internal self-regulation of emotions and feelings that are displayed in the workplace during interpersonal transactions with colleagues, in order to follow the feeling rules and affective requirements the organization has set for their specific roles. There is a need for emotional labour when there is a mismatch between the internal emotions of the employees and what is expected by the organization from them to show. We also found important to include in our definition the different types of emotional labour – surface and deep acting – nurses engage in. It is highly important to clearly distinguish between both strategies, since they affect differently the employees and organizations (Bechtoldt et al., 2011).

Deep acting, occurs when a person tries to actually feel or experience the emotions one wants to display. It consists on bringing to the surface an expression that aligns with what is required by the organization, for instance, by turning a negative emotion into a positive one (Hülsheger & Schewe, 2011; Totterdell & Holman, 2003; Yang & Chang, 2008). This regulation method is usually achieved by exhorting feeling, when an employee tries to suppress or evoke an emotion, or by trained imagination, which consists on refocusing about other things, invoking thoughts, images or memories in order to control the internal feelings and thoughts to meet the displayed rules (Gross, 1998; Hochschild, 1983). When employees

make this effort and assuming that it is successful, deep actors will be able to restore their emotional resources and will not feel so much difficulty in maintaining the new emotional expression. Moreover, since deep actors treat the people with whom they are interacting as worthy of authentic emotion and expression, they will feel lower levels of depersonalization, (Chou et al., 2012).

Surface acting, as the name implies, is a method accomplished at a more surface level. It involves changing the external expression, for instance, the gestures, voice and facial expression, without changing the real emotions someone is feeling (Chou et al., 2012). In other words, it consists in hiding, suppressing, faking or exaggerating one's true emotion and expression and changing it into one that is acceptable in the organizational environment (Brotheridge & Grandey, 2002; Grandey, 2003; Hochschild, 1983). This may be accomplished by presenting verbal or nonverbal cues, such as gestures, facial expressions and voice tone. For instance, when a nurse smiles even though he/she is in a bad mood when interacting with someone (Brotheridge & Grandey, 2002; Brotheridge & Lee, 2003; Hülsheger & Schewe, 2011). Employees that testified higher levels of surface acting found more difficulties in managing negative emotion experiences (Beal, Trougakos, Weiss, & Green, 2006; Gross, 1998).

Moreover, the differentiation between these two strategies is also due to the evidence that they predict work and health outcomes differently. Deep acting has been positively associated with higher positive feedback by customers (Côté, 2005; Martínez-Iñigo, Totterdell, Alcover, & Holman, 2007; Totterdell & Holman, 2003), role identification (Brotheridge & Lee, 2003), job and role satisfaction, organizational commitment, job performance, self-perceived authenticity and efficacy, personal well-being and accomplishment, and negatively associated with burnout (Bechtoldt et al., 2011; Brotheridge & Lee, 2002; Grandey, 2003; Hochschild, 1983; Hülsheger & Schewe, 2011; Humphrey et al., 2015; Yang & Chang, 2008). Surface acting has been more linked with negative work-related outcomes and harmful consequences to employees' performance and well-being (Hochschild, 1983; Hülsheger & Schewe, 2011; Nguyen, Groth, & Johnson, 2016; Sanz-Vergel et al., 2012), such as cynicism, work-family conflict (Montgomery, Panagopolou, & Benos, 2005), burnout, stress and health problems (Brotheridge & Lee, 2003; Hülsheger & Schewe, 2011; Kammeyer-Mueller et al., 2013; Karimi et al., 2014), emotional dissonance, anxiety, depression, strain and insomnia (Hochschild, 1983; Wagner et al., 2014), negative affect, emotional exhaustion, depersonalization, lower personal accomplishment, self-esteem, self-authenticity and job dissatisfaction (Brotheridge & Grandey, 2002; Côté, 2005; Grandey,

2003; Kruml & Geddes, 2000; Martínez-Iñigo et al., 2007; Mesmer-Magnus, DeChurch, & Wax, 2012; Totterdell & Holman, 2003).

Nonetheless, surface acting may have positive outcomes, especially for organizations and clients. By regulating the interactions between employees and clients, the employees' task effectiveness may increase, avoiding possible interpersonal problems that may arise between employees and clients (Ashforth & Humphrey, 1993). Moreover, Côté (2005) stated that an emotion regulation strategy has an effect on both the sender and the receiver of that strategy, in the sense that an "emotional contagion process" may occur. Therefore, when individuals perceive that employees are displaying authentic positive emotions or they do not simply detect the insincerity in a social interaction, they will respond to an employee with positive feedback and emotions (Beal et al., 2006; Groth et al., 2009; Hülsheger & Schewe, 2011). Consequently, this guarantees a positive experience for all involved, it assures a good service to the client, a good performance by the employee and an increase in his degree of personal accomplishment, the establishment of a good environment in the organization, and a good service feedback, which will ultimately result in better results for the organization. However, this only occurs when people perceive the employees' display of emotions as genuine and sincere (Sanz-Vergel et al., 2012).

Unfortunately, when engaging in surface acting, employees are faking their emotions and hence, the individuals with whom they are interacting have a higher probability of perceiving those emotions as fake. When they are not convinced, they will react negatively, and that should, in turn, increase employee's strain and decrease their satisfaction and motivation to continue interacting with clients (Brotheridge & Lee, 2002; Groth et al., 2009). On the other hand, deep acting assures a more sincere expression of emotions since it truly changes the employees' inner emotional state (Hülsheger & Schewe, 2011; Sanz-Vergel et al., 2012).

Given that surface acting has been shown to have more detrimental affects on employees' well-being than deep acting (Humphrey et al., 2015) and the fact that nurses use predominantly surface acting when interacting with patients and colleagues (Golfenshtein & Drach-Zahavy, 2015), we will focus our study on surface acting rather than on both emotional labour strategies, or only on deep acting.

In this study, we propose that work-family conflict can affect the employees' use of emotional labour at work. Since WFC is considered to be a very stressful phenomenon that affects both family and work domains it becomes clear that employees have to have strategies

to deal with this phenomenon. We hypothesize that nurses who feel work-family conflict, on a given work day, have higher needs to engage on an emotion regulation strategy.

4.3 Work-Family Conflict and Emotional Labour in Nurses

Over the last few years the majority of researchers have studied the influence that emotional labour at work may have on work-family conflict, namely on strain-based WFC, through the depletion of valuable resources and not considering the reverse relationship (Carlson, Ferguson, Hunter, & Whitten, 2012; Cheung & Tang, 2009; Sanz-Vergel et al., 2012; Seery, Corrigall, & Harpel, 2008; Tavares & Dias, 2014; Wagner et al., 2014; Yanchus et al., 2010). According to these researches, the loss of resources due to the management of emotional dissonance that happens when individuals have to enact emotions they do not feel, or supress emotions they experience will "make the individual ill-equipped to manage the demands of work and family and thus she/he will struggle to keep the two domains from interfering with one another" (Carlson et al., 2012: 851).

In this study, we suggest that the expectation of WFC is associated to higher levels of emotional labour, more specifically of surface acting. For example, we suppose that people with higher levels of WFC would more probably feel the need to supress at work the negative emotions associated with the WFC felt when interacting with colleagues or faking positive emotions. With this, we will extend the literature to understand in what way WFC influences the need for nurses to hide their true emotions in the workplace through surface acting and how that may be amplified by the cognitive job demands of their jobs.

According to the COR theory applied to the work-family conflict interface, WFC can be a taxing process since there are resources lost in the process of juggling both work and family roles. In fact, Tavares and Dias (2014) found that when people experience higher levels of WFC they report lower levels of vigour and vitality. These losses of resources will lead to emotional exhaustion, anxiety, stress and depression (Grandey & Cropanzano, 1999). Thus, we propose that the WFC felt would lead to a need for the individual to self-regulate his/hers emotions at work as a way to be able to comply with the emotional display rules of the organization and to interact with their colleagues supressing their negative emotions associated with the WFC felt.

In regards to the nursing profession, it becomes imperative to test the consequences of WFC in this profession due to the demands placed on nurses. In fact, a study conducted on registered nurses, reported that 50% of nurses had chronic WFC and 41% had occurrences of conflict between the family and work domains (Grzywacz, Frone, Brewer, & Kovner, 2006).

Moreover, Yildirim and Aycan (2008) showed that the majority of times, nurses who feel high levels of work-family conflict are likely to blame their working conditions for it. Associated with this, it is also noted that the more WFC nurses feel the lower their health state, organizational commitment (Benligiray & Sönmez, 2013), job and life satisfaction and overall well-being (Bacharach, Bamberger, & Conley, 1991). The higher the WFC felt the higher their levels of fatigue, depression, burnout, emotional exhaustion, absenteeism and intention to leave the hospital and profession (Bacharach et al., 1991; Burke & Greenglass, 2001; Cortese, Colombo, & Ghislieri, 2010; Unruh et al., 2016; van der Heijden et al., 2008; Yildirim & Aycan, 2008).

Being faced with this type of stress, and ensuring that they preserve their resources while meeting their demands, individuals have several ways to cope with this phenomenon. One of the strategies most used is emotional labour (Brotheridge & Lee, 2002). The more WFC individuals feel, the more ill-being they will have, however, the majority of employees do not have the luxury of feeling "bad" at their workplace. Their job demands require them to demonstrate specific emotions that follow accordingly with their work environment. Faced with this, and similarly to other populations, nurses can react in three distinct ways: they can either express the genuine emotions they are feeling, engage in deep acting or in surface acting (Brotheridge & Lee, 2002).

Golfenshtein and Drach-Zahavy (2015) found in a recent study that nurses adapt the emotion regulation strategy they use according with the patients' behaviours and/or conditions. However, they also suggest that in the vast majority of cases it is surface acting the strategy most used. Nevertheless, this form of emotion regulation is the most detrimental to individuals' health (Hülsheger & Schewe, 2011) and the one that requires more effort, since in order to change the expressed emotion while maintaining the same internal feelings, individuals are required a considerable mental effort that ultimately drains their mental resources (Bechtoldt et al., 2011; Brotheridge & Lee, 2002, 2003; Holman, Martínez-Iñigo, & Totterdell, 2008b; Hülsheger & Schewe, 2011; Mesmer-Magnus et al., 2012). This way, since nurses use surface acting when interacting with patients we most firmly believe that this emotional regulation strategy will also be used when interacting with colleagues, the scope of our study.

In the nursing profession, emotional labour refers mainly to the thoughts and emotions nurses feel and have to hide when interacting with other individuals, and with the support they give them through feelings of care and compassion (Huynh et al., 2008). Over the last years, it was shown that emotional labour in nursing may have positive and negative

consequences. Nurses view emotional labour as a fundamental part of their daily responsibilities, in order to create a caring environment between them and their patients and colleagues and impacting directly in their well-being (Gray & Smith, 2009; Mann & Cowburn, 2005; Phillips, 1996; Smith & Gray, 2000).

Considering the nurses' performance, although it may increase due to the alignment of emotions with what is required by the hospital (Zapf & Holz, 2006), it is important to remember that, in doing so, nurses' mental resources will reduce, leading to a lack of resources for other tasks fundamental in their daily work routines (Hülsheger & Schewe, 2011). Moreover Bakker and Heuven (2006), noted that when nurses' energy and resources are diminished, it will ultimately lead them to have cynical interactions with their patients. Once patients perceive those interactions as cynical, nurses will no longer meet their performance goals and provide patients with a high-quality service (Bakker & Heuven, 2006).

As noted, the vast majority of research of emotional labour on nurses concerns the interactions between nurses and patients (Cheng et al., 2013; Delgado et al., 2017; Golfenshtein & Drach-Zahavy, 2015; Hayward & Tuckey, 2011). However we believe that some of the conclusions taken upon these interactions can be transposed to the interactions between nurses and their co-workers (Grandey et al., 2012; Pugliesi, 1999; Tschanh et al., 2005). As any other employee, nurses also have display rules concerning their interactions with colleagues that they have to comply with. It being an interaction in private or an interaction in front of patients. For instance, nurses should not argue regarding a course of treatment, complaint to a colleague about a patient, or make negative comments in front of a patient. Even if in some interactions the management of emotions may help nurses improve their performance, create a safer environment and improve the perception that the patients have on them (Tschanh et al., 2005; Zapf & Holz, 2006), surface acting negative consequences' will evoke other negative reactions in the organization, such as decrease in organizational commitment, disappointment, anger and disrespect leading to the worsening of the social interactions with patients and colleagues (Hülsheger & Schewe, 2011; Nguyen et al., 2016; Yang & Chang, 2008).

In sum, we expect that higher levels of WFC felt by nurses will be associated with the need to fake their emotions when interacting with their colleagues, enhancing their surface acting use at work as a strategy to suppress the negative emotions originated by the experience of conflict between the work role demands and the family demands. Nevertheless

we expect that this effect would be stronger when nurses also face high levels of cognitive job demands at work.

4.4 The Moderator Role of Cognitive Job Demands

Job demands are referred in the literature as psychological, social, physical and organizational characteristics of a job that entail psychological, cognitive and/or physical efforts associated with specific (Demerouti et al., 2001: 501). These demands may be short term, persistent, or they may be very broad.

According with the DISC model (demands-induced strain compensation model (De Jonge & Dormann, 2003)), job demands may be divided in three different categories. They may have a physical, emotional or cognitive nature. We are going to study the moderator role of cognitive job demands on the impact of WFC on the surface acting used by nurses. We chose to study specifically the cognitive job demands since, we are already indirectly studying the impact of emotional demands through focusing on the impact of WFC on emotional self-regulation display, and since cognitive job demands are a great determinant to nurses' daily responsibilities. Cognitive job demands focus mainly on brain processes that are involved in processing information, making decisions and finding solutions to complex problems (De Jonge & Peeters, 2009). Since nurses are constantly dealing with new, relevant and highly important information concerning their patients their level of cognitive job demands is considerably high.

Nursing is regarded as a stressful occupation since it requires nurses to cope with cognitive, physical and emotional demands (McVicar, 2003). Therefore on a daily basis nurses have high levels of physical, emotional but also cognitive strain (Bakker, Killmer, Siegrist, & Schaufeli, 2000), since they have a high level of interactions with patients, and have to be prepared to act quickly while under great pressure, in emergency situations (Schaubroeck & Jones, 2000).

Job demands only become job stressors when meeting them involves a high effort that individuals are not prepared to take and if they cannot recover their resources during non-working hours (Bakker, van Veldhoven, & Xanthopoulou, 2010; Janssen et al., 2004; Schaufeli, Bakker, & van Rhenen, 2009). Therefore, when job demands increase, individuals must make an additional effort to mobilize their resources from one role to another, in order to maintain high performance levels. This compensatory effort drains individual's energy and does not allow them to relax and recuperate from it (Bakker, Demerouti, & Dollard, 2008). This leads to negative consequences on well-being and physical and mental health, such as

job strain, fatigue, burnout, irritability, absenteeism (Bakker, Demerouti, Taris, Schoufeli, & Schreurs, 2003; Lee & Ashforth, 1996; Schaufeli et al., 2009; Schaufeli & Taris, 2014), insomnia (Åkerstedt, Fredlund, Gillberg, & Jansson, 2002), depression, anxiety, depersonalization, emotional exhaustion, low personal accomplishment, job satisfaction and performance (Bakker et al., 2003; Demerouti et al., 2001; Schaufeli & Taris, 2014). These outcomes are especially worrisome in employees who have jobs with high levels of interaction with other individuals (van Daalen, Willemsen, Sanders, & van Veldhoven, 2009). Employees may recover their lost energy by changing their tasks to less demanding ones or by taking breaks. Nonetheless, when they cannot do that, which is the case in the majority of times, this will result in a continuous exhaustion and depletion of workers mental and/or physical resources.

To cope with the daily demands, individuals spend a lot of effort regulating their behaviour. Trying to hide, this way, the true impact these demands have on them, one of the strategies most used is emotional labour (Holman et al., 2008a).

Concerning emotional labour, job demands also have an important role. First, research shows that job demands are one of the most influential factors on how individuals manage their emotions (Brotheridge & Lee, 2002; Cheng et al., 2013). Specially job demands are considered one of the major antecedents of emotional labour (Gosserand & Diefendorff, 2005; Huynh et al., 2008; Morris & Feldman, 1996).

Taking this into account we may suggest that the more WFC individuals feel, the higher the need they have to hide their true feelings at the workplace, leading to an increase on the use of surface acting. However, the impact of WFC on the need to regulate the emotion display will be higher when nurses feel that their job is too demanding on the cognitive point of view.

As we said before, WFC is a demand in itself, in the sense that it requires some effort from the worker. Namely, the effort to deal with the negative affect it elicits. So, WFC has emotional regulation costs and depletes individuals' energetic resources (Tavares & Dias, 2014). Moreover, Hobfoll (1989) proposed that depletion of resources is stressful in itself. According to the COR theory, when the energetic resources of the individual are threatened (as it can be when cognitive job demands are high), he/she has less capability to deal with new demands, since his/her resources have suffered a depletion. In fact, De Jonge and Dormann (2003: 59) also say that "the higher a particular demands is, the more likely it is that other job demands cannot be compensated or balanced anymore". Therefore, the accumulation of demands, namely of WFC and cognitive job demands will enhance the need

of the individual to regulate the expression of his/hers emotions at the workplace, thus increasing the surface acting. Hence, we hypothesize that nurses' cognitive job demands will enhance the impact of the felt WFC on their surface acting at work.

Hypothesis: Cognitive job demands moderates the impact of work-family conflict on surface acting; such that the impact of work-family conflict on surface acting will be stronger at higher levels of cognitive job demands.

5. Method

5.1 Sample and Procedure

We designed a two-wave study with one week interval, using two different questionnaires focused on the relationship between work-family conflict and emotional labour, and the importance of cognitive job demands as a moderator of this relationship.

The participants of the study were nurses from a large private hospital in Lisbon. In the beginning of the preparation for the data collection, the chosen hospital was contacted via email and was informed about the goals of the study. After a meeting with the head nurse of the hospital and a long period of deliberation, the hospitals' Research Committee and Ethical Committee for Health approved the application of the questionnaires and the respective data collection, during the work schedule of the nurses.

On the first day of the data collection, and after an email explaining the purpose and process of the study was sent to the chief nurses' coordinator, we met with her and with the nurses' managers responsible for every speciality. In this meeting, data regarding the number of nurses in all the specialities and the time of their shift work was collected. In order to have the largest sample possible it was agreed that during the first days of the first week of the study we would deliver the first questionnaire to the nurses, trying, this way, to reduce the risk of lack of participation in the study due to the nurses' shift work. In the last days of the first week, we would proceed to the collections of the questionnaires. The same would occur on the following week with the second questionnaire. At the end of the meeting, five nurses' managers agreed to participate in the study. The speciality areas involved were outpatient surgery and internment services, inpatient medical surgical service, medical surgical service, gynaecology, obstetrics and neonatology service and the palliative care unit.

When delivering the questionnaires among the nurses, we explained once again the purpose of the study and reinforced the fact that the participation would remain completely anonymous and would be voluntary.

At Time 1 (T1) 90 nurses answered the questionnaire measuring sociodemographic variables, the WFC felt that week and the cognitive job demands of their work in that week. When one week later, at Time 2 (T2) we measured the emotional labour experienced, the sample decreased to 65 nurses (response rate = 72%). Due to difficulties in data collection because of the time shifts and the fact that some nurses began their summer vacations in the second week of the study, 25 nurses dropped out of the study at T2. Overall we could only match the responses of 60 nurses, corresponding to 67% of the initial sample. Since this difference was quite significant it was necessary to assure that there were no divergences in the responses given by the nurses who answered only at T1 and the nurses who answered at T1 and T2, regarding the socio-demographic questions and the ones concerning the predictor and moderator variables, WFC and cognitive job demands respectively. Using the one-way analysis of variance method (ANOVA), we observed that there were no significant differences regarding sex, age or tenure and also regarding the variables of interest in this study: WFC and cognitive job demands. Therefore, we analysed the data concerning the 60 nurses that answered in both T1 and T2.

The majority of the sample was composed by women (87%) and around 90% of the participants had less than 34 years, their age ranging from 22 to 53 years old (M = 28.72; SD = 6.14). Forty nine participants had a graduation degree (82%) and 17% of nurses a master's degree. Sixteen nurses (17%) worked in the palliative care unit, 20% worked in the inpatient medical surgical service, 10 nurses (16%) worked in the outpatient surgery and internment services and there was an equal number of nurses (18%) who worked at the medical surgical service and in the gynaecology, obstetrics and neonatology service. The participants worked, on average, around 4 years in the hospital (M = 4.1; SD = 3.3; N = 58), and around 4 years in their current service (M = 3.7; SD = 3.1; N = 58). Approximately 58% of nurses had a permanent contract and 35% had independent contracts.

Ninety three per cent of nurses did shift work, and of those, 71% worked in all of them – morning, afternoon and evening shifts. Only 17 nurses (29%) worked in another hospital. Therefore the majority of the nurses (68%) had a full-time schedule. The majority of nurses (60%) said that they worked 40 hours per week, and 17% of nurses admitted working more than 40 hours per week. Furthermore, figures showed that only 12 nurses (20%) had children (mean number of children = 1.25) and that only 2% of the sample had other dependents at their care. Lastly, the majority of nurses either lived alone (25%), or with their spouse or life partner (25%). There were 11 nurses (18%) that lived with their spouse or life partner and children.

5.2 Measures

Considering that the questionnaires were applied to Portuguese nurses, all measures were translated into Portuguese following the conventional procedure of translation - back translation (Brislin, 1980). In T1 the questionnaire was divided in three parts. The introductory part included a brief explanation of the purpose and background of the study, the confidentiality clause and a short description on the correct method to answer the questionnaire and guarantee the maximum confidentiality, also presented in the questionnaire at T2. On the second part, participants were asked to answer questions regarding WFC and cognitive job demands. In the third part, nurses were asked to provide some socio-demographic and organizational information. In the second questionnaire, participants reported their emotional labour felt in that week. Since the participants were asked to answer two questionnaires within a 1 week interval, in their work hours, the scales used were short. All used scales were previously validated in the literature and demonstrated internal consistency for the sample used.

Emotional Labour. We measured emotional labour using an adapted version of the subscale of Surface Acting, developed from the Emotional Labour Scale by Brotheridge and Lee (2003). This scale was altered in order to assess the levels of surface acting in the previous week from the one when the participants answered the questionnaire: "In the last week… "I resisted expressing my true feelings", "I pretended to have emotions that I did not really have" and "I hid my true feelings about a situation"". A 5-point Likert scale was used, ranging from 1 (*Never*) to 5 (*Always*). The internal consistency of this three items' scale was $\alpha = .88$.

Work-Family Conflict. We assessed WFC adapting the three items of Matthews, Kath, & Barnes-Farrell (2010) Abbreviated Scale for Measuring Work-Family Conflict: "I have to miss family activities due to the amount of time I must spend on work responsibilities", "I am often so emotionally drained when I get home from work that it prevents me from contributing to my family" and "The behaviours I perform that make me effective at work do not help me to be a better parent and spouse". The participants were asked to answer the level of agreement regarding these statements, taking into account the previous week. Items were rated using a 5-item Likert scale, from 1 (*Strongly disagree*) to 5 (*Strongly agree*). The internal consistency of this three items' scale was $\alpha = .74$.

Cognitive Job Demands. In order to measure cognitive job demands, we adapted the specific five items ($\alpha = .84$) of the cognitive job demands subscale of the demands-induced strain compensation questionnaire - DISC Questionnaire 2.1 (De Jonge & Peeters, 2009). The

items were: “I had to make complex decisions at work”, “I needed to display high levels of concentration and precision at work”, “I had to solve work-related problems within a limited time frame”, “I had to remember many things simultaneously” and “I had to do a lot of mentally taxing work”. The scale was adapted in order to measure the degree in which nurses had cognitive job demands, in their workplace, in the previous week from the one when they answered the questionnaire. The items were rated using a 5-item Likert scale, ranging from 1 (*Never*) to 5 (*Always*).

Taking into account the previous information, the higher the scores on the three variables, the higher the levels of emotional labour, work-family conflict and the presence of high cognitive job demands.

Control Variables. Variables such as sex (0 = Male; 1 = Female), age, academic qualifications (1 = Bachelor Degree; 2 = Graduation Degree; 3 = Master’s Degree; 4 = PhD), type of contract (1 = Permanent Contract; 2 = Fixed Term Contract; 3 = Independent Contract), tenure in the hospital and in the current service, and having or not children were included as control variables. It was found that children increase the levels of distress of women (Coverman, 1989), secondly research shows that older workers and women are more capable of managing emotions (Hur, Moon, & Han, 2014; Kruml & Geddes, 2000; Wharton & Erickson, 1993), and third it was also noted by a wide range of authors (Grandey & Cropanzano, 1999; Kinnunen et al., 2004; Posig & Kickul, 2004) that sex affects differently the impact of WFC. As women most of the times are the one with fewer resources and more family responsibilities, according with the conservation of resources theory they will be the ones more affected by WFC (Unruh et al., 2016).

6. Results

The information regarding the correlation, descriptive statistics, inter-correlations and internal consistency of the variables in the empirical model are presented in Table 1. After concluding the preliminary correlation analysis it was possible to observe that none of the control variables, such as, sex, age, type of contract, tenure and children had a significant correlation with emotional labour. Therefore, for reasons of parsimony we did not include them in the regression model.

We conducted a hierarchical regression analysis to test the interaction between WFC and cognitive job demands in the prediction of emotional labour. Following Aiken and West (1991) we centered the predictor (WFC) and moderator variable (cognitive job demands),

before computing the interaction term. Those same centered scores, were the ones included in the regression model. Being so, the hierarchical regression model was conducted by firstly inputting the predictor variable WFC; in step 2, we entered the cognitive job demands variable and, in step 3, we entered the interaction term between work-family conflict and cognitive job demands. The results of this hierarchical regression analysis can be seen in Table 2. Results show that the interaction of WFC and cognitive job demands significantly predicted emotional labour, $\beta = .26$, $p = .045$. The model accounted for 11.3% of the variance in emotional labour levels.

Table 1 – Means, Standard Deviations, Pearson Correlations and Internal Consistencies

Variable	*M*	*SD*	1	2	3	4	5	6	7	8	9	10
1. Emotional Labour	2.41	1.01	(.87***)									
2. WFC	3.56	0.93	.24	(.74***)								
3. CJD	4.12	0.62	.26*	.32*	(.84***)							
4. Sex[a]	0.88	0.33	-.04	.20	-.10	-						
5. Age[b]	29	5.64	-.08	-.12	.26*	-.19	-					
6. Qualifications[c]	2.17	0.41	.03	-.05	-.01	-.16	.21	-				
7. Type of Contract[d]	1.98	1.04	-.11	-.01	-.07	.16	-.31*	-.30*	-			
8. Organization Tenure[b]	4.01	3.18	.17	.14	.24	-.17	.60**	.49**	-.61**	-		
9. Service Tenure[b]	3.72	3.06	.25	.16	.33*	-.23	.56**	.45**	-.55**	.95**	-	
10. Children[e]	0.22	0.41	.02	-.05	.24	-.17	.61**	.05	-.24	.50**	.53**	-

Note. N = 60. WFC = Work-Family Conflict; CJD = Cognitive Job Demands. Higher scores express higher levels of Work-Family Conflict and Emotional Labour and Cognitive Job Demands. Cronbach's Alpha values (internal consistencies) are provided in diagonal and in parentheses.

[a]0 = Male, 1 = Female.

[b]Measured in years.

[c]1 = Bachelor Degree; 2 = Graduation Degree; 3 = Master's Degree; 4 = PhD.

[d]1 = Permanent Contract; 2 = Fixed Term Contract; 3 = Independent Contract.

[e]0 = No; 1 = Yes; N = 59

* $p \leq .05$

** $p \leq .01$

*** $p \leq .001$

Table 2 – Results of Hierarchical Regression Analysis Predicting Emotional Labour

	Step 1	Step 2	Step 3
Main effects			
WFC	.24	.18	.16
CJD		.20	.28*
ΔR^2	.06		
Interaction effect			
WFC x CJD			.26*
ΔR^2		.04	
Total R^2	.06	.10	.16
Adjusted R^2	.04	.06	.11*
F-value	3.57	2.99	3.51*

Note. N = 60. WFC = Work-Family Conflict; CJD = Cognitive Job Demands

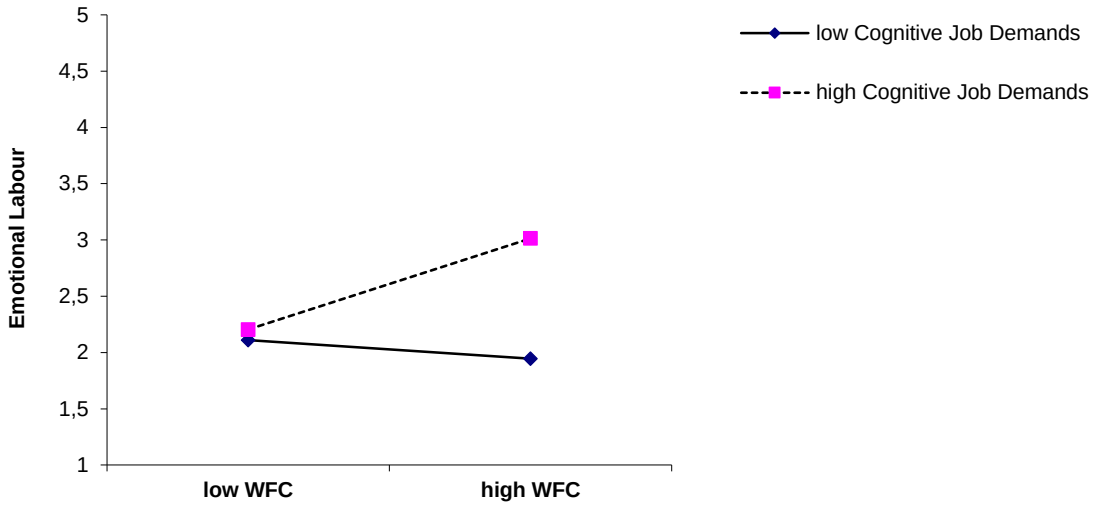
* $p \leq .05$

** $p \leq .01$

*** $p \leq .001$

Following Cohen, Cohen, Aiken and West (2013) we tested the simple slopes, for the participants with lower levels of perceived work-family conflict (one standard deviation below the mean) and for the participants with higher levels of perceived work-family conflict (one standard deviation above the mean) to determine the nature of the interaction between WFC and cognitive job demands. Figure 1 shows the moderating effects of cognitive job demands on the relationship between work-family conflict and emotional labour. In Figure 1 we can observe that the level of WFC employees felt at T1 is only significantly associated with higher levels of emotional labour at T2 when they perceived having higher cognitive job demands (b = .42, t = 2.35, p = .002). For nurses that perceived that their cognitive job demands were not highly demanding, WFC measured at T1 was not significantly related with the levels of emotional labour they felt, measured a week later (b = -.08, t = .44, p = .66).

Figure 1 - Emotional labour levels as function of work-family conflict and cognitive job demands.



Note. Regression lines are drawn at 1 standard deviation above and below the mean of cognitive job demands.

7. Discussion

The present study aimed to analyse the impact of the work-family conflict felt on the emotional labour experiences, one week later by the worker, in the context of hospital nursing. We also focused on the boundary conditions of this effect, namely the possible moderating role of cognitive job demands. In fact, our findings showed that when people feel that their work collides with their family life and their work is highly cognitively demanding, they tend to hide their feelings and to fake their emotions when interacting with their co-workers. Therefore, the degree of cognitive demands felt at their work diminishes nurses' ability to deal with the WFC felt and enhances their need to self-regulate emotions. Individuals that considered that in the previous week they did not have a mentally taxing work, did not feel the need to fake their feelings to their co-workers even when they felt that work was colliding with their family life.

In contrast, individuals who considered that their work in the previous week was highly demanding felt the need to resist expressing their true feelings and emotions to their co-workers when they experienced a conflict between work and family.

Below we will present our specific conclusions and insights, as well as the study's practical implications for healthcare organizations, limitations and proposals for future research.

Most researchers view surface acting as an antecedent of work-family conflict (Seery et al., 2008; Wagner et al., 2014; Yanchus et al., 2010). However, our findings extend the literature showing that the WFC felt in one week is positively associated with an increase in the surface acting at work in the following week if the individual had a cognitively taxing work. Therefore, our results indicate that work-family conflict may not only be a consequence of surface acting but also a predictor of this phenomenon. In other words, and highlighting the singularity of our study, the results showed that nurses who have high levels of work-family conflict have a propensity to use surface acting more often with their co-workers as a coping mechanism. However, in our model, this relationship is only true if nurses also perceive having high cognitive job demands.

These results are in accordance with the conservation of resources theory which suggests that individuals have a considerable large pool of resources, but when there is a potential or real loss of these resources individuals will feel anxiety and stress (Hobfoll, 1989). Nurses who have higher levels of work-family conflict have more difficulties in retaining all their resources and in finding new ones to replace the ones they lost. This resource loss spiral will, without doubts, lead to considerable negative outcomes in their well-being (Grant-Vallone & Donaldson, 2001), such as depression, anxiety and burnout (Bakker et al., 2003; Schaufeli & Taris, 2014).

Our study goes beyond previous research by showing that cognitive job demands do have a moderator influence in the relationship between WFC and emotional labour.

The majority of studies show an existent relationship between emotional demands and emotional labour, in the sense that the more emotional demands and rules individuals have to comply with, the higher their need to hide their emotions (Bolton, 2000). Nonetheless, our results also showed that cognitive job demands have an important influence on emotional labour. As opposed with emotional demands, the relationship between cognitive job demands and surface acting does not concern the demands themselves but the negative outcomes of those same demands.

Taking this into account it becomes even clearer the role that cognitive job demands have as a moderator between WFC and emotional labour. If nurses cannot balance their work and family demands properly they will feel stressed (Amstad et al., 2011) in the workplace. According with the conservation of resources theory, WFC

depletes nurses resources, but if we add to this the high cognitive job demands nurses have on a daily basis, their social, mental, physical and emotional resources will be even more depleted (Hobfoll, 1989). Consequently individuals need a coping mechanism in order to hide those negative feelings and conserve their remaining resources. As evidenced by our results, nurses choose surface acting as a possible mechanism.

According to Humphrey et al. (2008), nurses are included in one of the job categories where emotional labour occurs more frequently – the caring professionals. However, the majority of studies and concerns regarding surface acting in this population focused on the relationship between nurses and patients (Golfenshtein & Drach-Zahavy, 2015; Hayward & Tuckey, 2011; Schmidt & Diestel, 2014). In our study we provide a new understanding of surface acting in the nursing profession by, instead, considering the relationship between nurses and their colleagues. In fact, with the notable exception of Grandey et al. (2012) and Pugliesi (1999), for the best of our knowledge this is one of the first studies that focuses on surface acting towards co-workers, in the nursing context.

With our results, we were able to show that, in fact nurses do engage in surface acting when interacting with their co-workers, extending, this way the results found in the interactions between nurses and patients (Golfenshtein & Drach-Zahavy, 2015; Hayward & Tuckey, 2011; Schmidt & Diestel, 2014). Nurses will try at all costs to retain the resources they have left, so when interacting with co-workers they will continue to use surface acting, since they believe that expressing their genuine emotions will further diminish their resources.

7.1 Limitations and Future Research

Despite the contributions of this study, the present work has some limitations that should be addressed in future research. The first limitation is related with the fact that all collected data was self-reported and hence we may not exclude the existence of common-method variance bias. Nonetheless, we collected the data at different times with one week interval (two-wave study) and guaranteed to the participants that the questionnaires were completely anonymous strongly recommending them to answer as truthfully as possible. All these efforts have an important influence in reducing the common-method bias (Podsakoff, MacKenzie, Lee, & Podsakoff, 2003). Moreover, the presence of interaction effects rules out possible method bias (Podsakoff, Mackenzie, & Podsakoff, 2012) since, in fact, the interaction effects can be deflated (rather than

inflated) through the existence of common method variance (Siemsen, Roth, & Oliveira, 2010). Thus, we can suppose that possible common method variance does not pose a serious threat to the validity of our conclusions. Even so, future research using a multisource design would be preferable (e.g. with WFC reported by family members).

Second, and perhaps the most worrying possible limitation, refers to the size of our sample. For several reasons, previously stated in the method section, our sample was smaller than what would be expected and therefore our findings should be replicated in larger samples of nurses. Furthermore, the sample was largely represented by women, and although the nursing profession continues to be highly represented by women (Unruh et al., 2016) and we were not able to find a correlation between the studied variables and the sex of nurses, it would be beneficial to have a more diverse sample.

Thirdly, although our study is a two-wave design, with emotional labour measured one week after assessing WFC and cognitive job demands it is not possible to clearly argue for causality between these variables.

Since previous literature has argued for an impact of emotional labour on WFC, future research would benefit from testing the here hypothesized model within a longitudinal design, identifying possible recursive effects and reinforcing loops between WFC and surface acting.

Following the suggestion of Wagner et al. (2014) we also believe that future research should extend the field of who is affected by surface acting on a given day. In other words, since we could establish a relationship between work-family conflict and emotional labour it would be interesting to view if the family members (e.g. spouse and children) are also affected by the surface acting performed in the workplace.

Contrastingly, it would also be interesting to assess more closely what are the positive and negative impacts of confiding family problems to colleagues in the workplace (Judge, Ilies, & Scott, 2006).

As noted throughout this study emotional labour is a highly complex issue. Therefore we commend for future research to take into account other possible moderators and mediators' constructs that may influence or help to explain the relationship between work-family conflict and emotional labour. We believe that it would be interesting to investigate the role of other type of demands on the relationship between these variables. Moreover, we consider it would be interesting to further clarify the role of organizational settings, work experience (Hur et al., 2014) and nurses'

personal characteristics in the choice of the emotional labour strategies and in the extent of its negative effects. More specifically, nurses with different personalities may react and cope differently in different situations, which in turn may also cause the negative effects of emotional labour to differ (Holman et al., 2008b).

Finally, future research could also explore if different cultures in different countries would influence the emotional regulation strategies nurses' use, and what measures healthcare organizations are using to reduce their negative impacts.

7.2 Practical Implications

Our results may have important practical implications. Our findings suggest that nurses' levels of WFC influences the surface acting they display in the next week at work, but this is only the case when they feel that in the present week their work was very demanding on the cognitive point of view. Being so, hospitals and other healthcare organizations should be interested in creating a healthier environment for their employees, in order to improve nurses' work-life balance and try to reduce the negative impacts cognitive job demands may have on their emotional regulation. Moreover, in doing so, organizations are not only helping reduce the negative impact on employees' well-being but also on their performance and in other work-related issues. Thus hospitals' supervisors may implement measures in two distinct areas: family-friendly environment and cognitive job resources.

Beginning with the strategies that could reduce the WFC felt, hospitals could use strategies such as flexible work arrangements (Byron, 2005; Duxbury et al., 1994), concierge services and coupons for child care (Cortese et al., 2010; Posig & Kickul, 2004), child care facilities, better work hours arrangements (Simon et al., 2004) and programs to help nurses improve their skills when managing family and job demands, for instance, training in time management (Nohe, Michel, & Sonntag, 2014; van der Heijden et al., 2008) or in coping strategies to better manage work and family conflicts (Byron, 2005). However, it is important to refer that the most effective strategy is a work-family friendly culture (Allen, 2001). Healthcare organizations could implement all the previously referred strategies, but if nurses perceive the hospital's culture as one that does not value or give importance to personal and family time, nurses will still have high levels of WFC. Good results may be accomplished if organizations implement supportive policies and if supervisors and managers lead by example, by being the firsts to follow those guidelines and by changing their attitudes towards them. In other words,

if nurses see that their supervisors believe in a family-friendly environment they will feel more compelled to do the same (Allen, 2001; Kossek, Pichler, Bodner, & Hammer, 2011; Posig & Kickul, 2004). Moreover, managers should support nurses with work-family related problems and inform them regarding the supportive organizational rules (Posig & Kickul, 2004; Yanchus et al., 2010).

In regards to cognitive job demands, it is important for hospital to evaluate correctly and monitor the cognitive job demands nurses have on a daily basis. This diagnosis should always take into account the nurses' own opinion and if there is a clear evidence that nurses have an excessive amount of cognitive job demands, measures to rearrange their work conditions (job redesign) and to give them more support should be taken (Schaufeli et al., 2009; van der Heijden et al., 2008; Yildirim & Aycan, 2008). Moreover, according to DISC model proposition of match making between the types of job demands with the specific job resources as a way to reduce the job demands on workers' stress levels (Daniels & De Jonge, 2010), healthcare organizations should increase nurses' cognitive job resources to buffer the effect of cognitive job demands. These could be resources that would diminish nurses' cognitive efforts and that would help them preserve their capacity to process complex information in an effective way and maintain their attention focused. One way of assuring this could be incentivising a culture of information sharing between co-workers and supervisors regarding decision-making. Moreover, literature on mindfulness shows that mindfulness interventions and training enhances concentration and workers ability to pay attention and get focused at work (Lomas, Medina, Ivtzan, Rupprecht, & Eiroa-Orosa, 2017).

Moreover, healthcare organizations should encourage their nurses to use deep acting instead of surface acting. In order to accomplish this, supervisors should firstly identify which nurses have the propensity in engaging in surface acting and should discuss with them what leads them to do so (Hülsheger & Schewe, 2011). After clearly identifying the root of the problem, healthcare institutions may facilitate transformational leadership programmes for nurses' managers in order to improve their emotional support skills, raise social consciousness and compassion, and teach them how to provide a constructive feedback (Bakker et al., 2000; Bartram et al., 2012; Chou et al., 2012; Gray & Smith, 2009; Hayward & Tuckey, 2011; Smith, Pearson, & Ross, 2009). They could also train and coach nurses in deep acting techniques understanding simultaneously the negative implications of surface acting (Grandey, 2003; Schmidt & Diestel, 2014; Yanchus et al., 2010), training in self-control and resources enhancement

(Schmidt & Diestel, 2014) communication, empathy, resources enhancement, stress management, self-awareness and interpersonal skills in order to teach them healthier emotional regulation strategies, to increase their job satisfaction and confidence when managing emotions and reduce their emotional exhaustion (Bakker & Heuven, 2006; Chou et al., 2012; Diefendorff, Erickson, Grandey, & Dahling, 2011; Huynh et al., 2008; Mann, 2005; Mann & Cowburn, 2005; Nguyen et al., 2016; Smith & Gray, 2001).

Although deep acting would be the clearest choice when it comes to emotional regulation strategies, healthcare institutions should also create a safe and flexible environment for nurses, reinforcing that sometimes it is not harmful for them to simply express their genuine emotions to colleagues, supervisors and patients, during their work day (Ashforth & Humphrey, 1993; Bakker & Heuven, 2006; Côté, 2005; Hülsheger & Schewe, 2011; Kruml & Geddes, 2000; Smith & Gray, 2000).

Accordingly, supervisors should always be ready to listen nurses concerns, support them and give them advise (Smith et al., 2009). Extending this suggestion, by reducing the constraints of the emotional labour environments, nurses job demands will be reduced and their resources would increase, which ultimately could have a more extended and lasting effect on nurses well-being (Holman et al., 2008b). On a more personal level nurses can also improve their emotional expressions by observing and seeking feedback from their more experienced colleagues (Nguyen et al., 2016).

The previously mentioned measure of changing the organizational culture may also be applied in order to reduce the negative outcomes of surface acting. Specifically, managers should support team work, and create a safe, authentic and shared environment where nurses may interact with each other, discuss the emotional interactions they have to face, support without blaming each other and even vent their anger and frustration. This, in turn, will allow the creation of a positive role environment, it will promote nurses to reflect on their practices and it will reduce their levels of burnout (Cheng et al., 2013; Chou et al., 2012; Grandey et al., 2012; Henderson, 2001; Smith & Gray, 2000; Smith et al., 2009). This type of environment where nurses may reflect and discuss the best emotional way to act in a specific situation, would be especially beneficial for nurses who just entered the job market (Brotheridge & Lee, 2002; Cheng et al., 2013; Diefendorff et al., 2011; Erickson & Grove, 2008). Furthermore, and although we previously discussed that managers have a critical role in teaching the display rules to nurses, it is only at an initial level, since as soon as nurses perceive having a safe and shared environment those rules will be

implicit and they will rely more on observation of their co-workers, freeing, this way, the managers to meet other demands (Diefendorff et al., 2011).

If measures are not taken and healthcare institutions do not create a safe environment where nurses could discuss, between themselves and with their supervisors, the challenges they face on a daily basis and confide their work and family frustrations, the negative outcomes will increase substantially. In fact, if nurses start using surface acting too regularly they may simply stop sharing information with their colleagues (Côté, 2005; Kahn, 1990), creating a hostile environment that can have important consequences to patients' safety (Leonard, Graham, & Bonacum, 2004).

There is clear evidence that the job demands, emotional labour and work-family conflict of nurses is increasing (Aiken et al., 2001). We believe that these strategies will reduce its negative impacts and, therefore, benefit both nurses and organizations.

8. Conclusion

Although emotional labour is a highly researched topic in healthcare organizations and especially in nurses (Hunter & Smith, 2007; Mann, 2005), little research has been done considering work-family conflict as a predictor of emotional labour, and with cognitive job demands as a moderator of this relationship.

Our work extends thus the literature, by showing that surface acting can be a coping mechanism nurses use to deal with WFC and cognitive job demands and still be professional when interacting with their colleagues. Taken together, our findings show that when nurses feel that their work is cognitively taxing, they fake their emotions as a way to suppress the negative affect generated by feeling that their work collides with their family role. This research illustrates the detrimental effect that the accumulation of stressors can have for the individuals' well-being, namely for their need to be less authentic in the expression of their affect in the work setting.

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