

The Source of Display Rules and their Effects on Primary Health Care Professionals' Well-Being

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Employees' perceptions of the emotional requirements of their work role are considered a necessary antecedent of emotion work. The impact of these requirements on the emotions employees display, their well-being, and their clients' satisfaction has been explored in previous research. Emotional requirements have been characterized as organizationally-based expectations (e.g., Brotheridge & Lee, 2003), formal and informal organizational rules (e.g., Cropanzano, Weiss & Elias, 2004), occupational norms (e.g., Rafaeli & Sutton, 1987; Smith & Kleinman, 1989) and job-based demands (Brotheridge & Lee, 2002). Although all these definitions assume some kind of shared source for perceptions of emotional requirements, it remains unclear to what extent these different sources contribute and to what extent the requirements are shared by different units, teams and individuals in the organization. The present study analyses the perception of emotional requirements from a survey of ninety-seven Primary Health Care teams composed of general practitioners, nurses and administrative staff (N = 1057). The relative contribution of different sources of variance (team, organizational, and occupational) to perceived emotional requirements and the effects on employees' job satisfaction and well being are examined. Results confirm the relevance of the source and show the contribution of emotional demands to prediction of emotional exhaustion and job satisfaction levels.

Keywords: display rules, emotional labor, primary care, emotional exhaustion, burnout, job satisfaction.

La percepción de demandas emocionales asociadas al rol laboral es una condición necesaria para que tenga lugar el trabajo emocional. La investigación precedente ha explorado el impacto que este tipo de demandas sobre la expresión emocional de los empleados tiene sobre su bienestar y sobre la satisfacción de los clientes. Las demandas emocionales han sido caracterizadas como expectativas organizacionales (p.ej., Brotheridge & Lee, 2003), reglas organizacionales informales y formales (p.ej., Cropanzano, Weiss & Elias, 2004), normas propias de una profesión u ocupación (p.ej., Rafaeli & Sutton, 1987; Smith & Kleinman, 1989) y como demandas ligadas al puesto (Brotheridge & Lee, 2002). A pesar de que todas estas definiciones asumen que la percepción que un empleado tiene de las demandas emocionales no es única, sino compartida como consecuencia de un origen común (la organización, el grupo profesional o el puesto), todavía no ha sido explorado en qué medida cada una de las fuentes propuestas contribuyen a crear esas demandas ni hasta qué punto la percepción de las mismas es compartida por las diferentes unidades, equipos e individuos que integran una organización. El estudio analiza la percepción de demandas emocionales en una muestra de noventa y siete Centros de Salud en Atención Primaria compuestos por Médicos de Familia, Diplomados Universitarios en Enfermería y Auxiliares Administrativos (N=1057). Los análisis realizados determinan la contribución relativa de las diferentes fuentes de variación (equipo, ocupación y organización) a la percepción de demandas emocionales y la asociación de dicha percepción con los niveles de satisfacción y bienestar laboral. Los resultados confirman la relevancia de las fuentes propuestas y la contribución significativa de las demandas emocionales a la predicción del agotamiento emocional y la satisfacción laboral.

Palabras clave: reglas de expresión, trabajo emocional, atención primaria, agotamiento emocional, satisfacción laboral.

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The demand for emotion regulation associated with the performance of a work role is a characteristic that affects an increasing number of jobs. According to a survey performed by the European Foundation for the Improvement of Living and Working Conditions (2007), one third of European employees consider their job to be emotionally demanding either “frequently” or “very frequently”.

The presence of such demands is reflected in the development of norms for emotional expression or *display rules*, which prescribe what emotions must be expressed at work and how (Diefendorff & Gosserand, 2003). These emotional rules are important both for job well-being at work and for organizational outcomes that depend on the quality of the service provided and customer or user satisfaction.

In the case of job well-being, exposure to emotional demands has been included among the ten most important emerging psycho-social risks by the European Agency for Safety and Health at Work (2007). Meanwhile, empirical research confirms the existence of a significant relationship between the presence of emotional demands and well-being at work (Brotheridge & Grandey, 2002; Brotheridge & Lee, 2002; Diefendorff & Richard, 2003; Diefendorff, Richard & Croyle, 2006; Grandey, 2003; Holman, Chissick, & Totterdell, 2002; Côté & Morgan, 2002; Schaubroeck, & Jones, 2000; Zapf & Holz, 2006). Empirical evidence also exists for a connection between compliance with emotional display rules and customer attitudes (e.g. satisfaction and loyalty) and customer behaviors (e.g. length-of-stay in an establishment or purchase of a service) (Barger & Grandey, 2007; Cropanzano, Weiss, & Elias, 2004; Grandey, Fisk, Mattila, Jansen, & Sideman, 2005, Hochschild, 1983; Pugh, 2001; Rafaeli & Sutton, 1991; Taylor, 1998; Tsai, 2001; van Dolen, de Ruyter, & Lemmink, 2004).

This study has three purposes. First place, the study describes the different kinds of emotional demands perceived by primary health care professionals. Second, the study includes an analysis of how group, organizational and occupational sources explain the type of emotional display rule used and the intensity of perceived emotional demands. Third, the study examines the predictive power of such emotional display rules with regard to job satisfaction and well-being.

Types of display rules

The type of display rules perceived by an employee and their intensity depend on the specific content of the employment role and the characteristics of the organization in which that role is performed. Thus, the emotional displays we might expect from a waiter or hotel receptionist (Grandey, Fisk, Mattila, Jansen & Sideman, 2005) are not the same as those expected from a debt collector (Sutton, 1991). In a recent study, Diefendorff and Greguras (2006) show that emotional display rules vary depending on the

specific emotion to which they refer and the target of interactions, which suggests that display rules are in fact much more complex than had hitherto been believed.

The majority of studies have focused on a small number of display rules (Diefendorff & Greguras, 2006). Specifically, earlier research looked mainly at “service with a smile”, a pattern of rules and demands defined by the expression of positive and the suppression of negative emotions (Grandey, et al., 2005). This pattern is proper to a wide range of commercial services defined by short, one-off interactions, but it falls short when applied in other areas. For example, in the provision of social services, where interactions are longer and more drawn out over time, it would seem reasonable for display rules to embrace rather more than mere “service with a smile”. This would also be the case in managing the behavior of a ‘hyper-user’ at a primary health care center, a task that would require display and control over a combination of positive, neutral and negative emotions (Strous, Ulman, & Kotler, 2006).

Holman, Martinez-Íñigo and Totterdell (2008) have recently proposed an exhaustive classification of the emotional demands associated with different job roles. Since these demands form part of the expectations associated with the role (Diefendorff et al., 2006), their definition is in large part a matter for the organization or occupational group in which the role occurs. Hence, various scholars have defined them as display rules (Ashforth & Humphrey, 1993) or feeling rules (Schaubroeck & Jones, 2000).

This differentiation between “display rules” and “feeling rules” defines the first dimension in the classification of emotional demands, identifying the emotional component to which the rule refers (Ekman, 1973). Thus, “display rules” refer to the emotions the employee should *express* but do not allude to his or her feelings (e.g. a supermarket cashier is expected to smile at customers but not to be glad to see them). “Feeling rules” in contrast prescribe the internal experience of the individual with a view to ensuring the quality of the emotional display presented to the customer.

The second dimension in the classification distinguishes between expansive and restrictive display rules. The former require the intensification of the emotional component displayed. For example, it helps to intensify positive reactions to any progress made by the patient in rehabilitation processes, however small. Restrictive rules, meanwhile, demand the moderation or suppression of an emotion, such as the restraint of emotional involvement with the members of a deceased patient’s family (Parkinson, Fischer & Manstead, 2005).

Finally, the type of emotion (positive, negative or neutral) that the rule refers to defines the third dimension of the classification (Diefendorff & Gosserand, 2003; Brotheridge & Grandey, 2002; Schaubroeck & Jones, 2000; Zapf & Holz, 2006; Zapf, Vogt, Seifert, Mertini, & Isic, 1999). Some scholars have added a fourth dimension to these three, distinguishing between rules that focus on the subjects own

emotions (e.g. the restraint of anger directed towards customers) and those that refer to customers' or users' emotions (e.g. containing the anger of an aggressive patient) (Zapf et al., 1999).

The classification of display rules above and beyond "service with a smile" is important from the standpoint of intervention. Basic research and applied studies in work contexts show that different demands have differential effects on the well-being and health of individuals. For example, the suppression of emotions can have negative impact health outcomes, while the expression of positive emotions is positively correlated with well-being (Gross & Levenson, 1997; Richards & Gross, 1999). The identification of other emotional display rules in the work context and the manner in which they may be associated with different levels of employee well-being will advance our knowledge of demands of this kind and their consequences for employees, especially in studies that focus on the expression of emotions in different contexts from those considered in the existing research, as in the case of primary health care services.

This study looks at public health contexts, where the objectives of interaction are not commercial, interactions are more complex, assistance is provided in a professional and technical role, and an important part of interactions are related with suffering and illness. In this scenario, it would seem reasonable to suppose that the principles of "service with a smile" may be insufficient or ineffective and, therefore, a greater diversity of emotional rules may be expected. Studies performed on a range of health professionals support this hypothesis, reflecting greater diversity and complexity and including the expression of neutral emotions and the ability to empathize with the patient (Denison & Sutton, 1990; Locke, 1996; Staden, 1998; Smith & Kleiman, 1989). The majority of these studies are based on qualitative methodologies and data referring exclusively to one or other of the groups of professionals working in different health contexts. This study examines the perception of display rules affecting three occupational groups forming part of primary care teams (PCT), namely general practitioners, nursing staff and clerical staff. Given the characteristics of this type of service context and the findings of existing research, it is expected that the participants will perceive display rules related with the expression and suppression of different kinds of emotions either by the professionals themselves or by the patient, as well as the traditional "service with a smile" kind. However, the provision of health services involves working with people in situations where they require help, and it is therefore to be expected that the expression of positive emotions and the suppression of negative feelings, as well as the demand for sympathy, will predominate in the display rules perceived (Brotheridge and Grandey, 2002). Finally, we expect the expression of neutral emotions to be perceived as a characteristic requirement for patient care, in line with earlier

studies (Smith & Kleinman, 1989). As mentioned above, affective neutrality may be a sign of professionalism. However, an excess of neutrality could suggest to the organization a lack of involvement or commitment and to the patient a lack of interest in his/her situation. Given the need to combine both professionalism and involvement, it is expected that the display of neutral emotions will occur at medium levels between the dominant display requirements and those that are assumed to be less important. Based on the above, it is expected that the perception of display rules in primary health care will be characterized by the following:

Hypothesis 1: The display rules perceived by PCT professionals will include the expression and suppression of positive, negative and neutral emotions, and sympathy with patients.

Hypothesis 2: The perception of emotional rules concerning sympathy, the expression of positive emotions and the suppression of negative emotions will be significantly greater than the other rules perceived by PCT professionals.

Hypothesis 3: The perception of display rules concerning neutral emotions will be significantly less than the perception of the characteristic rules for caring professionals (sympathy, expression of positive emotions and suppression of negative emotions), and it will be significantly greater than the perception of marginal or atypical rules (expression of negative emotions, suppression of positive emotions and suppression of neutral emotions).

Sources of variation in display rules

The study of rules governing the emotions in organizations represents an extension of research in other disciplines like sociology, anthropology and social psychology in which the emotions are defined as psychological mechanisms or processes related with the development and upkeep of a culture, the symbolization of status and power, and the regulation of social exchanges (Armon-Jones, 1986; Ekman, 1982; Harré, 1986; Lawler & Thye, 1999; Parkinson et al., 2005). In the case of the rules found in organizations, the interest of previous research focuses more on outcomes than the origin or sources of change.

The consequences of display rules for the well-being of the individual are conditioned by their specific characteristics in terms of intensity and valence. Consequently, it seems relevant to determine the factors related with changes in the perception of different kinds of rules. For example, it would be interesting from the standpoint of workplace hazard prevention to determine the factors associated with the perception of rules requiring the suppression of emotions (which are negatively associated with employee well-being). Likewise, a deeper understanding of the factors that predict perceptions of positive emotional display rules (which are positively associated with job satisfaction) would be of value for job design purposes.

However, there is scant empirical evidence concerning the origin of display rules and the perception of emotional demands. Even so, a number of scholars have speculated on the sources of change affecting these rules. To begin with the more general case, Stearns (1988) identifies the emergence of new forms of production and the need for new forms of work behavior control as being among the factors that create current emotional standards. In a similar vein, Rafaeli and Sutton (1989) argue that social norms “determine the content, intensity and significance of the emotions transmitted in the life of organizations” (p. 8).

At the organizational level, a number of authors have argued that the rules governing the expression of emotions at work form an important part of an organization’s culture (Rafaeli & Worline, 2001; van Manen & Kunda, 1989). Thus, it is organizations that develop patterns for the emotions and their expression in order to influence the behavior of their members and promote the attainment of their objectives (e.g. maintaining status, effectiveness, etc.). In this regard, the present study is intended to confirm, on an exploratory basis, the presence of significant differences in the display rules perceived by primary health care professionals depending on the area to which they belong.

In addition to historical, social and organizational factors, some studies have identified specific emotional rules applicable to certain groups of professionals (Harris, 2002; Smith & Kleiman, 1989; Yanay & Shahar, 1998). Thus, the rules followed by nursing staff reflect certain specific features (e.g. the need to show sympathy and affection to patients) compared to those pertaining to physicians. These differences seem to take shape as a greater expectation of sympathy and the expression of affection towards the patient in the case of nursing staff, in contrast with the weaker emotional involvement and greater affective “neutrality” displayed by doctors (Dennison & Sutton, 1990; Smith & Gray, 2001; Smith & Kleiman, 1989). From a gender standpoint, some scholars have theorized that the origin of these differences was due to the construction of the nursing identity as a “female” profession. Consequently, it is expected that nursing care for the sick will be more affective than technical (Thoits, 1989). Similarly, the professional identity of the doctor is held to be based on masculine values like affective neutrality (Halpern, 2001).

As mentioned above, scholars have theorized about the role of the emotions in maintaining status and role systems from a sociological perspective. In this regard, our study was expected to reveal differences in the perception of rules associated with differences in power between groups of professionals. Existing research has already identified these factors as a source of change in emotional display rules in organizational contexts. Thus, lower-status people perceive a stronger demand to control their emotions, especially negative feelings, while higher-status individuals perceive a weaker requirement to suppress negative emotions (Gibson & Schroeder, 2002; Hecth & LaFrance, 1998; Lively, 2000;

Morris & Feldman, 1997; Yanay & Shahar, 1998). The lowest status members of Primary Health Care Teams are clerical staff and, therefore, higher levels of emotional suppression are expected among these workers.

Finally, work groups and teams have been proposed as a source of change in an organization’s emotional rules, as is the case with the development of other rules and compliance (Cropanzano, Weiss, & Elias, 2004). Once again on an exploratory basis, the study looks for the presence of significant differences in the emotional display rules perceived by participants in view of the teams in which they work.

In light of the above, the following hypotheses are proposed in relation with variations in the emotional display rules perceived by Primary Care Teams:

Hypothesis 4: The levels of perceived display rules will vary significantly in line with the organizational context in which the health professionals perform their functions.

Hypothesis 5a: The perception of display rules requiring the expression of neutral emotions will be significantly greater among the group of general practitioners than among the other occupations.

Hypothesis 5b: The perception of display rules requiring the suppression of neutral emotions will be significantly greater among the nursing staff group than among the other occupations.

Hypothesis 5c: The perception of display rules requiring the expression of positive emotions and sympathy will be greater among the nursing staff group than among the other occupations.

Hypothesis 5d: The perception of display rules requiring the suppression of negative emotions will be greater among clerical staff than in the general practitioners group.

Hypothesis 6: There will be significant differences in the perception of emotional display rules depending on the work team of which each employee is a member.

Emotional rules and employee well-being

From its inception, research into emotional display rules has focused on the effects that compliance with those norms has on employees’ well-being (Hochschild, 1983). This research has also largely concentrated on compliance with “service with a smile” rules. Findings confirm the presence of a significant correlation between the perception of display rules and the levels of stress experienced by the individual. The majority of studies ground the relationship between display rules and employee well-being on demand-control models of job stress, or on theories of emotion regulation and self-regulation processes. In the demand-control model, emotional rules represent a requirement that is associated with the job role that, to the extent that demands exceed the resources available to the individual or prevent recovery, may create a source of strain that can result in negative outcomes for well-being at work (Brotheridge & Lee, 2002;

Heuven & Bakker, 2003). Turning to the emotion regulation approach, Grandey (2000) proposes applying the regulation strategies model devised by Gross (1998) to the analysis of emotional labor. Subsequent studies have shown that regulation of the emotions in line with the strategies described by Gross (1998) consumes the individual's limited emotional regulation resources, leading to emotional exhaustion (Baumeister, Bratslavsky, Muraven, & Tice, 1998), and this phenomenon can be applied to work contexts (Totterdell & Holman, 2003; Martínez-Iñigo, Totterdell, Alcover & Holman, 2007).

The direction of the correlation with employee well-being is also determined by the content of rules. Thus, existing research has found a positive relationship with job satisfaction and emotional exhaustion in the case of display rules requiring the expression of positive emotions (Adelmann, 1995; Brotheridge & Grandey, 2002; Brotheridge & Lee, 2003; Côté & Morgan, 2002; Diefendorff & Richard, 2003; Zapf et al., 1999). Although the relationship with emotional burnout was not significant in some of this research, we expect in this study to find the same pattern of correlations between the perception of rules requiring the expression of positive emotions and emotional exhaustion and job satisfaction. In contrast, strain levels rise when people perceive rules demanding the suppression of negative emotions (Brotheridge & Grandey, 2002; Brotheridge & Lee, 2003; Côté & Morgan, 2002; Diefendorff & Richard, 2003; Zapf & Holz, 2006; Zapf et al., 1999). In this study, therefore, we expect to find a positive correlation between rules of this kind and emotional exhaustion, and a negative correlation with job satisfaction dimensions.

Recent studies dealing with the expression of negative and neutral emotions and the suppression of positive feelings suggest that the feedback from the receiver of the display mediates the effect of emotion regulation on employee well-being (Côté, 2005; Martínez-Iñigo et al., 2007). Thus, positive feedback from a customer or a patient would help the recovery of the emotional resources expended to comply with display rules and would become a factor in well-being and satisfaction. Existing studies have shown that the expression of positive emotions and the suppression of negative feelings give rise to feedback of this kind (Pugh, 2001; Tsai, 2001) and this suggests that rules which inhibit this pattern will result in weaker positive, or even negative, feedback. In this light, the expression of negative and neutral emotions and the suppression of positive emotions are expected to correlate positively with emotional exhaustion and negatively with satisfaction.

Hypothesis 7a: The perception of display rules requiring the expression of positive emotions and sympathy will be significantly and negatively correlated with the level of emotional exhaustion.

Hypothesis 7b: The perception of display rules requiring the expression of positive emotions and sympathy will be

significantly and positively correlated with the level of satisfaction with patients and intrinsic satisfaction.

Hypothesis 8a: The perception of display rules requiring the suppression of negative emotions will be significantly and positively correlated with the level of emotional exhaustion.

Hypothesis 8b: The perception of display rules requiring the suppression of negative emotions will be significantly and negatively correlated with the level of satisfaction with patients and intrinsic satisfaction.

Hypothesis 9a: The perception of display rules requiring the expression of negative and neutral emotions and the suppression of positive emotions will be significantly and positively correlated with the level of emotional exhaustion.

Hypothesis 9b: The perception of display rules requiring the expression of negative and neutral emotions and the suppression of positive emotions will be significantly and negatively correlated with the level of satisfaction with patients and intrinsic satisfaction.

The literature describes the existence of negative relationships between the suppression of negative emotions and psychological well-being, but no studies exist with regard to the suppression of neutral emotions. Consequently, no hypothesis is proposed for this case.

Finally, it is expected that the different demands of display rules will contribute significantly to the prediction of emotional burnout and job satisfaction in line with the correlations defined in the above hypotheses.

Hypothesis 10a: The perception of emotional display rules associated with the job role will contribute significantly to prediction of the level of emotional burnout.

Hypothesis 10b: The perception of emotional display rules associated with the job role will contribute significantly to prediction of the level of satisfaction with patients and intrinsic satisfaction.

Method

Sample

A total of 1,057 professionals forming part of 97 primary health care teams took part in the study. Participation was voluntary, and the participation rate was 54.2% of the population of professionals working in the organizations included in the study. Participation was 53.9% among the group of doctors (GPs), 56.6% among qualified Nursing Staff (Nurses) and 49.2% among Clerical Staff (Clerks). The study included a total of 97 Primary Care Teams. The percentage of participants forming the teams was above 60% in all cases, and all teams included members of each of the three professional groups referred to above. The sample comprised 48.1% morning shift workers and 51.9% afternoon shift workers. Doctors represented 44.6% of the

participants, 38.6% were qualified Nursing Staff and 16.8% were members of the Clerical Staff group. Male participants represented 23% of the sample. The average age was 40.41 years ($Sd= 8.12$) with average experience of 15.15 years ($Sd= 8.15$). The number of participants per team ranged from 4 to 23, and the minimum percentage of members per team was 75%, representing the three occupational groups on each one (GPs, Nurses and Clerks).

Procedure

The data was gathered over a period of three months. In order to ensure that the results would not reflect one-off high pressure situations, a period of “normal” activity was selected in each case, avoiding periods of maximum workload (e.g. vaccination campaigns) or potential conflict (e.g. performance appraisals). The data were gathered in person by one of the members of the research team at each of the clinics where the Primary Care Teams participating in the study work. The survey was carried out during the training hour provided for the professionals between each shift. In the case of clerical staff, at least one member of the team had to remain at his/her post to take incoming calls. These participants were provided with a questionnaire and an envelope to return the survey after completion. Attendance at the session assigned to the study was voluntary and was not remunerated. The participants were informed that an independent institution was carrying out a study, that their participation was voluntary and that any information they might provide would be treated anonymously.

Measures

Display rule for emotional expression. The perception of display rules was assessed on the basis of items from the sub-scales for the expression of positive, neutral and negative emotions included in the *Frankfurt Emotional Work Scale* (Zapf et al., 1999). Four of the five items from the original scale were used for positive emotions. An example of these items is, “In my dealings with patients I have to express positive emotions (e.g. friendly or pleasant).” The internal consistency index was $\alpha= .75$. Perceptions of display rules requiring the expression of negative emotions were evaluated using five of the seven original items in the scale. A sample item is, “In my dealings with patients I have to express

disagreeable emotions (e.g. being strict or getting angry if they do not follow the rules).” The internal consistency index was $\alpha= .70$. Finally, the expression of neutral emotions was measured applying three of the five items in the original scale¹. A sample item is, “In my dealings with patients I have to express emotions that are neither positive nor negative (e.g. impartiality).” The internal consistency index was $\alpha= .79$. The response format for the items was a five-point scale ranging from 1 (never) to 5 (very often).

Display rules for emotional suppression. The suppression of negative emotions was assessed using the relevant sub-scale from the *Emotional Labor Demands Scale* (Schaubroeck and Jones, 2000). The scale comprises four items with a five-point response scale ranging from 1 (never) to 5 (very often). A sample item is, “In my dealings with patients I have to try not to show any anger or annoyance I may feel.” The internal consistency index was $\alpha= .87$. At the time the study was carried out no scales existed for the suppression of positive or neutral emotions, and for this reason two sub-scales, each with two items, were developed, with the same response scale as mentioned above. Sample items for each of these scales are, “In my dealings with patients I have to try to hide positive emotions (e.g. affection, friendliness, kindness) I may feel,” and “In my dealings with patients I have to suppress any message implying neutrality or distance.” The internal consistency index was $\alpha= .75$ and $\alpha= .68$, respectively.

Display rules requiring sympathy. Demands for sympathy with patients’ emotions were assessed by applying six of the items from the two relevant sub-scales (sympathy and sensitivity) in the *Frankfurt Emotional Work Scale* (Zapf et al., 1999). A sample item is “In my dealings with patients I have to put myself in their position”. The internal consistency index was $\alpha= .80$.²

Emotional exhaustion. This was measured using the Spanish version (Seisdedos, 1997) of the *Maslach Burnout Inventory* (Maslach, Jackson & Leiter; 1996). The scale includes 9 items. A sample item is “I feel emotionally exhausted by my work”. The measure uses a seven-point response scale ranging from 0 (never) to 6 (every day). The internal consistency index was $\alpha= .89$.

Job satisfaction. Two of the dimensions included in the Basic Module from the Job Satisfaction Modular Questionnaire for Health Professional (*Módulo Básico del*

¹ The items eliminated were those that described two different scenarios to the participant, one for a subject A and the other for a subject B. The participant was asked to indicate which of the two scenarios was most similar to his/her post. In pre-piloting the study, subjects displayed certain difficulties understanding these scenarios and the response procedure.

² An exploratory factor analysis with *promax* rotation was performed for the items evaluating the different emotional display rules. The items from the same sub-scale saturated the relevant factor by over .60. Only three of the items for the expression of positive emotions saturated (.33–.36) slightly above .30 in the sympathy factor. The saturation of the remaining items in other factors was less than .30.

Cuestionario Modular de Satisfacción Laboral de Profesionales de la Salud (Bravo, Peiró & Zurriaga; 1991) were measured. Specifically, the evaluation focused on satisfaction with patient interactions, applying two of the items included in the relevant sub-scale, and intrinsic satisfaction, applying five of the items from the relevant sub-scale. Both measures use a seven-point response scale ranging from 1 (very dissatisfied) to 7 (very satisfied). Sample items for each scale are, “To what extent are you satisfied with your dealings with patients and their reactions?” and “To what extent are you satisfied with the tasks and activities you perform during your working day?” The internal consistency index was $\alpha = .73$ and $\alpha = .83$, respectively.

Analysis

In order to confirm hypothesis 1, one sample t-tests were performed to determine whether the mean for each of the display rules measured was different from 1 (never). Meanwhile, t-tests for related samples were carried out to confirm hypotheses 2 and 3. The presence of differences in the perception of emotional display rules linked to the organizational level (H. 4) and the occupational group (H. 5a, b, c, d) was verified by a variance analysis for one factor. The organizational factor had three levels corresponding to the health care areas in which the primary health care teams operate. The occupational factor had three levels: general practitioners, nurses and clerks. Hypothesis 6 concerning the team as the origin of perceptions of display rules was confirmed applying multi-level analysis techniques; the null model was tested to establish whether the inter-group variance was significant. Bivariate correlations were calculated to test hypotheses 7a, 7b, 8a, 8b, 9a and 9b. To test Hypotheses 10a and 10b regression equations were computed using the stepwise method for emotional exhaustion, satisfaction with patients and intrinsic satisfaction, including all display rules for which the correlation with the dependent variable was significant. The linear regression assumptions were tested before the analysis of results. The assumption was validated in the case of independence, as the values of the Durbin-Watson statistic were found to be acceptable in the case of emotional exhaustion ($DW = 1,7$), intrinsic satisfaction ($DW = 1,8$) and satisfaction with patients ($DW = 1,9$). The dispersion diagram for the predictions and typified residuals is consistent with the assumption of homoscedasticity for the three outcome variables. Meanwhile, the dispersion diagram does not display the presence of non-linear relationships between the different independent variables and each of the dependent variables. The probability plot for the standardized residuals confirms normality for the emotional exhaustion and intrinsic satisfaction variables. In the case of satisfaction with patients, however, the diagram is somewhat asymmetrical, displaying more scores in the negative tail of the distribution. Hence, the results for this

variable warrant some caution. Finally, the tolerance value in the regression equations for emotional burnout, intrinsic satisfaction and satisfaction with patients were equal to or higher than .80 in all cases. Likewise, the conditions indices were within an acceptable range, reflecting the absence of colinearity between the different independent variables.

Results

Table 1 provides the descriptive statistics for the variables included in the study.

Types of emotional display rules in primary health care

Hypothesis 1 predicts that the existence of levels of perception of the display rules included in the study will be significantly different from 1 (never), the minimum score a subject could obtain in the scale. This hypothesis was confirmed (see Table 2).

Hypothesis 2 was confirmed, as it was found that average levels for the perception of display rules concerning sympathy, the expression of positive emotions and the suppression of negative emotions were significantly greater than the average scores obtained for the remaining display

Table 1
Mean scores and standard deviations for the variables included in the study (N = 1047)

Variable	<i>M</i>	<i>SD</i>
Positive expression	3.85	.60
Negative expression	2.28	.52
Neutral expression	2.84	.75
Positive suppression	2.11	.72
Negative suppression	2.93	.86
Neutral suppression	2.53	.79
Sympathy	4.04	.56
Emotional burnout	3.04	1.36
Intrinsic satisfaction	3.63	1.22
Satisfaction with patients	5.10	1.11

Table 2
T-test for the sample (test value = 1)

	<i>t</i>	<i>df</i>	<i>p</i>
Positive expression	152.912	1050	.001
Negative expression	79.881	1050	.001
Neutral expression	79.559	1049	.001
Positive suppression	49.873	1048	.001
Negative suppression	72.832	1050	.001
Neutral suppression	62.672	1047	.001
Sympathy	175.501	1052	.001

rules. Likewise, hypothesis 3 was confirmed, as the average score for the expression of neutral emotions was significantly lower than for previous demands, and higher than the score for the expression of negative and the suppression of positive and neutral emotions (see Table 3).

Sources of variation in display rules in primary health care

The variance analyses for hypothesis 4, concerning the existence of differences in the level of perception of display rules associated with the health care area, confirm that the perception of rules requiring the suppression of negative emotions differs significantly between of the areas included in the study $F(2, 1048) = 4.21; p = .015$. This confirms the hypothesis with regard to the rule mentioned but not for the others, which did not display significant differences.

Differences in the level of expression of neutral emotions were not significant in the comparison between the group of general practitioners and clerical staff. In line with earlier studies (Thoits, 1989), the level of this demand was significantly higher among the group of doctors in comparison with the sample of nursing staff $Brown-Forsythe(2, 649) = 8.37; p = .001$. According to hypothesis 5a both differences should be significant, and it was therefore only partially confirmed.

Hypothesis 5b was not confirmed, as the highest average level of perception with regard to display rules requiring the suppression of neutral emotions was not found in the

group of nurses, as expected, but among clerical staff. No significant differences were found between nursing staff and the other two groups, although the level of probability was marginal $Brown-Forsythe(2, 597.73) = 2.74; p = .066$.

Hypothesis 5c, which predicts the existence of higher levels of perception of display rules requiring the expression of positive emotions and sympathy among the nursing staff group, was not confirmed. In fact, differences in the expression of positive emotions were not significant among the three professional groups. The nursing staff group did not perceive a significantly higher demand for the expression of sympathy. However, the difference was significant in comparison with the clerical staff group, $Brown-Forsythe(2, 526.35) = 24.41; p = .001$.

As expected the highest average score with regard to perceived display rules requiring the suppression of negative emotions was found among the group of clerical staff, although the difference was significant only in comparison with the nursing staff group, $Brown-Forsythe(2, 580.02) = 4.67; p = .01$, but not with doctors. Consequently, hypothesis 5d was not confirmed.

The results of the multilevel analysis confirm the exploratory hypothesis that the work team is a source of changes in the perception of display rules (hypothesis 6), but only those requiring the suppression of negative emotions. Intra-group variance was significant for the suppression of negative emotions when the null model was tested ($\chi^2 = 142.9; df = 96, p = .002$).

Table 3
Mean differences for perception of emotional demands

	<i>M</i>	<i>DS</i>	<i>SE Mean</i>	<i>t</i>	<i>p</i>
ExpPos - ExpNeg	1.57	.81	.02501	62.659	.001
ExpPos - ExpNeu	1.01	1.03	.03190	31.631	.001
ExpPos - SupPosi	1.74	1.02	.03142	55.417	.001
ExpPos - SupNeg	.92	.96	.02964	31.129	.001
ExpPos - SupNeu	1.32	.96	.02982	44.256	.001
ExpPos - Sympathy	-.19	.63	.01949	-9.704	.001
ExpNeg - ExpNeu	-.56	.87	.02676	-20.872	.001
ExpNeg - SupPos	.18	.82	.02524	6.969	.001
ExpNeg - Supneg	-.64	.94	.02914	-22.113	.001
ExpNeg - SupNeu	-.25	.89	.02767	-8.912	.001
ExpNeg - Sympathy	-1.76	.77	.02363	-74.318	.001
ExpNeu - SupPos	.74	.94	.02894	25.465	.001
ExpNeu - SupNeg	-.084	1.10	.03392	-2.480	.013
ExpNeu - SupNeu	.31	1.05	.03261	9.644	.001
ExpNeu - Sympathy	-1.20	.98	.03021	-39.664	.001
SupPos - SupNeg	-.82	.99	.03074	-26.613	.001
SupPos - SupNeu	-.42	.93	.02877	-14.724	.001
SupPos - Sympathy	-1.93	.98	.03032	-63.806	.001
SupNeg - SupNeu	.40	.87	.02684	14.757	.001
SupNeg - Sympathy	-1.11	.97	.02984	-37.366	.001
SupNeu - Sympathy	-1.51	.96	.02972	-50.903	.001

Display rules and employee well-being

The expected correlations between the perception of display rules and the dependent variables confirm many of the hypotheses; although the correlation coefficients are low (see Table 5). In the case of emotional exhaustion, the correlation with the perception of rules requiring the expression of positive emotions and sympathy was found not to be significant ($r = .00, p = .98$; $r = .04, p = .20$), so hypothesis 7a was rejected. The positive correlations of emotional exhaustion with the perception of rules requiring the suppression of negative emotions (hypothesis 8a), the expression of negative and neutral emotions and the suppression of positive emotions (hypothesis 9a) were all statistically significant ($r = .27$; $r = .15$; $r = .16$; $r = .10, p < .01$), so hypothesis 8a and 9a were confirmed.

The hypotheses proposed with regard to correlations between the perception of display rules and intrinsic satisfaction and satisfaction with patients were confirmed. Thus, positive and significant correlations (hypothesis 7b) exist between the two dimensions of job satisfaction and the expression of positive emotions ($r = .08$; $r = .13, p < .01$, respectively) and sympathy ($r = .12$; $r = .16, p = .01$, respectively). The correlations with rules requiring the suppression of negative emotions were negative and significant ($r = -.12$; $r = -.16, p < .01$, respectively) (hypothesis 8b). As predicted in hypothesis 9b, the

correlation of these rules with intrinsic satisfaction ($r = -.06, p < .05$; $r = -.12, p < .01$; $r = -.12, p < .01$) and satisfaction with patients ($r = -.17$; $r = -.16$; $r = -.16, p < .01$) was also significant.

Finally, analysis of the multiple regression for emotional exhaustion, intrinsic satisfaction and satisfaction with patients confirms that the regression coefficients for certain display rules are significant, although the model has little predictive power (hypotheses 10a and b).

Specifically, the perception of display rules concerning the expression of negative ($\beta = .11, p < .001$) and neutral emotions ($\beta = .14, p < .001$), and those concerning the suppression of negative emotions ($\beta = .25, p < .001$) contribute significantly to the prediction of the levels taken by the emotional exhaustion variable, $F(3, 1031) = 40.50, p < .001$; Adjusted $R^2 = .10$. In the case of intrinsic satisfaction, the regression coefficients for the expression of neutral emotions ($\beta = -.16, p < .001$), suppression of negative emotions ($\beta = -.29, p < .001$) and sympathy ($\beta = .29, p < .001$) are significant predictors of emotional burnout $F(3, 1027) = 25.40, p < .001$; Adjusted $R^2 = .07$. Finally, rules requiring the expression of positive ($\beta = .16, p < .01$), negative ($\beta = -.29, p < .001$) and neutral ($\beta = -.15, p < .001$) emotions, as well as the suppression of negative emotions ($\beta = -.26, p < .001$) and sympathy ($\beta = .27, p < .001$) contribute significantly to predicting satisfaction with patients, $F(5, 1026) = 24.96, p < .001$; Adjusted $R^2 = .10$.

Table 4
Bi-variate correlations between the study variables

Variable	1	2	3	4	5	6	7	8	9	10
1. ExpPositive	—									
2. ExpNegative	-.03	—								
3. ExpNeutral	-.16**	.10**	—							
4. SupPositive	-.17**	.16**	.18**	—						
5. SupNegative	.17**	.12**	.07*	.21**	—					
6. SupNeutral	.06*	.11**	.06	.24**	.45**	—				
7. Sympathy	.42**	.00	-.10**	-.16**	.12**	.02	—			
8. Emotional exhaustion	.00	.15**	.16**	.10**	.27**	.17**	.04	—		
9. Intrinsic satisf.	.08*	-.06*	-.12**	-.12**	-.20**	-.15**	.12**	-.48**	—	
10. Satisf. Patients	.13**	-.17**	-.16**	-.16**	-.19**	-.13**	.16**	-.42**	.46**	—

** $p < .01$ * $p < .05$ (bilateral).

Table 5
Estimate of the parameters for each of the result variables in the study

Dependent variable	Independent variables							
	Adj. R ²	ExpPos	ExpNeg	ExpNeu	SupPos	SupNeu	SupNeg	Sympathy
Emotional exhaustion	.10		.11**	.14**			.25**	
Intrinsic satisfaction	.07			-.16			-.29**	.29**
Satisfaction with patients	.10	.16*	-.29**	-.15**			-.26**	.27**

* $p < .01$ ** $p < .001$.

Discussion

The results of the study allow us to draw some conclusions regarding the type of emotional display rules perceived in primary health care contexts, the sources of change in such perceptions and their relationship with well-being and job satisfaction. However, the results are not always as expected, and they raise new questions for future research.

The study confirms that the display rules perceived in primary health care contexts are more diverse than the “service with a smile” type hitherto analyzed in commercial contexts. However, requirements for the expression of positive emotions and the suppression of negative ones, and for the expression of sympathy, are the three most frequently perceived display rules. This suggests that the core of the “service with a smile” paradigm expands in primary health care, and is accompanied by other display rules that have been largely ignored in the existing research, such as the expression of neutral emotions, the expression of negative emotions and the suppression of neutral and positive emotions. In line with recent papers (Dieffendorf & Greguras, 2006), this study confirms the need for a more detailed examination of display rules and their definition in different organizational contexts. Furthermore, the presence of different rules raises questions for both research and applications, as we shall explain below.

With regard to the sources of variations in the perception of display rules, the study confirms the existence of differences linked with the professional group to which the person belongs, the work team and the health area, although some of the expected differences were not confirmed and others that were not hypothesized were found. With regard to the professional group and the expression of neutral emotions, the study confirmed that the level of perceived demand was higher among doctors than nursing staff, although this characteristic was shared with the clerical staff group, contrary to expectations. The first of these differences (doctors-nurses) confirms in quantitative terms the results of existing qualitative studies (Thoits, 1989), which assumed that the emotions play a role in the configuration of professional identities (Daniels, 1960; DiLalla, Hull, & Dorsey, 2004; Stepien & Baernstein, 2006). Thus, “distance” and “neutrality” symbolize the scientific status of the doctor within the organization, while emotional aspects are left to nursing staff. One possible explanation for the unexpectedly high level of this demand among clerical staff would involve a combination of two factors, namely frequent exposure to events with a negative emotional charge (excessive demands, abusive and aggressive patients, and so forth) and the association between lower status and greater difficulties displaying negative emotions (Gibson & Schroeder, 2002; Yanay & Shahar, 1998). The most viable way to manage this situation would be affective neutrality in order to maintain professional distance.

With regard to the remaining elements defining professional identity, the results did not confirm the presence of a greater demand to suppress neutral emotions among nursing staff.

The role of the demand for sympathy in differentiating between nursing staff and GPs was not confirmed. The expected difference between the two groups was not significant, and only when each group was compared with clerical staff were perceptions of sympathy demand found to be significantly higher. Some existing studies have suggested a greater expectation of sympathy among nursing staff, while others confirm a decline in the ability to sympathize with the patient over the course of medical training and specialization (Halpern, 2001; Stepien & Baernstein, 2006). The explanation of our results could be related with the specific circumstances of the health care context analyzed and the type of medical speciality. The majority of existing studies have focused on medical professionals in hospital institutions and not on general practitioners (Dennison & Sutton, 1990; Smith & Gray, 2001; Smith & Kleiman, 1989). In recent decades the training of family doctors has stressed a bio-psycho-social approach to the patient, resulting in a “patient centered” care model (Laine & Davidoff, 1996). An important part of this model in primary health care is related with the exploration of the patient not only in purely medical terms, but also with regard to his or her feelings about the illness, ideas about what is wrong and expectations of how a symptom will affect the sufferer’s daily life, as well as arriving at an understanding of the patient’s overall experience (Steward et al., 2000). This approach may explain the presence of higher levels of sympathy among doctors working in primary health care than among their colleagues from other specialities, as well as the erosion of differences with nursing staff in this regard.

Likewise, this change in the primary care model may explain the partial confirmation of the assumption concerning the suppression of negative emotions. In this case too, the group of doctors unexpectedly equaled clerical staff, the group that was expected to perceive these display rules most strongly, while the level found among nursing staff was significantly lower. However, these are *a posteriori* explanations, and their only value is to suggest future questions and research issues, which would include the existence of variations in the perception of emotional display rules in different medical specializations and some kind of association between the perceived status of doctors in different health care contexts and their perceptions of emotional display rules. These results are compatible with a “humanized” model of the general practitioner, who holds onto the central characteristic of “objectivity” but is at the same time able to put him or herself in the patient’s shoes and remove the expression of negative emotions.

With regard to the work group, the second source of variation in the perception of display rules, the results

confirm the existence of differences in the perceived requirement for the suppression of negative emotions. These differences have been suggested theoretically (Cropanzano et al., 2004), but no empirical evidence has been obtained. Finally, the results confirm variations in the perception of display rules requiring the suppression of negative emotions depending on the health area to which the professional belongs.

The third objective of the study was to examine the extent to which the perception of display rules is relevant to employee well-being and job satisfaction. In the first place, all of the display rules correlated positively and significantly with emotional exhaustion, except the expression of positive emotions and sympathy, the correlations for which were not significant. Second, all of the display rules requiring some form of expression were significantly correlated with the two satisfaction dimensions. These correlations were positive for the expression of positive emotions and sympathy, and negative in the remaining case. Caution is needed in the interpretation of these results because the correlation coefficients were low, despite the sample size. Furthermore, the significant correlation between the perception of display rules requiring the expression of positive emotions and sympathy and the emotional exhaustion observed in earlier studies was not found in our study (Adelmann, 1995; Brotheridge & Grandey, 2002; Brotheridge & Lee, 2003; Côté & Morgan, 2002; Dieffendorff & Richard, 2003; Zapf & Holz, 2006; Zapf et al, 1999). This could be because the processes associated with compliance were not included, in contrast to earlier studies. Recent work suggests the coexistence of intra- and interpersonal psychological processes to explain the impact that compliance with emotion rules at work have on employee well-being (Côté, 2005). The former refer to the exhaustion of the self-regulation resources needed to align experience and/or expression with emotional demands. Given the limited nature of these resources, display rules entail a risk of emotional exhaustion. This risk is associated with all display rules, although it is moderated by the type of emotion regulation strategy deployed. The interpersonal mechanism refers to the type of response elicited by the emotion expressed from the receiver, which is to say the patient. Once again in this case, the patient's response is moderated by the type of regulation strategy, but the kind of feedback varies as a function of the display rule invoked. It is possible that the expression of positive emotions and sympathy elicit a positive response from the patient more often. This kind of feedback helps the recovery of psychological resources and, therefore offsets the resources invested in self-regulation (Goldberg & Grandey, 2007). The compensation of resources may explain the absence of any relationship with emotional exhaustion in the case of expression of positive emotions and sympathy. Patient responses are unlikely to be positive in the case of the other display rules, and therefore they will not provide the

resources to offset those lost in regulation. The absence of compensation mechanisms would explain the negative relationship with emotional exhaustion.

The fact that these variables, and others involved in dealing with display rules, are not included may explain the low predictive power shown by the display rules in the regression equations, where emotional exhaustion is predicted by the perception of rules requiring the expression of negative and neutral emotions, and the suppression of negative emotions. Intrinsic satisfaction is thus predicted both by the perception of low levels of demand for neutral expression and the suppression of negative emotions, and by high perceived demand for sympathy, while satisfaction with patients is predicted by the perception of high levels of demand for positive expression, low demand for the expression of negative and neutral emotions and the suppression of negative emotions, as well as rules requiring a high level of sympathy.

The study also points to conclusions from an applied standpoint. In the first place, it confirms the presence in the primary health care environment of emotional display rules that do not form part of the "service with a smile" model and are related with employee well-being. This matter needs to be considered in training programs aimed at improving the emotional competence of professionals and developing specific techniques for emotional management. Likewise, the dimension of the correlation between the different emotional demands suggests that it is important to focus on the management of display rules regarding the suppression of negative emotions and to include training in techniques to induce moods that reduce the frequency of inappropriate, negative emotional experiences. However, the results of the study also make clear that a purely individual approach to the problem is insufficient. Since levels of demand for the suppression of negative emotions vary depending on the work group and organization to which the professional belongs, interventions need to be complementary on both levels.

At the group level, special attention needs to be given to the style and competences of the group leaders, as their behavior is directly related with the perception of display rules, compliance and the group's mood, as well as the consequences of these factors (Sy, Côté & Saavedra, 2005). It is also important to provide teams with strategies that will allow them to regulate their mood and prevent contagion of negative emotional states that could increase the demand for suppression (Barsade, 2002; Van Kleef, 2009), especially in crisis situations (e.g. training in debriefing techniques after violent incidents). At the level of the organization, meanwhile, it would be advisable to develop human resources policies that explicitly consider the presence of display rules, providing planned actions for their management (training, hazard assessment, prevention plans, job design, organizational support in the face of abusive patients, etc.). The results obtained with regard to the variation in display rules depending on the professional group concerned should be considered

for the design of specific strategies adapted to the conditions and characteristics of the work performed by each of the professional groups involved in primary health care.

Despite the contributions made by this study, it has a number of limitations. The cross-sectional nature of the study makes it impossible to establish the presence of causal relations between the variables with any degree of certainty. Meanwhile, the use of self-reporting and the absence of information from other sources (e.g. supervisors, colleagues, and patients) mean it is possible that a part of the variance in scores may be due to the use of a common method. Also, we have employed sub-scales comprising only two items in some cases, which may affect the content validity of the construct measured. We may also note here that doubts exist with regard to the normality fit in the case of the regression equation for satisfaction with patients, and the results therefore warrant some caution. The validity of these results could have been enhanced by controlling for the effect of the individual variables related with emotion regulation (e.g. positive and negative affectivity, neuroticism and so forth). While the regression analyses threw up significant relationships between display rules and the variables examined that were similar to those found in other studies (Goldberg & Grandey, 2007; Zapf & Holz, 2006), the regression coefficients were low. It would have been interesting in this regard to have considered other variables that would have explained the relationships found. For example, it might have been possible to arrive at a better understanding of the phenomenon and of the relationships existing between the variables by throwing light on the moderating role of the strategies employed by the subjects to meet emotional demands (Martínez-Iñigo et al., 2007), or the role of certain emotional competences, such as emotional intelligence (Giardini & Frese, 2006), attitudes like commitment and job characteristics like autonomy (Goldberg & Grandey, 2007). Likewise, additional information concerning emotion management processes in the different health care areas would allow these to be explained more precisely, providing conclusions from an applied standpoint. Finally, the explanation of differences associated with the group level is another limitation. Subsequent research should thus look at which group processes (e.g. climate, leadership style, and emotional contagion) might be responsible for these differences.

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