

Emotional Labour, Social Identity, and Psychological Distress among Nurses from the North-East Working in Delhi NCR

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ABSTRACT

The present study examined the association between emotional labour dimensions, social identity, and psychological distress among nurses from the North-East region of India working in Delhi NCR. Emotional labour, defined as the regulation of emotions to meet organisational display rules, is particularly relevant in healthcare contexts where sustained patient interaction and caregiving demands are high. Drawing on emotional labour theory and social identity perspectives, the study investigated whether Surface Acting, Deep Acting, and Social Identity significantly predicted psychological distress in migrant nursing professionals.

A quantitative cross-sectional design was employed with a sample of 295 nurses from the North-East working in hospitals across Delhi NCR. Standardised measures of emotional labour dimensions, social identity, and psychological distress were administered. Data were analysed using Pearson's correlation and hierarchical multiple regression analyses.

Results indicated that Surface Acting was significantly associated with higher psychological distress and emerged as a significant positive predictor. Deep Acting was not a significant predictor of distress. Social Identity was negatively associated with psychological distress and independently predicted lower levels of distress.

The findings suggest that emotion regulation strategies involving inauthentic emotional expression may increase occupational vulnerability, whereas stronger social identity may function as a protective psychosocial resource among migrant nurses. The study highlights the importance of considering both emotional labour processes and socio-relational identity factors in understanding psychological well-being in healthcare settings. It also underscores the need for culturally responsive and supportive workplace environments for migrant healthcare professionals.

Keywords: emotional labour, surface acting, deep acting, social identity, psychological distress, nurses, North-East India

INTRODUCTION

Healthcare professionals are required to engage in continuous emotional regulation and interpersonal interaction in order to maintain professional standards of caregiving and patient care. Among healthcare professionals, nurses are particularly expected to display empathy, emotional composure, patience, reassurance, and compassion irrespective of their own emotional experiences (Mann & Cowburn, 2005). Such regulation of emotional expression in accordance with occupational expectations is conceptualised as emotional labour, a concept introduced by Hochschild (1983) to describe the management of emotions and emotional expressions in line with organisational and professional expectations.

Research on emotional labour has largely focused on two emotional regulation strategies: Surface Acting and Deep Acting (Brotheridge & Grandey, 2002). Surface Acting involves suppressing genuinely experienced emotions while displaying emotions that are organisationally expected, whereas Deep Acting involves attempts to genuinely modify internal emotional experiences so that displayed emotions become more authentic and congruent. Existing literature has consistently shown that Surface Acting is associated with emotional exhaustion, burnout, stress, and reduced psychological wellbeing, whereas Deep Acting is often comparatively less psychologically harmful (Grandey, 2000; Zapf, 2002). Psychological distress, broadly referring to

experiences of emotional suffering, stress, anxiety, and psychological strain, may therefore emerge when emotional regulation becomes chronic and psychologically demanding.

The emotional demands associated with nursing may become particularly significant within urban healthcare environments characterised by high patient loads, long working hours, institutional hierarchies, and sustained interpersonal engagement. Within Indian healthcare settings, nurses often work under emotionally demanding conditions while simultaneously negotiating workload pressures, institutional expectations, and limited psychosocial support (Khamisa et al., 2015). Recent research in other occupational settings similarly suggests that psychological strain may be influenced by the interaction between individual factors, work-related demands, and contextual support systems (Patra & Singh, 2026). Research conducted within Indian healthcare contexts has similarly highlighted concerns related to occupational stress, burnout, emotional exhaustion, and mental health challenges among nurses and healthcare workers (Bhatia et al., 2010; Sharma et al., 2014). Contemporary post-pandemic literature further indicates elevated levels of distress, fatigue, and burnout among healthcare professionals working within under-resourced and high-pressure healthcare systems (Das et al., 2023).

In addition to occupational emotional demands, migrant healthcare professionals may also experience broader psychosocial stressors related to migration, cultural adjustment, identity negotiation, and social belongingness. Within metropolitan cities such as Delhi NCR, nurses from the North-East region of India constitute a substantial component of the healthcare workforce. Despite their visible contribution to urban healthcare systems, the psychosocial experiences of nurses from the North-East remain relatively underrepresented within Indian psychological research.

Existing literature examining migration experiences among individuals from the North-East in metropolitan Indian contexts has highlighted concerns related to stereotyping, racial discrimination, social exclusion, cultural marginalisation, and identity negotiation (McDuie-Ra, 2012; Haokip, 2012; EP, Negi, AP, & A, 2022). Individuals from the North-East are often perceived as culturally and physically distinct within metropolitan spaces, which may contribute to experiences of alienation and psychosocial stress. Such experiences may significantly shape emotional wellbeing and workplace adjustment among migrant nursing professionals working away from their home regions and support systems.

Within this context, Social Identity Theory provides an important framework for understanding psychological wellbeing among migrant professionals. Social identity refers to an individual's sense of belongingness and identification with meaningful social groups (Tajfel & Turner, 1979). Previous literature suggests that strong social identity contributes positively to wellbeing through belongingness, emotional support, collective meaning, and resilience (Haslam et al., 2009; Jetten et al., 2012). For migrant nurses working within culturally unfamiliar environments, identification with one's regional or cultural community may therefore function as an important psychosocial resource.

The present study is further informed by Conservation of Resources (COR) Theory, which proposes that individuals strive to obtain, retain, and protect valued psychological and social resources (Hobfoll, 1989). Within emotionally demanding professions such as nursing, repeated emotional regulation may gradually deplete psychological resources and contribute to emotional exhaustion and distress. In contrast, psychosocial resources such as belongingness, social connectedness, and group identification may help buffer stress and support psychological wellbeing.

For nurses from the North-East working in Delhi NCR, emotional labour may therefore operate within broader socio-cultural contexts shaped by migration, identity negotiation, workplace adjustment, and belongingness. Emotional regulation within such contexts may involve not only maintaining professional emotional displays but also navigating socio-cultural pressures associated with adjustment and social integration within metropolitan environments.

Although emotional labour has been widely examined within organisational and healthcare psychology, existing literature has largely focused on Western populations and generalised healthcare contexts. Within Indian psychology, relatively limited research has examined how emotional labour dimensions and psychosocial identity processes jointly shape psychological wellbeing among migrant nurses from the North-East working in metropolitan healthcare environments. Furthermore, few studies have specifically explored the differential psychological implications of Surface Acting and Deep Acting within socio-culturally complex urban healthcare settings in India. Cross-disciplinary healthcare research also highlights the importance of careful validation, transparent reporting, and context-sensitive interpretation when evaluating evidence in

applied clinical settings (Pandey, 2025).

Accordingly, the present study aimed to examine the relationship between emotional labour dimensions, social identity, and psychological distress among nurses from the North-East region of India working in Delhi NCR. Specifically, the study sought to examine whether Surface Acting, Deep Acting, and Social Identity significantly predicted psychological distress among migrant nursing professionals.

REVIEW OF LITERATURE

Emotional Labour and Psychological Wellbeing

The concept of emotional labour was introduced by Hochschild (1983), who described emotional labour as the regulation and management of emotional expressions in accordance with occupational expectations. Emotional labour is particularly relevant within professions involving sustained interpersonal interaction and caregiving responsibilities, such as nursing, teaching, hospitality, and healthcare services.

Subsequent theoretical developments distinguished between Surface Acting and Deep Acting as two primary emotional labour strategies (Brotheridge & Grandey, 2002). Surface Acting involves suppressing genuine emotions while displaying emotions that are professionally expected, whereas Deep Acting involves attempts to genuinely modify internal emotional experiences so that displayed emotions become more authentic and congruent. Emotional regulation perspectives further suggest that Deep Acting may involve comparatively adaptive forms of emotional engagement because internally experienced emotions become more aligned with displayed emotions (Gross, 1998).

Research across organisational and healthcare settings has consistently demonstrated that Surface Acting is associated with emotional exhaustion, burnout, stress, depersonalisation, and reduced psychological wellbeing (Grandey, 2000; Zapf, 2002; Hülshager & Schewe, 2011). The psychological strain associated with Surface Acting is commonly explained through emotional dissonance, wherein individuals experience a discrepancy between genuinely felt emotions and organisationally expected emotional displays (Morris & Feldman, 1996). In contrast, Deep Acting often demonstrates weaker or inconsistent associations with psychological strain because it may reduce emotional dissonance and facilitate comparatively authentic emotional regulation (Brotheridge & Grandey, 2002; Zapf, 2002).

Studies conducted within healthcare settings have similarly shown that emotional labour contributes significantly to occupational stress and burnout among nurses (Mann & Cowburn, 2005). Nursing professionals are often expected to regulate emotional expressions while simultaneously managing emotionally intense caregiving responsibilities, interpersonal interactions, and institutional expectations (Smith & Gray, 2001). Surface Acting, in particular, has been associated with emotional exhaustion and reduced wellbeing because continuous suppression of genuine emotions may gradually produce emotional depletion over time.

Within Indian healthcare contexts, research has increasingly highlighted concerns related to occupational stress and psychological wellbeing among nurses and healthcare workers. Studies conducted in India have reported high levels of stress, burnout, emotional exhaustion, and work-related psychological strain among nursing professionals due to demanding workloads, institutional pressures, long working hours, and emotionally intensive caregiving responsibilities (Bhatia et al., 2010; Sharma et al., 2014). More recent post-pandemic literature has additionally documented elevated levels of distress, fatigue, and burnout among healthcare professionals operating within high-pressure and under-resourced healthcare systems (Das et al., 2023). However, relatively limited Indian research has specifically examined emotional labour processes among migrant nurses working in metropolitan healthcare systems.

Social Identity and Psychological Wellbeing

Social Identity Theory proposes that individuals derive part of their self-concept from membership in social groups (Tajfel & Turner, 1979). Identification with meaningful social groups contributes positively to belongingness, emotional support, collective meaning, and psychological security. Research has shown that strong social identity is associated with improved psychological wellbeing, resilience, coping, and reduced stress (Haslam et al., 2009; Jetten et al., 2012).

Within migrant populations, social identity may become particularly important because migration often disrupts familiar social and cultural support systems. Identification with one's regional, cultural, or community group may therefore provide emotional continuity, social connectedness, and psychosocial stability within unfamiliar environments.

Studies within Indian contexts have similarly highlighted the role of social belongingness and community support in shaping adjustment and wellbeing among migrant populations (Haokip, 2012). For individuals from the North-East living in metropolitan cities, regional identity may function as an important source of emotional support and belongingness within socially unfamiliar environments.

Migrant Nurses from the North-East in Metropolitan Contexts

Nurses from the North-East region of India form a substantial component of the healthcare workforce in metropolitan cities such as Delhi NCR. However, migration to urban healthcare environments may involve multiple psychosocial challenges, including separation from family support systems, linguistic adjustment, workplace hierarchies, cultural adaptation, discrimination, and social exclusion.

Research examining the experiences of individuals from the North-East in metropolitan India has documented experiences of racial stereotyping, marginalisation, discrimination, and identity negotiation (McDuaie-Ra, 2012; Haokip, 2012; EP, Negi, AP, & A, 2022). Such experiences may influence psychological wellbeing, social adjustment, and workplace experiences among migrant healthcare workers.

For nurses from the North-East, emotional labour may therefore operate within broader socio-cultural contexts shaped by migration and identity negotiation. Emotional regulation may involve not only meeting professional caregiving expectations but also navigating interpersonal discomfort, cultural misunderstanding, social exclusion, and psychosocial stress within urban environments.

Despite their substantial contribution to urban healthcare systems, relatively limited Indian psychological research has specifically examined the emotional wellbeing of nurses from the North-East working in metropolitan healthcare settings. Consequently, there remains a need to examine how emotional labour dimensions and psychosocial identity processes jointly shape psychological distress among migrant nurses working within socio-culturally complex urban healthcare environments in India.

Research Gap

Although emotional labour and psychological wellbeing have been widely studied within organizational psychology, existing research has largely focused on Western populations and generalized healthcare settings. Within Indian psychology, relatively limited research has examined the psychosocial consequences of emotional labour among migrant healthcare professionals, particularly nurses from the North-East working in metropolitan cities such as Delhi NCR.

Furthermore, although previous studies have explored occupational stress and burnout among nurses, limited attention has been paid to the differential psychological implications of Surface Acting and Deep Acting within socio-culturally complex healthcare environments shaped by migration, identity negotiation, and social adjustment.

Existing emotional labour literature has also largely overlooked how psychosocial identity processes shape wellbeing among migrant nurses within Indian urban healthcare contexts. Given the unique experiences of nurses from the North-East, including migration-related adjustment, cultural marginalization, workplace adaptation, and identity negotiation, there is a need for contextually grounded psychological research examining how emotional labour dimensions and social identity contribute to psychological distress among this population.

The present study therefore seeks to address this gap by examining the relationship between emotional labour dimensions, social identity, and psychological distress among nurses from the North-East working in Delhi NCR. By situating emotional labour within broader socio-cultural experiences of migration, belongingness, and identity negotiation, the study attempts to contribute to culturally grounded understandings of occupational wellbeing among migrant healthcare professionals in India.

Objectives

1. To examine the relationship between Surface Acting, Deep Acting, Social Identity, and Psychological Distress.
2. To examine whether emotional labour dimensions predict Psychological Distress.
3. To examine whether Social Identity predicts Psychological Distress.

Hypotheses

1. Surface Acting will positively predict Psychological Distress.

2. Deep Acting will show weaker or non-significant associations with Psychological Distress.
3. Social Identity will negatively predict Psychological Distress.

METHOD

Research Design

The present study employed a quantitative cross-sectional correlational research design to examine the relationship between emotional labour dimensions, social identity, and psychological distress among nurses from the North-East region of India working in Delhi NCR.

Participants

The sample consisted of 295 nurses from the North-East region of India working in hospitals across Delhi NCR. Participants were recruited using purposive sampling. The study focused specifically on nurses from the North-East due to the unique psychosocial and occupational experiences associated with migration, cultural adaptation, and healthcare work in metropolitan contexts. Participants who identified as belonging to the North-East region of India and were currently employed as nurses in Delhi NCR hospitals were included in the study.

Measures

Emotional Labour

Emotional labour was assessed using the refined 9-item version of Spratt's Emotions at Work Scale (1996) developed by research team led by AB de Castro (2006). The scale measured two dimensions of emotional labour: surface acting and deep acting. Surface acting consisted of 5 items assessing the suppression of genuine emotions and display of organizationally expected emotions, whereas deep acting consisted of 4 items assessing attempts to internally modify emotional experiences to align with required emotional displays. Responses were recorded on a Likert-type scale ranging from 1 to 5. In the present study, Cronbach's alpha coefficients were .90 for surface acting and .71 for deep acting.

Social Identity

Social identity was assessed using Cameron's Three-Dimensional Strength of Group Identification Scale (2004). The scale consisted of 12 items measuring participants' sense of belongingness and identification with their social group. Responses were recorded on a Likert-type scale ranging from 1 to 7. The scale demonstrated acceptable internal consistency in the present study ($\alpha = .70$).

Psychological Distress

Psychological distress was assessed using Brief Symptom Inventory 18 (BSI-18) by LR Derogatis. The scale consisted of 18 items examining emotional strain and distress-related experiences. Responses were recorded on a Likert-type scale ranging from 0 to 4. The scale demonstrated excellent internal consistency in the present study ($\alpha = .93$).

Procedure

Participants were approached through hospitals and professional networks across Delhi NCR. Data were collected using self-report questionnaires administered either in person or through online forms. Informed consent was obtained prior to participation. Participants were informed about the voluntary nature of participation, confidentiality of responses, and their right to withdraw from the study at any stage without penalty. Ethical considerations related to anonymity and confidentiality were maintained throughout the study.

Data were analyzed using IBM SPSS Statistics. Descriptive statistics and reliability analyses were first conducted for all study variables. Pearson product-moment correlation analyses were performed to examine relationships between emotional labour dimensions, social identity, and psychological distress. Hierarchical multiple regression analysis was subsequently conducted to examine the predictive contribution of surface acting, deep acting, and social identity to psychological distress.

Cronbach's alpha reliability coefficients calculated from the dataset (N = 295)

Scale	Number of Items	Cronbach's α	Interpretation
Surface Acting	5	.90	Excellent reliability
Deep Acting	4	.71	Acceptable reliability
Social Identity	11	.70	Acceptable reliability
Psychological Distress	16	.93	Excellent reliability

Ethical Considerations

Ethical considerations were carefully maintained throughout the study. Ethical approval for the study was obtained from the Institutional Ethics Committee/Institutional Review Board (IRB Approval No. F.No.-RGU/EO-55/IEC/2022/). Participation in the study was entirely voluntary, and informed consent was obtained from all participants prior to data collection. Participants were informed about the purpose of the study, the confidentiality and anonymity of their responses, and their right to withdraw from the study at any stage without any penalty. No personally identifying information was collected, and the data were used solely for academic and research purposes. Care was taken to ensure that participation did not cause psychological discomfort or professional disadvantage to the participants. All responses were stored securely and handled with strict confidentiality.

Results

Preliminary Analyses

The dataset consisted of 295 participants. Prior to hypothesis testing, descriptive statistics and Pearson product-moment correlations were computed for Surface Acting, Deep Acting, Social Identity, and Psychological Distress.

Descriptive Statistics and Correlations

Table 1 presents the means, standard deviations, and intercorrelations among the study variables.

Table 1: Means, Standard Deviations, and Correlations Among Study Variables (N = 295)

Variable	M	SD	1	2	3	4
1. Surface Acting	14.45	3.85	—			
2. Deep Acting	14.71	3.34	-.07	—		
3. Social Identity	5.22	0.71	.04	.04	—	
4. Psychological Distress	3.78	0.55	.48**	-.06	-.11	—

Note. * $p < .05$, ** $p < .01$, *** $p < .001$

Surface Acting demonstrated a moderate positive correlation with Psychological Distress, indicating that individuals who engaged in greater levels of surface acting tended to report higher levels of distress. Social Identity showed a small negative association with Psychological Distress, suggesting that stronger social identity was associated with lower distress. Deep Acting demonstrated a weak and non-significant relationship with Psychological Distress.

Hierarchical Multiple Regression Analysis

A hierarchical multiple regression analysis was conducted to examine the extent to which emotional labour dimensions and social identity predicted Psychological Distress.

In Model 1, Surface Acting and Deep Acting were entered as predictors. The model was statistically significant, $F(2, 292) = 44.13$, $p < .001$, explaining 23.2% of the variance in Psychological Distress ($R^2 = .232$).

In Model 2, Social Identity was added to the model. The inclusion of Social Identity significantly improved the model, with the final model explaining 25.0% of the variance in Psychological Distress ($R^2 = .250$).

Table 2: Hierarchical Regression Predicting Psychological Distress

Predictor	B	SE B	β	t	p
Model 1					
Surface Acting	0.069	0.007	.48	9.31	< .001
Deep Acting	-0.005	0.009	-.03	-0.57	.568
Model Statistics					
R^2	.232				
Adjusted R^2	.227				
$F(2,292)$	44.13***				
Model 2					
Surface Acting	0.070	0.007	.49	9.52	< .001
Deep Acting	-0.004	0.008	-.02	-0.46	.649
Social Identity	-0.105	0.040	-.13	-2.63	.009

<i>Model Statistics</i>					
R ²	.250				
Adjusted R ²	.242				
F (3,291)	32.32***				

Note. * $p < .05$, ** $p < .01$, *** $p < .001$

The findings indicated that Surface Acting emerged as a strong positive predictor of Psychological Distress across both models. Individuals who engaged in higher levels of surface acting reported significantly greater psychological distress.

Deep Acting did not significantly predict Psychological Distress in either model.

Social Identity emerged as a significant negative predictor of Psychological Distress in Model 2, indicating that stronger social identity was associated with lower levels of distress even after accounting for emotional labour dimensions.

DISCUSSION

The present study examined the relationship between emotional labour dimensions, social identity, and psychological distress among nurses from the North-East region of India working in Delhi NCR. Specifically, the study explored how surface acting, deep acting, and social identity contributed to psychological distress within the context of migrant nursing professionals working in metropolitan healthcare environments.

The findings demonstrated that surface acting emerged as a significant positive predictor of psychological distress. Nurses who reported higher levels of surface acting also reported greater psychological distress. This finding is consistent with emotional labour theory and previous research suggesting that surface acting is among the more psychologically demanding dimensions of emotional labour (Brotheridge & Grandey, 2002; Grandey, 2000; Zapf, 2002). Previous literature has similarly shown that suppressing genuinely experienced emotions while displaying institutionally expected emotional expressions contributes to emotional dissonance, emotional exhaustion, stress, and burnout among healthcare professionals (Morris & Feldman, 1996; Mann & Cowburn, 2005; Hülsheger & Schewe, 2011).

The findings suggest that the continuous suppression of authentic emotional experiences may contribute to cumulative psychological strain among migrant nurses working in emotionally demanding healthcare environments. Nursing professions require repeated emotional engagement with patients experiencing illness, pain, uncertainty, and vulnerability. Within such settings, the expectation to consistently maintain emotional composure, reassurance, empathy, and patience may become psychologically exhausting when displayed emotions do not align with internally experienced emotions. From a conservation of resources perspective, repeated efforts to monitor, suppress, and regulate emotional expressions may gradually deplete psychological resources over time, thereby increasing vulnerability to stress and psychological distress (Hobfoll, 1989).

The significance of surface acting becomes particularly important within the socio-cultural context of nurses from the North-East working in Delhi NCR. For many migrant nurses, emotional labour may extend beyond professional caregiving responsibilities and intersect with broader experiences of migration, cultural adjustment, and identity negotiation. Nurses working away from their home regions may simultaneously navigate workplace expectations, linguistic adjustment, separation from familial support systems, and experiences of stereotyping or social exclusion within metropolitan environments (McDuie-Ra, 2012; EP, Negi, AP, & A, 2022). In such contexts, emotional regulation may involve not only meeting professional expectations but also managing broader socio-cultural pressures associated with adjustment, visibility, and belongingness within culturally unfamiliar environments. Consequently, the emotional demands associated with surface acting may become particularly psychologically taxing for migrant healthcare professionals already negotiating multiple occupational and social stressors.

In contrast, deep acting did not significantly predict psychological distress. This finding is broadly consistent with previous literature suggesting that deep acting often demonstrates weaker or inconsistent associations with psychological strain compared to surface acting (Brotheridge & Grandey, 2002; Zapf, 2002). Unlike surface acting, deep acting involves attempts to genuinely align internal emotional experiences with professional expectations, thereby reducing the discrepancy between felt and displayed emotions.

It is also possible that within caregiving professions such as nursing, emotional engagement with patients may be perceived as an integral component of professional identity rather than merely an organizational

requirement. Deep acting involves attempts to genuinely align internal emotional experiences with externally displayed emotions, thereby reducing emotional dissonance and facilitating more authentic emotional engagement (Gross, 1998). In collectivistic socio-cultural contexts such as India, caregiving, empathy, and emotional responsiveness may additionally be viewed as socially meaningful and relationally valued practices (Markus & Kitayama, 1991). Consequently, deep acting may not necessarily produce the same degree of psychological strain as surface acting and may instead function as a comparatively adaptive emotional regulation strategy within caregiving interactions.

The study further found that social identity significantly predicted lower levels of psychological distress. Nurses who reported stronger social identity also reported comparatively lower distress levels. This finding aligns with social identity theory, which proposes that identification with meaningful social groups contributes positively to psychological wellbeing through belongingness, emotional support, collective meaning, and resilience (Haslam et al., 2009; Tajfel & Turner, 1979). Previous research has similarly demonstrated that shared social identification may function as an important psychological resource that buffers stress and promotes wellbeing among individuals experiencing social or occupational challenges (Jetten et al., 2012).

For migrant nurses working away from culturally familiar environments, social identity may function as an important source of emotional continuity, familiarity, and psychosocial stability. Identification with one's regional, cultural, or social community may provide emotional security and social connectedness within metropolitan contexts that may otherwise feel socially unfamiliar or demanding. Such identification may therefore help mitigate feelings of isolation and contribute positively to psychological wellbeing among nurses from the North-East working in Delhi NCR.

The findings of the present study therefore suggest that emotional labour dimensions and social identity represent distinct yet interconnected psychosocial processes associated with wellbeing among migrant nurses. While surface acting appears to reflect occupational emotional strain linked to emotional dissonance and caregiving demands, social identity appears to function as a psychosocial resource associated with belongingness, resilience, and emotional wellbeing.

Overall, the findings indicate that emotional wellbeing among migrant nurses cannot be understood solely in terms of occupational stress. Rather, emotional labour operates within broader socio-cultural contexts shaped by migration, belongingness, identity negotiation, and interpersonal adjustment. Understanding psychological distress among nurses from the North-East therefore requires attention not only to workplace emotional demands but also to the psychosocial realities surrounding migration and social integration within metropolitan healthcare environments. More broadly, research in applied healthcare settings highlights the importance of considering contextual factors and appropriate validation when interpreting evidence from clinical environments (Pandey, 2025).

The present study contributes to emotional labour literature in three important ways. First, it extends existing research to an underrepresented population within Indian psychology—nurses from the North-East working in metropolitan healthcare settings. Second, the study distinguishes between the differential psychological implications of surface acting and deep acting within a culturally complex caregiving context. Third, by situating emotional labour within broader experiences of migration, identity negotiation, and belongingness, the study contributes to culturally grounded understandings of occupational wellbeing among migrant healthcare professionals in India.

From an applied perspective, the findings suggest that healthcare institutions should recognize the psychological costs associated with excessive reliance on surface acting among nurses. Interventions aimed at promoting adaptive emotional regulation strategies, supportive workplace environments, and greater psychosocial inclusion may contribute positively to employee wellbeing. Healthcare institutions may additionally benefit from developing culturally sensitive workplace practices, peer support systems, psychosocial wellbeing interventions, and migrant-sensitive organizational policies that acknowledge the unique experiences of nurses working away from familiar social and cultural support systems.

IMPLICATIONS

The present study has several practical implications for healthcare institutions and organizational wellbeing initiatives. First, the findings highlight the importance of addressing emotional labour as a significant occupational health concern within nursing professions. Training programs focusing on adaptive emotional regulation strategies may help reduce emotional dissonance and psychological strain associated with surface acting.

Second, the findings emphasize the importance of creating supportive and socially inclusive workplace environments for migrant healthcare professionals. Hospitals and healthcare organizations may benefit from implementing peer support networks, culturally sensitive supervision practices, and institutional mechanisms that promote belongingness and psychosocial support among nurses from diverse socio-cultural backgrounds.

Third, the study underscores the importance of recognizing the differential psychological implications of emotional labour dimensions. While surface acting appears associated with psychological strain, deep acting may function as a comparatively adaptive emotional regulation strategy within caregiving professions. Organizational interventions should therefore move beyond generalized understandings of emotional labour and instead recognize the distinct emotional consequences associated with different emotional regulation processes.

Finally, the findings highlight the broader need for migrant-sensitive organizational policies within metropolitan healthcare systems. Addressing issues related to inclusion, cultural sensitivity, workplace discrimination, and psychosocial wellbeing may contribute positively not only to employee mental health but also to overall institutional functioning and quality of patient care.

LIMITATIONS AND FUTURE DIRECTIONS

Despite the contributions made by this study, there exist some limitations that need to be addressed. First, because of the nature of this design, causality cannot be concluded since it is impossible to establish the direction of the effects between emotional labor, social identities, and distress levels. In addition, this study only used self-reporting scales as means of data collection.

This implies that there may be a chance of response distortion through social desirability bias. Third, although this study used macro-level identity (the 'North-East Region') for the purposes of this research, the region is very heterogeneous as it comprises eight separate states with unique micro-level social identities, such as ethnicity, tribes, languages, and religion. Further studies should utilize qualitative or mixed methods approaches to examine the effects of these particular identities.

CONCLUSION

The present study found that nurses from the North-East working in Delhi NCR who engaged more frequently in surface acting reported higher levels of psychological distress, whereas deep acting appeared to be comparatively less psychologically harmful. Social identity also emerged as an important protective factor, with stronger feelings of belongingness and group identification being associated with lower psychological distress and better emotional wellbeing.

Overall, the findings highlight that emotional wellbeing among migrant nurses cannot be understood only in terms of workplace stress or professional demands. The emotional experiences of nurses are also shaped by broader socio-cultural realities such as migration, adjustment to unfamiliar environments, identity negotiation, social belongingness, and experiences of inclusion or exclusion within metropolitan settings.

By locating emotional labour within the everyday lived experiences of nurses from the North-East working in urban healthcare environments, the present study contributes to a more culturally grounded understanding of occupational wellbeing in India. The findings further underscore the importance of developing healthcare environments that are not only professionally supportive but also socially inclusive, culturally sensitive, and responsive to the psychosocial needs of migrant healthcare professionals.

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