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. PRACTICE ENVIRONMENT AND COMMUTING STRESS AS PREDICTORS OF EMOTIONAL LABOUR AMONG NURSES IN IBADAN, OYO STATE

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ABSTRACT
Nursing has been described as one of the most stressful professions considering their exposure to emotional demands from their patients, and prolonged working duration. This study examined practice environment and commuting stress as predictors of Emotional Labour in Ibadan, Oyo State. This study employed ex-post facto design, purposive sampling technique was used in selecting 301 nurses in Ibadan, Oyo State, with participants' ages ranging between 17 and 64, and a mean age of 32.93±10.18 years. A 61-item self-report questionnaire comprising socio-demographics, practice environment (α=.95), commuting stress (α=.80) and emotional labour (α=.87) was administered. Data collected were analyzed using descriptive statistics, Pearson r, hierarchical multiple regression and ANOVA analysis. After statistically controlling for sex, age and practice experience, the results revealed that psychosocial factors significantly and jointly predicted Emotional labour and its components. Furthermore, age, practice experience, participation in the centre affairs, the nursing foundation for quality of care, adequate human resources, Nurses-physician relationship and commuting stress independently predicted nurse's emotional labour and its components (surface action, deep acting, naturally felt emotion and emotional termination) More also, marital status predict bullying behaviour. Finally, psychosocial factors are important joint predictors of emotional labour and its components. It's recommended that nurses should be more involved in the hospital policy-making and decision process, and the latest hospital equipment should be provided. Furthermore, nurse hostels in the hospital vicinity and public transport should be provided to reduce commuting stress.

Keywords: *Emotional labour, Practice environment, Commuting stress*

INTRODUCTION
Nursing is one of the professions with the highest levels of stress due to the emotional demands placed on nurses by their patients, the length of their shifts, conflicts with coworkers from other fields, interpersonal issues, and traumatic events such as having contact with seriously ill and near-death patients, multiple emergencies, and being the first victim of violence (Adeyemi, Adeyemi, Ogunbanwo, Oshunpidan, & Fatungase, 2024). When expressing emotions, nurses come across many circumstances with patients, family, and coworkers. The ability of nurses to express their feelings is seen to be a crucial component in maintaining stronger patient relationships, which may aid patients in recovering. Additionally, there are rules for what types of emotions should be displayed and which ones should be kept to oneself in nursing. Emotional labour is thus the act of faking, augmenting, or suppressing feelings to modify one's emotional expression. This change in emotional expression might lead to more productive professional engagement.

Nurses are at the forefront of patient care, often dealing with a diverse array of emotions daily. Their role extends beyond clinical tasks, encompassing the emotional and psychological support of their patients. Emotional labour, a critical component of nursing, involves managing and sometimes modifying one's emotions to meet the demands of the job and provide compassionate, effective care. This complex process not only influences patient outcomes but also impacts the nurses' own psychological and physical well-being (Ojo & Lawal, 2023; Olorunfemi, Nwozichi, & Anokwuru, 2024). Emotional labour in nursing involves mobilizing unique potentials such as offering calm and support, easing pain, displaying courtesy, a good sense of humour, tolerance, kindness, understanding, and assisting patients in solving their difficulties. Emotional labour, a crucial aspect of nursing, involves the regulation of emotions to meet the demands of patient care. This regulation of emotion is essential for creating a therapeutic environment for patients, but it can be taxing on nurses over time. However, this

process can be understood through different strategies that nurses employ to manage their feelings: surface acting, deep acting, and natural felt emotion.

The concept of emotional labour was first introduced by sociologist Arlie Hochschild, who identified two primary strategies for managing emotions in the workplace: surface acting and deep acting (Hochschild, 2003). Surface acting occurs when nurses modify their external emotional expressions—such as facial expressions, gestures, or tone of voice—to display the emotions required by their role, despite experiencing different internal feelings. This often involves displaying a calm and compassionate demeanour while internally feeling stress, frustration, or sadness. Surface acting is essentially a performance where the displayed emotions do not align with the nurse's true feelings. Deep acting, on the other hand, involves efforts to align one's internal emotions with the required emotional display. Nurses engaging in deep acting attempt to manage their inner feelings to genuinely experience the emotions they need to express. This technique involves changing one's internal emotional state to produce authentic emotional expressions, such as genuinely feeling empathy or compassion towards a patient. Deep acting is a more internally focused strategy that seeks to bridge the gap between felt and expressed emotions by adjusting one's inner emotional experience (Amissah, et al., 2022; Oliveira, et al., 2023).

Additionally, some situations allow for the expression of naturally felt emotions, where nurses' internal feelings naturally align with their professional emotional expressions. This authentic emotional expression is often effortless and reflects a congruence between internal feelings and outward expressions. However, emotional termination occurs when nurses cease to express their emotions, especially in challenging situations involving patient interactions. When there is a problem or conflict with a patient, nurses might attempt to explain their perspective to seek understanding and forgiveness. If the patient does not respond positively, nurses might withdraw emotionally and choose to listen silently to the patient's grievances without engaging further. This emotional disengagement serves as a protective mechanism to manage their emotional well-being while maintaining professional conduct. While emotional labour is influenced by various factors, this study focuses on two key independent variables: the practice environment and commuting stress.

Practice environment is defined as both the emotional and physical aspects of the working settings that motivate employees to be productive and committed. It involves, among other things, working circumstances, employee rights, employee voice, a safe working environment, collaborative teammates, and a kind supervisor (Alegbeleye, Unegbu, Babalola, & Gbemi-Ogunleye, 2020). The nurse practice environment is described as the workplace features that encourage or inhibit the delivery of quality nursing care. Particularly in the healthcare sector, which is always followed by unrelenting strike activities due to the inadequate practice environment, a better practice environment plays a critical role in motivating employees' emotions. Nkemakolam et al., (2021) found that to uphold laws and make working conditions for staff members more favourable, all the factors together determined the emotions of the nurses, but that salary has been the most basic and important indicator that motivates nurses' emotions, followed by advancement and promotion.

Commuting stress is the distress a person experiences while commuting to and from work. It is typically a result of the pressure to arrive on time, which frequently results in extreme anxiety and stress. According to Malomo, (2023), commuters are people who often travel between their homes and places of employment, which may be in different cities, or whose homes and places of employment may be in other locations. However, factors that contribute to the stress that commuters experience include longer commutes, longer drives, traffic jams, road construction, time constraints, fuel prices, the distance from home to work or other non-driving tasks that involve time and energy, unpredicted difficulties, accidents, vehicle breakdowns, and weather (Oweisana, & Ordua, 2022; Hashikami, Li, Kobayashi, & Shigeno, 2023). According to Olsson, Garling, Ettema, Friman, and Fujii (2013), travel times on public transportation are often greater than those on private vehicles and range between 40 and 80 minutes on average. As a result, workers commute for 4 to 10 percent of their awake time each weekday.

Nursing is widely recognized as a challenging profession, primarily due to the high emotional demands placed on nurses. The need to constantly manage and regulate emotions, often through surface and deep acting, significantly contributes to the emotional labour inherent in nursing roles. Despite this, much of the research on emotions within the nursing context has traditionally focused on patients' emotions, the overall pleasant and unpleasant emotional experiences, and the role of nurses' emotional intelligence (Okhakhu & Adekunle, 2021; Amissah et al., 2022; Yıldız & Dinc, 2023; Johnston, 2024). A notable gap in the literature exists regarding the specific aspects of nurses' emotional labour. Although studies such as those by Amissah, Blankson-Stiles-Ocran, and Mensah (2022) have explored emotional management criteria, including emotional exhaustion, psychological distress, and job satisfaction, they often overlook the discrete components of emotional labour. This oversight is significant given the substantial impact that both surface and deep acting have on nurses' emotional well-being.

Furthermore, there is a scarcity of research examining the distinct facets of emotional labour within nursing, as highlighted by Lee and Jang (2019). This gap is particularly evident in the context of commuting stress, which remains an underexplored area, especially among nurses in Nigeria. The physical and psychological toll of commuting long distances to work could potentially exacerbate the emotional demands faced by nurses, thereby influencing their overall emotional labour. Given these gaps, the present study aims to investigate the practice environment and commuting stress as predictors of emotional labour among nurses in Ibadan, Oyo State.

The following hypotheses were tested:

1. Practice environment and commuting stress would significantly jointly and independently predict Emotional labour among nurses?
2. Practice environment and commuting stress would significantly jointly and independently predict surface acting among nurses?
3. Practice environment and commuting stress would significantly jointly and independently predict deep acting among nurses?
4. Practice environment and commuting stress would significantly jointly and independently predict naturally felt emotions among nurses?
5. Practice environment and commuting stress would significantly jointly and independently predict emotional termination among nurses?
6. There will be a significant prediction of marital status on emotional labour among nurses?

MATERIALS AND METHODS

Design and Sampling

This study employed ex-post facto design because the variables of interest practice environment, commuting stress and emotional labour would have already occurred in nature before the commencement of this study. Therefore, the researcher collected the necessary data needed for the study to draw inferences about these variables in association with the dependent variable (emotional labour) which is of interest. Therefore, this study employed a convenience sampling technique, the reason for the choice of this type of sampling technique is that the research has a focus group of interest which is nurses.

Setting

This study was carried out among nurses in Ibadan, Oyo State. This setting was used because of its highly concentrated number of nurses; it has the highest number of professional nurses in Ibadan, Oyo State.

Participants

Participants consist of nurses in Ibadan, who were selected by convenience sampling technique. However, Cochran's (1977) sampling size determinant was adopted for this study. A total of three hundred and one (301) nurses served

as participants in the study. Their age ranged between 17 and 64; the Mean age was 32.93 (SD = 0.39) (**See table 1 for demographic information).**

Inclusion/ Exclusion Criteria

The participants in this study include nurses in Ibadan and exclude other nurses who are not working in Ibadan.

Instrument

A standardized questionnaire was adopted for this study; this questionnaire will be divided into five sections:

Section A: This section measures demographic variables such as gender, age, marital status and years of working experience.

Section B: This section measures Emotional labour. This variable was measured by 16 items developed by Chunjiang, Yashuo and Xinyuan (2019). This scale is designed to assess the emotional presentation that the nurses perform. The scale is divided into 4 dimensions which are; surface acting, deep acting, expression of naturally felt emotions and emotion termination. The scale is measured on a seven-point Likert scale ranging from (1 = strongly disagree, to 7 = strongly agree). The study reported a Cronbach alpha ranging from .71 to .85. This study reported a Cronbach alpha of 0.87, with a reliability ranging between 0.67 and 0.86.

Practice Environment: This section measures the Practice environment which scale was adopted from Gea-Caballero, et al., (2021). The practice environment scale has 5 dimensions, namely, Nurse Participation in centre affairs (9 items), Nursing foundation for quality of care (10 items), Management and leadership of head nurse (5 items), Adequate human resources to ensure quality of care (4 items) and Nurse physician relationship (3 items). This scale has a total of 31 items measured on a 4-point Likert scale ranging from Strongly disagree =1, Disagree =2, Agree =3, Strongly agree =4, with scores ranging from 4 to 124. Total scores are interpreted as follows: values≥80.6 are interpreted as positive environments for nursing work, values between 74.5 and 80.5 are identified as controversial environments and values≤74.4 are classed as negative environments for nursing work. The study reported a Cronbach's alpha for the PES-NWI was 0.93, with a reliability range between 0.84 and 0.94 for each dimension. This study reported a Cronbach's alpha of 0.95, with a reliability ranging between 0.81 and 0.91.

Commuting Stress: This section will measure Commuting stress. This variable was measured with a 10-item instrument developed by Kwesi, Francis and Beckham, (2016). This 10-item instrument is designed to assess individuals' subjective experience of their commute to and from work. Sample questions include: It takes me longer than necessary to commute to work in the morning. All the items were rated on a 5-point scale ranging from 5 (strongly agree) to 1 (strongly disagree). Item 8 is reverse-scored. The study reported a high Cronbach alpha of .90. This study reported an overall Cronbach alpha of .85.

Procedure

The researcher informed the hospital management of the purpose of the study and sought permission to gain informed consent to proceed with the study. Then the researcher visited different wards where nurses were been posted and informed the participants about the purposes, objectives and importance of the study. During the interaction, the researcher assured the entire participant that their responses would be confidential and be used only for the study. The questionnaire was shared among the nurses and directions on how to complete the questionnaire were explained by the researcher. The researcher was asked to come back the following day for the questionnaires. On no account did the researcher force the participant to fill out the questionnaire and no form of incentives was given. After the collection of the questionnaire, the researcher appreciated the management and participants for their utmost cooperation throughout the process.

Ethical Consideration

The researcher followed ethical guidelines by getting informed consent from the subjects, in accordance with the concept of individual autonomy. Participants were guaranteed their voluntary involvement, anonymity, privacy, and confidentiality throughout the data-gathering

process. Their right to participate was likewise honoured. Data was collected over a period of 3 weeks.

Statistical Method

The data was analyzed using the Statistical Package for Social Sciences (SPSS) version 22.0 Hypothesis one, two, three, four, and five was tested using hierarchical multiple regression analysis while hypothesis six was tested using one-way analysis of variance.

RESULTS

The first hypothesis which states that Practice Environment and Commuting Stress would jointly and independently predict Emotional Labour among nurses was tested using hierarchical multiple regression.

Table 1: Summary showing the distribution of the participants' characteristics across specified demographic variables.

Variables	Category		n(301)	n%
Sex	Male		55	18.3
	Female		246	81.7
Age	17-64	Mean= 32.93±0.39	300	99.7
Marital Status	Single		143	47.5
	Married		150	47.0
	Divorced		5	1.7
	Widowed		3	1.0
Practice experience	1 – 5 years		163	54.2
	5 – 10 years		70	23.3
	10 – 15 years		22	6.6
	15 – 20 years		19	6.3
	20 years and above		29	9.6

Table 2: Independent and joint prediction of Practice Environment and Commuting Stress on Emotional Labour among Nurses.

	Predictors		β	t	Sig	R	R^2	R^2Change	F	p
Model 1	Gender		.05	.85	>.05					
	Age		.28	3.00	<.01	.25	.06	.06	6.65	<.001
	Practice Experience		-.39	-4.28	<.001					
Model 2	Gender	-.02	-.39	>.05						
	Age		.15	2.03	<.05					
	Practice Experience		-.24	-3.12	<.01					
	Nurse participation in H.C.A		.10	1.40	>.05	.65	.42	.36	26.37	<.001
	Nursing foundation for Q.C	.38	5.95	<.001						
	Management & Leadership of H.N	.09	.98	>.05						
	Adequate Human Resources		-.02	-.29	>.05					
	Nurse-Physician Relationships		.16	1.97	>.05					
Model 3	Gender	-.00	-.09	>.05						
	Age		.16	2.18	<.05					
	Practice Experience		-.23	-3.07	<.01					
	Nurse participation in H.C.A		.10	1.41	>.05	.69	.47	.05	28.45	<.001
	Nursing foundation for Q.C	.30	4.81	<.001						
	Management & Leadership of H.N	.09	1.03	>.05						
	Adequate Human Resources		.03	.42	>.05					
	Nurse-Physician Relationships		.11	1.34	>.05					

Commuting Stress	.24	5.16	<.001

Table 2 shows that, in the first model, the covariate demographic factors showed a significant joint and independent prediction on emotional labour ($F_{(3,295)}$ =6.65, R=.25, R^2=.06, p<.001) and was statistically controlled for in the analysis. For the second model, the predictor variables of practice environment components were added to the analysis. The result revealed a significant joint prediction of these predictors on Emotional Labour ($F_{(8,290)}$ =26.37, R=.65, R^2=.42, p<.001). So, therefore, the R^2 change value of (.36) associated with this model suggests that the addition of practice environment components to the first model accounted for 36% of the variation observed in emotional labour. In the third model, the predictor variable of commuting stress was added to the analysis. The result showed that demographic factors, practice environment, and commuting stress jointly predicted emotional labour ($F_{(9,289)}$ =28.45, R=.69, R^2=.47, p<.001) thereby accounting for 47% variation on the dependent variable. Additionally, the R^2 Change value of (.05) associated with this model significantly contributed 5% to emotional labour. Independently, Age (β= .16, t= 2.18; p<.05), practice experience (β= -.23, t= -3.07; p<.01), Nursing foundation for quality of care (β= .30, t= 4.81; p<.001) and commuting stress (β= .24, t= 5.16; p<.001) significantly accounted for 16%, 23%, 30% and 24% variation respectively in the dependent variable. Thus, this hypothesis partly supported the stated hypothesis.

The second hypothesis which states that Practice Environment and Commuting Stress would jointly and independently predict Surface Acting among nurses was tested using hierarchical multiple regression.

Table 3: Independent and joint prediction of Practice Environment and Commuting Stress on Surface Acting among Nurses.

	Predictors		β	t	Sig	R	R^2	R^2Change	F	p
Model 1	Gender		-.01	-.23	>.05					
	Age		.16	1.68	>.05	.17	.03	.03	3.05	<.05
	Practice Experience		-.27	-2.87	<.01					
Model 2	Gender	-.04	-.77	>.05						
	Age		.08	.82	>.05					
	Practice Experience		-.15	-1.59	>.05					
	Nurse participation in H.C.A		.03	.28	>.05	.36	.13	.10	5.27	<.001
	Nursing foundation for Q.C	.21	2.66	<.01						
	Management & Leadership of H.N	-.05	-.44	>.05						
	Adequate Human Resources		.17	2.12	<.05					
	Nurse-Physician Relationships		.02	.15	>.05					
Model 3	Gender	-.03	-.49	>.05						
	Age		.08	.92	>.05					
	Practice Experience		-.13	-1.47	>.05					
	Nurse participation in H.C.A		.02	.25	>.05	.45	.20	.08	8.17	<.001
	Nursing foundation for Q.C	.11	1.46	>.05						
	Management & Leadership of H.N	-.05	-.45	>.05						
	Adequate Human Resources		.23	2.92	<.01					
	Nurse-Physician Relationships		-.06	-.56	>.05					
	Commuting Stress		.30	5.24	<.001					

Results in Table 3 show that, in the first model, the covariate demographic factors showed a significant joint and independent prediction on surface acting ($F_{(3,295)}$ =3.05, R=.17, R^2=.03, p<.05) and was statistically controlled for in the analysis. For the second model, predictor variables of practice environment components were added to the analysis. The result revealed a significant joint prediction on Surface acting ($F_{(3,295)}$ =3.05, R=.17, R^2=.03, p<.05) Therefore, the R^2 change value of (.10) associated with this model suggests that the addition of practice environment components to the first model accounted for 10% of the variation observed in surface acting. In the third model, the predictor variable of commuting stress was added to the analysis. The result showed that demographic factors, practice environment, and commuting stress jointly predicted surface acting ($F_{(9,289)}$ =8.17, R=.45, R^2=.20, p<.001). In addition, the R^2 change value of (.08) associated with this model suggests that the addition of commuting stress

to the second model accounted for 8% of the variation observed in surface acting. Independently, practice experience (β= -.27, t= -2.87; p<.01), Nursing foundation for quality health (β= .21, t= -2.66; p<.01), adequate human resources (β= .23, t= 2.92; p<.01) and commuting stress (β= .30, t= 5.24; p<.001) significantly accounted for 21%, 27%, 23%, and 30% variation respectively in surface acting. Based on this result, the stated hypothesis is partly supported.
The third hypothesis which states that Practice Environment and Commuting Stress would jointly and independently predict Deep Acting among nurses was tested using hierarchical multiple regression.

Table 4: Independent and joint prediction of Practice Environment and Commuting Stress on Deep Acting among Nurses.

	Predictors		β	t	Sig	R	R^2	R^2Change	F	p
Model 1	Gender		.05	.92	>.05					
	Age		.24	2.54	<.05	.17	.03	.03	2.87	<.05
	Practice Experience		-.25	-2.62	<.01					
Model 2	Gender	.00	-.03	>.05						
	Age		.15	1.78	>.05					
	Practice Experience		-.14	-1.50	>.05					
	Nurse participation in H.C.A		.03	.31	>.05	.54	.29	.26	14.62	<.001
	Nursing foundation for Q.C	.36	5.06	<.001						
	Management & Leadership of H.N	.12	1.25	>.05						
	Adequate Human Resources		-.03	-.43	>.05					
	Nurse-Physician Relationships		.12	1.26	>.05					
Model 3	Gender	.00	.05	>.05						
	Age		.15	1.78	>.05					
	Practice Experience		-.13	-1.53	>.05					
	Nurse participation in H.C.A		.02	.30	>.05	.54	.29	.01	13.25	<.001
	Nursing foundation for Q.C	.33	4.60	<.001						
	M&L of Head Nurse		.12	1.26	>.05					
	Adequate Human Resources		-.02	-.23	>.05					
	Nurse-Physician Relationships		.09	1.06	>.05					
	Commuting Stress		.08	1.40	>.05					

Table 4 revealed a significant joint and independent predictor of deep acting ($F_{(3,295)}$ =2.87, R=.17, R^2=.03, p<.05) and was statistically controlled for in the analysis. For the second model, the predictor variables of practice environment components were added to the analysis. The result revealed a significant joint prediction on deep acting ($F_{(8,290)}$ =14.62, R=.54, R^2=.29, p<.001). So, therefore, the R^2 change value of (.26) associated with this model suggests that the addition of practice environment components to the first model accounted for 26% of the variation observed in deep acting. In the third model, the predictor variable of commuting stress was added to the analysis. The result showed that demographic factors, practice environment, and commuting stress jointly predicted deep acting ($F_{(9,289)}$ =13.25, R=.54, R^2=.29, p<.001). Additionally, the R^2 Change value of (.01) associated with this model suggests that the addition of commuting stress to the second model accounted for 1% of the variations in deep acting. Independently, Age (β= .24, t= 2.54; p<.05), practice experience (β= -.25, t= -2.62; p<.01) Nursing foundation for quality of care (β= .33, t= 4.60; p<.001) significantly accounted for 24%, 25%, and 33% variation respectively in the dependent variable. Thus, this hypothesis partly supported the stated hypothesis.

The fourth hypothesis which states that Practice Environment and Commuting Stress would jointly and independently predict naturally felt emotion among nurses was tested using hierarchical multiple regression.

Table 5: Independent and joint prediction of Practice Environment and Commuting Stress on Natural Felt Emotion among Nurses.

Predictors		β	t	Sig	R	R^2	R^2Change	F	p
Model 1	Gender	.09	1.60	>.05					
	Age	.20	2.11	<.05	.21	.04	.04	4.31	< .01
	Practice Experience	-.29	-3.08	<.01					
Model 2	Gender	.02	-.48	>.05					
	Age	.13	1.76	>.05					
	Practice Experience	-.18	-2.38	>.05					
	Nurse participation in H.C.A	.25	3.56	<.001	.69	.47	.43	31.99	<.001
	Nursing foundation for Q.C	.52	8.59	<.001					
	Management & Leadership of H.N	-.01	-.17	>.05					
	Adequate Human Resources	-.11	-1.80	>.05					
	Nurse-Physician Relationships	.02	.28	>.05					
Model 3	Gender	.02	.50	>.05					
	Age	.13	1.76	>.05					
	Practice Experience	-.18	-2.37	<05					
	Nurse participation in H.C.A	.25	3.56	<.001	.69	.47	.00	28.35	<.001
	Nursing foundation for Q.C	.52	8.28	<.001					
	Management & Leadership of H.N	-.01	-.17	>.05					
	Adequate Human Resources	-.11	-1.76	>.05					
	Nurse-Physician Relationships	.02	.25	>.05					
	Commuting Stress	.01	.21	>.05					

The result in Table 5 shows that, in the first model, results revealed a significant joint predictor of the demographic variable on Natural felt emotion ($F_{(3,295)}$ =4.31, R=.21, R^2=.04, p<.01) and was statistically controlled for in the analysis. For the second model, the predictor variables of practice environment components were added to the analysis. The result revealed a significant joint prediction on naturally felt emotion ($F_{(8,290)}$ =31.99, R=.69, R^2=.47, p<.001). So, therefore, the R^2 change value of (.43) associated with this model suggests that the addition of practice environment components to the first model accounted for 43% of the variation observed in naturally felt emotion. In the third model, the predictor variable of commuting stress was added to the analysis. The result showed that demographic factors, practice environment, and commuting stress jointly predicted naturally felt emotion ($F_{(9,289)}$ =28.35, R=.69, R^2=.47, p<.001)

Additionally, the R^2 Change value of (.00) associated with this model suggest that the addition of commuting stress to the second model accounted for 0% of the variation in naturally felt emotion. Independently, age (β= .20, t= 2.11; p<.0), practice experience (β= -.29, t= -3.08; p<.01), Nurses' participation in the centre affairs (β= .25, t= 3.56; p<.001), and Nursing foundation for quality of care (β= .52, t= 8.28; p<.001) had a significantly independent influence on natural felt emotion by accounting for 20%, 29%, 25% and 52% variation respectively in the dependent variable. Based on this result, the hypothesis was partly supported.

The fifth hypothesis which states that Practice Environment and Commuting Stress would jointly and independently predict Emotional termination among nurses was tested using hierarchical multiple regression.

Table 6: Independent and joint prediction of Practice Environment and Commuting Stress on Emotional Termination among Nurses.

Predictors		β	t	Sig	R	R^2	R^2Change	F	p
Model 1	Gender	.03	1.46	>.05					
	Age	.24	2.60	<.05	.25	.06	.06	6.54	<.001
	Practice Experience	-.29	-4.21	<.001					
Model 2	Gender	.02	-.48	>.05					
	Age	.12	1.39	>.05					
Practice Experience		-.26	-3.07	<.01					
Nurse participation in H.C.A		.06	.72	>.05	.55	.31	.24	16.01	<.001
Nursing foundation for Q.C		.14	2.05	<.05					
Management & Leadership of H.N		.15	1.61	>.05					
Adequate Human Resources		-.08	-1.12	>.05					
Nurse-Physician Relationships		.28	3.13	<.01					
Model 3	Gender	-.01	-.15	>.05					
	Age	.12	1.54	>.05					
Practice Experience		-.24	-3.04	<.01					
Nurse participation in H.C.A		.05	.71	>.05	.62	.38	.08	19.98	<.001
Nursing foundation for Q.C		.05	.68	>.05					
Management & Leadership of H.N		.15	1.72	>.05					
Adequate Human Resources		-.02	-.34	>.05					
Nurse-Physician Relationships		.02	2.47	<.05					
Commuting Stress		.31	6.02	<.001					

Table 6. Results in model 1 revealed a significant joint predictor of demographic variables on Emotional termination ($F_{(3,295)}$ = 6.54, R=.25, R^2=.06, p<.001) and was statistically controlled for in the analysis. For the second model, the predictor variables of practice environment components were added to the analysis. The result revealed a significant joint prediction on emotional termination ($F_{(8,290)}$ =16.01, R=.55, R^2=.31, p<.001). However, the R^2 change value of (.24) associated with this model suggests that the addition of practice environment components to the first model accounted for 24% of the variation observed in emotional termination. In the third model, the predictor variable of commuting stress was added to the analysis. The result

showed that demographic factors, practice environment, and health commuting stress jointly predicted emotional termination ($F_{(9,289)}$ =19.98, R=.62, R^2=.38, p<.001). In addition, the R^2 change value of (.08) associated with this model suggests that the addition of commuting stress to the second model accounted for 8% of the variation observed in emotional termination. Independently, Age (β= .24, t= 2.60; p<.05) and practice experience (β= -.29, t= -4.21; p<.001), nursing foundation for quality of care (β= .14, t= 2.05; p<.05), Nurses-physician relationship (β= .02, t= 2.47; p<.05) and Commuting stress (β= .31, t= 6.02; p<.001), had significantly independent influence on emotional termination by accounting for 24%, 29%, 14%, 02% and 31% variation in the dependent variable. Based on this result, the hypothesis was partly supported.

The sixth hypothesis states that there will be a significant difference in marital status in emotional labour. This was tested using one-way Analysis of Variance (ANOVA) and the result is presented in Table 7.

Table 7: One-Way ANOVA Summary Table Showing the differences among Staff's Marital status on Emotional labour

Source	SS	Df	MS	F	P
Between Groups	4859.004	3	1619.681	4.19	<.01
Within Groups	114937.162	297	386.994		
Total	124350.446	300			

Table 7 revealed that there was a significant difference in the mean score of emotional labour on marital status [F (3, 297) = 4.19; P<.01]. Based on the result, the stated hypothesis is fully supported.

Table 7b: Post Hoc Multiple comparisons showing means difference of emotional labour among Single, Married, Divorced and Widowed Nurses

Marital Status	1	2	3	Mean	S.D
Single	--			70.73	16.76
Married	6.34*	--		64.39	22.03
Divorced	-11.47	-17.81	--	82.20	18.74
Widowed	-13.93	-20.27	-2.47	84.67	25.79

The result in Table 7b shows that divorced nurses ($\bar{x}$ = 82.20) and widowed nurses ($\bar{x}$ = 84.67) performed better emotional labour than single ($\bar{x}$ = 70.73) and married ($\bar{x}$ = 64.39) nurses.

DISCUSSION

The first hypothesis suggests that practice environment and commuting stress would jointly and independently predict Emotional Labour among nurses was partly supported. Results revealed that age, practice experience, nursing foundation for quality of care and commuting stress independently predicted nurses' emotional labour. Meanwhile, the relationship observed in practice experience was inverse, meaning that nurses with longer years of practice experience

exhibited lower emotional labour than nurses with fewer years of practice experience. On the other hand, the relationship observed in age, nurses' quality of care and commuting stress were positive, implying that older nurses, nurses who perceived the hospital has a quality care service and who pass through stress when commuting to work exhibited more emotional labour. These findings contrast with the outcome study of Mikyoung Lee and Keum-Seong Jang (2019) observed in their study that age and professional experience influence nurses' emotional labour, implying that the more experience they have, the less emotional labour they display.

However, Akinwale and George, (2020) observed that while all variables contributed to nurses' emotions, remuneration was the most important predictor, followed by growth and promotion. All seven indicators, including sociopolitical atmosphere, administrative and management support, autonomy and responsibility, remuneration, supervision and working conditions, recognition and success, development and promotion, have a favourable impact on nurses' emotional labour. Similarly, Andrew, Dare, Robinson and Costello, (2022) and Festini, Ciofi, and Bisogni (2011) revealed that nurses under the age of 30 travel longer distances, and spend more time and money than their older counterparts. Travelling to work affects nurses' emotional labour, especially among younger nurses. Nurses appear to have less opportunity to relax and recuperate energy than other employees.

The second hypothesis suggests practice environment and commuting stress would jointly and independently predict surface acting among nurses was partly supported. Findings revealed that gender, practice experience, nurse's foundation for quality of care, adequate human resources and commuting stress independently predicted surface action among nurses. Meanwhile, the relationship observed in practice experience was inverse, meaning that nurses with longer years of practice experience exhibited lower emotional labour than nurses with fewer years of practice experience. However, the relationship observed in nurses' foundation for quality of care, adequate human resources and commuting stress was positive implying that older nurses, nurses who perceived hospitals as having a quality care service, nurses who have adequate human and technological resources to carry out their duty and nurses who pass through stress when commuting to work are more likely to display higher surface acting. However, this study found support in the findings of Chen, (2019) whose results show that zealous employees tend to adopt a deep-acting strategy when dealing with emotionally draining situations, protecting themselves from emotional exhaustion. Furthermore, Aiken, Sloane, Bruyneel, Van, and Sermeus (2013) discovered that lack of time for crucial nursing activities and the frequent occurrence of unfavourable occurrences were both noted. As a result of these issues in the job environment, nurses were claimed to have failed to perform professionally in deep acting.

The third hypothesis suggests practice environment and commuting stress would jointly and independently predict deep acting among nurses was partly supported. However, age, practice experience and nurses' foundation for quality of care, independently predicted deep action among nurses. Meanwhile, the relationship observed in practice experience was inverse, meaning that nurses with longer years of practice experience exhibited lower deep acting than nurses with fewer years of practice experience. However, the relationship observed in age and nurses' foundation for quality of care was positive implying that that older nurses and nurses who perceived the hospital as a quality care service displayed higher surface acting. However, this study found support in the findings of Kim, Han, and Choi (2019) who ascertained that the practising environment has well-known detrimental effects on deep acting. Additionally, Chu, (2024) found that emotional labour performed by nurses is above average and that deep acting was superior to surface acting. While job hierarchy and working conditions had a detrimental impact on displaying deep acting. The outcome also demonstrates that the hospital's expectations prevented nurses from doing their jobs because those activities did not call for emotional labour on their part. Meanwhile, Mesmer-Magnus et al., (2023) discovered that employees with lengthy commutes exhibit negative feelings as a result of the stress they face while commuting to and from work reported displaying poor emotions at work. Ojo, and Lawal, (2023) discovered that nurses with more years of experience are more likely to show less deep-acting emotional labour due to the experience they've gathered on the job.

The fourth hypothesis suggests practice environment and commuting stress would jointly and independently predict naturally felt emotion among nurses was partially supported. Findings revealed that age, practice experience, nurses' participation in the centre affairs and nurses' foundation for quality of care, independently predicted natural felt emotion among nurses. Meanwhile, the relationship observed in practice experience was inverse, meaning that nurses with longer years of practice experience exhibited lower deep acting than nurses with fewer years of practice experience. On the other hand, the relationship observed in age, nurse's participation in the centre affairs and nurses' foundation for quality of care was positive implying that older nurses, nurses who were allowed to take part in the hospital affair and nurses who perceived hospital has a quality care service displayed higher natural felt emotion. However, this study found support in the findings of Choi and Kim (2019) revealed that employee needs and job contentment strongly influence real workplace emotion. However, it was discovered that expressing naturally felt emotion at work was connected with a positive quality of work-life and work environment (Cheng & Yang. 2018), work satisfaction, and reduced psychological distress (Choi & Kim 2019). However, Amissah, et al., (2022) discovered that when employees face long travel times to physically show up for work, they are less likely to exhibit naturally felt emotions at work.

The fifth hypothesis suggests practice environment and commuting stress would jointly and independently emotional termination among nurses. The findings of this study showed that age, practice experience, nurse's foundation for quality of care, Nurse-physician relationship and Commuting stress independently predicted a nurse's emotional termination. Therefore, the relationship observed in practice experience was inverse, meaning that nurses with longer years of practice experience exhibited lower emotional termination than nurses with fewer years of practice experience. Furthermore, the relationship observed for age, nurses' foundation for quality of care, nurses-physician relationship and commuting stress was positive, implying that nurses who perceived the hospital as having a better quality care service, nurses who have a better relationship with the hospital management and had stress when commuting to work exhibited high emotional termination. However, this study found support in the findings of Johnson (2018) who discovered that workers who use emotional termination are frequently in a powerless situation, which contributes to employee dissatisfaction. Furthermore, emotional termination is a result of poor management and poor practising conditions. However, emotional termination causes employees to limit emotional engagement with customers, which results in poor service delivery.

The sixth hypothesis suggested that there will be a significant difference in marital status in emotional labour was fully supported. Findings revealed that there was a significant difference in the mean score of emotional labour on marital status. Furthermore, it was discovered that divorced nurses and widowed nurses performed better emotional labour than single and married nurses. However, married nurses performed worse in emotional labour. The outcome contradicts that of Gross, Gulsen and Ozmen, (2020) revealed that married individuals report greater emotional control and better emotional labour than single nurses. They suggested that this may be the result of older participants adopting increasingly antecedent-focused strategies to influence their emotional labour.

Conclusion

The findings of this study revealed that practice environment and its components and commuting stress are extremely important factors in explaining emotional labour and its components among nurses. As such, it was concluded that psychosocial factors jointly predicted emotional labour and its components. Instead of this, age, practice experience, participation in the centre affairs, the nursing foundation for quality of care, adequate human resources, Nurses-physician relationship and commuting stress independently predicted nurse's emotional labour and its components (surface action, deep acting, naturally felt emotion and emotional termination) among nurses in Ibadan. However, the further result shows that the mean value of Emotional labour was significantly different between single and married. Furthermore, it was discovered

that divorced nurses and widowed nurses performed better emotional labour than single and married nurses. However, married nurses performed worse in emotional labour.

Recommendation

To better understand how nurse's emotional labour is affected by psychosocial factors, it is now recommended that collaborative and multidisciplinary approaches to research be used. Based on the findings of this study, several recommendations can be made to enhance the well-being and effectiveness of nurses in managing emotional labour. Healthcare institutions should focus on improving the practice environment by addressing key psychosocial factors such as the nurse-physician relationship, adequate human resources, and active participation in centre affairs. By creating a supportive and well-resourced work environment, nurses may experience reduced commuting stress and improved job satisfaction, which can positively impact their ability to manage emotional labour effectively. Furthermore, tailored interventions should be developed to support nurses based on their demographic characteristics and personal circumstances. For instance, special attention should be given to married nurses who were found to perform worse in emotional labour compared to their single, divorced, and widowed counterparts. Providing access to stress management programs, flexible working hours, and family support services could help married nurses balance their professional and personal responsibilities better, thereby enhancing their emotional well-being and job performance. Lastly, healthcare administrators should consider the significant differences in emotional labour performance between different marital statuses. Specific training programs and workshops on emotional intelligence and coping strategies can be particularly beneficial for nurses navigating different life stages. Finally, nurse's hostels in the hospital vicinity, work shifts and public transportation should be provided.

Limitations and Suggestions for Further Studies

Regardless of the study's relevance, it must be stated that the study does have limitations which are highlighted as follows;

- This study assessed the study's respondents at a single point in time, but the variables in the research are not static and may change as situations change. As a result, adopting a longitudinal data collection method can be effective in overcoming this limitation.
- The severity of the nurse's poor emotional labour on the patient's recovery process was not taken into consideration in this study, even though it could have a significant impact on the patient's recovery process. As a result, future research should ensure condition uniformity to be concise about emotional labour.
- A single study cannot examine all of the variables that can explain emotional labour among nurses. As a result, it is suggested that future research along this line be conducted to discover other psychosocial predictors of emotional labour among nurses and other professions like bankers, teachers etc.

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