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Emotion work within eldercare and depressive symptoms: A cross-sectional multi-level study assessing the association between externally observed emotion work and self-reported depressive symptoms among Danish eldercare workers

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ABSTRACT

Background: Danish professional caregivers have high rates of depressive symptoms. One proposed cause is exposure to emotion work. However, emotion work is usually measured by self-report which may bias results.
Objectives: The objective of this study was to examine the association of emotion work, externally observed at the workplace, with self-reported depressive symptoms of professional caregivers.
Design and data sources: The study was a cross-sectional observational study. Data was collected by 9 observers who assessed emotion work stressors and emotion work resources in 124 individual professional caregivers working in 56 work units across 10 eldercare homes. Emotion work stressors were defined as i) barriers for empathetic care, ii) taxing aggressive events, and iii) taxing non-aggressive events. Emotion work resources were defined as i) meaningful events, and ii) social interactions between professional caregivers and residents. Depressive symptoms were measured by a questionnaire sent to all professional caregivers at the 10 eldercare homes. We constructed two samples for analysis: a) a sample of 95 directly observed professional caregivers with full information on covariates, and b) a sample of 205 observed and non-observed professional caregivers with full information on covariates working in one of the 56 observed work units.
Methods: Using multilevel regression models we analysed associations of individual and work unit averaged levels of emotion work with depressive symptoms among professional caregivers.
Results: None of the three emotion work stressors were associated with depressive symptoms. Of the two emotion work resources, a high amount of social interactions between professional caregivers and residents were, contrary to expectations, related to higher levels of depressive symptoms at both the individual level and the work unit averaged level.
Conclusions: The unexpected association between social interactions and depressive symptoms need to be replicated in future studies. These future studies should also investigate whether the association of social interactions and level of depressive symptoms depends on the content of the interactions between professional caregivers and residents.

Contribution of the paper

What is already known about the topic?

- Care workers have higher rates of depressive symptoms than the general working population.

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- Studies using self-reported measures of working conditions or job exposure matrices to identify high risk occupations point to emotion work as a potential cause of this higher rate.

What this paper adds?

- By using observation to assess emotion work and self-report to measure depressive symptoms, this paper demonstrates that more social interactions between care workers and residents are associated with a higher level of depressive symptoms among care workers.
- Other observed emotion work variables were not associated with depressive symptoms among care workers.

1. Introduction

In care work, emotion work is a main characteristic of the job. Emotion work includes interactions between residents and professional caregivers that are characterised by sociability (Zapf et al., 1999), but occurs also when professional caregivers use emotional effort to facilitate practical work tasks. For example, professional caregivers may try to sense the residents' mood and then react to this mood by displaying appropriate emotions to create a positive atmosphere (Ashforth and Humphrey, 1993; Grandey, 2000; Zapf, 2002). As a concept emotion work covers emotional demands in the job requiring sustained emotional effort by professional caregivers (van Vegchel et al., 2004) and situations characterised by emotional dissonance, that is when felt emotions differs from displayed emotions (Hochschild, 2003).

Research has shown that emotion work can make care work meaningful, and that there are positive effects when emotion work facilitates task performance and heightens identification with an organisational role (Liebst and Monrad, 2008; Tufte et al., 2012). However, emotion work may be a double-edged sword and negative effects of emotion work have also been discussed (Mann, 2004). In particular there is a concern that emotional dissonance and unrealistic expectations about emotional interactions between a care provider and a care recipient exacerbate stress and performance failures among professional caregivers (Rafaeli and Worline, 2001). Negative effects of emotion work may be one reason for the higher risk of developing mental health problems among professional caregivers compared with members of other job groups (Madsen et al., 2010; Tennant, 2001; van Daalen et al., 2009; Wieclaw et al., 2006).

Most research on emotion work and depressive symptoms has relied on questionnaire data. However, assessing emotion work by self-administered questionnaires may introduce biases when existing depressive symptoms affect the reporting of the working conditions (Harmer et al., 2009; Kolstad et al., 2011). In addition, when both emotion work and depressive symptoms are measured by questionnaires, common method bias may be introduced. To alleviate this, some studies have measured depression by register data on dispensation of prescribed drugs (Madsen et al., 2010) or by hospital treatment (Hannerz et al., 2009; Kold Jensen et al., 2010; Madsen et al., 2010; Wieclaw et al., 2006; Wieclaw et al., 2008). However, this has the disadvantage that only treated and relatively severe cases of depression are included in these studies. Other studies have used alternative approaches to measure emotion work. One approach is to use job exposure matrices to separate jobs that are expected to contain a high versus a low level of emotion work (Wieclaw et al., 2006; Wieclaw et al., 2008). This strategy, however, seems to be a crude approximation of actual emotion work, and it introduces problems of non-differential misclassification (Rugulies, 2012).

The objective of this study was to examine the association of emotion work, externally observed at the workplace, with self-reported depressive symptoms of professional caregivers. Trained observers followed the professional caregivers throughout an entire shift and assessed emotion work aspects based on a predefined set of criteria. By associating observed emotion work and self-reported level of depressive symptoms, we avoided the problems of common method bias, while preserving the possibility of analysing lower levels of depressive symptoms. Our understanding of emotion work was set in the frame of Action Regulation Theory in general and the emotion work theory by Zapf and colleagues in particular (Zapf et al., 1999; Zapf, 2002). Emotion work is conceptualised as a job characteristic which exists independently of the individual worker. It is a job requirement, such as the organisational expectation to express desired emotions in particular interactions, for example empathy and friendliness. We augmented this framework by the concepts of emotion work stressors and emotion work resources.

1.1. Emotion work stressors

In Action Regulation Theory work stressors are conceptualized as barriers (Greiner and Leitner, 1989). We applied this model to emotion work. In our definition, barriers in emotion work occur when the set-up of the work hinders professional caregivers in performing emotional care for the resident during practical tasks or when sociability is a task in itself. For an event to constitute a true barrier, the workers' action in response to the barrier has to fulfil three criteria: it has to be necessary in order to complete the task; the time to deal with the barrier is not provided for; and there cannot be another way of dealing with the event, e.g. lowering the quality of work or removing the hindrance (Greiner, 1999; Greiner and Leitner, 1989). Some organisational structures may obstruct the delivery of the care tasks by the professional caregiver so that the residents' social and emotional needs cannot be met or only be met by applying additional effort. Emotional taxation, when delivering the care activity, is likely for the individual worker and also for groups of workers delivering service in a unit characterised by many work barriers. We therefore expected barriers both at the individual level and at the work unit averaged level to be associated with a higher level of depressive symptoms.

Hypothesis 1. Professional caregivers experiencing more barriers for providing emotional care will report higher levels of depressive symptoms than professional caregivers experiencing fewer barriers.

Emotional dissonance occurs when the felt emotion differs from the required display of emotion. Even though professional caregivers may wish to feel and display required emotions, situations may arise where they are unable to genuinely feel appropriate emotions (Mann, 2004). These situations require extra effort and take place at conscious regulation levels (Zapf, 2002). In care work, most situations involving emotional dissonance will involve suppressing negative feelings such as anger, irritation and resentment. We cannot measure emotional dissonance directly through observation. Instead, we measure the number of situations where the likelihood of emotional dissonance may be high. This may be the case when professional caregivers have to deal with physically or verbally aggressive residents. Previous research has linked suppression of negative feelings with depressive symptoms (Côté, 2005), and we therefore expect these situations to be associated with higher levels of depressive symptoms regardless of whether they are experienced directly by the individual or are prevalent in the unit.